

Hanging Out or Hooking Up:

An Integrated Approach to Prevention and Intervention



A Train the Trainers Curriculum on Responding to Adolescent Relationship Abuse

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ABOUT THE NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE

For more than two decades, the National Health Resource Center on Domestic Violence has supported health care practitioners, administrators and systems, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence. A project of Futures Without Violence, and funded by the U.S. Department of Health and Human Services, the Center supports leaders in the field through ground breaking model professional, education and response programs, cutting-edge advocacy and sophisticated technical assistance. The Center offers a wealth of free culturally competent materials that are appropriate for a variety of public and private health professions, settings and departments.

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- 6) Olivia: Forced Sex Identified During Visit/Trauma Informed Mandatory Reporting

INTRODUCTION

Futures Without Violence, a leading advocate for addressing intimate partner violence (IPV) in the health care setting, has worked over many years to develop evidence- and practice-based, adolescent-appropriate guidance and tools to address adolescent relationship abuse (ARA). Through *Project Connect: A Coordinated Public Health Initiative to Prevent Violence Against Women (Project Connect)*, a national public health initiative funded by the U.S. Department of Health and Human Services' Office on Women's Health to prevent domestic and sexual violence in reproductive, perinatal/MCH, and adolescent health settings, state level partners across the country are training their adolescent health providers on how to respond to adolescent relationship abuse. ***Hanging Out or Hooking Up: An Integrated Approach to Prevention and Intervention in Adolescent Relationship Abuse: A Train the Trainers Curriculum*** has been developed to guide and support health care providers in addressing the issues of relationship quality and safety in the context of adolescent health visits.

This training curriculum has been developed to assist health care providers in enhancing their skills working with youth to promote healthy relationships, assess for and respond to adolescent relationship abuse. The curriculum provides training, tools, and resources to help adolescent health providers address the complex and sometimes uncomfortable issue of relationship quality with adolescents. When it comes to promoting health and safety outcomes for young people, there is a methodology to effective assessment, primary prevention, and anticipatory guidance messaging during health care visits. What a provider says and how it is said—whether through universal education or by direct assessment—matters and can make a difference for young people learning about relationships or experiencing relationship abuse. First, adolescent health providers need education about the impact of abusive relationships on young people's physical and mental health outcomes. They also require tools to support assessment and conversations about adolescent relationship abuse. This curriculum provides simple tools to support assessment and education through the use of scripts and safety cards during primary care and reproductive health care visits. These tools have been designed to facilitate safety assessment and supported referrals to domestic violence programs. Our hope is that every provider serving adolescents, from private pediatricians to school-based health centers and family planning clinics will integrate these approaches and tools into their routine care for youth to support them in forming healthy relationships and create futures without violence.

System wide changes in practices will only be implemented and sustained when there are tangible changes in policies and the infrastructure to support these changes. A Quality Assessment/Quality Improvement (QA/QI) tool is also included to guide managers and policymakers in implementing and evaluating a trauma-informed, coordinated response to ARA in the adolescent health care setting. The QA/QI tool can help clinics and programs to identify their goals and monitor their progress.



BACKGROUND

In October, 2009, Futures Without Violence (Futures) convened a round table discussion of leading experts in the fields of reproductive health and intimate partner violence (IPV) to discuss the clinical and policy implications of addressing IPV and reproductive coercion (RC) within the context of reproductive health visits. The round table discussion and consultations with reproductive health experts highlighted the need for a resource that provides basic guidelines and tools for addressing RC in the reproductive health care setting.

In June 2010, California Adolescent Health Collaborative, in partnership with Futures and University of California Davis School of Medicine, received funding from the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice to develop a toolkit and accompanying in-person training for California health care providers for addressing adolescent relationship abuse in the clinical setting. Over the course of a year, The Healthcare Education, Assessment, and Response Tool for Teen Relationships (HEART) Primer and Training Program provided training to over 500 providers throughout the state of California. In response to these projects, driven by twenty years of data that make the connection between violence and poor reproductive health outcomes, Futures developed this training curriculum, a companion to our *Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse*. The goal of this resource is to reframe the way in which health care systems respond to adolescent relationship abuse (ARA) such that the adolescent health care provider is the hub in a wheel of a trauma-informed, coordinated health care response.

In the summer of 2011, the Institute of Medicine (IOM) issued guidelines that include screening for domestic and interpersonal violence as a core component of preventive health services for women and adolescent girls. The recommendations require that new health insurance plans cover domestic violence screening without co-pay and were adopted by the Department of Health and Human Services. Since August of 2012, domestic violence screening and counseling have been reimbursed as part of preventive health care services at no additional cost to patients.

Further support for screening for IPV comes from the US Preventative Services Task Force (USPSTF), an independent panel of non-Federal experts in prevention and evidence-based medicine that conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health care providers. The USPSTF found sufficient evidence for the value of routine screening and follow up for intimate partner violence to issue a Grade B¹ recommendation: “The USPSTF recommends the use of a validated tool to screen women of childbearing age for IPV and follow up with any woman with a positive screen”.²

1 The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.”

2 USPSTF Clinical Guideline, Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med. 2013;158:478-486.

Specific recommendations that address screening in reproductive health care were provided by the American College of Obstetricians and Gynecologists (ACOG). ACOG's February 2013 Committee Opinion on Reproductive and Sexual Coercion recommends that OB/GYNs routinely screen women and adolescent girls for reproductive and sexual coercion.³

To meet these governmental and professional guidelines and requirements, health care providers need to understand how to routinely assess for and respond to victims of violence. ARA involves dynamics that are distinct from adult dynamics, and adolescents are a special population that requires unique skills and approaches.

3 Committee opinion no. 554: reproductive and sexual coercion. *Obstetrics and gynecology*, 121(2 Pt 1), 411-415. 3, 2013

HOW TO USE THIS TRAINERS CURRICULUM

This curriculum has been designed for programs and providers serving adolescents, and is focused on developing provider's skills and broadening their thinking through interactive exercises and activities.

THE CURRICULUM INCLUDES:

- Overview of how to use the PowerPoint slides, instructions for training, exercises, and directions for small group activities
- A Companion DVD, which includes participant handouts, assessment tools, and video vignettes
- Samples of the *Hanging Out or Hooking Up* materials

Each module in this curriculum covers a separate topic so that you can include all of the content or delete some modules based on the training needs of your audience and the time available for the training. There are several factors that will influence the length of your training when you use these slides. Factors include:

- Whether you include all of the modules
- If you adjust the time allowed for interactive activities
- How much time you allow for questions and answers
- The amount of local/regional data and information that you add to your presentation

Intended audience:

This curriculum was designed for health care providers working with adolescents in a range of settings and programs. It can be adapted for youth counselors, mental health providers, social service workers and educators. *It is important to note, however, that the video vignettes all model health care provider/youth interactions, and when utilizing this training with non-health care provider participants, adaptations to the approach modeled in the vignettes should be discussed.*

Participant familiarity with adolescent relationship abuse:

Participants receiving this training should have a basic understanding of domestic violence and adolescent relationship abuse. However, there is considerable variability among youth providers in terms of how much training they have received. Domestic violence advocates at local shelters and advocacy programs **that serve adolescents** are an excellent resource to contact for domestic violence training and information.

If your audience has not had domestic violence and ARA training before or would benefit from a basic overview, partner with your local advocacy organization or state domestic violence coalition for training materials to provide an overview of ARA, including definitions and dynamics.

Special notes about PowerPoint:

For those who have not used PowerPoint previously, as you look at the modules in the curriculum, each page shows both the PowerPoint slide view (top half of the page) and the Notes Page view (bottom half of the page). Speaker's notes for slides are provided in the Notes Page view of PowerPoint. Information provided in the Notes Page view includes: sources of data cited and a synopsis of research findings, and recommendations on how to: facilitate discussion of the data/information reviewed in the slide; incorporate the exercises to support participant learning; and use the tools and handouts during the training.

If you have not used the Notes Page view in PowerPoint before, it can be accessed either by selecting the tab called "View" or the tab called "Slideshow" across the top of your computer screen and then selecting the "Presenter View" option. This means that you can access the speakers' notes during your presentation or while you are preparing for a presentation by changing the view on your screen in PowerPoint.

Time needed for training modules:

- If all of the training modules are used, this is an all-day training.
- We strongly suggest working with another trainer as a team. Ideally this team would include a domestic violence advocate and an adolescent health care provider.
- The curriculum is designed to be flexible. Each module can be used separately so it is possible to do a series of trainings.
- Each module has its own learning objectives. The modules vary in length depending on the topic.
- Modules include discussion questions and/or activities, which will influence the length of the training depending on how much time is allowed for these interactive components. While estimated times are provided for discussions and activities, these times could be extended so that the training event is more than one day in length.

Trainer's tip: There are many variables that influence the length of the training including the familiarity of the trainer with the material, the size of the audience, and the time allowed for discussion and activities. Consider doing a practice training with co-workers to become familiar with the content and activities in this curriculum. We strongly recommend that you keep the interactive activities in place for optimal adult learning.



Materials needed to conduct training:

(Many of these resources may be downloaded at www.FuturesWithoutViolence.org or ordered from our online catalog for a small shipping and handling fee.)

- Trainer's Curriculum, PowerPoint slides and DVD
- *Hanging Out or Hooking Up* Teen Health Safety Cards (available at www.FuturesWithoutViolence.org)
- *Hanging Out or Hooking Up*: Clinical Guidelines on Responding to Adolescent Relationship Abuse: An Integrated Approach to Prevention and Intervention (available at www.FuturesWithoutViolence.org)
- PowerPoint set-up: laptop with DVD player or laptop and external DVD player, LCD projector and screen, power cords, and extension cords if needed
- External speakers for playing DVDs (this is very important to have so that your audience can hear the content of the video clips and DVDs)
- Flip-chart with stand and markers
- Masking tape to tape completed flip-chart sheets around the room
- Copies of handouts including the Pre- and Post-training
- All participants should have a pen or pencil and a few sheets of note paper

Technical skills for trainers:

If trainers are not already comfortable using PowerPoint, trainers will need to become familiar and comfortable with this in order to provide training. A copy of the PowerPoint presentation can be downloaded at www.FuturesWithoutViolence.org. It is always important to be prepared for possible equipment issues such as getting your computer to mesh with a LCD projector, so test the equipment ahead of time. Also, consider having a back-up projector and/or an extra bulb for the projector available during the training.

Trainer's Tip: Review the notes *before* the training and add tabs or markers for information in the notes that you want to highlight during the training.



How this trainer's curriculum is organized:

Each training module comprises a separate section in this guide, which includes:

- Estimated time
- Learning objectives
- Instructions for exercises and activities
- Trainer's Notes with additional supporting information or points to emphasize
- References for studies (in alphabetical order by author's last name by module)

Important notes for trainers:

- Due to the high prevalence of domestic violence and reproductive coercion among women in the general population, many participants may have had direct or indirect experiences with abuse.
- This type of training can trigger painful memories and feelings for participants. Talking about domestic violence, relationship abuse, reproductive coercion, and the effects of ARA on adolescents are sensitive topics that can be emotional regardless of whether a person has had any direct experiences with abuse.
- Invite domestic violence advocates from your local/regional domestic violence program/shelter to participate in the training. They can provide the latest information on resources, contact information, and invaluable insights into the topics being discussed. Including domestic violence advocates in your training can help to build partnerships between adolescent providers and local domestic violence service providers.
- It is also advisable, whenever possible, to have a domestic violence advocate available during this type of training to talk to any participants who need additional support. If this is not possible, have the number of a local/regional DV program available during the training.
- Remember to be watchful of participants' reactions to the content of this training. Check-in during breaks with any participant that you think may be having difficulties during the training. Give extra breaks as needed, consider turning the lights down if someone is struggling with emotions, give participants an opportunity to debrief, and incorporate breathing and stretching exercises to reduce stress.

Training site:

- If possible, visit the location for the training ahead of time to determine equipment needs and considerations such as where the projector and laptop will be located, tables/carts for the projector and laptop, if extension cords are needed and what type, where the screen will go, etc.
- Whenever possible, round-tables or other flexible seating arrangements are recommended versus traditional classroom seating to facilitate group work and discussion.
- Assess parking options, location of restrooms, places to eat if lunch is not provided, and any information that you need to share with participants prior to the training.
- Provide refreshments if possible.

Trainer's Tip: To find more information about a study that has been referenced in a slide, paste the citation into your search bar (to be automatically redirected to the article in "PubMed") or go to www.ncbi.nlm.nih.gov/pubmed/ or use a search engine for the term "pub med." Once you are in Pub Med, you can enter the author's name and a word or two from the title of the publication to obtain a listing of publications for that author. Once you have identified the publication you are looking for, you can click on that title to access and print an abstract for that article at no cost. Many, but not all, full-text articles are available for free. If you want to purchase the article, that information is often provided. Journal publications can also be accessed and copied at medical and university libraries.

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SAMPLE FULL DAY AGENDA

As a result of attending this training, participants will be better able to:

- Promote healthy relationships through universal education in their health settings,
- Provide targeted assessment for reproductive coercion with sexually active young women
- Connect patients experiencing violence to community resources
- Balance adolescent safety and confidentiality with mandated reporting requirements, and
- Identify 3 strategies to reduce secondary traumatic stress

9:00 - 9:30 am Welcome & Introduction

9:30 - 10:15 am Making the Connection: The Impact of Adolescent Relationship Abuse on Health Outcomes

10:15 - 10:30 am BREAK

10:30 - 11:40 am “I talk about this with all my patients...”: Providing Universal Education on Healthy Relationships

11:40 - 12:00 pm Beyond Anticipatory Guidance: Targeted Use of the Safety Card

12:00 - 1:00 pm LUNCH

1:00 - 2:30 pm “Is this happening in your relationship?”: Direct Assessment for Reproductive Coercion with Sexually Active Young Women

2:30 - 3:00 pm “What will happen when you tell him you have an STI?”: Safer Partner Notification

3:00 - 3:15 pm BREAK

3:15 - 3:45 pm Building Bridges Between Adolescent Health and Domestic Violence Advocacy

3:45 - 4:10 pm Preparing Your Program: Supporting Staff Exposed to Violence

4:10 - 4:30 pm Closing, Resources and Evaluation

SAMPLE HALF DAY AGENDA

See sample slide set on trainer's CD: "Project Connect Half Day Training"

This session is intended for health settings unable to accommodate a full day of training. We recommend follow-up trainings to cover additional content.

As a result of attending this training, participants will be better able to:

- Promote healthy relationships through universal education in their health settings,
- Provide targeted assessment for reproductive coercion with sexually active young women
- Connect patients experiencing violence to community resources
- Balance adolescent safety and confidentiality with mandated reporting requirements, and
- Identify 3 strategies to reduce secondary traumatic stress

8:30 – 8:50 am Welcome & Introduction

8:50 – 9:20 am Making the Connection: The Impact of Adolescent Relationship Abuse on Health Outcomes

9:20 – 10:00 am "I talk about this with all my patients...": Providing Universal Education on Healthy Relationships

10:00 – 10:15 am BREAK

10:15 – 11:30 am "Is this happening in your relationship?": Direct Assessment for Reproductive Coercion with Sexually Active Young Women

11:30 – 12:00 pm Building Bridges Between Adolescent Health and Domestic Violence Advocacy

12:00 – 12:15 pm Preparing Your Program: Supporting Staff Exposed to Violence

12:15 – 12:30 pm Closing, Resources and Evaluation

SAMPLE ONE HOUR SESSION

See sample slide set on trainer's CD: "Project Connect Introductory Session"

This session is intended to introduce participants to the intervention. We recommend additional training and/or technical assistance before implementing the intervention.

NOTE: You will be covering the "Hanging out or Hooking up?" card only

- 9:00 – 9:05 am** Welcome & Introduction
- 9:05 – 9:15 am** Making the Connection: The Impact of Adolescent Relationship Abuse on Health Outcomes
- 10:30 – 11:40 am** "I talk about this with all my patients...": Providing Universal Education on Healthy Relationships
- 9:40 – 9:50 am** Building Bridges Between Adolescent Health and Domestic Violence Advocacy
- 9:50 – 10:00 am** Resources and Next Steps

Module 1: Adolescent Relationship Abuse is an Adolescent Health Issue



Promoting Healthy Relationships and Responding to Adolescent Relationship Abuse in Adolescent Health Programs

Estimated Total Training Time: 5 hours and 30 minutes

(Depending on the amount of discussion time and activities)

Notes to Trainer: There are many variables that influence the length of this training, including the familiarity of the Trainer with the material, the size of the audience, and the time allowed for discussion and activities. It is important to include elements of interactivity (group discussion, video vignettes, role plays, etc.) for optimal adult learning and to avoid overloading the participants with didactic material. We suggest that you schedule AT LEAST 1 break during the training, with an opportunity to stretch, eat, and socialize. Remember that this is difficult content and participants will need a “breather.”





Adolescent Relationship Abuse is a Adolescent Health Issue

Estimate Module Time: 25 minutes

Training Outline

- Pre-training Survey
- Workshop Guidelines
- Introduction to Project Connect
- Review the importance of addressing adolescent relationship abuse (ARA) in adolescent health programs

Overview

The purpose of this module is to help the learner understand how universal education and assessment for adolescent relationship abuse (ARA) can make a difference in the lives of adolescents. The module makes the case for adolescent health care providers – showing how ARA is connected to many other adolescent health program outcome goals and that clinics that serve adolescents are strategic sites for adolescent health promotion, prevention, and intervention.



Please Complete the Pre-Training Survey



Module 1

Estimated Activity Time: 5 minutes

Hand-out the pre-training survey for participants to complete and advise them that they will be asked to do a post-training survey at the end of the training. Allow approximately five minutes for participants to complete the survey. Advise participants that they do not need to put their names on the surveys and that their responses are confidential.

Workshop Guidelines

- Because family violence is so prevalent, assume that there are survivors among us.
- Be aware of your reactions and take care of yourself first
- Respect confidentiality
- Please turn off your phones, laptops, tablets, etc.



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Notes to Trainer: It is very helpful to have a domestic violence advocate present or on call when you are doing a training on domestic violence. This type of training can trigger painful memories while also creating the opportunity for survivors to process their feelings and experiences.

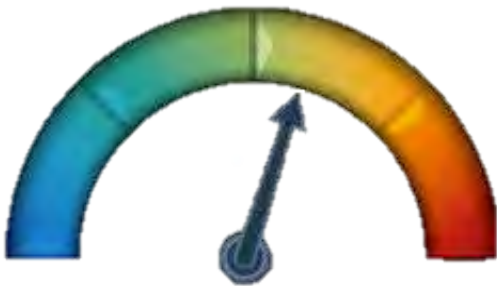
Discuss confidentiality, specifically - “what we say here, stays here.” Information that participants may choose to disclose in the workshop should NOT be shared outside of the room.

Encourage participants to do what they need to feel safe and comfortable throughout the training such as leaving the room and taking unscheduled breaks. They may also approach one of the Trainers at breaks or lunch to talk about issues. As a Trainer, you should anticipate that survivors will come forward and want to talk to you, or an advocate for support.

Remain aware of anyone who may be reacting to or be affected by the content of the training. Consider giving extra breaks after particularly sensitive material, or when you observe that someone is having a difficult time. Connect with that person during the break to check-in and ask if he or she would like to talk with someone and determine how follow-up can occur.

“Where Am I?”

- Draw a “comfort meter”
- On the left end of the meter is “not at all comfortable”
- On the right end of the meter is “very comfortable”



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Estimated Activity Time: 2-3 minutes

Ask participants to follow the directions below. Advise them that they do not have to share what they draw/write.

1. Take out a sheet of paper and draw a line with the words “not at all comfortable” on the far left side of their line and the words “very comfortable” on the far right side of their line.
2. Ask participants to take a minute to think about their current comfort level with talking to adolescent patients about ARA—and if he or she feels comfortable asking questions and getting a “yes” as the answer.
3. Discuss how the goal at the end of today’s session is that each person has personally moved that needle toward the ‘very comfortable’ end of the scale.
4. Advise participants that this exercise will be repeated at the end of today’s session and that you will ask them to consider whether the needle moved as a result of the training, where it moved, and their thinking about this in the context of what they have learned.

The “Where Am I?” exercise is followed by small group discussion (see next slide) to help participants identify and share why it is important to know about ARA.

Getting
Started:
Small Group
Discussion

Why is it important for adolescent health providers to know about Adolescent Relationship Abuse (ARA)?



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Estimated Activity Time: 10 minutes

1. Ask participants to discuss this question for five minutes, breaking up into small groups of 2 or 3, if feasible. Instruct each group to prepare a two-sentence answer.
2. Ask each group to share their answers (or just 1-2 groups if there is a large number of participants).
3. Go to the next slide, which describes how domestic violence is connected to the goals of many family planning and adolescent health programs.

ARA negatively impacts meeting adolescent health program goals such as:

- Reducing unplanned pregnancy
- Preventing sexually transmitted infections
- Reducing unprotected sex
- Promoting health and safety, including mental health



Notes to Trainer: These are common goals among many adolescent health programs. There is an extensive body of research that has shown adolescent relationship abuse is connected to each of these outcomes. These connections will be described in this training.

For women, being in an abusive relationship increases the likelihood of:

- Her having multiple sex partners
- Inconsistent or nonuse of condoms
- Unprotected anal sex
- Having a partner with known HIV risk factors
- Exchanging sex for money, drugs, or shelter
- Alcohol or drug use before sex

Adolescent relationship abuse is rarely identified in clinics serving adolescents, but is common among adolescents seeking clinical services.

(Miller et al, 2010; Asheley & Foshee, 2005; Schoen et al, 1991)

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Notes to Trainer: As adolescent care-seeking and health care utilization differ significantly from those of adults, clinics that serve adolescents, such as confidential teen clinics and school health centers, are strategic sites for adolescent health promotion, prevention, and intervention.

- Adolescent females utilizing teen clinics, school health centers, and reproductive health clinics report higher rates of physical and sexual victimization in their dating relationships than adolescents in the general population.
- In adolescent clinic-based samples, the lifetime prevalence of physical and/or sexual violence in dating relationships is about 1.5 to 2 times greater than population-based estimates, ranging from 34% to 53%.

Miller E, Decker MR, Raj A, Reed E, Marable D, Silverman JG. (2010). Intimate Partner Violence and Health Care-seeking Patterns among Female Users of Urban Adolescent Clinics. *Maternal and Child Health Journal*, 14(6):910-917.

Ashley OS, Foshee VA. (2005). Adolescent Help-seeking for Dating Violence: Prevalence, Sociodemographic Correlates, and Sources of Help. *Journal of Adolescent Health*, 36(1):25-31.

Schoen C, Davis K, Scott-Collins K, Greenberg L, Des Roches C, Abrams M. The Commonwealth Fund Survey of the Health of Adolescent Girls [Internet]. The Commonwealth Fund; 1997 [cited 2011 Jan 4]. Available from:

<http://www.commonwealthfund.org/Content/Publications/Fund-Reports/1997/Nov/The-Commonwealth-Fund-Survey-of-the-Health-of-Adolescent-Girls.aspx>

By conducting an assessment and a brief intervention, health care providers can dramatically decrease risk for violence AND unplanned pregnancy.

(Miller et al, 2011)



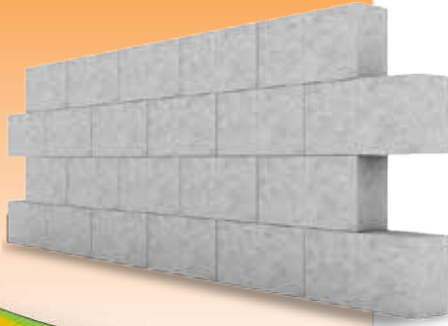
Notes to Trainer: Adolescent health care providers play an essential role in violence prevention by discussing healthy, consensual, and safe relationships with all patients.

Health care providers serving adolescents can:

- offer confidential, safe spaces in which to discuss behaviors that may be abusive and that may be affecting a young person's health,
- have discussion in the clinical context of how abusive behaviors are linked to health risk, helping to facilitate adolescents' recognition of ARA,
- introduce harm reduction behaviors to increase safety and protect their health, and
- connect adolescents resources to help them stay safe

Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. (2011). A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. *Contraception*, 83 (3):274-80.

Barriers to Identifying and Addressing ARA



- Providers identified the following barriers:
 - Comfort levels with initiating conversations with patients about ARA
 - Feelings of frustration with patients when they do not follow a plan of care
 - Not knowing what to do about positive disclosures of abuse
 - Worries about mandatory reporting
 - Lack of time



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Estimated Activity Time: 5 minutes

Notes to Trainer: This Train the Trainer toolkit is designed to address the barriers identified by adolescent health care providers in the field.

Large group discussion: What might get in your way when addressing relationship abuse?

- Ask participants to identify ***their personal barriers*** in addressing relationship abuse.
- Ask participants to think about ***structural or process barriers*** that may exist in their service sites.



**Module 2: Making the
Connection:
The Impact
of Adolescent
Relationship
Abuse on Health
Outcomes**



Making the Connection: The Impact of Adolescent Relationship Abuse on Health Outcomes

Estimated Module Time: 45 minutes

(Depending on the amount of discussion time and activities)

Training Outline

- Learning Objectives
- Definition of Adolescent Relationship Abuse (ARA) and magnitude of problem
- Adolescent vulnerability to ARA
- Social networking and media as a form of controlling behavior
- Relationship between ARA and adolescent health and well-being
- Relationship between ARA and adolescent pregnancy

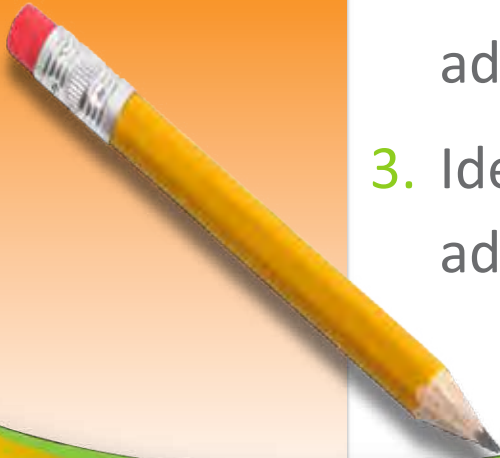
Overview

This module presents an overview of the data on the prevalence and health consequences of ARA.

Learning Objectives

As a result of this activity learners will be better able to:

1. Define Adolescent Relationship Abuse (ARA)
2. Identify three ways ARA affects adolescent health
3. Identify two ways that ARA impacts adolescent pregnancy



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Notes to Trainer: Read the learning objectives aloud. Remind the participants that this section will give a context for today's training – establishing common definitions and building the case for why it is important to address ARA in the health setting. The rest of the day will focus on specific clinical interventions for adolescent health providers.

A pattern of repeated acts in which a person physically, sexually, or emotionally abuses another person of the same or opposite sex in the context of a dating or similarly defined relationship, in which one or both partners is a minor.



Notes to Trainer: This is the definition of adolescent relationship abuse. Read the definition aloud and/or allow time for participants to read the slide.

While ARA is included in the definition of intimate partner violence, experts in the field have noted that while many aspects of ARA are similar to IPV, there are also distinct characteristics relative to the age of the victim and/or perpetrator and different patterns of abusive behaviors.

- Similar to adult intimate partner violence, the emphasis on repeated controlling and abusive behaviors distinguishes relationship abuse from isolated events (e.g. a single occurrence of sexual assault at a party with two people who did not know each other).
- Sexual and physical assaults often occur in the context of relationship abuse, but the defining characteristic is a repetitive pattern of behaviors aiming to maintain power and control in a relationship. Such behaviors can include monitoring cell phone usage, telling a partner what she/he can wear, controlling whether the partner goes to school that day, and interfering with contraceptive use.

Hanging Out of Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse, An Integrated Approach to Prevention and Intervention, Second Edition. San Francisco, CA: Futures Without Violence. 2013.

“I talk to all my patients about this because we know...”

1 in 5 (20%) U.S. teen girls report having experienced physical and/or sexual violence in an intimate relationship.

(Silverman et al, 2001)



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Notes to Trainer: With data slides such as this one, try to make the connection to the participant’s practice. For example, “this means that if you see 20 young people a day, it is likely that at least 4 of them have experienced physical or sexual abuse in their relationship...and this doesn’t even begin to reflect those young people who experience verbal, psychological or emotional abuse or sexual coercion...”

Silverman JG, Raj A, Mucci LA, Hathaway JE. (2001). Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality. *Journal of the American Medical Association*, 286(5): 572-579.



Each year in the U.S. at least
400,000 adolescents
experience serious physical
and/or sexual violence in a
dating relationship.

(Wolitzky-Taylor et al, 2008)



Notes to Trainer: ARA is a pervasive and persistent problem that has major implications for girls, young women, and society at large.

This suggests that it would be good practice to use normalizing language in your discussion with adolescents. For example, *"I talk to all my patients about this because we know that..."* and then you can cite a statistic such as: 1 in 5 teen girls report having been sexually or physically hurt by a partner.

Wolitzky-Taylor KB, Ruggiero KJ, Danielson CK, Resnick HS, Hanson RF, Smith DW, Saunders BE, Kilpatrick DG. (2008). Prevalence and Correlates of Dating Violence in a National Sample of Adolescents. *Journal of American Academy of Child and Adolescent Psychiatry*, 47(7):755-762.

Group Discussion

- How do you think experiencing violence is different for adolescents than adults?
- Why do we need different tools and interventions when working with youth?



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Estimated Activity Time: 10 minutes

1. Depending on the size of your group, ask participants to discuss this question for five minutes in small groups, or discuss together as a large group.
2. If breaking into groups, instruct them to prepare a two-sentence answer. Ask each group to share their answers.
3. Go to the next slides which describe adolescent vulnerability to ARA.

Adolescent Relationship Abuse

VS.

Teen Dating Violence



Notes to Trainer: The term 'Teen Dating Violence' doesn't accurately represent the full spectrum of risky or unhealthy relationships. Adolescent Relationship Abuse is much broader in scope and encourages providers to keep conversations open when framing discussions with patients about relationships. Also, the term 'abuse' includes a wider spectrum of controlling behaviors (i.e., emotional/psychological, social, financial, sexual, and physical) than 'violence.'

Keep in Mind:

- Adolescence spans a LONG time (ages 10 – 24), not just “teens”
- ARA is inclusive of a range of abusive behaviors (not only violence)



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**“Are you hanging out
with anyone?”**

**“Are you seeing
anyone right now?”**



Notes to Trainer: Ask participants to think about how often you hear from adolescents that they are dating.

Adolescents use a lot of different words for dating and romantic relationships. These relationship can be a fleeting occurrence or more long term. Therefore, it's important for providers to note that if they ask a question like, “Are you dating anyone?” and get a ‘no’, that it doesn’t mean that the young person is not at risk. The adolescent may use different terminology to describe it like ‘hanging out’, ‘hooking up’, ‘seeing someone’, or ‘talking’ instead of dating. Keep conversations open when framing discussions with patients about relationships.

Keep in Mind:

- Interventions need to be developmentally appropriate
- Opportunity for youth and young adults to define diverse “romantic relationships” (e.g., “going out”; “hooking up”; “talking to”; “seeing someone”)

What Makes Adolescents Especially Vulnerable for Abuse?



Estimated Activity Time: 5 minutes

1. Ask participants to discuss this question for five minutes, breaking up into small groups, if feasible. Instruct groups to prepare a two-sentence answer.
2. Ask each group to share their answers.

Notes to Trainer: Add/emphasize any of the following that are not identified in the small groups.

Adolescents:

- Are inexperienced with romantic relationships
- Want independence from parents
- Have romanticized views of love, often informed by media images
- Are pressured by peers to have dating relationships
- Are more likely to turn to a friend than a parent or other adult when they experience dating violence

Previous exposure to abuse (child abuse and/or witnessing DV)

Being YOUNG (16-24y.o.)

Substance involvement

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Notes to Trainer: These are the risk factors that are consistently found in the research literature.

- Lifetime exposure to violence increases the risk of being a victim or perpetrator
- Youth between the ages of 16-24 have the highest rates of intimate partner violence
- Youth also have higher rates of alcohol and drug use, which can contribute to unhealthy relationships.

What do we know about the impact of adolescent relationship abuse on health?



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Estimated Activity Time: 5 minutes

1. Ask participants to discuss this question for five minutes, breaking up into small groups, if feasible. Instruct groups to prepare a two-sentence answer.
2. Ask each group to share their answers.

Technology as a Tool For Exerting Power and Control

- **One in four teens** in a relationship report having been called names, harassed, or put down by their partner via cell phone/texting (Zweig et al, 2013)

- **One in five teen girls** have electronically sent or posted nude/semi-nude photos or videos of themselves (12% of these girls say they felt 'pressured' to do so)

(The National Campaign to Prevent Teen and Unplanned Pregnancy and CosmoGirl.com, 2008)



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Notes to Trainer: Electronic relationship abuse is a prevalent form of controlling behavior among youth in romantic relationships. That's why it's important to go broad with your conversations and educational materials with adolescents.

A 2013 study by the Urban Institute, published in the *Journal of Youth and Adolescence* found:

- Girls in a relationship are victimized more often than boys, especially when the abuse is sexual. Approximately 15 percent of girls report sexual electronic abuse, compared with 7 percent of boys.
- Tampering with a partner's social media account is the most prevalent form of electronic abuse. More than one in twelve teens in a relationship (8.7 percent) say their partner used their social networking account without their permission.
- Acts of sexual electronic abuse are the second and third most-reported complaints. Approximately 7 percent of teenagers say their partner sent them texts and/or emails asking them to engage in unwanted sexual acts. The same percentage says their partner pressured them to send a sexually explicit photo of themselves.
- Schools are relatively free from electronic harassment, but remain the centers for physical and psychological abuse. Most electronic harassment happens before or after school; only 17 percent of the teens who report electronic harassment say they experienced it during school hours.

Zweig, J M, Dank, M, Yahner, J, et al. (2013). The Rate of Cyber Dating Abuse Among Teens and How It Relates to Other Forms of Teen Dating Violence. *Journal of Youth and Adolescence*, 42(7): 1063-1077. The National Campaign to Prevent Teen and Unplanned Pregnancy and CosmoGirl.com. (2008). Sex and Tech: Results from a Survey of Teens and Young Adults. Available at http://www.thenationalcampaign.org/sextech/PDF/SexTech_Summary.pdf.

Technology-based harassment is a red flag for other abuse

- **84%** of the teens who report cyber abuse said they were also psychologically abused by their partners
- **52%** say they were also physically abused
- **33%** say they were also sexually coerced (Zweig et al, 2013)



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Notes to Trainer: Electronic harassment is a red flag for other types of abuse.

- Roughly 1 out of 12 teens report being both perpetrators and victims of cyber abuse. Approximately 8 percent of teens say they were subjected to cyber abuse, but also said they treated their partners the same way.

Zweig, J M, Dank, M, Yahner, J, et al. (2013). The Rate of Cyber Dating Abuse Among Teens and How It Relates to Other Forms of Teen Dating Violence. *Journal of Youth and Adolescence*, 42(7): 1063-1077.

Young women who have experienced abuse have higher rates of:

- Depression and anxiety
- Disordered eating
- Suicidality
- Substance abuse



(Kim-Godwin YS, et al, 2009; Howard DE, et al, 2008; Brossarte RM, et al, 2008; Ackard DM & Neumark-Sztainer D, 2002)

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Notes to Trainer: The presence of mental health issues such as depression, thoughts of suicide, substance abuse and disordered eating may be clinical indicators to assess for ARA.

- Teens experiencing teen dating violence are more likely to suffer long-term negative behavioral and health consequences, including suicide attempts, depression, cigarette smoking and marijuana use.
- Teen victims of physical dating violence are more likely than their non-abused peers to engage in unhealthy diet behaviors (taking diet pills or laxatives or vomiting to lose weight).

Kim-Godwin YS, Clements C, McCuiston AM, Fox JA. (2009). Dating violence among high school students in southeastern North Carolina. *Journal of School Nursing*, 25(2):141-151.
Howard DE, Wang MQ, Yan F. (2008). Psychosocial factors associated with reports of physical dating violence victimization among U.S. adolescent males. *Adolescence*, 43(171):449-460.
Brossard RM, Simon TR, Swahn MH. (2008). Clustering of Adolescent Dating Violence, Peer Violence, and Suicidal Behavior. *Journal of Interpersonal Violence*, 23(6):815 -833.
Ackard DM & Neumark-Sztainer D. (2002). Date Violence and Date Rape among Adolescents: Associations with Disordered Eating Behaviors and Psychological Health. *Child Abuse & Neglect*, 26(5): 455-473.

“It got so bad, I tried to kill myself. I tried jumping off the bridge, and stuff like that; cause I just couldn't deal with it anymore. I couldn't deal with it. I stopped talking to all my friends. I had a ton of friends from [my hometown], and I wasn't allowed to talk to any of them.



Notes to Trainer: The training includes quotes from patients and providers. All are examples of themes that have emerged from the literature – they are a way to bring the statistics to life. Be sure to give the quotes a context, rather than simply reading them. Ask for participants reactions – is the quote surprising? Have they heard similar stories from their patients?

This quotation is from a qualitative study by Miller et al. (2007) on adolescent partner violence. Notice that the young woman had been isolated from her friends. Abusers often “forbid” their partners from seeing supportive friends and family. At first it can be flattering– the abuser will say that they want to spend all their time with the victim out of love. But over time, victims can come to feel trapped and alone.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics*, 7(5):360-366.

Youth who experience sexual dating violence are more likely to:

- Initiate sex before age 15
- Have had sexual intercourse with 4 or more people
- Use alcohol or drugs before sex
- Have a past or current sexually transmitted infection
- Report inconsistent use or nonuse of condoms
- Have a partner with known HIV risk factors

(Kim-Goodwin et al, 2009; Wu et al, 2003; Silverman et al, 2001)



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Notes to Trainer: It is important to “unpack” these associations, reminding participants that these outcomes are often related to the youth’s personal history of physical and sexual abuse as a child, which results in a higher risk of ARA and other negative reproductive health outcomes.

Kim-Goodwin et al. (2009) used data from the Youth Risk Behavior Survey for southeastern North Carolina to examine the relationship between dating violence and risk behaviors. The sexual risk behaviors described in the slide are from 2007 data (n=372 male and female high school students).

In a study by Silverman and colleagues (2001), data from the 1997 and 1999 Massachusetts Youth Risk Behavior Surveillance System was analyzed. High school age girls who were physically (but not sexually) abused by a dating partner were 1.6 times more likely to have intercourse before age 15. Girls who were physically and sexually abused by a dating partner were 3.5 times more likely to have intercourse before age 15.

Kim-Godwin YS, Clements C, McCuiston AM, Fox JA. (2009). Dating violence among high school students in southeastern North Carolina. *Journal of School Nursing*, 25(2):141-151.
Wu e, El-Bassel N, Witte SS, Gilbert L, Chang M. (2003). Intimate partner violence and HIV risk among urban minority women in primary health care settings. *AIDS and Behavior*, 7(3):291-301.
Silverman JG, Raj A, Mucci LA, Hathaway JE. (2001). Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality. *Journal of the American Medical Association*, 286(5): 572-579.

Adolescent girls in physically abusive relationships were **3.5 times more likely** to become pregnant than non abused girls.

(Roberts et al, 2005)



Notes to Trainer: It may be interesting for the participants to consider what we know about teen pregnancy from media. Pose this question to the audience: Is this something the average American thinks about when they think about teen pregnancy?

A large body of research points to the connection between ARA and teen pregnancy. However, few teen pregnancy programs address the connection between ARA and pregnancy risk, or recognize the identification of one of these risks as a clinical indicator to screen for the other.

This study by Roberts and colleagues (2005) analyzed data from the National Longitudinal Study of Adolescent Health. The analyses adjusted for sociodemographic factors, the number of intimate partners, and a history of forced sexual intercourse. A past history or current involvement in a physically abusive relationship was associated with a history of being pregnant among sexually active adolescent girls. Physical abuse was defined as “push you,” “shove you,” or “throw something at you.”

In a study by Silverman et al. (2001), adolescent girls who experienced physical or sexual dating violence were 6 times more likely to become pregnant than their peers.

Roberts TA, Auinger MS, Klein JD. (2005). Intimate Partner Abuse and the Reproductive Health of Sexually Active Female Adolescents. *Journal of Adolescent Health*, 36:380-385.

Silverman JG, Raj A, Mucci LA, Hathaway JE. (2001). Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality. *Journal of the American Medical Association*, 286(5): 572-579.



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Pregnant adolescents are **2-3 times more likely** to have experienced violence during and after pregnancy than older pregnant women.

(Parker et al,1993)



The aim of this study was to obtain and compare measures of physical and emotional abuse among 691 urban, pregnant women. 31% (214) were teenagers aged 13-19 years, and 69% were adults aged 20-42 years. On their first prenatal visit, 182 (26%) women reported physical or sexual abuse within the past year. There were significant differences between the teens and adults, with a higher percentage of teens (31.6%) reporting abuse during the prior year than adults (23.6%). The rate of abuse during pregnancy was 21.7% for teens and 15.9% for adult women.

Parker, B, McFarlane, J, Soeken, K, et al. (1993). Physical and emotional abuse in pregnancy: a comparison of adult and teenage women. *Nursing Research*, 42(3), 173-178.

Rapid Repeat Pregnancy

Adolescent mothers who experienced physical abuse within three months after delivery were **nearly twice** as likely to have a repeat pregnancy within 24 months than non-abused mothers.

(Raneri & Wiemann, 2007)



In this study of teenage mothers (ages 12-18) who were recruited from a labor and delivery unit at a university hospital, physical abuse by an intimate partner was defined as being hit, slapped, kicked, or physically hurt enough to cause bleeding, or having been hit during an argument or while their partner was drunk or high.

The odds of repeat pregnancy was 1.9 times higher among teen mothers who were physically abused by their partner within three months of delivery compared to non-abused teen mothers.

In an earlier study by Jacoby et al. (1999), low income adolescents who experienced physical or sexual abuse were 3 times (OR= 3.46) more likely to have a rapid repeat pregnancy within 12 months and 4 times (OR=4.29) more likely to have a rapid repeat pregnancy within 18 months.

Raneri LG, Wiemann CM. (2007). Social Ecological Predictors of Repeat Adolescent Pregnancy. *Perspectives on Sexual and Reproductive Health*, 39(1):39-47.

Jacoby M, Gorenflo D, Black E, Wunderlich C, Eyler AE. (1999). Rapid repeat pregnancy and experiences of interpersonal violence among low-income adolescents. *American Journal of Preventive Medicine*, 16(4):318-321.

What Happens at School for These Teens?

- Victims and perpetrators are **more likely** to carry weapons, as well as engage in physical fighting and other high risk behaviors.
- Physical and sexual victimization is associated with an **increased risk** for school dropout, lower grades, and less connectedness to school.



(Goldstein et al, 2009; Champion et al, 2008; Banyard & Cross, 2008)



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Notes to Trainer: In addition to health issues, ARA is linked to other risk behaviors and adverse outcomes. The findings of these studies illustrate the striking associations between ARA and outcomes in school. Emphasize that “getting in trouble at school” may be a red flag for ARA, yet it is an issue that is rarely addressed when helpful adults try to intervene in school problems.

Goldstein AL, Walton MA, Cunningham RM, Resko SM, Duan L. (2009). Correlates of Gambling Among Youth in an Inner-city Emergency Department. *Psychology of Addictive Behaviors*, 23 (1):113-121.

Champion H, Foley KL, Sigmon-Smith K, Sutfin EL, DuRant RH. (2008). Contextual Factors and Health Risk Behaviors Associated with Date Fighting among High School Students. *Women & Health*, 47(3): 1-22.

Banyard VL, Cross C. (2008). Consequences of Teen Dating Violence: Understanding Intervening Variable in Ecological Context. *Violence Against Women*, 14(9):998-1013.

A third (32%) of female homicides among adolescents between the ages of 11 and 18 are committed by an intimate partner.



(Coyne-Beasley et al, 2003)



Notes to Trainer: Similar to adult data, adolescent females in abusive relationships are at risk of death at the hands of their abusive partner.

The goal of today's training is to give providers the tools and resources to do prevention and early intervention for ARA – reducing these tragedies. We have an opportunity to give clients/patients information about healthy relationships, and also resources on where to get help if they or a friend are in an unhealthy relationship.

Coyne-Beasley T, Moracco KE, Casteel MJ. (2003). Adolescent Femicide: A Population-based Study. *Archives of Pediatrics & Adolescent Medicine*, 157(4):355-360.

Summary of Research on Adolescent Relationship Abuse



- It is **COMMON**
- It is associated with multiple risk behaviors and poor health indicators
- It has **SIGNIFICANT CONSEQUENCES** for health and well-being of youth
- It is highly prevalent among youth seeking clinical services

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Notes to Trainer: Review “take home” points and ask if participants have any additional questions or comments.

Section Recap

- ARA is experienced by many young people and takes a variety of forms
- General health and well-being, as well as psychological health and sexual health are impacted by ARA
- Providers working with youth should be aware of the links between ARA and problem behaviors and outcomes in all arenas of young people's lives.



Notes to Trainer: Read the “Section Recap” out loud to close each section.

**Module 3: “I talk about
this with all my
patients...”
Providing
Universal
Education
on Healthy
Relationships**



"I talk about this with all my patients..."

Providing Universal Education on Healthy Relationships

Estimated Module Time: 90 minutes

Training Outline

- Universal Education on Healthy Relationships
- Limits of Confidentiality and Mandatory Reporting
- Using the "*Hanging out or Hooking up?*" Safety Card
- Supported Referral

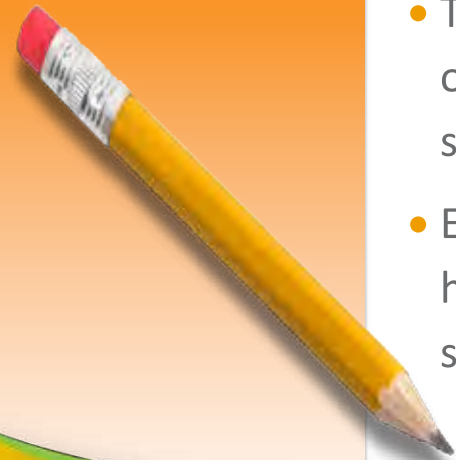
Overview

This module is essential for training on the assessment and intervention of ARA in health care settings. It includes approaches to addressing the limits of confidentiality, and the use of the "*Hanging out or Hooking up?*" Safety Card for universal education on healthy relationships with all youth, as well as target assessment according to visit type.

Learning Objectives

As a result of this activity, learners will be better able to:

- Describe how to counsel patients on healthy relationships through universal education using the "**Hanging out or Hooking up?**" safety card intervention.
- Talk with patients about textual harassment and other forms of technology abuse, as well as strategies for help.
- Educate patients about what they can do if they have a friend or family member who may be struggling with abuse.



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Notes to Trainer: Read the learning objectives aloud.

Goals for Universal Education About Healthy Relationships

- Distinguish between healthy and unhealthy relationships
- Encourage youth to take action if they witness unhealthy behavior
- Educate sexually active adolescents about sexual coercion and the importance of consent
- Create a safe environment to discuss relationships



Notes to Trainer: Participants will learn how to counsel patients on healthy relationships using the "Hanging out or Hooking up?" safety card. This universal education has several distinct and important goals:

- Distinguish between healthy and unhealthy relationship behavior
- Focus on healthy relationships
- Encourage youth to choose safe and respectful relationships, and reject unhealthy relationship behavior
- Encourage youth to report or confront unhealthy behavior they witness among peers
- Educate sexually active adolescents about sexual coercion and the importance of consent
- Create an environment where youth will see the clinic as a safe place to discuss relationships and seek related advice and assistance

Intervention Elements

- Review limits of confidentiality
- Provide universal education on healthy relationships
- Discuss youth-friendly ARA resources
- Offer support, validation, and harm reduction strategies if abuse is disclosed
- Make a warm referral to ARA advocacy services

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Notes to Trainer: Anticipatory guidance on healthy relationships can be used to identify early warning signs of unhealthy relationships, to promote safe and healthy relationships, and to prevent unintended pregnancies and poor health outcomes. Because of the high prevalence of ARA, this discussion should be introduced at the 11-12 year old well child visit, before patients start dating.

We recommend anticipatory guidance as universal education for all patients. If patients are sexually active, we recommend following up with more direct assessment questions.

Getting Started:

- Always review the limits of confidentiality, even if you are not asking DIRECT questions about abuse, in case there is disclosure and you need to report.



- For state specific information, go to <http://nnedv.org/resources/coalitions.html>, to find your state's DSV coalition and talk about how implementation works.



Notes to Trainer: In preparation for the training, visit the link above for state-specific info, and talk to your state coalition about how implementation varies.

Navigating the balance between confidentiality and abuse reporting requirements is the fundamental challenge in ARA intervention. Laws vary widely from state to state for adolescents when it comes to sexual or physical abuse by a partner. Therefore, as a provider, it is critical to understand your state's minor consent and confidentiality laws as well as physical and sexual abuse laws, and be able to clearly articulate them to your patients.

Because providing anticipatory guidance may trigger a positive disclosure of abuse or other situation that requires a report to law enforcement or child welfare, it is essential that the limits of confidentiality are reviewed with all patients prior to *any* anticipatory guidance about healthy relationships or direct assessment for ARA.

The following slides address confidentiality and mandated reporting from a general perspective, and have NO state law specific information.

Script for Disclosing Limits of Confidentiality with Adolescents

“Before I get started, I want you to know that everything here is confidential, meaning I won’t talk to anyone else about what is happening unless you tell me that you are being hurt physically or sexually by someone or planning to hurt yourself”

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Notes to Trainer: Any time a sample script is provided, remind participants that the intention is to give them an idea of how to address the issue, not for them to memorize a script to repeat word-for-word.

Reviewing the Limits of Confidentiality



The following video clip demonstrates common pitfalls providers encounter when addressing confidentiality and mandatory reporting requirements



Estimated Activity Time: 3 minutes to watch video and 5 minutes for discussion

Notes to Trainer: Remind participants to focus on the issues of confidentiality and child abuse reporting, not aspects of the clinical care delivered (for example, don't focus on medication instructions).

See next slide for discussion questions.

- What worked well?
- What would you change?
- What additional safeguards can your setting put into place to ensure that patients/clients understand the limits of confidentiality?

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Notes to Trainer: Discuss video clips. Assure participants that there will be time later in the training to discuss mandatory reporting-- this section is intended to remind clinicians about the importance of reviewing the limits of confidentiality.

What worked well:

- It appears the provider had rapport with the patient/client, since she was willing to open up so quickly.

What would you change:

- Make sure to address the patient's presenting health concerns (take care of medical issues and provide referrals) **BEFORE** discussing the need to report. In this vignette, the patient may have wanted Emergency Contraception, a pregnancy test, etc.
- Remind participants that "Report immediately" does not prevent you from providing care.
- Remain calm. If the provider seems flustered or surprised, the patient/client may assume they have done something "bad"/wrong.

What additional safeguards can you put into place:

- It is important to have MULTIPLE opportunities for patients to hear and see information about confidentiality
- Information sheet at check in
- Posters in waiting rooms and exam rooms
- Providers should discuss confidentiality with patients and check for comprehension

Guidelines For Universal Education

- **How Often Should You Educate?**

- At least annually and with each new partner

- **When Should You Provide Universal Education?**

- During any health appointment including sports physicals

- **Where Should You Provide Education?**

- When the patient is by him/herself without parents, partners, or friends present

- **Who Should Receive Education About Healthy Relationships?**

- Every teen regardless of gender or sexual orientation should learn about healthy relationships



Notes to Trainer: All adolescents need universal education about safe, consensual and healthy relationships. Universal education is an opportunity to educate patients about how abusive and controlling behaviors in a relationship can affect health and safety. Simple educational messages about ARA let teens know that they are not alone and that you are a safe person to talk to, should abuse occur.

Universal Anticipatory Guidance: Making Healthy Relationship Conversations Simple



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Notes to Trainer: Make sure all participants have the "Hanging out or Hooking up?" safety cards available. Ask participants to take the card out, open it up, and follow along as you review the content on the next few slides.

The "Hanging out or Hooking up?" safety card includes information about a range of issues and helps youth make the connection between unhealthy relationships and poor health outcomes. You can use safety card to discuss relationship quality.

This Safety Card is Part of a Simple, Evidence-Informed Intervention

- Discuss healthy relationships
- Identify signs of an unhealthy relationship
- Educate patients about how to help others
- Plant seeds for victims
- Help victims learn about harm reduction strategies and support services.



Notes to Trainer: These are the goals of the safety card intervention. Emphasize that the goal is NOT disclosure or the patient leaving the relationship, but rather enhancing young people's understanding about healthy relationships and increasing their safety in their relationships.

How to Introduce the Card:

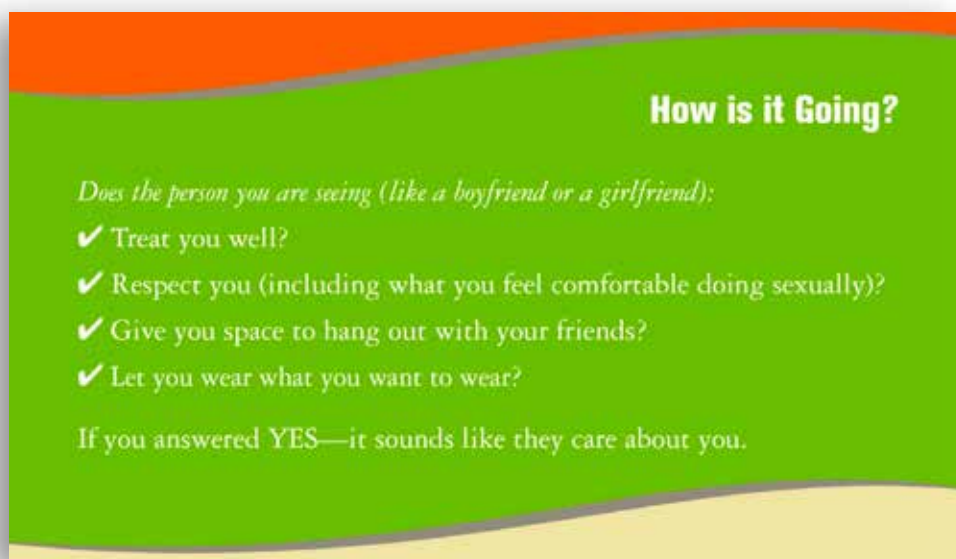
- "We've started giving this card to all our patients so they know how to get help for themselves or so they can help others."
- (Unfold card and show it) "It's kind of like a magazine or online quiz. It talks about respect, sex and texting."



Notes to Trainer: Before clinicians introduce the safety card with patients, it is important to normalize the activity. This sample script gives guidance on how to begin the conversation.

It is important to open the card and review it with clients, not simply hand the card to them.

“We’ve started talking to all the teens in our clinic about what they deserve in relationships...”



Notes to Trainer: This panel covers characteristics of healthy relationships.

Patients may not be receiving positive messages about relationships from the media, their families or their communities. Adolescent health providers have a unique opportunity to offer anticipatory guidance on healthy and safe relationships.

In our *Project Connect* sites, many young people have told us this is the first time they have had the opportunity to discuss healthy relationships, and the fact that a health care provider would take the time to discuss them must mean they are important.

Providers are not expected to read through every line, but pick out one or two points to highlight.

“Everyone deserves to be treated with respect but defining what that looks like can be confusing.”

What About Respect?

Anyone you're with (whether talking, hanging out, or hooking up) should:

- Make you feel safe and comfortable.
- Not pressure you or try to get you drunk or high because they want to have sex with you.
- Respect your boundaries and ask if it's ok to touch or kiss you (or whatever else).

How would you want your best friend, sister, or brother to be treated by someone they were going out with? Ask yourself if the person you are seeing treats you with respect, and if you treat them with respect.



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Notes to Trainer: This panel gives some concrete examples of healthy and respectful relationships.

When getting feedback from teens in focus groups when the card was being developed, the question “how would you want your best friend to be treated?” resonated with the youth. Many youth were able to see their own relationships with “fresh eyes” when they thought about how they would react if a sibling, friend, or family member was in the same situation.

Talk About Healthy Relationships With BOTH Teen Girls and Boys

And on a Bad Day?

How often does the person you are seeing:

- ✓ Shame you or make you feel stupid?
- ✓ Pressure you to go to the next step when you're not ready?
- ✓ Control where you go, or make you afraid?
- ✓ Grab your arm, yell at you, or push you when they are angry or frustrated?

Nobody deserves to be treated this way. If these things ever happen in your relationship, talk to someone about it. For more info, go to www.loveisrespect.org.



Notes to Trainer: This panel identifies signs of an unhealthy relationship. It is important to review this panel, as well as the preceding panels about healthy relationships, with both young women AND young men.

This may bring up the comment “girls are just as violent as boys.” while some of the national surveys show that boys and girls report similar rates of having ever been hurt physically by a boyfriend or girlfriend, these types of questions do not tell us about the context or severity of the violence. Overall, girls (and women) experience more severe forms of physical violence. Additionally, girls (and women) experience significantly more sexual violence victimization.

When does texting stop being fun?

Everybody Texts

Getting a lot of texts can feel good—"Wow, this person really likes me."

What happens when the texts start making you uncomfortable, nervous, or they keep coming nonstop?

Figuring out what to say can be hard, especially if you like the person.

Be honest. "You know I really like you, but I really don't like it when you text me about where I am all the time or pressure me for naked pics." For more tips on what to say go to: www.thatsnotcool.com.

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Notes to Trainer: This panel addresses some adolescent specific relationship abuse patterns.

As mentioned earlier in the training, the use of technology is an emerging issue. Ask the audience: What have you seen in your practice? How are youth using cell phones and social media (Facebook, Twitter, etc.) in their relationships?

For additional information, review the National Child Traumatic Stress Network's factsheet, "Staying Safe While Connected":

<http://www.chkd.org/documents/CAP/Staying%20Safe%20While%20Staying%20Connected.pdf>

Adolescents Report Disclosing Abusive Experiences to Friends Far More Often Than to Health Professionals

How to Help a Friend

Do you have a friend who you think is in an unhealthy relationship?

Try these steps to help them:

- Tell your friend what you have seen in their relationship concerns you.
- Talk in a private place, and don't tell other friends what was said.
- Show them www.loveisrespect.org and give them a copy of this card.
- If you or someone you know is feeling so sad that they plan to hurt themselves and/or wish they could die—get help.
Suicide Hotline: 1-800-273-8255



Notes to Trainer: This panel builds on adolescents' desire to help their friends, with the goal of engaging peers to change "bystander behavior." Research shows that young people are more likely to turn to a peer than an adult when they experience ARA or other problems.

In our *Project Connect* sites, patients would often ask for cards to give to friends. Providers would often hear: "My relationship is fine, but I have some friends... can I have a few more to give to them?"

Review the Resources Panel

“On the back of the card are some phone numbers and websites, in case you or a friend ever needs information or support”

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**FUTURES
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Formerly Family Violence Prevention Fund

FuturesWithoutViolence.org

 The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

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If you or someone you know ever just wants to talk, you can call these numbers. All of these hotlines are free, confidential, and you can talk to someone without giving your name.

National Teen Dating Abuse Helpline
1-866-331-9474 or online chat
www.loveisrespect.org

Suicide Prevention Hotline
1-800-273-8255

Teen Runaway Hotline
1-800-621-4000

Rape, Abuse, Incest, National Network (RAINN)
1-800-656-HOPE (1-800-656-4673)

Notes to Trainer: Even when doing universal education on healthy relationships, it is important to highlight the back panel with youth-friendly resources.

Sam: Parts 1 & 2



The following video clips demonstrate providing universal education on healthy relationships during an adolescent health visit



Estimated Activity Time: 10 minutes to watch videos and 10 minutes for discussion.

Notes to Trainer: Review videos Sam, Parts 1 & 2, or Taryn, and choose which you plan to use based on the environments that your participants provide services in. “Sam” is more appropriate for school-based and confidential, “teen only” service sites, and “Taryn” is a better choice for primary care or other service sites where parents frequently accompany their teens to visits. If you use the “Taryn” video, be sure to change the name on the slide.

See next slide for discussion questions.

Video Debrief

- What worked well in this video? What would you change?
- Do you talk to your adolescent male patients about how to respect girls?
- Do you talk to your female patients about what they deserve from their male partners?
- How can you see using this card in your practice?

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Notes to Trainer: Discuss the video clips.

Steps to Safety Card Intervention

1. Universal Education - Normalize activity:

"I've started giving this card to all of my patients"

2. Open the Card - Do a quick review: "It talks about healthy and safe relationships"

3. Make the Connection - Create a sense of empowerment: "We give this to everyone so they know how to get help for themselves if they were to need it and so they can help a friend or family member."

4. Hotline and/or Local Referral



Notes to Trainer: This slide is provided to remind participants of the elements of the intervention in preparation for the practical application exercise on the next slide.

Practical Application

- Divide into groups of three. One person is the provider, one person is the client, one person is the observer
- Take 3 minutes to practice using the **Hanging Out or Hooking Up** safety card to provide anticipatory guidance on healthy relationships. *Your goal is to introduce the card.*
- Take 3 minutes to discuss as a group – what worked, what would you change?

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Estimated Activity Time: 10 minutes

Notes to Trainer: Having time to practice using the card is **CRITICAL**. Make sure you build enough time in ANY presentation over an hour to have participants practice **AT LEAST ONCE**.

1. Read the instructions on the slide. Stress the importance of introducing the card QUICKLY - in a real clinical interaction there will have been more time for rapport building- assume that has already happened and you are ready to discuss the safety card. There does not need to be a crisis or complicated back story for the patient– the goal is to introduce the card, **NOT** to do a direct assessment for ARA.
2. When the participants are in their groups, walk around the room and stop to hear how each group is doing. Some groups will be reluctant to do role plays and will default to discussing how to use the card. Gently nudge them to participate in the exercise.
3. Come back together as a group to debrief. How did it feel to use the card? Can providers imagine using this in their practice? What other questions do they need answered before they can confidently introduce a conversation about healthy relationships with all of their patients?



Beyond Anticipatory Guidance: Targeted Use of the Safety Card

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Notes to Trainer: Discuss the use of the safety card for targeted assessment. Depending on the purpose and scope of the visit, the “Hanging out or Hooking up?” safety card can also be used as a tool to talk about other issues, such as substance abuse, disordered eating, depression, and suicidal ideation in a trauma-informed manner. As previously mentioned, ARA is closely linked to many adverse health outcomes and risk behaviors.

Integrating Assessments: Substance Use

If a patient reveals they are using substances regularly

What About Respect?

Anyone you're with (whether talking, hanging out, or hooking up) should:

- Make you feel safe and comfortable.
- Not pressure you or try to get you drunk or high because they want to have sex with you.
- Respect your boundaries and ask if it's ok to touch or kiss you (or whatever else).

How would you want your best friend, sister, or brother to be treated by someone they were going out with? Ask yourself if the person you are seeing treats you with respect, and if you treat them with respect.

“This card talks about being pressured to get drunk or high with someone because they want to have sex with you...”

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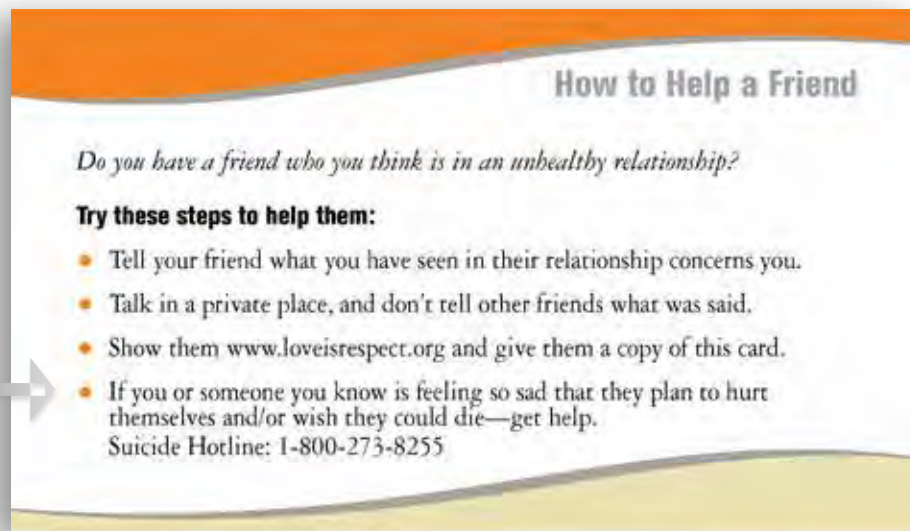
Notes to Trainer: If the youth discloses substance use, you can use this panel of the card to provide guidance and discuss the interaction of substance use and relationship safety.

Victims of physical and sexual violence in dating relationships are more likely to engage in substance use. Population-based data indicates that adolescents who experienced forced sexual intercourse were more likely to engage in binge drinking and attempt suicide.

Sample script: “This card talks about being pressured to get drunk or high with someone because they want to have sex with you—because when you are drunk or high it is a lot easier for someone to pressure you to do something you aren’t ready to do. Does s/he ever try to make you drink when you don’t want to? Do you drink or do other drugs regularly before having sex? Has the drinking or substance use ever gotten in the way of your using birth control?”

Kim-Godwin YS, Clements C, McCuiston AM, Fox JA. (2009). Dating violence among high school students in southeastern North Carolina. *Journal of School Nursing*, 25(2):141-151.
Behnken MP, Le YC, Temple JR, Berenson AB. (2010). Forced sexual intercourse, suicidality, and binge drinking among adolescent girls. *Addictive Behaviors*, 35(5):507-509.

If a patient reveals they are sad, irritable, not sleeping well, and/or not motivated



“Has anyone you were going out with every made you feel so bad about yourself that you thought about hurting yourself?”



Notes to Trainer: Because Depressed adolescents are more likely to report having ever been physically or sexually hurt by someone they were dating or going out with:

- Assess for depression and suicidality in youth experiencing ARA: ““Has anyone you were going out with every made you feel so bad about yourself that you thought about hurting yourself?”
- Assess for ARA with youth who are depressed: “Do you feel like your relationship may be contributing to these feelings?”

Remind participants that any youth who exhibits symptoms of depression or of feeling like hurting or killing him/herself should be evaluated for suicidality and that facilitated referrals to mental health services should be available. Highlight the Suicide Hotline as a resource. As always, safety is the first concern.

Howard DE, Wang MQ, Yan F. (2008). Psychosocial factors associated with reports of physical dating violence victimization among U.S. adolescent males. *Adolescence*, 43(171):449-460.

Integrating Assessment: Disordered Eating

Unhealthy eating behaviors in the context of an unhealthy relationship



“Sometimes a response to feeling out of control in a relationship, is controlling what and how you eat...”

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Notes to Trainer: Women in abusive relationships are at higher risk for disordered eating, including binge eating and bulimia. Discuss relationship quality with youth with disordered eating.

Young women may be engaging in unhealthy eating behaviors (for example, severely restricting food or binge eating) as a way to feel “in control” when their partner is controlling other aspects of their lives.

Section Recap

- Use the **"Hanging out or Hooking up?" safety card** to provide anticipatory guidance on healthy relationships with all adolescent patients as part of routine care.
- Talk with patients about texting, other forms of technology, and strategies for help.
- Educate patients about what they can do if they have a friend or family member who may be struggling with abuse.



Notes to Trainer: Read the "Section Recap" out loud to close each section.

Module 4: “Is this happening
in your
relationship?”

Direct Assessment
for Reproductive
Coercion With
Sexually Active
Young Women



“Is this happening in
your relationship?”



Direct Assessment for Reproductive Coercion With Sexually Active Young Women

Module 4

Estimated Module Time: 80 minutes

Training Outline

- Definitions, statistics, and examples of reproductive coercion
- Group discussion: birth control sabotage
- Assessment for reproductive coercion and responding to disclosures
- Video vignette and role play (slide)

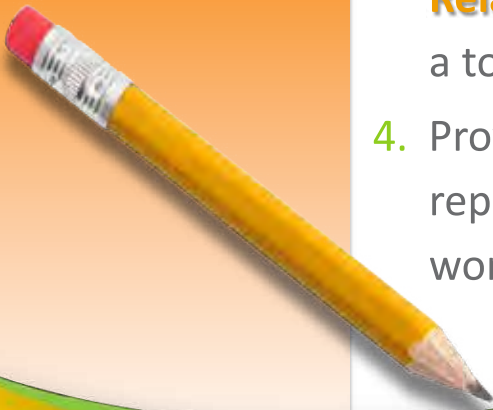
Overview

As we have learned more about different forms of abusive and controlling behaviors that are used by partners to maintain power and control in a relationship, patterns of behaviors that affect women's reproductive health have been identified. These behaviors, which are referred to as reproductive and sexual coercion, include forced sex, birth control sabotage, pregnancy pressure, and condom manipulation. Using a skills-based approach, this module includes assessment questions and information about birth control options that may be less visible and more effective for clients whose partners are interfering with their birth control.

Learning Objectives

As a result of this activity, learners will be better able to:

1. Define reproductive and sexual coercion.
2. Identify two ways reproductive and sexual coercion may present in Reproductive Health settings.
3. Describe how to use the **Did You Know Your Relationship Affects Your Health?** safety card as a tool for assessment and intervention
4. Provide targeted education and response for reproductive coercion with sexually active young women



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Notes to Trainer: Read the learning objectives aloud.



Domestic violence increases women's risk for **Unintended Pregnancies**

(Sarkar, 2008)



Sarkar conducted a literature review of publications from 2002 through 2008 on the impact of domestic violence on women's reproductive health and pregnancy outcomes.

In a study by Goodwin et al (2000), women who had unintended pregnancies were 2.5 times more likely to experience physical abuse compared to women whose pregnancies were intended.

Sarkar NN. (2008). The Impact of Intimate Partner Violence on Women's Reproductive Health and Pregnancy Outcome. *Journal of Obstetrics and Gynaecology*, 28(3):266-271.

Goodwin MM, Gazmararian JA, Johnson CH, Gilbert BC, Saltzman LE. (2000). Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996-1997. PRAMS Working Group. Pregnancy Risk Assessment Monitoring System. *Maternal and Child Health Journal*, 4(2):85-92.

What are some ways a partner can interfere with a young woman's reproductive health?



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Estimated Activity Time: 3-5 minutes

1. Ask participants to give some examples they have seen in their practice?
Responses may include examples of birth control sabotage, condom refusal, intentional exposure to STIs, pregnancy pressure, forced sex, etc.

Women tell us that controlling reproductive health is used as a tool for abuse

“He [used condoms] when we first started, and then he would fight with me over it, and he would just stop [using condoms] completely, and didn't care. He got me pregnant on purpose, and then he wanted me to get an abortion.”

”



Notes to Trainer: This quotation is from a qualitative study by Miller et al. (2007) on male pregnancy-promoting behaviors and adolescent partner violence. A 16-year-old female with a physically and verbally abusive partner who was 6 years older; she left the relationship and continued the pregnancy.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics*, 7(5):360-366.

Reproductive Coercion involves behaviors aimed to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent.



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Notes to Trainer: Read the definition of Reproductive Coercion (RC) aloud including the information below and ask the group: “How many of you have heard the term reproductive coercion before today?”

RC is related to behaviors that interfere with contraception use and/or pregnancy. This includes:

- Explicit attempts to impregnate a partner against her wishes
- Controlling outcomes of a pregnancy
- Coercing a partner to have unprotected sex
- Interfering with birth control methods

Two types of reproductive coercion, birth control sabotage and pregnancy pressure and coercion, will be described in the following slides.

Ask the group: “How many of you have talked to clients/patients who have experienced this?”

What Is Sexual Coercion?

Creating a feeling, situation or atmosphere where emotional and physical control lead to sexual abuse or rape, or a victim feeling that he or she has no choice but to submit to sexual activity with the perpetrator.



Notes to Trainer: This definition of sexual coercion expands our understanding beyond traditional definitions of sexual assault and rape.

It includes a range of behaviors that a partner may use related to sexual decision-making to pressure or coerce a person to have sex without using physical force such as:

- Repeatedly pressuring a partner to have sex when he or she does not want to
- Threatening to end a relationship if a person does not have sex
- Forced non-condom use or not allowing other prophylaxis use
- Intentionally exposing a partner to a STI or HIV
- Threatening retaliation if notified of a positive STI result

Ask the group *“How many of you think your adolescent patients have a clear understanding of sexual coercion?”* Acknowledge that this can be a complex issue to address, and it is important to identify youth-friendly resources for sexual violence.

Tactics include:

- Destroying or disposing contraceptives
- Impeding condom use (e.g., threatening to leave her, poking holes in condoms)
- Not allowing her to obtain or preventing her from using birth control
- Threatening physical harm if she uses contraceptives



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Birth Control sabotage is active interference with a partner's contraceptive methods. Qualitative and quantitative research have shown an association between birth control sabotage and domestic violence.

Fanslow et al. (2008) conducted interviews with a random sample of 2,790 women who have had sexual intercourse. Women who had ever experienced domestic violence were more likely to have had partners who refused to use condoms or prevented women from using contraception compared to women who had not experienced domestic violence (5.4% vs. 1.3%).

Miller et al (2007) conducted interviews with 53 sexually active adolescent females. One-quarter (26%) of participants reported that their abusive male partners were actively trying to get them pregnant. Common tactics used by abusive male partners included:

- Manipulating condom use
- Sabotaging birth control use
- Making explicit statements about wanting her to become pregnant

Fanslow J, Whitehead A, Silva M, Robinson E. (2008). Contraceptive Use and Associations with Intimate Partner Among a Population-based Sample of New Zealand Women. *Australian & New Zealand Journal of Obstetrics & Gynaecology*, 48(1): 83-89.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics*, 7(5): 360-366.

Lang DL, Salazar LF, Wingood GM, DiClemente RJ, Mikhail I. (2007). Associations Between Recent Gender-based Violence and Pregnancy, Sexually Transmitted Infections, Condom Use Practices, and Negotiation of Sexual Practices Among HIV-Positive Women. *Journal of Acquired Immune Deficiency Syndromes*, 46(2):216-221.

“Like the first couple of times, the condom seems to break every time. You know what I mean, and it was just kind of funny, like, the first 6 times the condom broke. Six condoms, that's kind of rare, I could understand 1 but 6 times, and then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid.”



Notes to Trainer: This quotation is from a qualitative study by Miller et al. (2007) on male pregnancy-promoting behaviors and adolescent partner violence. The teen girl was parenting a baby from a different relationship and the abusive relationship started shortly after she broke up with her son's father. She went to a teen clinic and started Depo-Provera injections without her new partner's knowledge.

Question: Do you think the condom was breaking accidentally every time?

Why not? We do know that youth may need more condom education but there is also a Red Flag: her partner expressing his desire to get her pregnant once she goes on hormonal birth control.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics*, 7(5):360-366.

Women, including teens, experiencing physical and emotional abuse are more likely to report **not using their preferred method of contraception** in the past 12 months (OR=1.9).

(Williams et al, 2008)



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Notes to Trainer: Williams and colleagues conducted a case control study with 225 women to examine whether IPV was associated with women's risk for problems in contraception use. This statistic reminds us that many patients are not able to negotiate contraceptive methods with their partners.

Williams CM, Larsen U, McCloskey L. (2008). Intimate Partner Violence and Women's Contraceptive Use. *Violence Against Women*, 14(12) 1382-1396.



Women with high STI knowledge who were fearful of abuse, were **less likely to consistently use condoms** than nonfearful women with low STI knowledge.

(Raiford et al, 2009)



Notes to Trainer: Don't assume that young women need more condom education, it may be that they are afraid of what will happen if they ask their partner to use a condom. For young women in abusive relationships, the threat of harm is worse than the threat of negative health consequences.

In this study by Raiford et al. (2009), women were asked about the degree to which they were worried that if they talked about using condoms with their sexual partner that he would respond in negative ways including threatening to hit, push or kick them; leave them, swear at them; or call them names.

Almost half (47.6%) of the young (18-21 years) African American women (n=715) reported having experienced relationship abuse in their lifetime; 15% reported abuse by a main sexual partner in the past 60 days. Under high levels of fear for abuse, 76% of women with high STI knowledge were more likely to exhibit inconsistent condom use during their last sexual intercourse with a man compared to 60% of women with low levels of knowledge.

One of the explanations for this counterintuitive finding that the authors offer is that women with more knowledge about STI transmission may balance the risk of abuse with the risk of acquiring an STI, particularly if they know or suspect that their partner is at low risk for STIs. Overall these findings emphasize the importance of integrating dating violence assessment and prevention into STI and HIV prevention programs.

Raiford JL, DiClemente RJ, Wingood GM. (2009). Effects of fear of abuse and possible STI acquisition on the sexual behavior of young African American women. *American Journal of Public Health*, 99(6): 1067-1071.

Pregnancy Pressure and Coercion

Tactics include:

- Threatening to leave a partner if she does not become pregnant
- Threatening to hurt a partner who does not agree to become pregnant
- Forcing a female partner to carry to term against her wishes through threats or acts of violence
- Forcing a female partner to terminate a pregnancy when she does not want to
- Injuring a female partner in a way that may cause a miscarriage

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Notes to Trainer: Pregnancy pressure involves behaviors that are intended to pressure a female partner to become pregnant when she does not wish to be pregnant. Pregnancy coercion involved coercive behaviors such as threats or acts of violence if a partner does not comply with the male partner's wishes regarding the decision of whether to terminate or continue a pregnancy.

One-quarter (26.4%) of adolescent females reported that their abusive male partners were

TRYING TO GET THEM PREGNANT

(Miller et al, 2007)



In this qualitative study by Miller and colleagues (2007), 53 teen girls between the ages of 15 and 20 years (21% African American, 38% Latina) with known history of IPV were recruited from adolescent clinics, domestic violence agencies, schools, youth programs for pregnant/parenting teens, and homeless and at-risk youth. Approximately one-third of the participants were recruited from pregnant and parenting teen programs to ensure sufficient representation of teens experiencing both IPV and pregnancy. Older male partners were typical with the median age difference between the female and the male partner being 4 years. Pregnancy-promoting behaviors by their abusive male partners included:

- Poking holes in condoms
- Explicit statements (e.g. “I want a baby”)
- Getting angry if she asked him to use a condom
- Removing the condom during intercourse

Several girls reported hiding contraceptive use from their abusive male partner.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007). Male partner pregnancy-promoting behaviors and adolescent partner violence: Findings from a qualitative study with adolescent females. *Ambulatory Pediatrics*, 7(5):360-366.

“He really wanted the baby—he wouldn’t let me have—he always said, “If I find out you have an abortion,” you know what I mean, “I’m gonna kill you,” and so I really was forced into having my son. I didn’t want to; I was 18. [...] I was real scared; I didn’t wanna have a baby. I just got into [college] on a full scholarship, I just found out, I wanted to go to college and didn’t want to have a baby but I was really scared. I was scared of him.”



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Notes to Trainer: This respondent described how her partner threatened her into carrying an unwanted pregnancy to term. Respondents described abusive partners making them feel bad about their desire to abort; begging, badgering and making promises to support the baby to pressure them into giving birth. Some respondents described giving in to this pressure, and some did not. One woman’s partner kept on making her eat which prevented her from going in for her second trimester abortion for which she needed to be sedated since one of the rules was that she could not eat anything the day of her abortion. Respondents also described more invasive tactics used by partners to keep them from obtaining abortions such as refusing to pay or help pay for an abortion.

What Are the Messages for Adult and Adolescent Men?

- Male patients need to hear the same messages about the importance of healthy relationships, consensual sex, and consensual contraception to prevent unwanted pregnancies.
- Strategies for assessment, harm reduction, and intervention can be adapted for male patients.



Most forms of behaviors used to maintain power and control in a relationship impacting reproductive health disproportionately affect females. There are, however, some forms of reproductive and sexual coercion that males experience.

- Male rape victims and male victims of non-contact unwanted sexual experiences reported predominantly male perpetrators.
- Approximately 1 in 21 men (4.8%) reported that they were made to penetrate someone else during their lifetime; most men who were made to penetrate someone else reported that the perpetrator was either an intimate partner (44.8%) or an acquaintance (44.7%).
- 8.0% of men have experienced sexual violence other than rape by an intimate partner at some point in their lifetime
- 11.7% of men have experienced unwanted sexual contact.

As research evidence is being accumulated, clinical experience will help to inform best practices for male patients.

Black MD, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

What About Same-Sex Relationships?

- Sexual coercion or rape may occur in heterosexual or same sex couples.
- Recent research provides some insight into gay and bisexual males' experiences with sexual coercion. In a survey with gay and bisexual men, 18.5% reported unwanted sexual activity.

(Houston and McKirnan, 2007)



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Qualitative data from interviews with gay and bisexual men suggest many of the factors underlying sexual coercion are related more to masculine sexuality versus gay sexuality and that society's response to same sex relationships leads to circumstances such as marginalization that increases vulnerability to sexual violence.

According to data from the National Violence Against Women Survey approximately 11% of women who lived with a woman as part of a couple reported being raped, physically assaulted, and/or stalked by a female cohabitant compared to 30.4% of the women who had married or lived with a man as part of a couple. Approximately 15% percent of men who lived with a man as a couple reported being raped, physically assaulted, and/or stalked by a male cohabitant compared to 7.7% of men who had married or lived with a woman as a couple. Men and women who had lived with a same-sex partner as part of a couple disclosed significantly higher levels of IPV than opposite-sex cohabitants.

However, comparisons of these rates by the gender of the couple and gender of the perpetrator indicate that same-sex cohabiting women were three times more likely to report being victimized by a former male partner than by a female partner in their lifetime and same-sex cohabiting men were more likely to report being victimized by a male partner than a female partner in their lifetime. These findings suggest that IPV is perpetrated primarily by men, whether against male or female partners.

Braun V, Schmidt J, Gavey N, Fenaughty J. (2009). Sexual Coercion Among Gay and Bisexual Men in Aotearoa/New Zealand. *Journal of Homosexuality*, 56:336-360.

Houston E, McKirnan DJ. (2007). Intimate Partner Abuse Among Gay and Bisexual Men: Risk Correlates and Health Outcomes. *Journal of Urban Health, Bulletin of the New York Academy of Medicine.*, 84(5):681-690.

Tjaden P and Thoennes N. (2000). Full report of the prevalence, incidence, and consequences of violence against women: finding from the national violence against women survey. U.S. Department of Justice, National Institute of Justice, and U.S. Department of Health and Human Services, Centers for Disease Control. NCJ 183781.

A Community-Based Family Planning Intervention to Reduce Partner Violence

A pilot community-based research study conducted in partnership with family planning clinics in Northern California

Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception*. 2011 Mar; 83 (3):274-80. PMID: PMC3052939



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Module 4

Futures Without Violence, in collaboration with researchers, advocates and community partners shown here had the extraordinary opportunity to work on a community-based NIH funded study—and develop the safety card intervention that we will be describing in this training.

The safety card-based intervention has been identified as one of five effective in reducing IPV by the US Preventive Services Task Force. For more information, visit the USPSTF website:

<http://www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderfinalrs.htm>

Miller E, Decker MR, McCauley H, Tancredi DJ, Levenson R, Waldman J, Schoenwald P, Silverman JG. (2010). Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy. *Contraception*, 81(4):316-22.

Miller E, Levenson R, Jordan B, Silverman JG. (2010). Reproductive coercion: Connecting the dots between partner violence and unintended pregnancy. *Contraception*, 81(6):457-9.

Miller E, Decker MR, McCauley H, Tancredi DJ, Levenson R, Waldman J, Schoenwald P, Silverman JG. (2011). A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. *Contraception*, 83: 274-80.

Miller E and Silverman JG. (2010). Reproductive Coercion and Partner Violence: Implications for Clinical Assessment of Unintended Pregnancy. *Expert Review in Obstetrics and Gynecology*, 5(5): 511-15.

What We Know

Among a random sample of 1,278 women, ages 16-29, seen at five family planning clinics:

**53% experienced domestic/
sexual partner violence**

This data mirrors other findings from reproductive health clinics nationwide. Family planning clients experience high rates of violence.

(Miller, et al 2010)



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76% of the women in the sample were <24 years old, 43% were 16-20 years old, so these findings are applicable to both youth and adult populations

Emphasize the high prevalence of women exposed abuse who are seeking care in family planning programs – *demonstrating that family planning settings are a critical place to identify and assist women, particularly young women.*

Miller E, Decker MR, McCauley H, Tancredi DJ, Levenson R, Waldman J, Schoenwald P, Silverman JG. (2010). Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy. *Contraception*, 81(4):316-22.

Among women who received the intervention and experienced recent partner violence:

71% reduction in the odds of *pregnancy pressure and coercion* compared to control group

60% more likely to end a relationship because it felt unsafe or unhealthy



Notes to Trainer: This study examined the efficacy of a family-planning-clinic-based intervention to address intimate partner violence (IPV) and reproductive coercion. Four free-standing urban family planning clinics in Northern California were randomized to intervention (trained family planning counselors) or standard of care. English-speaking and Spanish-speaking females ages 16-29 years (N = 906) completed audio computer-assisted surveys prior to a clinic visit and 12-24 weeks later (75% retention rate). Analyses included assessment of intervention effects on recent IPV, awareness of IPV services and reproductive coercion.

RESULTS: Among women reporting past-3-months IPV at baseline, there was a 71% reduction in the odds of pregnancy coercion among participants in intervention clinics compared to participants in the control clinics that provided standard of care. Women in the intervention arm were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe regardless of IPV status (adjusted odds ratio = 1.63; 95% confidence interval=1.01-2.63).

CONCLUSIONS: Results of this pilot study suggest that this intervention may reduce the risk for reproductive coercion from abusive male partners among family planning clients and support such women to leave unsafe relationships. This contributes to the evidence base for using a safety card-based intervention.

Miller E, Decker MR, McCauley H, Tancredi DJ, Levenson R, Waldman J, Schoenwald P, Silverman JG. (2011). A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. *Contraception*, 83: 274-80.

Resource for Targeted Assessment and Response: Reproductive Health Safety Card



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Notes to Trainer: Make sure all participants have the “Did You Know Your Relationship Affects Your Health” safety cards available. Ask participants to take the card out, open it up, and follow along as you review the content on the next few slides.

Unlike the "Hanging out or Hooking up?", this card is NOT for universal use – it focuses an intervention for reproductive coercion with sexually active young women. This card is appropriate for reproductive health visits.



How to Introduce the Card:

- "We started giving this card to all our patients so they know how to get help for themselves or so they can help others."
- (Unfold card and show it) "See, it's kind of like a magazine or online quiz."



Notes to Trainer: Emphasize that the card should be opened up and introduced to the patient/client rather than just handed to patient. In this way, the most appropriate panel can be utilized to focus the intervention.

Provider Tip: Start with Healthy Relationships



“We have started talking to all of our patients about how you deserve to be treated by the people you go out with and giving them this card – it’s kind of like a magazine quiz – Are you in a HEALTHY relationship?”



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Notes to Trainer: Note that the “healthy relationship” messages here are not specifically targeted to adolescents and may need some interpretation by the provider.

Ask participants to open the safety card and find the appropriate panel. Read the “Sample Script” aloud, noting that it is a suggested approach, and that each participant should be familiar with the card content and adapt what they say to their own personal style as well as the specific patient and situation.

Provider Tip:
Use this panel
with
contraceptive
counseling
visits

Ask yourself:

- ✓ Does my partner mess with my birth control or try to get me pregnant when I don't want to be?
- ✓ Does my partner refuse to use condoms when I ask?
- ✓ Does my partner make me have sex when I don't want to?
- ✓ Does my partner tell me who I can talk to or where I can go?

If you answered **YES** to any of these questions, your health and safety may be in danger.

“Before I review all of your birth control option, I want to understand if your partner is supportive of your using birth control. Has your partner ever messed or tampered with your birth control or tried to get you pregnant when you didn't want to be?”



Notes to Trainer: Every panel of the card was developed with a specific visit in mind. You do not need to review every panel– or even every question/statement on a panel– with all patients. We will be highlighting how different panels and different questions can be used based on the reason for the visit. As you become more familiar with the card, you will be able to easily identify which panels to use.

It is important to establish whether or not contraceptive methods are being tampered with, so you can counsel on appropriate method. For example, it does not make sense to spend time talking about condoms if the patient discloses that her partner refuses to use condoms, or to suggest oral contraceptives if her partner has a history of throwing them away.

Provider Tip:
Use this
panel with
EC and STI
visits

Is your BODY being affected?

Ask yourself:

- ✓ Am I afraid to ask my partner to use condoms?
- ✓ Am I afraid my partner would hurt me if I told him I had an STD and he needed to be treated too?
- ✓ Have I hidden birth control from my partner so he wouldn't get me pregnant?
- ✓ Has my partner made me afraid or physically hurt me?

If you answered **YES** to any of these questions, you may be at risk for STD/HIV, unwanted pregnancies and serious injury.

“ Anytime someone tells me they use condoms as their main method of contraception, I always ask if using condoms is something that you are able to talk with him about? Does he ever get mad at you for asking? Do they break often?”



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Notes to Trainer: Review the bullets on the card.

The sample script provided is useful when talking to young women whose primary contraceptive method is condoms. Point out that the second bullet *“Am I afraid my partner would hurt me if I told him I had an STI and he needed to be treated, too?”* is a prompt to discuss safer partner notification which will be discussed later in the training.

For EC visits, also ask *“Does your partner know you are here for EC?”* to start a conversation about her ability to negotiate contraception. Is the patient using EC because she cannot talk to her partner about using condoms? Is he sabotaging her other birth control methods?

Review Last Bullet for Every EC Visit



Taking Control:

Your partner may see pregnancy as a way to keep you in his life and stay connected to you through a child—even if that isn't what you want.

If your partner makes you have sex, messes or tampers with your birth control or refuses to use condoms:

- ✓ Talk to your health care provider about birth control you can control (like IUD, implant, or shot/injection).
- ✓ The IUD is a safe device that is put into the uterus and prevents pregnancy up to 10 years. The strings can be cut off so your partner can't feel them. The IUD can be removed at anytime when you want to become pregnant.
- ✓ Emergency contraception (some call it the morning after pill) can be taken up to five days after unprotected sex to prevent pregnancy. It can be taken out of its packaging and slipped into an envelope or empty pill bottle so your partner won't know.



“Was the sex you had consensual, something you wanted to do? Are you at all concerned that a partner may be trying to get you pregnant when you don’t want to be? Sometimes women have to worry about someone else finding their EC and throwing it away. If that is an issue for you it may be useful for you to try out some of the strategies listed on the card.”



Notes to Trainer: Emphasize that the “sample scripts” are offered as an example of how to approach integrating the safety card into their routine work, and that each provider will need to find their own approach to feeling comfortable using the safety cards. We do not expect the participants to memorize the “scripts” for future use. Rather, we provide them to emphasize the key points to cover in the targeted assessment.

Provider Tip:
Use this
panel with
pregnancy
test visits

Who controls PREGNANCY decisions?

Ask yourself. Has my partner ever:

- ✓ Tried to pressure or make me get pregnant?
- ✓ Hurt or threatened me because I didn't agree to get pregnant?

If I've ever been pregnant:

- ✓ Has my partner told me he would hurt me if I didn't do what he wanted with the pregnancy (in either direction—continuing the pregnancy or abortion)?

If you answered **YES** to any of these questions, you are not alone and you deserve to make your own decisions without being afraid.

“Because this happens to so many women, we ask all of our patients who come in for a pregnancy test if they are able to make decisions about pregnancy and birth control without any threats or fear from a partner. Who makes these decisions in your relationship?”



Notes to Trainer: Review the bullets on the card, as well as the sample script.

Harm Reduction

Taking Control:

Your partner may see pregnancy as a way to keep you in his life and stay connected to you through a child—even if that isn't what you want.

If your partner makes you have sex, messes or tampers with your birth control or refuses to use condoms:

- ✓ Talk to your health care provider about birth control you can control (like IUD, implant, or shot/injection).
- ✓ The IUD is a safe device that is put into the uterus and prevents pregnancy up to 10 years. The strings can be cut off so your partner can't feel them. The IUD can be removed at anytime when you want to become pregnant.
- ✓ Emergency contraception (some call it the morning after pill) can be taken up to five days after unprotected sex to prevent pregnancy. It can be taken out of its packaging and slipped into an envelope or empty pill bottle so your partner won't know.



“I’m really glad you told me about what is going on. It happens to a lot of women and it is so stressful to worry about getting pregnant when you don’t want to be. I want to talk with you about some methods of birth control your partner doesn’t have to know about – take a look at this section of the safety card called *Taking Control*.”



Notes to Trainer: In addition to assessment and support, offering HARM REDUCTION STRATEGIES is a key component of this intervention.

This panel gives information on the unique and important role that health care providers play in helping young women experiencing reproductive coercion. As a reproductive health provider, you have the skills, tools, and training to offer her forms of contraception that are less detectable and less able to be tampered with.

Specific to sexual and reproductive health:

- Birth control that your partner doesn't have to know about (IUD, Implant)
- Emergency contraception
- Regular STI testing
- STI partner notification in clinic vs. at home



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Notes to Trainer: Remember that the goal is to enhance the patient's SAFETY, and she may not want to (or it may not be safe for her to) leave her relationship. These are approaches to reduce the risk of harm (unintended pregnancy or an untreated STI), and while they are not a solution to her abusive relationship, they *are* approaches that reduce her risk.

These methods are less vulnerable to tampering by a sexual partner—but are detectable due to loss of period/irregular bleeding.

Intrauterine Device



Injection



Implant

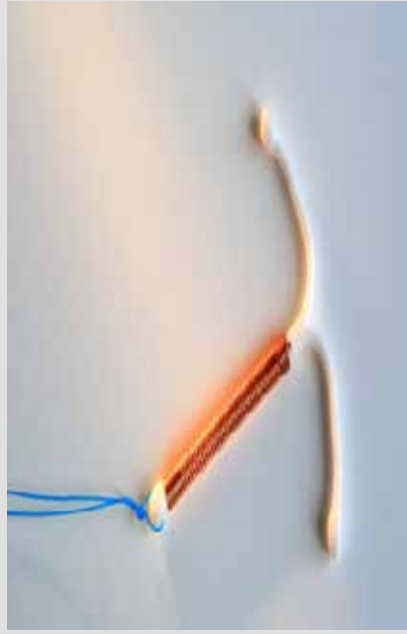


Notes to Trainer: Safety First! Asking if her partner monitors menstrual cycles/bleeding patterns is essential to enhancing patients safety. It helps when making a decision about contraception they can control with the least risk of retaliation.

When training participants that are both DV/SA advocates and reproductive health providers, a contraceptive methods handout may be useful to make sure all participants understand in detail the ways various forms of contraception work, and safety considerations to take into account when providing patient education about which method may help keep her safer.

1. Ask participants to review the birth control information sheet
2. Any if there are any questions about these methods and how a partner might interfere with them

Key Consideration



- If her partner monitors her menstrual cycles, an IUD may be the safest method to offer her.
- Especially if we cut the strings in the cervical canal so they can't be pulled out or felt by a partner.
- The inconvenience of IUD removal with ultrasound may well be worth avoiding an unwanted pregnancy by an abusive partner.

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Notes to Trainer: If a patient's partner monitors her menstrual cycles, a non-hormonal ParaGuard/Copper T IUD may be the safest method to offer her. Period or bleeding pattern isn't altered as it may be with other methods mentioned previously. It's important that this information be included in our patient education.

It is possible to cut the strings in the cervical canal so they can't be pulled out or felt by a partner. The inconvenience of IUD removal with ultrasound may well be worth avoiding an unwanted pregnancy by an abusive partner.

American College of Obstetricians and Gynecologists. Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices. American College of Obstetricians and Gynecologists Committee Opinion Bulletin: Clinical Guidelines for Obstetrician-Gynecologists, Number 539, October 2012. Available at <http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Adolescent%20Health%20Care/co539.pdf?dmc=1&ts=20130913T1650450598>.

Practice Bulletin No. 121

- It is important to note that some providers and health care systems have older protocols on IUDs and patient eligibility.
- In fact, ACOG states that LARC methods have few contraindications, and almost all women, including teens, are eligible for implants and IUDs.



It is important to note that some providers and health care systems have older protocols on IUDs and patient eligibility.

The American College of Obstetricians and Gynecologists states that long acting reversible contraceptive (LARC) methods have few contraindications, and almost all women, including teens, are eligible for implants and IUDs. In addition, LARCs have higher effectiveness rates than pills or condoms.

American College of Obstetricians and Gynecologists. Long-Acting Reversible Contraception: Implants and Intrauterine Devices. American College of Obstetricians and Gynecologists Practice Bulletin: Clinical Guidelines for Obstetrician-Gynecologists, Number 121, July 2011. Available at <http://www.acog.org/~media/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Gynecology/Public/pb121.pdf?dmc=1&ts=20130913T1703054905>.

“What you’ve told me also makes me worried about your health and safety in other ways. Sometimes when a partner is trying to get you pregnant when you don’t want to be, they might also try and control or hurt you in other ways.”



“Is anything like this happening in your relationship?”

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Women who experience reproductive coercion are also at risk for other forms of abuse. After addressing reproductive and sexual coercion, providers can make the bridge to asking direct questions about other abusive and controlling behaviors, using a script similar to the one on the slide.

6 Steps for Responding to Disclosures

1. Validate patient's experience.
2. Offer a safety card for patient to review and keep if it is safe to do so.
3. Discuss where patient can go to learn more about and obtain birth control options.
4. Ask patient if she has immediate safety concerns and discuss options
5. Refer to a domestic violence advocate for safety planning and additional support.
6. Follow up at next visit.



Notes to Trainer: Let participants know responding to disclosures will be covered at length later in the training– including a video vignette and practical application.

What if she is not ready for any intervention today?

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FUTURES WITHOUT VIOLENCE
Formerly: Family Violence Prevention Fund
FuturesWithoutViolence.org

 The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

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All these national hotlines can connect you to your local resources and provide support:

For help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

National Dating Abuse Helpline
1-866-331-9474
www.loveisrespect.org

National Sexual Assault Hotline
1-800-656-HOPE (1-800-656-4673)
www.rainn.org

“You mentioned things are sometimes complicated in your relationship. I just want you to know that sometimes things can get worse. I hope this is never the case, but if you are ever in trouble you can come here for help. I am also going to give you a card with a hotline number on it. You can call the number anytime.”



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Note to Trainer: Accept her response and respect her choice. Keep the door open for further conversations, and be sure to give her referral information. Remind participants that adolescents may prefer text, chat or internet options to 24 hr. phone lines. As stated previously, youth are more likely to talk to peers about their relationships.

“You mentioned things are sometimes complicated in your relationship. I just want you to know that sometimes things can get worse. I hope this is never the case, but if you are ever in trouble you can come here for help. I am also going to give you a card with a hotline number on it. You can call the number anytime. The staff really get how complicated it can be when you love someone and sometimes it feels unhealthy or scary. They have contact with lots of women who have experienced this or know about it in a personal way.”

Olivia: Pregnancy Test



The following video clip demonstrates an approach to integrated reproductive coercion during a pregnancy test visit.



Estimated Activity Time: 5 minutes to watch video and 10 minutes for discussion.

Notes to Trainer: See next slide for discussion questions

- What worked well?
- What would you change?
- Were there some other questions that should have been asked?

Notes to Trainer: Universal education and focusing on friends opens the door for direct assessment. *“So Olivia is anything like this happening to you?”*

1. What do you think worked well?
2. What did not work well?
3. Were there some other questions that should have been asked?
4. What did the provider do effectively with Olivia?
 - Normalized the prevalence of relationship abuse among her clinic population.
 - Talked with Olivia about healthy and safe relationships.
 - Talked with her about information she could share with a friend.

- Divide into groups of three. One person is the provider, one person is the patient, one person is the observer
- Take 5 minutes to practice using the **Did You Know Your Relationship Affects Your Health** card to assess for reproductive coercion. Your goal is to introduce the card.
- Take 5 minutes to discuss as a group – what worked, what would you change?
- Switch roles so that each person has a chance to try out the skills.



Estimated Activity Time: 10 minutes

1. Read the instructions on the slide. Stress the importance of introducing the card QUICKLY- in a real clinical interaction there will have been more time for rapport building- assume that has already happened and you are ready to discuss the safety card. The triad should decide the reason for the visit (pregnancy test, contraceptive counseling, EC visit, etc.) There does not need to be a crisis or complicated back story for the patient– the goal is to introduce the card and use the appropriate panel to assess for reproductive coercion.
2. When the participants are in their groups, walk around the room and stop to hear how each group is doing. Some groups will be reluctant to do role plays and will default to discussing how to use the card. Gently nudge them to participate in the exercise.
3. Come back together as a group to debrief. How did it feel to use the card? Can providers imagine using this in their practice? What other questions do they need answered before they can confidently use the card in all of their reproductive health visits with female clients/patients?

Section Recap



- Use the **Did You Know Your Relationship Affects Your Health** safety card to provide education on reproductive coercion as part of routine care with sexually active young women.
- Simple harm reduction strategies can prevent a woman from becoming a victim of a forced, unwanted pregnancy.
- Health care providers are key to intervention for reproductive coercion by providing harm reduction and discreet methods of contraception

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Notes to Trainer: Read the “Section Recap” out loud to close each section.

Module 5: “What will
happen when
you tell him you
have an STI?”
Safer Partner
Notification



“What will happen
when you tell him you
have an STI?”



Safer Partner Notification

Estimated Module Time: 30 minutes

Training Outline

- Learning objectives
- Association between relationship abuse and STIs
- Safety assessment for STI partner notification
- Approaches to safer partner notification

Overview:

This module provides guidance for sites that provide STI screening and treatment. Experiencing IPV dramatically increases the risk of STIs and HIV among women and girls. In addition, patient-initiated partner notification for treatment of STIs/HIV can compromise a patient's safety if she is in an abusive relationship.

Learning Objectives

As a result of this activity, learners will be able to:

1. Give one example of a clinic policy that should be in place to ensure the safety of all patients presenting for diagnosis and treatment of an STI.
2. Describe how to assess for patient safety prior to any partner STI notification recommendations.
3. List two harm reduction strategies for partner STI notification when you know or suspect that the patient is in an abusive and/or controlling relationship.

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Notes to Trainer: Read the learning objectives aloud.



More than one-third (38.8%) of adolescent girls tested for STIs/HIV have experienced dating violence.

(Decker et al, 2005)



Notes to Trainer: Remind participants that given this statistic, every patient/client coming in for testing or treatment of STIs should be considered at risk for domestic violence and coercion—which makes seeking testing for STI a clinical indicator to screen for domestic violence.

In a review study of U.S. and international research on the intersection between IPV and HIV/AIDS, the increased risk of HIV/AIDS related to IPV among women and adolescents was related to several mechanisms, including compromised negotiation of safer sex practices, forced sex with an infected partner, and increased sexual risk-taking behaviors.

- Violence is both a significant cause and a significant consequence of HIV infection in women.
- More than one-half (51.6%) of adolescent girls diagnosed with an STI/HIV experience dating violence
- Qualitative research with adolescent girls who were diagnosed with STIs and disclosed a history of abuse suggests that the powerlessness they feel leads to a sense of acceptance that STIs are an inevitable part of their lives, stigma, and victimization

Decker MR, Silverman JG, Raj A. Dating Violence and Sexually Transmitted Disease/HIV Testing and Diagnosis Among Adolescent Females. *Pediatrics*. 2005; 116(2):3272-276.

“I told him to put a condom on, he didn't...I went to a clinic, and they were like, "Oh, he gave you Chlamydia." [H]e said it was me messin' around with some other guy, and that's not true, 'cause I was like, "You were the only guy I was with." And he's like, "Oh, that's you, you're messin' around," he's like, "f__k you, I thought you loved me.”



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Notes to Trainer: This quote was collected in a qualitative study about young women's experiences with reproductive coercion. In this case, the abusive male partner refused to use condoms and had multiple partners, while she remained monogamous. When the respondent tested positive for Chlamydia, he blamed her.

Miller E., Personal Communication, March 2, 2007.

Assessment Questions With Positive STI:

- How is your partner going to react if they find out you have an infection?
- Are you afraid he/she will hurt you if you tell him/her you have an STI?
- Would it help for us to talk to him/her?
- What can we do to help?



Notes to Trainer: Review safety assessment questions with a positive STI.

The Centers for Disease Control and Prevention (CDC) define Expedited Partner Therapy as:

“...the clinical practice of treating the sex partners of patients diagnosed with Chlamydia or Gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner.”

In many states the patient with the infection can bring the medication or the script for medication to their partner and the partner can be treated without ever seeing a health care provider.

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Notes to Trainer: Although Expedited Partner Treatment (EPT) is recommended by the CDC and ACOG as an approach that facilitates partner treatment and disease control, it may present unacceptable risks to a patient/client in an abusive relationship.

In a study with a culturally diverse sample of women seeking care at family planning clinics, female patients exposed to IPV were more likely to have partners who responded to partner notification by saying that the STI was not from them or accusing her of cheating. Some of the women reported threats of harm or actual harm in response to notifying their partner of an STI.

Always assess for safety before recommending a treatment approach. If EPT is part of your clinic protocol, modify the protocol to include a safety assessment prior to prescribing EPT.

For more information, go to: <http://www.cdc.gov/std/ept/default.htm>

McFarlane J, Parker B, Soeken K, Silva C, Reel S. Safety Behaviors of Abused Women Following an Intervention Program Offered During Pregnancy. *Journal of Obstetrical, Gynecological and Neonatal Nursing*. 1998; 27 (1):64-9.

Provider Tips for Safe Partner Notification:

- It is important that we notify the people you've had sex with about the infection.
 - We can talk to him about it in clinic
 - We can have someone call anonymously from the health department
 - You may be able to use an anonymous internet card service (www.sotheycanknow.org)
- If you decide you want to tell him yourself, tell him in a public place so you can leave easily if you need to.
- If you would like I can put you on the phone right now with (name of local advocate) and we can create a plan for you to maintain your safety.



Notes to Trainer: Offer different strategies to promote safety when notifying a partner about an STI. Reinforce that the risk of STI re-infection may be a more acceptable risk than the risk of abuse by the partner if notified of the need for treatment. STI control approaches may be too dangerous for an individual who is experiencing ARA.

Trainer can acknowledge that these are not a perfect solutions but that they are better than not addressing safety at all.

Sarah is a 17 year-old young woman. You have been seeing her since she turned 15. Today you are telling her that she has a Gonorrhea infection. This is her 3rd in the last year. Use the “Is your body being affected?” panel of the card to guide your conversation.



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Exercise Activity Time: 10 minutes

- Divide participants into groups of three.
- Advise participants that one person will role play the clinician, one is the client, and the third person is the observer.
- Advise the person who is role playing the clinician to use the “Is your body being affected” panel of the card to assess for reproductive coercion.
- Read the scenario, as shown on the slide, aloud to participants
- Allow 3-5 minutes for the role play.

Section Recap

- Partner notification may be dangerous for clients experiencing abuse.
- Patients may not be able to negotiate safe sex with an abusive partner.
- ARA may be a more immediate threat to a client than a sexually transmitted infection or HIV status.
- Explore alternative approaches to partner notification to enhance safety



Notes to Trainer: Read the “Section Recap” out loud to close each section.

Module 6: Building Bridges Between Adolescent Health and Domestic Violence Advocacy



Building Bridges Between Adolescent Health and Domestic Violence Advocacy

Estimated Module Time: 30 minutes

Training Outline

- Supported “Warm” Referral
- Partnering with local domestic and sexual violence advocacy groups
- Principles of patient-centered mandatory reporting

Overview

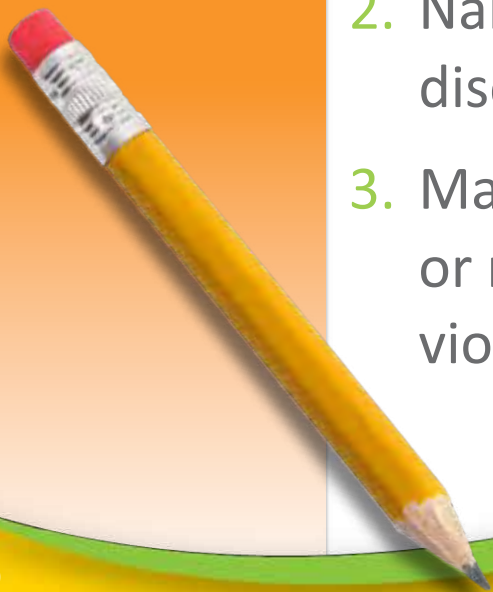
Prior to assessment for abuse and violence, practitioners should ensure protocols are in place for a safe and effective response. This means having specified roles and responsibilities within the clinic setting, knowledge of existing violence prevention and intervention resources within the local community and an established system for activating these resources depending on the situation.

Providers should not feel that they must have “all the answers.” In these moments, having a team in place to call upon is necessary so the provider is not left carrying the weight of the situation alone. It is ideal to have an in-person introduction to an advocate or social worker to connect the young person with ongoing support.

Learning Objectives

As a result of this activity, learners will be better able to:

1. Understand what services domestic violence programs provide.
2. Name the steps to responding to a disclosure of abuse.
3. Make a supported referral to local or national domestic and/or sexual violence resources



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Notes to Trainer: Read the learning objectives aloud.

Intervention: Supported Referral

- Adolescent health providers are key to help youth contact resources
 - Annotated referral list for violence related community resources that serve adolescents
 - Providers should know names of staff, languages spoken, how to get there on public transportation, etc.
- Educate patients that the clinic is safe place for them to connect to such resources
- Normalize the use of referral resources

Outcome: Increased awareness and utilization of DV/SA victim services



Notes to Trainer: Supported referral is the final element of the intervention. By offering support to facilitate the referral process, providers can increase the likelihood that a patient follows through with a referral. Two key strategies for supported referral are acknowledging a patient's safety concerns and offering options.

Stress here that this is different than just handing out a phone number – that the key here is knowing the services involved, discussing the people who are there: *“I know a woman Clara – she really understands this – and she could be really helpful to talk to.”*

Role of the Domestic Violence Advocate



- Domestic violence advocates provide safety planning and support
- Get to know local programs that SERVE youth
- Advocates can work with youth on safety planning and additional services like:
 - Housing
 - Legal advocacy
 - Support groups
 - One-on-one counseling
 - Referrals to other programs for health, mental health, etc.



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Contact the nearest domestic violence shelter that serves youth in your community or the domestic violence coalition in your state to talk with domestic violence advocates and learn more about services they provide, languages spoken, safety planning, training, and resources for youth who have experience ARA.

Remember that not all DV programs provide adolescent focused or appropriate services. Contact programs in your community to find out if SPECIFIC adolescent services are offered, and ascertain what options are available for youth under 18 years old who may need shelter services.

When you can connect to a local program it makes all the difference

“If you are comfortable with this idea, I would like to call my colleague at the local program, (fill in person's name), she is really an expert in what to do next and she can talk with you about a plan to be safer. ”



A key step in developing supported referral is to connect with existing support services for IPV in the community. Getting to know your local DV program staff will help ensure that each referral feels genuine and supportive to your patients. Making this connection can be mutually beneficial. Team-training with domestic violence advocates from local programs acknowledges their expertise and provides an opportunity to build working partnerships.

- DSV advocates are an excellent resource for training and advocacy
- DSV advocates will become more aware of what reproductive health services are available for women experiencing IPV.

- In the clinics that have close partnerships with local advocacy programs:

- Advocates did safety planning on site or by phone
- Advocates escorted women to safety out the backdoor of clinic

This did not happen in the sites without strong partnerships



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In work with *Project Connect* sites, we have seen that strong partnerships with local advocacy programs are key to providing compassionate and effective services.

Strategies for building the partnership included:

- Having an MOU (Memorandum of Understanding) in place, outlining each program's roles and responsibilities
- Cross-training for clinic and DV program staff. Offering "Reproductive Health 101" to advocates and "ARA 101 and health" to clinic staff helps create the context for the partnership
- Meetings to discuss policies and protocols related to addressing ARA, as well as supporting staff affected by relationship violence in the clinic setting
- Case reviews/regular check-ins
- Having a direct number to reach program staff (not having to go through the front desk/voice prompt system)

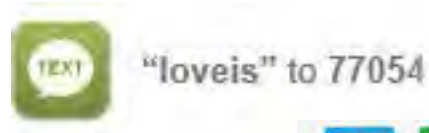
Barriers to Youth Receiving Services

- Get to know local programs that SERVE YOUTH
- Problem solving – what's the next step if there are not any?
- What is the work around?



Contact the nearest domestic and/or sexual violence program that serves youth in your community. Or contact the domestic and/or sexual violence coalition in your state to talk with domestic and/or sexual violence advocates and learn more what services are available for youth under 18 years old who may need shelter services.

Internet Resources, Texts or Chats May be Better Options for Youth



<http://www.loveisrespect.org>



<http://www.thatsnotcool.com/>

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Young people may be more interested and feel more comfortable using text, chat or internet-based options rather than calling a hotline. Provide information to youth about these options. Additional information about internet-based resources can be found online:

Staying Safe While Staying Connected Fact Sheet:

<http://www.chkd.org/documents/CAP/Staying%20Safe%20While%20Staying%20Connected.pdf>

Urban Institute's Digitizing Abuse Infographic:

<http://www.urban.org/digitizingabuse/infographic.cfm>

Providing a Warm Referral to the National Hotline

Funded in part by the U.S. Department of Health and Human Services' Office on Women's Health (Grant #1 ASTWH110023-01-00) and Administration on Children, Youth and Families (Grant #90EV0414).



Formerly Family Violence Prevention Fund

FuturesWithoutViolence.org



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

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If you or someone you know ever just wants to talk, you can call these numbers. All of these hotlines are free, confidential, and you can talk to someone without giving your name.

National Teen Dating Abuse Helpline
1-866-331-9474 or online chat
www.loveisrespect.org

Suicide Prevention Hotline
1-800-273-8255

Teen Runaway Hotline
1-800-821-4000

Rape, Abuse, Incest,
National Network (RAINN)
1-800-656-HOPE (1-800-656-4673)

“There are national confidential hotline numbers and the people who work there really care and have helped thousands of women. They are there 24/7 and can help you find local referrals”



If there are not any local resources or you do not have information about local referrals, the National Domestic Violence Hotline can help. The National Domestic Violence Hotline staff have been trained on both sexual and reproductive coercion so the staff are very familiar with these issues. They would be an excellent referral for survivors.

Offering a patient use of a phone at the clinic to call a domestic violence hotline or an advocate can be a safe strategy that increases access to services. Remind participants that youth may prefer to use internet, chat or text options instead of a call in hotline.

6 Steps for Responding to Disclosures

1. Validate patient's experience.
2. Offer a safety card for patient to review and keep if it is safe to do so.
3. Discuss where patient can go to learn more about and obtain birth control options.
4. Ask patient if she has immediate safety concerns and discuss options.
5. Refer to a DSV advocate for safety planning and additional support.
6. Follow up at next visit.

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Notes to Trainer: Distribute and review the *Six Steps for Responding to Disclosures* handout. Participants will use it for the Practical Application featured later in this section.

Examples of validation & supportive messages:

- "I'm glad you talked to me about this today."
- "I'm so sorry this happening in your life, you don't deserve this."
- "It's not your fault."
- "I'm worried about the safety of you and your children."
- "You deserve to be treated with respect."
- "There is help available."

Preparing Your Practice for Mandatory Reporting

- Learn your state law and how it is applied in your county
- Partner with local DV and SA programs that can provide guidance and support
- Find out what to report and to whom
- Many forms of ARA are not reportable but some forms of sexual and physical violence are
- Even when reporting requirements are not triggered, an intervention is indicated



Notes to Trainer: Participants may be concerned about what to do when a report for abuse is mandated. The following three slides cover the basic principles of client-centered mandatory reporting. They do NOT include specific laws or local referrals. As you prepare for your training, it is critical that you find out as much as possible about the applicable laws, as well as identify local experts in confidentiality and reporting.

The National Center for Youth Law's "Teen Health Law" website, http://www.teenhealthlaw.org/resources_for_other_us_states/, has information about minor consent and child abuse reporting for many, but not all states.

Physicians for Reproductive Health has created "minor's Access Cards" which address consent, confidentiality and child abuse reporting in 13 states, <http://prh.org/resources/minors-access-cards/?q=resources-minors-access-cards>.

Remember that Title X Family Planning Clinics protect minor consent and confidentiality even when State law does not. **HOWEVER**, even when services are provided in a Title X clinic, state child abuse reporting laws define situations when confidentiality must be breached in order to comply with reporting laws

The following information should be documented:

- Was the patient screened for IPV and if not, what was the reason it was not done?
- Patient's response to screening
- Health impact if any abuse disclosed
- Resources provided and discussed
- Referrals offered

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Notes to Trainer: The following information should be routinely documented in patients' charts:

- Confirmation that the patient was assessed for IPV and reproductive and sexual coercion or the reason why assessment could not be done and any plans for follow-up actions to ensure that the patient will be screened
- Patient response to screening
- Documentation of resources provided such as Safety Cards
- Any referrals provided

In addition to offering appropriate referrals and assistance when a patient discloses victimization, ask the patients if a follow-up appointment can be scheduled at this time. It is also helpful to ask the patient for contact information, such as a phone number it is safe to contact her or him, so that any future contact will be done in a way that minimizes risk to the patient.

Documentation

- Good documentation potentially allows a provider to avoid needing to give testimony if subpoenaed (note: good hand writing matters)
- Write legibly
- Use documentation forms to help guide you
- Photograph all injuries



Notes to Trainer: Good documentation really matters. In cases when charges are pressed against the abuser or if a patient is pursuing a criminal or civil protective order. For example, if at trial the medical record and the abuser's testimony are in conflict, the record is often considered more credible. Old records may also be helpful in uncovering and documenting a pattern of past abuse. So, write legibly so that you're less likely to be called into court to interpret your records.

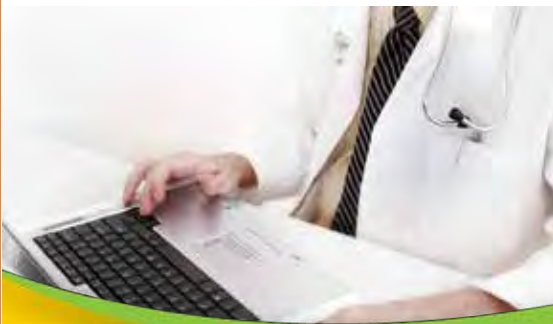
For more information about documentation:

<http://www.healthcaresaboutipv.org/tools/documentation/> toolkit will take you through best practices for photo documentation and/or how to hand draw a body map if the injuries don't show up well in a photograph. It will also help you consider other diagnostics tools including x-rays and cat scans and other imaging that can provide additional evidence of abuse related to trauma.

How Do I Code for the Service Provided?

Although there is no specific CPT code for IPV screening, others can be used:

- Code V82.89 (Special screening for other conditions)
- Preventive Medicine Service codes 99381-99397 include age appropriate counseling/anticipatory guidance/risk factor reduction interventions. These codes could be used to record assessment and counseling for IPV.



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Notes to Trainer: Some providers may ask how to code for screening and brief counseling for IPV. It is important to note that there is currently no procedural code (CPT) for IPV. However, these general preventive services codes could be used.

Diagnostic (or ICD9) codes

The following diagnostic codes could also be used:

- 995.81 - Adult physical abuse
- 995.82 - Adult emotional/psychological abuse
- 995.83 - Adult sexual abuse



Notes to Trainer: In addition, the ICD9 codes above can be used as diagnostic codes.

When You Need to Report:

- After the reason the patient was seeking care has been addressed, remind the young person of the limits of confidentiality discussed at the start of the visit, then inform her of the requirement to report.



"Remember at the start of this visit we talked about situations where if your safety is at risk that we would have to get others involved? This is one of those times. I know it took a great deal of courage to share this with me, and we need to make sure that you are safe."

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Notes to Trainer: It is important to keep in mind adolescents' fears about disclosure to parents or authorities (police, school, etc.) when abuse reporting is mandated.

Supporting a Patient When You need to Make a Report

- Inform your patient of your requirement to report
- Explain what is likely to happen when the report is made
- Maximize the role of the patient in the process
- Ask your patient if she is willing to call or meet with an advocate to develop a safety plan in case of retaliation



Notes to Trainer: Before you do training, learn about the reporting requirement for your county and state. Information that you will need to know includes:

- Who is required to report?
- What must be reported?
- To whom is the report made?
- What are the likely outcomes of calling the police or child protective services?
- What are the safety considerations you can address with your client?
- Are there provisions for confidentiality of reports?

Ways to involve the patient/client in the process include asking if she would like to be present when you make the report if that is safe to do and keeping her informed about the process.

Encourage participants to contact local domestic violence program/shelter and domestic violence coalitions in their state to learn about additional training, consultation on particular cases, and resources for their patients.

Remind participants that making a report can never substitute for the important care they provide.

Olivia: Forced Sex



The following video clip demonstrates disclosing limits of confidentiality and trauma-informed reporting

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Estimated Activity Time: 5 minutes to watch video and 10 minutes for discussion.

Note to Trainer: Remind participants to focus on the issues of confidentiality and trauma-informed child abuse reporting, not aspects of the clinical care delivered. See next slide for discussion questions.

- What worked well?
- What would you change?
- What are some key approaches to trauma-informed reporting that you can integrate into your practice?



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Notes to Trainer: Discuss video clip.

What did the provider do well?

- Addressed the patient's medical concerns before discussing the need to report
- Built a good patient rapport
- Offered patient a way to feel more in control once it became clear the report had to be made

Practical Application

- Divide into groups of three. One person is the provider, one person is the patient, one person is the observer
- Scenario: Your patient discloses abuse: “Yes, sometimes I am afraid.”
- Use the ***Six Steps for Responding to Disclosures*** and the safety card as your guide to respond.
- Discuss as a group – what worked, what would you change?

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Estimated Activity Time: 10 minutes

1. Read the instructions on the slide. Stress the importance of introducing the card QUICKLY- in a real clinical interaction there will have been more time for rapport building- assume that has already happened and the patient has already disclosed abuse.
2. When the participants are in their groups, walk around the room and stop to hear how each group is doing. Some groups will be reluctant to do role plays and will default to discussing how to use the card. Gently nudge them to participate in the exercise.
3. Come back together as a group to debrief. How did it feel to use the card? Can providers imagine using this in their practice? What other questions do they need answered before they can confidently respond to disclosures?


Section Recap

- Health care providers play an important role in connecting victims to advocacy services
- Become familiar with the resources on the safety card.
- Create partnerships with your local domestic violence program, so that you can make warm referrals



Notes to Trainer: Read the “Section Recap” out loud to close each section.

Module 7: Preparing Your Program: Supporting Staff Exposed to Violence and Trauma



Supporting Staff Exposed to Violence and Trauma



Preparing Your Program

Module 7

Estimated Module Time: 20 minutes

Training Outline

- Learning objectives
- Secondary traumatic stress
- Handout on common reactions to working with trauma
- Strategies for clinicians and program managers
- Organizational self-assessment tool

Overview

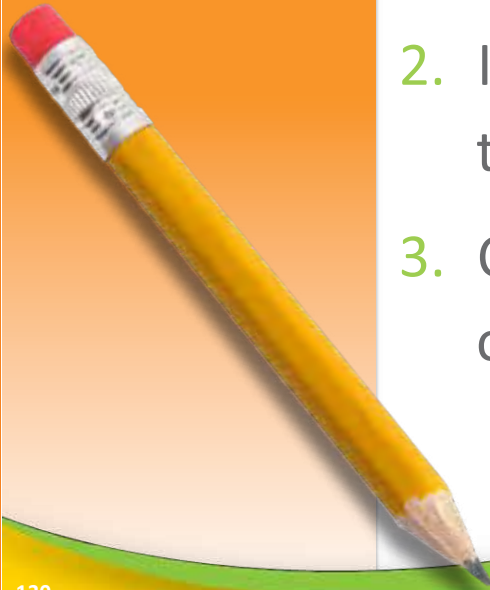
Working with clients who experience trauma can affect the service provider, creating secondary traumatic stress. This module reviews personal safety and self-care strategies for providers and policies that managers can implement to support their staff.

Review the explanation of secondary traumatic stress and acknowledge that personal experiences with violence can impact how providers respond to clients experiencing violence and vulnerability to secondary traumatic stress. Then provide the handout on common reactions to caring for survivors of trauma and give participants a few minutes to review the handout.

Learning Objectives

As a result of this activity learners will be better able to:

1. Identify 3 signs of secondary trauma
2. Identify 3 strategies to prevent traumatic stress
3. Complete a trauma-informed organizational self-assessment



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Notes to Trainer: Read the learning objectives aloud.

Secondary Traumatic Stress

Secondary traumatic stress, also referred to as vicarious trauma, burnout, and compassion fatigue, describes how caring for trauma survivors can have a negative impact on service providers.

Handout: Secondary Trauma



Notes to Trainer: Pass out handout “Secondary Trauma”

Secondary traumatic stress, also referred to as vicarious trauma, burnout, and compassion fatigue, describes how caring for trauma survivors can have a negative impact on service providers. Have participants review the handout- can they identify any of the symptoms of vicarious trauma in themselves or their colleagues? Are there other reactions they would add to the list?

Exposure to Violence and Secondary Traumatic Stress

- Lifetime exposure to violence is common
- Working with patients who are experiencing domestic violence can trigger painful memories and trauma for staff
- A personal history of exposure to violence increases the risk of experiencing secondary traumatic stress

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Notes to Trainer: Revisit the concept that individuals doing this work may have their own personal history with abusive relationships, domestic violence and/or child abuse. These experiences and memories may be triggered by working with clients in similar situations. Self awareness, time for reflection, and organizational support are essential in creating an environment that promotes the health of both clients and providers.

Personal Strategies to Prevent Traumatic Stress

- Identify resources available through employee assistance/human resource programs
- Implement debriefing sessions and periodic case reviews
- Develop plans for how to respond to different situations that are stressful for staff
- Offer stress management training to staff
- Implement policies to maintain a secure and violence-free work environment



Notes to Trainer: Ask participants what strategies are in place at their workplace. Encourage participants to talk with their supervisors to assure that their safety and well-being is supported by the agency or clinic where they work.

Workplaces Respond to Domestic and Sexual Violence: A National Resource Center, makes it easier than ever for employers to adopt vitally important policies to protect employees from domestic and sexual violence. The new Center was formed by a partnership of seven national organizations led by Futures Without Violence, and funded by the Justice Department's Office on Violence Against Women (OVW). For more information, visit: www.workplacesrespond.org

Encourage program managers to implement strength-based practices so that only staff who have had training on domestic violence, who are comfortable with doing screening, and who are prepared to respond appropriately to disclosures are assessing patients.

Resource: Trauma- Informed Organizational Self- Assessment



- Instrument designed to help agencies create trauma-informed, supportive work environments
- Checklist format for organizations to evaluate:
 - Training and education
 - Support and supervision
 - Communication
 - Employee control and input
 - Work environment
- Self-assessment handout for employees

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Notes to Trainer: Trauma-informed Organizational Self Assessment. The National Center on Family Homelessness. Download at www.familyhomelessness.org

Section Recap

- Working with patients who experience violence can affect the service provider, creating secondary traumatic stress.
- A key component to institutionalizing a trauma-informed, coordinated response to IPV and reproductive and sexual coercion is creating a safer and more supportive working environment.



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Notes to Trainer: Read the “Section Recap” out loud to close each section.

Safety Cards, Pregnancy Wheels, Posters and Clinical Guidelines



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Notes to Trainer: Safety cards, posters, clinical guidelines and pregnancy wheels are available from the FWV website for free with a nominal shipping charge. Patient materials are available in English and Spanish. Safety cards have also been developed for special populations (e.g. Native American women, Perinatal Health, Campus Safety, Behavioral Health, etc.). Visit the website to preview and order materials

<http://www.futureswithoutviolence.org/content/features/detail/790/>

Technical Assistance

For questions about how to introduce and facilitate training vignettes and for other free technical assistance and tools including:

- Posters
- Safety cards
- Guide to Addressing Intimate Partner Violence, Reproductive and Sexual Coercion
- Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse

Visit: www.FuturesWithoutViolence.org/health

Call: **415 678-5500**

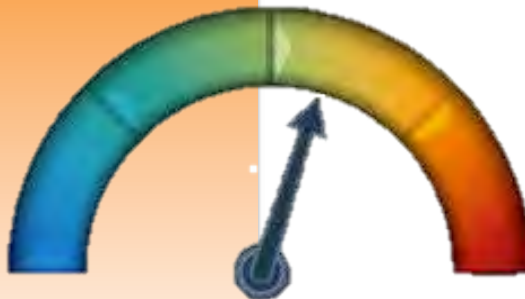
Email: **health@FuturesWithoutViolence.org**



Notes to Trainer: Contact information is also listed in the Adolescent Health Guidelines. Encourage participants to visit the Futures Without Violence website for additional information.

REVISIT: Where Am I?

- Draw a “comfort meter”
- On the left end of the meter is “not at all comfortable”
- On the right end of the meter is “very comfortable”



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Estimated Activity Time: 2-3 minutes

Notes to Trainer: Ask participants if anyone would like to share their observations about any impact that the training has had on their level of comfort with addressing adolescent relationship abuse with patients.

A key strategy for effective trainers is always having the last word at a training. Complete the discussion and then provide your closing comments about what you want the participants to take home from this training.

Please Complete the Post-Training Survey

Thank You!



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Module 7

Notes to Trainer: Hand-out the post-training survey for participants to complete and provide your contact information for any questions and follow-up. Remind participants that their responses are confidential.

Share your closing thoughts and thank participants for their time, expertise, and dedication to making a difference for the families and communities they work with.

Appendices



PRE-TRAINING SURVEY FOR ADOLESCENT PROVIDERS

Thank you very much for joining us!

As you know, exposure to violence is associated with multiple poor health outcomes for adolescents, and is likely to impact the lives of many of the clients you work with and counsel. We are developing strategies for incorporating discussions about promoting healthy relationships and adolescent relationship abuse (ARA) into current protocols.

We would like to ask you a few questions about your experiences as a health care provider talking to your adolescent patients about healthy relationships, exposure to ARA, and which areas you would like to have additional training and support.

Please take a few moments to answer the following questions. Your responses will be kept confidential. You may skip any questions that you do not want to answer, and can stop taking the survey at any time.

We would also like to contact you in a few months to find out how useful this training was to you in practice, whether you were able to use any of the components presented, and to have you reflect on additional training, resources, and supports you want to see.

We greatly appreciate your taking the time to answer these questions for us as we aim to promote healthy relationships in adolescent health settings.

Date: _____

State: _____



Pre-Training Survey For Adolescent Providers

1. Have you ever attended any professional development sessions specific to adolescent relationship abuse (ARA) and reproductive and sexual coercion (RSC) in adolescent health settings?
A) Yes
B) No

IF YOU ARE A PRACTICE MANAGER/ADMINISTRATOR

(meaning you work in an adolescent setting but are not directly interacting with clients)

please skip to page 4, question #11

2. How often do you talk to your adolescent clients about healthy relationships?
A) All of the time (100%)
B) Most of the time (75% or more)
C) Some of the time (25% - 75%)
D) Not so often (10% - 25%)
E) Rarely (less than 10%)
F) Not applicable
3. How often do you review the limits of confidentiality with your adolescent clients before asking about coercion or violence?
A) All of the time (100%)
B) Most of the time (75% or more)
C) Some of the time (25% - 75%)
D) Not so often (10% - 25%)
E) Rarely (less than 10%)
F) Not applicable
4. How often are you giving your adolescent clients a *Hanging Out or Hooking Up* safety card about healthy relationships?
A) All of the time (100%)
B) Most of the time (75% or more)
C) Some of the time (25% - 75%)
D) Not so often (10% - 25%)
E) Rarely (less than 10%)
F) Not applicable



Pre-Training Survey For Adolescent Providers

5. When seeing an adolescent client, how often do you assess for adolescent relationship abuse (ARA)?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
6. When seeing an adolescent client, how often do you assess for reproductive and sexual coercion (RSC)?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
7. In a visit addressing alcohol and other drug use, how often do you ask whether their relationship may be affecting their substance use (including self-medication, managing fear or trauma)?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
8. In a visit addressing depression or suicidality, how often do you ask whether their relationship may be affecting their mood and self-worth?
 - A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable

Pre-Training Survey For Adolescent Providers

- 9. How often do you assess clients' safety and discuss ways to stay safe in an unhealthy relationship?**
- A) All of the time (100%)
 - B) Most of the time (75% or more)
 - C) Some of the time (25% - 75%)
 - D) Not so often (10% - 25%)
 - E) Rarely (less than 10%)
 - F) Not applicable
- 10. What are reasons that you may not address ARA/RSC during a visit? (mark all that apply)**
- A) Not enough time
 - B) It is against my organization's policy (for example, we do not initiate conversations about sex or sexual relationships)
 - C) The partner is present for the visit
 - D) A family member is present for the visit
 - E) Worried about upsetting the client
 - F) Not sure what to say if they disclose an abusive/violent relationship
 - G) Not sure how to ask questions without seeming too intrusive
 - H) Not knowing where to refer them to
 - I) Worried about mandated reporting
 - J) Have already screened them at past visit
 - K) Does not apply to my patient population
 - L) Other (please be as specific as you can)
-
- 11. In your clinic/practice are there specific protocols about what to do when a client discloses adolescent relationship abuse (ARA) or reproductive and sexual coercion (RSC)?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 12. In your clinic/practice are there any instructions/protocols on when reports on sexual assault and ARA need to be filed?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know

Pre-Training Survey For Adolescent Providers

- 13. In your clinic/practice are there sample scripted tools or written instructions on how to provide validation and supported referrals to advocacy services with clients who disclose ARA/RSC?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 14. In your clinic/practice, do you have local and/or regional information about ARA/RSC resources that staff and providers can access easily?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 15. Does your clinic/practice/adolescent health setting have (mark all that apply):**
- A) Adolescent focused brochures, cards or information about adolescent relationship abuse (ARA) and reproductive and sexual coercion (RSC)
 - B) Posters about ARA/RSC displayed
 - C) *Hanging Out or Hooking Up* safety cards about ARA/RSC that clients can take
 - D) A list of violence-related resources and who to call with questions
 - E) Prompts inserted into charts to remind providers to assess for ARA/RSC
 - F) In-service trainings for all clinic staff on ARA/RSC
 - G) Other (please be as specific as you can)
-
- 16. Are educational materials available on adolescent relationship abuse (ARA) and reproductive and sexual coercion (RSC) in the languages most commonly spoken in your setting?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know
- 17. Are the materials available on ARA/sexual coercion inclusive of diverse relationships including sexual minorities, LGBTQ (lesbian, gay, bisexual, transgender, queer or questioning) youth?**
- A) Yes
 - B) No
 - C) Not applicable
 - D) Don't know

Pre-Training Survey For Adolescent Providers

18. What ongoing support do you need to confidently incorporate discussion of ARA/RSC in all your encounters with adolescent clients? (mark all that apply)

- A) Workshops and training sessions
 - B) Protocols that include specific questions to ask
 - C) List of violence-related resources and who to call with questions
 - D) Case consultation
 - E) Online training
 - F) Other (please be as specific as you can)
-

19. Does your clinic/practice/adolescent health setting participate in school-based sexual or reproductive health education?

- A) Yes
- B) No
- C) Not applicable
- D) Don't know

20. To what level are you able to affect change in your clinic/practice?

- A) Very able to affect change
- B) Somewhat able to affect change
- C) Uncertain
- D) Unable to affect change
- E) Very unable to affect change

Additional Comments:



Pre-Training Survey For Adolescent Providers

Optional: Please tell us a little about yourself. This information will help us better understand who we are reaching with these trainings. Please remember this information is anonymous and confidential, no names attached.

21. In what kinds of settings do you provide adolescent health care? (mark all that apply)

- A) Free-standing clinic
 - B) Community health center
 - C) Hospital-based clinic
 - D) Reproductive Health/Family Planning clinic
 - E) School-based health center
 - F) School nurses' office
 - G) Other (please specify)
-

22. What is your training background? (mark all that apply)

- A) Reproductive health specialist/family planning counselor
 - B) Promotora or community health worker
 - C) Nurse practitioner (specify specialty area _____)
 - D) Physician assistant (specify specialty area _____)
 - E) Nurse (specify specialty area _____)
 - F) Physician (specify specialty area _____)
 - G) Clinic administrator/Practice manager
 - H) Other
-

23. How many years have you been providing adolescent health care?

- A) Fewer than 5 years
- B) 5-10 years
- C) More than 10 years

24. How do you describe your gender?

- A) Female
- B) Male
- C) Transgender
- D) Other



Pre-Training Survey For Adolescent Providers

25. How do you describe your ethnic background? (mark all that apply)

- A) Caucasian/White
 - B) African American/Black
 - C) Native American/Native Hawaiian
 - D) Asian American
 - E) Hawaiian/Pacific Islander American
 - F) Hispanic/Latino(a)
 - G) Multi-racial
 - H) Other (please specify)
-

26. What is your age?

- A) Less than 20 years
- B) 20-39 years
- C) 40-59 years
- D) Greater than 60 years

Thank you for your time!





EXAMPLES OF THE ADOLESCENT HEALTH SAFETY CARD

(ENGLISH AND SPANISH)

Tear out these sample cards and fold them to wallet size. To order additional cards for your program go to: www.futureswithoutviolence.org/onlinestore.

FOLD >

¿Qué hay del respeto?

La persona con quien estás (ya sea hablando, saliendo, o conectándote) debe:

- ✓ Hacerte sentir segura(o) y cómoda(o).
- ✓ No presionarte o tratar de emborracharte o drogarte para tener sexo contigo.
- ✓ Respetar tus límites y preguntar si puede tocarte o besarte (o cualquier otra cosa).

¿Cómo te gustaría que tu mejor amiga(o), o tu hermana(o) fuera tratada(o) por la persona con quien está saliendo? Pregúntate si la persona que tú estás viendo te trata con respeto y si tú le tratas con respeto.

Cómo Ayudar a Un(a) Amiga(o)

¿Crees que alguna(o) de tus amigas(os) está en una relación que no es buena para ella (él)?

Sigue estos pasos para ayudarlo:

- ✓ Dile a tu amiga(o) que lo que has visto en su relación te preocupa.
- ✓ Habla con tu amiga(o) en privado, y no le cuentes a otras(os) amigas(os) lo que platicaron.
- ✓ Muéstrale www.loveisrespect.org y dale una copia de esta tarjeta.
- ✓ Si tú o alguien que tú conoces se siente tan triste que planea hacerse daño o desea morir—busca ayuda. Red Nacional de Prevención del Suicidio: 1-800-273-8255

FOLD >

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Fundado en parte por el Departamento de Salud y Servicios Humanos de EE. UU. para la Oficina de la Salud de la Mujer y la Administración de Niños, Jóvenes y Familias.

Si tú o alguien que tú conoces quisiera hablar acerca de su situación con personas que ofrecen apoyo, llama a estos números. Todas estas líneas directas son gratis y confidenciales, y puedes hablar con alguien sin tener que dar tu nombre.

Línea Nacional sobre el Abuso de Novios Adolescentes
1-866-331-9474
o platica/chatea (Chatroom) en Internet
www.loveisrespect.org

Red Nacional de Prevención del Suicidio
1-800-273-8255

Línea Directa Para Jóvenes que Huyen de Casa (National Runaway Switchboard)
1-800-621-4000

Red Nacional de Violación, Abuso, Incesto (RAINN)
1-800-656-HOPE (1-800-656-4673)

FOLD >



¿Saliendo o Conectando?

What About Respect?

Anyone you're with (whether talking, hanging out, or hooking up) should:

- ✓ Make you feel safe and comfortable.
- ✓ Not pressure you or try to get you drunk or high because they want to have sex with you.
- ✓ Respect your boundaries and ask if it's ok to touch or kiss you (or whatever else).

How would you want your best friend, sister, or brother to be treated by someone they were going out with? Ask yourself if the person you are seeing treats you with respect, and if you treat them with respect.

How to Help a Friend

Do you have a friend who you think is in an unhealthy relationship?

Try these steps to help them:

- ✓ Tell your friend what you have seen in their relationship concerns you.
- ✓ Talk in a private place, and don't tell other friends what was said.
- ✓ Show them www.loveisrespect.org and give them a copy of this card.
- ✓ If you or someone you know is feeling so sad that they plan to hurt themselves and/or wish they could die—get help. Suicide Hotline: 1-800-273-8255

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Funded by the Administration on Children, Youth and Families, U.S. Department of Health and Human Services and the Office on Women's Health, U.S. Department of Health and Human Services.

If you or someone you know ever just wants to talk, you can call these numbers. All of these hotlines are free, confidential, and you can talk to someone without giving your name.

National Teen Dating Abuse Helpline
1-866-331-9474 or online chat
www.loveisrespect.org

Suicide Prevention Hotline
1-800-273-8255

Teen Runaway Hotline
1-800-621-4000

Rape, Abuse, Incest, National Network (RAINN)
1-800-656-HOPE (1-800-656-4673)



Hanging out or Hooking up?



Can you talk to the person you are seeing about:

- ✔ How far you want to go sexually?
- ✔ What you don't want to do?
- ✔ Preventing STDs by using condoms?
- ✔ Birth control?

If you answered NO to any of these questions, maybe this person is pushing you to do things you don't want to do. Or you might not feel comfortable bringing this up. Try using this card as a conversation starter. "I got this card in a clinic and wanted to talk about it with you."

What About Sex?

Getting a lot of texts can feel good—"Wow, this person really likes me!"

What happens when the texts start making you uncomfortable, nervous, or they keep coming nonstop?

Fighting out what to say can be hard, especially if you like the person.

Be honest. "You know I really like you, but I really don't like it when you, text me about where I am all the time or pressure me for naked pics." For more tips on what to say go to: www.thatnotcool.com.

Everybody Texts

How often does the person you are seeing:

- ✔ Shame you or make you feel stupid?
- ✔ Pressure you to go to the next step when you're not ready?
- ✔ Control where you go, or make you afraid?
- ✔ Grab your arm, yell at you, or push you when they are angry or frustrated?

Nobody deserves to be treated this way. If these things ever happen in your relationship, talk to someone about it. For more info, go to www.loveisrespect.org.

And on a Bad Day?

Does the person you are seeing (like a boyfriend or a girlfriend):

- ✔ Treat you well?
- ✔ Respect you (including what you feel comfortable doing sexually)?
- ✔ Give you space to hang out with your friends?
- ✔ Let you wear what you want to wear?

If you answered YES—it sounds like they care about you.

How is it Going?



Puedes hablar con la persona con quien estás saliendo acerca de:

- ✔ ¿Hasta dónde quieres llegar sexualmente?
- ✔ ¿Lo que tú no quieres hacer?
- ✔ El uso de condones para prevenir las infecciones de transmisión sexual (ITS)?
- ✔ Métodos anticonceptivos?

Si contestaste NO a cualquiera de estas preguntas, quizás esta persona te está presionando a hacer cosas que tú no quieres hacer. O quizás no te sientes cómoda(o) tocando este tema. Trata de usar esta tarjeta para comenzar la conversación. "Recogí esta tarjeta en la clínica y quiero hablar contigo acerca de ella."

¿Qué tal el sexo?

Recibir muchos textos puede hacernos sentir bien—"¡Vaya!, esta persona realmente me quiere."

¿Qué pasa cuando los textos te hacen sentir molesta(o), nerviosa(o), o llegan sin parar?

Decidir qué vas a decir puede ser difícil, especialmente si te gusta esta persona.

Sé honesta(o). "Sabes que tú me gustas, pero a mí no me agrada cuando me mandas textos tan seguido, preguntándome dónde estoy o presionándome para que te mande fotos desnuda(o)." Para más consejos sobre qué decir, visita: www.thatnotcool.com.

Todos enviamos textos

La persona con la que estás saliendo, qué tan seguido:

- ✔ Te humilla o te hace sentir avergonzada(o)?
- ✔ Te presiona a tomar el próximo paso cuando no estás lista(o)?
- ✔ Controla a dónde vas, o te da miedo?
- ✔ Te agarra por el brazo, te grita, o te empuja cuando estás enojado(a) o frustrado(a)?

Nadie merece ser tratado de esta manera. Si alguna vez esto pasa en tu relación, habla con alguien sobre esto. Para más información, visita el sitio en el Internet www.loveisrespect.org.

¿Y en un día malo?

La persona con quien estás saliendo (como novia o novia):

- ✔ Te trata bien?
- ✔ Te respeta (incluyendo tus deseos y límites sexuales)?
- ✔ Te da espacio para salir con tus amigas(os)?
- ✔ Te deja vestirse como tú quieres?

Si contestaste SI—Parece que te aprecia.

¿Cómo te va?

EXAMPLES OF THE REPRODUCTIVE HEALTH SAFETY CARD

(ENGLISH AND SPANISH)

Tear out these sample cards and fold them to wallet size. To order additional cards for your program go to: www.futureswithoutviolence.org/onlinestore.

¿Quién controla las decisiones de EMBARAZO?

Pregúntese. Mi pareja:

- ✓ ¿Ha intentado presionarme o forzarme para que me embarace?
- ✓ ¿Me ha lastimado amenazado porque no estoy de acuerdo en embarazarme?

Si alguna vez he estado embarazada:

- ✓ ¿Mi pareja me ha dicho que me lastimaría si no hacía lo que él quería con el embarazo (en cualquier dirección, continuar con el embarazo o aborto)?

Si respondió *SÍ* a cualquiera de estas preguntas, no está sola y merece tomar sus propias decisiones sin tener miedo.

FOLD >

Obteniendo Ayuda

- ✓ Si su pareja revisa su teléfono celular o textos, hable con su proveedor de atención médica acerca de cómo usar su teléfono para llamar a los servicios de violencia doméstica, para que su pareja no pueda verlo en su registro de llamadas.
- ✓ Si tienen una enfermedad de transmisión sexual (ETS) y teme que su pareja la lastime si le dice, hable con su proveedor de atención médica acerca de cómo estar más segura y como ellos le pueden decir a su pareja de la infección sin usar su nombre.
- ✓ Estudios muestran que educar a sus amigos y familiares sobre el abuso puede ayudarles a tomar pasos para estar más seguros—dándoles esta tarjeta puede hacer una diferencia en sus vidas.

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Todas estas líneas nacionales pueden conectarla a recursos locales y brindarle apoyo. Para obtener ayuda 24 horas al día, llame al:

Línea Nacional Sobre la Violencia Doméstica
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

Línea Nacional de Maltrato entre Novios Jóvenes
1-866-331-9474
www.loveisrespect.org

Línea de Crisis Nacional de Abuso Sexual
1-800-656-4673
www.rainn.org

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¿Sabía Que Su Relación Afecta Su Salud?

Who controls PREGNANCY decisions?

Ask yourself. Has my partner ever:

- ✓ Tried to pressure or make me get pregnant?
- ✓ Hurt or threatened me because I didn't agree to get pregnant?

If I've ever been pregnant:

- ✓ Has my partner told me he would hurt me if I didn't do what he wanted with the pregnancy (in either direction—continuing the pregnancy or abortion)?

If you answered *YES* to any of these questions, you are not alone and you deserve to make your own decisions without being afraid.

Getting Help

- ✓ If your partner checks your cell phone or texts, talk to your health care provider about using their phone to call domestic violence services—so your partner can't see it on your call log.
- ✓ If you have an STD and are afraid your partner will hurt you if you tell him, talk with your health care provider about how to be safer and how they might tell your partner about the infection without using your name.
- ✓ Studies show educating friends and family about abuse can help them take steps to be safer—giving them this card can make a difference in their lives.

Funded in part by the U.S. Department of Health and Human Services' Office on Women's Health (Grant #1 ASTWH110023-01-00) and Administration on Children, Youth and Families (Grant #90EV0414).

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All these national hotlines can connect you to your local resources and provide support:

For help 24 hours a day, call:
National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

National Dating Abuse Helpline
1-866-331-9474
www.loveisrespect.org

National Sexual Assault Hotline
1-800-656-HOPE (1-800-656-4673)
www.rainn.org

Did You Know Your Relationship Affects Your Health?



pill bottle so your partner won't know.
be taken out of its packaging and slipped into an envelope or empty
Emergency contraception (some call it the morning after pill) can be
The IUD can be removed at anytime when you want to become pregnant.
up to 10 years. The strings can be cut off so your partner can't feel them.
(like IUD, implant, or shot/injection).
Talk to your health care provider about birth control you can control

Taking Control:
Your partner may see pregnancy as a way to keep you in his life and stay
connected to you through a child—even if that isn't what you want.
If your partner makes you have sex, messes or tampers with your
birth control or refuses to use condoms:
Talk to your health care provider about birth control you can control

Ask yourself:
Am I afraid to ask my partner to use condoms?
Am I afraid my partner would hurt me if I told him I had an
STD and he needed to be treated too?
Have I hidden birth control from my partner so he wouldn't get
me pregnant?
Has my partner made me afraid or physically hurt me?
If you answered YES to any of these questions, you may be at
risk for STD/HIV, unwanted pregnancies and serious injury.

Are you in an UNHEALTHY relationship?
Does my partner mess with my birth control or try to get me
pregnant when I don't want to be?
Does my partner refuse to use condoms when I ask?
Does my partner make me have sex when I don't want to?
Does my partner tell me who I can talk to or where I can go?
If you answered YES to any of these questions, your
health and safety may be in danger.

Are you in a HEALTHY relationship?
Is my partner kind to me and respectful of my choices?
Does my partner support my using birth control?
Does my partner support my decisions about if or when I want to
have more children?
If you answered YES to these questions, it is likely that you are in a
healthy relationship. Studies show that this kind of relationship leads to
better health, longer life, and helps your children.



Tomando Control:
Su pareja puede ver el embarazo como una forma de mantenerse en su vida y
mantenerse conectado a través de un niño, aun cuando eso no es lo que usted desea.
Si su pareja le hace tener sexo, se entremete o altera su
anticonceptivo, o se niega a usar condones:
Hable con su proveedor de atención médica sobre anticonceptivos
que usted pueda controlar (como el dispositivo intrauterino (DIU),
implante anticonceptivo o inyección anticonceptiva).
El DIU es un dispositivo de seguro que se pone en el útero y evita
un embarazo hasta por 10 años. Los hilos se pueden cortar para que
su pareja no los sienta.
Anticonceptivos de emergencia (unos le llaman la píldora de la mañana
siguiente) se puede tomar hasta cinco días después de tener relaciones
sexuales sin protección para evitar un embarazo. Se pueden sacar de su
vacía para que su pareja no sepa.

Pregúntese:
¿Tengo miedo pedirle a mi pareja que use condones?
¿Tengo miedo que mi pareja me lastime si le digo que tengo una
infección de transmisión sexual (ITS) y él necesita tratamiento?
¿He escondido los anticonceptivos de mi pareja para que no me
embarace?
¿Mi pareja me ha lastimado físicamente o le he tenido miedo?
Si respondió SI a cualquiera de estas preguntas, puede estar en riesgo
de ITS/VIH, embarazos no deseados, y lesiones graves.

¿Está en una relación ENFERMIZA?
¿Mi pareja se entremete con mi anticonceptivo o trata de que quede
embarazada cuando no yo quiero estar?
¿Mi pareja se niega a usar condones cuando se lo pido?
¿Mi pareja me hace tener relaciones sexuales cuando no quiero?
¿Mi pareja me dice con quién puedo hablar o dónde puedo ir?
Si respondió SI a cualquiera de estas preguntas, su salud
y seguridad puede estar en peligro.

¿Está en una relación SANA?
¿Es mi pareja bueno conmigo y respetuoso de mis preferencias?
¿Apoya mi pareja mi uso de anticonceptivos?
¿Apoya mi pareja mis decisiones sobre si quiero y cuando quiero
tener más hijos?
Si respondió SI a estas preguntas, es probable que está en una relación
sana. Estudios muestran que este tipo de relación conduce a una mejor
salud, una vida más larga, y ayuda a sus hijos.

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BIRTH CONTROL EDUCATION

Methods that clients can use without their partners' knowledge

With the exception of Emergency Contraception (EC), all of these methods must be prescribed by a doctor or nurse practitioner. Clients can call 1-800-230-PLAN to find a health care provider near them who can prescribe birth control. If making appointments for birth control may put your client at risk with a partner, talk to them about safety planning around doctor's office reminder calls and scheduling visits. In the U.S., progestin-only EC is available on the shelf without age restrictions to women and men. Look for Plan B One-Step, Take Action, Next Choice One-Dose, My Way or other generics in the family planning aisle. ella is sold by prescription only, regardless of age.

WHAT IS IT?	HOW DOES IT WORK?	HOW LONG IS IT EFFECTIVE?	HELPFUL HINTS	RISKS OF DETECTION
Emergency Contraception (EC) This is also known as the "Morning After Pill, Plan B, and Next Choice"	A single dose of hormones given by one or two pills within 120* hours of unprotected sex to prevent pregnancy.	Single dose—must be taken after every instance of unprotected sex.	Clients can get emergency contraception to keep on hand before unprotected sex occurs. EC is NOT abortion—just like "regular" birth control pills, it prevents ovulation. Levonorgestrel (common trade name Plan B) may not be as effective among overweight women. The Copper IUD and ulipristal acetate (UPA) (common trade name Ella) are effective alternatives for women desiring EC.	Clients can remove the pills from the packaging so that partners will not know what they are.
Implant Nexplanon	A matchstick-sized tube of hormones (the same ones that are in birth control pills) is inserted into your inner arm that prevents ovulation.	3 years	Unlike previous implantable methods (Norplant), it is generally invisible to the naked eye and scarring is rare.	The implant might be detected if touched. Periods may stop completely. This may be a less safe option if her partner closely monitors menstrual cycles. Many women bruise around the insertion site, which goes away, but may be noticeable for several days after insertion.
Injection Depo-Provera ("the birth control shot")	Depo-Provera is a shot of hormones—the same ones that are in birth control pills.	3 months	Once administered, there is no way to stop the effects of the shot.	Periods may stop completely. This may be a less safe option if her partner closely monitors menstrual cycles.
Intrauterine Device (IUD) - ParaGard (non-hormonal)	A small T-shaped device is inserted into the uterus and prevents pregnancy by changing the lining of the uterus so an egg cannot implant.	ParaGard: 12 years	This IUD contains copper. Periods may get slightly heavier. Period cramping may increase. ParaGard can be used for emergency contraception if inserted up to 7 days after unprotected sex.	The IUD has a string that hangs out the cervical opening. If a woman is worried about her partner finding out that she is using birth control, she can ask the provider to snip the strings off at the cervix (in the cervical canal) so her partner can't feel the strings or pull the device out.
IUD – Mirena and Skyla (hormonal)	A small T-shaped device is inserted into the uterus and prevents pregnancy by: <ul style="list-style-type: none">Thickening cervical mucus to prevent sperm from entering the uterusInhibiting sperm from reaching or fertilizing an eggMaking the lining of the uterus thin so an egg cannot implant	Mirena: 5 years Skyla: 3 years	Hormonal IUDs (Mirena & Skyla) have a small amount of hormone that is released, which can lessen cramping around the time of a period and make the bleeding less heavy. Some women may stop bleeding altogether. All IUDs can be used by women regardless of their pregnancy history; however Skyla was FDA-approved specifically for women who have never been pregnant and younger women.	The IUD has a string that hangs out of the cervical opening, which can be felt when fingers or a penis are in the vagina. If a woman is worried about her partner finding out that she is using birth control, she can ask the provider to snip the strings off at the cervix (in the cervical canal) so her partner can't feel the strings or pull the device out. Periods may change or stop completely. This may be a less safe option if her partner closely monitors menstrual cycles.



SIX STEPS FOR RESPONDING TO DISCLOSURES

You do not have to be an expert in domestic and sexual violence, or adolescent abuse to help your patient. There are simple strategies and supportive messages you can utilize when a patient discloses that they are experiencing violence in their relationship.

1. Validate patient's experience.
2. Offer a safety card for patient to review and keep if it is safe to do so.
3. Discuss where patient can go to learn more about and obtain birth control options.
4. Ask patient if she has immediate safety concerns and discuss options
5. Refer to a domestic violence advocate for safety planning and additional support.
6. Follow up at next visit

Supportive messages

- ✓ "I'm glad you talked to me about this today."
- ✓ "I am so sorry this is happening in your life, you don't deserve this."
- ✓ "It's not your fault."
- ✓ "I'm worried about the safety of you and your children."
- ✓ "You deserve to be treated with respect."

REMEMBER: Disclosure is not the goal of the safety card intervention. By providing universal education about healthy and safe relationships, helping patients make the connection between experiencing violence and their health, and letting them know about violence-related resources for themselves or loved ones, you are helping to create a healthcare system that compassionately and effectively addresses violence against women.



CREATING A DOMESTIC VIOLENCE AND SEXUAL ASSAULT RESOURCE SHEET

Call your local programs and find out what services offered. Be sure to ask for services teens are eligible for as the **PRIMARY** client (on their own, NOT as the child of an adult woman accessing services):

- Crisis hotline
- Individual counseling
- Case management
- Support groups (teen-specific?)
- Emergency shelter (are children allowed? What ages? Boys and girls?)
- Transitional housing
- Housing advocacy
- Transportation vouchers
- Legal advocacy- police & court accompaniment, restraining order assistance, law clinics
- Hospital accompaniment (for sexual assault exams)
- Court-mandated counseling programs (parenting, batterer's intervention)
- Counseling for child witnesses to violence
- Services for LGBT community
- On-site health services
- Community education/outreach
- Children's programming offered?
- Other:

What languages are spoken?

Do they have any other culturally specific programs?

Are they near public transit or do they offer transportation services?

Is there any cost for services?

Are there evening hours?

Are there any restrictions for receiving services (sobriety, active restraining order, etc.)?

Do they currently or would they be willing to provide training to community members?

Ask if there is anything else you should know about their services and explain why you are calling

Identify a key contact for your program

Identify a staff person to update/confirm this information at least once a year



SECONDARY TRAUMA

Common Reactions to Caring for Survivors of Trauma

Helplessness

- Depressive symptoms
- Feeling ineffective with patients [clients]
- Reacting negatively to patients [clients]
- Thinking of quitting clinical [contact with clients] work

Fear

- Recurrent thoughts of threatening situations
- Chronic suspicion of others
- Sleep disruptions
- Physical symptoms
- Inability to relax or enjoy pleasurable activities

Anger

- Reacting angrily to patients [clients] /staff, colleagues
- Feelings of guilt
- Decreased self-esteem

Detachment

- Avoiding patients
- Avoiding emotional topics during patient encounters
- Ignoring clues from patients [clients] about trauma
- Failing to fulfill social or professional roles
- Chronic lateness

Boundary Violation and Transference

- Taking excessive responsibility for the patient [client]
- Seeing patient [client] after hours
- Doing something out of usual practice patterns
- Sharing own problems with patient [client]
- Patient [client] trying to care for service provider

Use of Alcohol and Drugs

- Increased use of alcohol
- Initiation or use of drugs
- Misuse of prescription medication

Source: *Intimate Partner Violence*, 2009 edited by Connie Mitchell and Deidre Anglin, Oxford Press

ORGANIZATIONAL SELF-CARE ASSESSMENT

Using the scale below (1=never, 5=always), identify how frequently your organization engages in the listed activities that support organizational self-care.

5 = Always 4 = Often 3 = Sometimes 2 = Rarely 1 = Never

TRAINING AND EDUCATION

- ☐ The organization provides education to all employees about stress and its impact on health and well-being.
- ☐ The organization provides all employees with education on the signs of burnout, compassion fatigue and/or vicarious traumatization.
- ☐ The organization provides all employees with stress management trainings.
- ☐ The organization provides all employees with training related to their job tasks.
- ☐ Staff are given opportunities to attend refresher trainings and trainings on new topics related to their role.
- ☐ Staff coverage is in place to support training.
- ☐ The organization provides education on the steps necessary to advance in whatever role you are in.
- ☐ Other: _____

SUPPORT AND SUPERVISION

- ☐ The organization offers an employee assistance program (EAP).
- ☐ Employee job descriptions and responsibilities are clearly defined.
- ☐ All staff members have regular supervision.
- ☐ Part of supervision is used to address job stress and self-care strategies.
- ☐ Part of supervision is used for on-going assessment of workload and time needed to complete tasks.
- ☐ Staff members are encouraged to understand their own stress reactions and take appropriate steps to develop their own self-care plans.
- ☐ Staff members are welcome to discuss concerns about the organization or their job with administrators without negative consequences (e.g., being treated differently, feeling like their job is in jeopardy or having it impact their role on the team).
- ☐ Staff members are encouraged to take breaks, including lunch and vacation time.
- ☐ The organization supports peer-to-peer activities such as support groups and mentoring.
- ☐ Other: _____



EMPLOYEE CONTROL AND INPUT

- ☐ The organization provides opportunities for staff to provide input into practices and policies.
- ☐ The organization reviews its policies on a regular basis to identify whether they are helpful or harmful to the health and wellbeing of its employees.
- ☐ The organization provides opportunities for staff members to identify their professional goals.
- ☐ Staff members have formal channels for addressing problems/grievances.
- ☐ Other: _____

COMMUNICATION

- ☐ Staff members have regularly scheduled team meetings.
- ☐ Topics related to self-care and stress management are addressed in team meetings.
- ☐ Regular discussions of how people and departments are communicating and relaying information are addressed in team meetings.
- ☐ The organization provides opportunities for staff in different roles to share what one another's days are like.
- ☐ The organization has a way of evaluating staff satisfaction on a regular basis.
- ☐ Other: _____

WORK ENVIRONMENT

- ☐ The work environment is well-lit.
- ☐ The work environment is physically wellmaintained (e.g., clean, secure, etc.).
- ☐ Information about self-care is posted in places that are visible.
- ☐ Employee rights are posted in places that are visible.
- ☐ The organization provides opportunities for community building among employees.
- ☐ The organization has a no-tolerance policy concerning sexual harassment.
- ☐ The organization has a no-tolerance policy concerning bullying.
- ☐ Workplace issues, including grievance issues and interpersonal difficulties, are managed by those in the appropriate role and remain confidential.
- ☐ Other: _____

Reflection Questions

1. What was this process of filling out the checklist like for you?
2. Were you surprised by any of your responses? If so, which ones?
3. What ideas did you find on the checklist that you liked/did not like?
4. What are the things that you found realistic/not realistic to implement?
5. What are some of the barriers or challenges to implementing these practices?

PERSONAL SELF-CARE ASSESSMENT TOOL

How often do you do the following? (Rate, using the scale below):

5 = Frequently 4 = Sometimes 3 = Rarely 2 = Never 1 = It never even occurred to me

Physical Self Care

- | | |
|--|--|
| <input type="checkbox"/> Eat regularly (e.g. breakfast & lunch) | <input type="checkbox"/> Do physical activity that is fun for you |
| <input type="checkbox"/> Eat healthily | <input type="checkbox"/> Take time to be sexual |
| <input type="checkbox"/> Exercise, or go to the gym | <input type="checkbox"/> Get enough sleep |
| <input type="checkbox"/> Lift weights | <input type="checkbox"/> Wear clothes you like |
| <input type="checkbox"/> Practice martial arts | <input type="checkbox"/> Take vacations |
| <input type="checkbox"/> Get regular medical care for prevention | <input type="checkbox"/> Take day trips or mini-vacations |
| <input type="checkbox"/> Get medical care when needed | <input type="checkbox"/> Get away from stressful technology, such as pagers, faxes, telephones, and e-mail |
| <input type="checkbox"/> Take time off when you're sick | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Get massages or other body work | |

Psychological Self Care

- | | |
|--|--|
| <input type="checkbox"/> Make time for self-reflection | <input type="checkbox"/> Let others know different aspects of you |
| <input type="checkbox"/> Go to see a psychotherapist or counselor for yourself | <input type="checkbox"/> Engage your intelligence in a new area - go to an art museum, performance, sports event, exhibit, or other cultural event |
| <input type="checkbox"/> Write in a journal | <input type="checkbox"/> Practice receiving from others |
| <input type="checkbox"/> Read literature unrelated to work | <input type="checkbox"/> Be curious |
| <input type="checkbox"/> Do something at which you are a beginner | <input type="checkbox"/> Say no to extra responsibilities sometimes |
| <input type="checkbox"/> Take a step to decrease stress in your life | <input type="checkbox"/> Spend time outdoors |
| <input type="checkbox"/> Notice your inner experience - your dreams, thoughts, imagery, feelings | <input type="checkbox"/> Other: _____ |



Emotional Self Care

- | | |
|---|--|
| <input type="checkbox"/> Spend time with others whose company you enjoy | <input type="checkbox"/> Identify and seek out comforting activities, objects, people, relationships, places |
| <input type="checkbox"/> Stay in contact with important people in your life | <input type="checkbox"/> Allow yourself to cry |
| <input type="checkbox"/> Treat yourself kindly (supportive inner dialogue or self-talk) | <input type="checkbox"/> Find things that make you laugh |
| <input type="checkbox"/> Feel proud of yourself | <input type="checkbox"/> Express your outrage in a constructive way |
| <input type="checkbox"/> Reread favorite books, rewatch favorite movies | <input type="checkbox"/> Play with children |
| | <input type="checkbox"/> Other: _____ |

Spiritual Self Care

- | | |
|---|---|
| <input type="checkbox"/> Make time for prayer, meditation, reflection | <input type="checkbox"/> Express gratitude |
| <input type="checkbox"/> Spend time in nature | <input type="checkbox"/> Celebrate milestones with rituals that are meaningful to you |
| <input type="checkbox"/> Participate in a spiritual gathering, community or group | <input type="checkbox"/> Remember and memorialize loved ones who have died |
| <input type="checkbox"/> Be open to inspiration | <input type="checkbox"/> Nurture others |
| <input type="checkbox"/> Cherish your optimism and hope | <input type="checkbox"/> Have awe-full experiences |
| <input type="checkbox"/> Be aware of intangible (nonmaterial) aspects of life | <input type="checkbox"/> Contribute to or participate in causes you believe in |
| <input type="checkbox"/> Be open to mystery, to not knowing | <input type="checkbox"/> Read inspirational literature |
| <input type="checkbox"/> Identify what is meaningful to you and notice its place in your life | <input type="checkbox"/> Listen to inspiring music |
| <input type="checkbox"/> Sing | <input type="checkbox"/> Other: _____ |

Workplace/Professional Self Care

- | | |
|--|---|
| <input type="checkbox"/> Take time to eat lunch | <input type="checkbox"/> Arrange your workspace so it is comfortable and comforting |
| <input type="checkbox"/> Take time to chat with co-workers | <input type="checkbox"/> Get regular supervision or consultation |
| <input type="checkbox"/> Make time to complete tasks | <input type="checkbox"/> Negotiate for your needs |
| <input type="checkbox"/> Identify projects or tasks that are exciting, growth-promoting, and rewarding for you | <input type="checkbox"/> Have a peer support group |
| <input type="checkbox"/> Set limits with clients and colleagues | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Balance your caseload so no one day is "too much!" | |

ADOLESCENT HEALTH PROGRAMS

Quality Assessment/Quality Improvement Tool

The following quality assessment tool is intended to provide adolescent health program managers with some guiding questions to assess quality of care related to promotion of healthy relationships and intervention related to adolescent relationship abuse (ARA) and reproductive and sexual coercion (RSC) within their programs. The information is to be used as a benchmark for each program to engage in quality improvement efforts.

This tool was created as part of Project Connect's efforts to improve services to adolescents for the prevention and intervention around ARA and RSC, and to optimize healthy relationship development. For the purposes of the overall evaluation within the state, we are asking that programs share their responses on their tool with the state leadership team. The names of each program will be kept confidential, and findings will only be shared in aggregate (meaning all the programs in general, not identifying specific programs). We will ask your program to complete the tool again in about 6 months. We hope that this tool will help provide guidance on how to enhance your program to respond to adolescent relationship abuse and reproductive and sexual coercion.

Completed by (title only):

Program/Clinic Name:

Date:

Protocols				
	Yes	No	N/A	Don't Know
Does your program provide universal education and anticipatory guidance on healthy relationships?				
Does your program have a written protocol for assessment and response to:				
Adolescent relationship abuse				
Reproductive and sexual coercion				
Does your program provide direct assessment for reproductive and sexual coercion during:				
Birth control counseling				
STI/HIV visits				
Emergency contraception visits				
Pregnancy tests				
Does your program provide direct assessment for adolescent relationship abuse during:				
a visit addressing alcohol or other drug use				
a visit addressing depression or suicidality				



	Yes	No	N/A	Don't Know
Does your program provide patients with a written explanation of confidentiality and the limits of confidentiality when they check-in?				
Are there any scripts or sample questions that providers can use to:				
Inform patients about confidentiality and mandated reporting requirements				
Ask patients about adolescent relationship abuse				
Ask patients about reproductive and sexual coercion				
	Yes	No	N/A	Don't Know
Are there specific prompts on the intake form (or in the electronic record) to encourage providers to assess for ARA and RSC?				
Is there a private place in your clinic to screen and talk with patients?				
Does your clinic have a policy to ensure that providers ask about ARA and RSC when the patient is alone (i.e. no friends, parents, etc. present)?				
Assessment Methods				
	Yes	No	N/A	Don't Know
How are patients assessed for adolescent relationship abuse and reproductive and sexual coercion?				
Assessment occurs in a private place				
Patients answer questions about ARA and RSC on a medical/health history form (paper or electronic)				
Staff use safety card to assess and educate				
Staff review the medical/ health history form and ask additional follow-up questions				
Which staff members are primarily responsible for assessing patients ARA and RSC? (please pick one)				
<input type="checkbox"/> Counselor <input type="checkbox"/> Medical Assistant <input type="checkbox"/> NP/RN <input type="checkbox"/> MD <input type="checkbox"/> Other (Please explain) _____				
How often are patients asked about ARA and/or RSC?				
<input type="checkbox"/> With each new sexual partner <input type="checkbox"/> At least every six months <input type="checkbox"/> At least once a year <input type="checkbox"/> No established time interval <input type="checkbox"/> During specific visit type (please list) _____				

	Yes	No	N/A	Don't Know
Are there tools (e.g. cards, scripts, and/or prompts) to help your staff:				
Explain to patients why they are being asked about ARA and RSC				
Inform patients about confidentiality and any mandated reporting requirements				
Educate patients about impact of ARA and RSC on health				
Documentation of Assessment and Response				
	Yes	No	N/A	Don't Know
On the medical/health history/assessment form(s) are the following steps documented?:				
<i>Hanging Out or Hooking Up</i> and/or <i>Did You Know Your Relationship Affects Your Health?</i> safety card was offered and discussed				
Harm reduction strategies were shared				
Referral to DV/SA program provided				
Intervention Strategies				
	Yes	No	N/A	Don't Know
Does your staff:				
Have instructions on how to file a mandated report when needed				
Know an on-call advocate or counselor who can provide follow-up with patients who disclose ARA or RSC				
Have a safe place where the patient can use a phone at your clinic/program to talk to a violence advocate/shelter/support services				
Know how to highlight the national hotlines on the card with a patient who discloses abuse				
Does your program have resource lists that:				
Identify referrals/resources (shelters, legal advocacy, housing, etc.) for patients who disclose ARA or RSC				
Identify referrals to agencies that have adolescent specific services				
Identify referrals to agencies that provide culturally or linguistically specific services				
Includes a contact person for each referral agency				
Does your program have a staff person who is responsible for updating the resource list? If so, who? (please identify by title; no names) _____				
Is your resource list updated at least once a year?				



Networking and Training

	Yes	No	N/A	Don't Know
Within the last year, has your staff had contact with representatives from any of the following agencies (contact means: called to refer a patient, called for assistance with a patient, called for information about a program):				
Domestic violence/sexual assault agency or shelter				
Rape crisis center				
Child protective services				
Legal advocacy/legal services				
Law enforcement				
<p>Is there anyone on your staff who is especially skilled/comfortable dealing with ARA and RSC issues that other staff can turn to for help?</p> <p><input type="checkbox"/> Yes (please identify staff by title) _____</p> <p><input type="checkbox"/> No</p>				
<p>Does anyone on your staff participate in a local adolescent relationship abuse task force or related subcommittee?</p> <p><input type="checkbox"/> Yes (please identify staff and describe task force/subcommittee) _____</p> <p><input type="checkbox"/> No</p>				
<p>Is there a buddy system or internal referral for staff to turn to for assistance when they are overwhelmed or uncomfortable addressing violence or coercion with a patient?</p> <p><input type="checkbox"/> Yes (please describe) _____</p> <p><input type="checkbox"/> No</p>				
	Yes	No	N/A	Don't Know
Do new hires receive training on assessment and intervention for ARA and RSC during orientation?				
Does your staff receive booster training on assessment and intervention for ARA and RSC at least once a year?				
Within the last 2 years, have representatives from any of the following agencies conducted a training for your staff:				
Domestic violence/sexual assault agency or shelter				
Rape crisis center				
Child protective services				
Legal advocacy/legal services				
Law enforcement				

Self-Care and Support				
	Yes	No	N/A	Don't Know
Does your program:				
Have a protocol for what to do if a staff person is experiencing intimate partner violence or reproductive and sexual coercion				
Have a protocol for what to do if a perpetrator is on-site and displaying threatening behavior or trying to get information				
Give staff the opportunity to meet and discuss challenges and successes with cases involving ARA or RSC				
Have an employee assistance program (EAP) that staff can access for help with current or past victimization				
Do your protocols advise staff on what to do if they feel uncomfortable or inadequately skilled to help a patient when ARA or RSC is disclosed? (e.g. Can staff 'opt out' if they are survivors of or currently dealing with personal trauma?) <input type="checkbox"/> Yes (please describe) _____ <input type="checkbox"/> No				
Environment and Resources				
	Yes	No	N/A	Don't Know
Does your program have:				
Posters/cards/posters about ARA and RSC displayed				
Posters/cards/posters about healthy and unhealthy relationships displayed				
Information specific to LGBTQ relationship violence				
Have these brochures/cards/posters been placed in an easily visible location?				
Have these brochures/cards/posters been reviewed by underserved communities for inclusivity, linguistic and cultural relevance?				
Has your program adapted any materials to make them more culturally relevant for your patient population? <input type="checkbox"/> Yes (please describe) _____ <input type="checkbox"/> No				
Who is responsible for stocking and ordering materials including reproductive and adolescent health cards, pregnancy wheels and posters? (please identify staff by title) _____				



Data and Evaluation				
	Yes	No	N/A	Don't Know
Does your program:				
Does your program record the rate of documented screening for ARA and RSC?				
Record the rate of documented disclosures of ARA or RSC by patients?				
Conduct an annual review and update of all protocols addressing violence and coercion?				
Do any consumer satisfaction surveys or focus groups asking patients' opinions about assessment and intervention strategies for ARA/RSC?				
Provide regular (at least annual) feedback to providers about their performance regarding ARA and RSC assessment?				
Education and Prevention				
	Yes	No	N/A	Don't Know
Does your program provide information to patients on how unhealthy relationships and violence can impact their health?				
Does any of the information that you provide to patients address healthy relationships?				
Does your program sponsor any patient or community education events to talk about healthy relationships and indicators of abuse?				
Additional Comments and Observations				

TRAINING SATISFACTION SURVEY

Please tell us which type of organization you represent:

- ☐ clinic providing care to adolescents
- ☐ domestic violence/sexual assault agency

Today's training increased my understanding of:

1. the impact of adolescent relationship abuse (ARA) and reproductive and sexual coercion (RSC) on adolescent health.

- ☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

2. how to discuss the limits of confidentiality with my adolescent clients.

- ☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

3. how to provide universal education on healthy relationships.

- ☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

4. how to assess for adolescent relationship abuse (ARA).

- ☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

5. how to assess for reproductive and sexual coercion (RSC).

- ☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

6. how birth control methods that a partner can't interfere with can be a harm reduction strategy for clients in abusive relationships.

- ☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

7. how to provide supported referrals to local and national resources available to assist teens who are experiencing ARA/RSC.

- ☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

8. how to provide patient-centered mandated reporting.

- ☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

Following the training today, I am more likely to:

9. talk to my adolescent clients about healthy relationships.

- ☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

10. offer all clients a *Hanging Out or Hooking Up* safety card on ARA and healthy relationships.

- ☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

Following the training today, I am more likely to:

11. assess clients' safety and discuss ways to stay safe in an unhealthy relationship.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

12. discuss the limits of confidentiality with adolescent clients before asking about coercion or violence.

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

13. assess for adolescent relationship abuse (ARA).

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

14. assess for reproductive and sexual coercion (RSC).

☐ Strongly Agree ☐ Agree ☐ Undecided ☐ Disagree ☐ Strongly Disagree ☐ N/A

15. Please mark at least one action that you intend to do differently following the training today:

- A. Put up posters about adolescent relationship abuse (ARA) and reproductive and sexual coercion (RSC)
- B. Make *Hanging Out or Hooking Up* safety cards available to all clients
- C. Work with medical records to insert a prompt into the chart to remind providers to assess for ARA/RSC
- D. Offer an in-service training for all of my clinic staff on ARA/RSC
- E. Set up a protocol for assessing for ARA/RSC for all emergency contraception or pregnancy testing visits
- F. Partner with school-based health education efforts to incorporate the promotion of healthy relationships
- G. Set up new partnerships with local DV/SA organizations
- H. Set up new partnerships with local adolescent healthcare providers
- I. Other (please be as specific as you can)

16. What ongoing support do you need to confidently incorporate discussion of ARA and RSC in all your encounters with adolescents?

Additional Comments:

Thank you for your time!

PROTOCOL FOR ADOLESCENT RELATIONSHIP ABUSE PREVENTION AND INTERVENTION

THIS IS A SAMPLE PROTOCOL INTENDED TO BE ADAPTED FOR USE IN CLINICAL SETTINGS. THE PROTOCOL SHOULD BE REVIEWED BY CLINIC ADMINISTRATION AND LOCAL DOMESTIC VIOLENCE/SEXUAL ASSAULT EXPERTS FOR CONTENT ACCURACY AND RELEVANCE TO LOCAL JURISDICTIONS.

SECTION I: INTRODUCTION

Adolescent relationship abuse is prevalent and is associated with multiple poor health outcomes for youth. Adolescents and young adults seeking care in health care settings report higher rates of intimate partner violence victimization. The _____ health center is committed to **preventing adolescent relationship abuse** by promoting healthy relationships, **identifying relationship abuse** and intervening using a safe, patient-centered approach.

The purpose of this protocol is aiding in the promotion of healthy relationships (universal education) with all adolescent patients, as well as encouraging assessment and support for adolescent relationship abuse with sexually active female patients. With one in five (20%) U.S. teen girls reporting ever experiencing physical and/or sexual violence from someone they were dating and one in four (25%) teens in a relationship reporting being called names, harassed, or put down by their partner via cell phone/texting, adolescent relationship abuse is highly prevalent and has major health consequences. Health care providers are often the first or only professionals to come into contact with adolescents in abusive situations. Thus, we have a unique responsibility and opportunity to intervene.

Definitions

Adolescent Relationship Abuse (ARA) is a pattern of repeated acts in which a person physically, sexually, or emotionally abuses another person of the same or opposite sex in the context of a dating or similarly defined relationship, in which one or both partners is a minor. Similar to adult intimate partner violence, the emphasis on repeated controlling and abusive behaviors distinguishes relationship abuse from isolated events (e.g. a single occurrence of sexual assault at a party with two people who did not know each other). Sexual and physical assaults often occur in the context of relationship abuse, but the defining characteristic is a repetitive pattern of behaviors aiming to maintain power and control in a relationship. Such behaviors can include monitoring cell phone usage, telling a partner what s/he can wear, controlling whether the partner goes to school that day, and interfering with contraceptive use.

Reproductive Coercion (RC) involves behaviors aimed to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent.

Reproductive coercion includes birth control sabotage, pregnancy pressure, and pregnancy coercion.

Birth Control Sabotage is active interference with a partner's contraceptive methods. Examples of birth control sabotage include:

- Hiding, withholding, or destroying a partner's birth control pills
- Breaking or poking holes in a condom on purpose or removing it during sex in an explicit attempt to promote pregnancy

- Not withdrawing when that was the agreed upon method of contraception
- Pulling out vaginal rings
- Tearing off contraceptive patches

Pregnancy Pressure and Coercion involves behaviors that are intended to pressure a female partner to become pregnant when she does not wish to become pregnant. Pregnancy coercion involves coercive behaviors such as threats or acts of violence if she does not comply with her partner's wishes regarding the decision of whether to terminate or continue a pregnancy. Examples of pregnancy pressure and coercion include:

- Threatening to leave a partner if she does not become pregnant
- Threatening to hurt a partner who does not agree to become pregnant
- Forcing a female partner to carry to term against her wishes through threats or acts of violence
- Forcing a female partner to terminate a pregnancy when she does not want to
- Injuring a female partner in a way that she may have a miscarriage

Sexual Coercion includes a range of behaviors that a partner may use related to sexual decisionmaking to pressure or coerce a person to have sex without using physical force. Examples of sexual coercion include:

- Repeatedly pressuring a partner to have sex when s/he does not want to
- Threatening to end a relationship if a person does not have sex
- Forced non-condom use or not allowing other prophylaxis use
- Intentionally exposing a partner to a STI or HIV
- Threatening retaliation if notified of a positive STI result

Guiding Principles

1. Regard the safety of victims as PRIORITY.
2. Treat patients with dignity, respect, and compassion including sensitivity to age, culture, ethnicity and sexual orientation.
3. Honor victims' right to self-determination by recognizing that the process of leaving an abusive relationship can be complex, long, and gradual.
4. Adapt a collaborative care model to best support patients by attempting to engage patients in long-term continuity of care within the health care system.

Training Requirements

All health center staff that have contact with patients will undergo mandatory Adolescent Relationship Abuse and Sexual Violence training regarding:

- Dynamics of Adolescent Relationship Abuse and Sexual Violence
- Effects of Violence on Health
- Promotion of Healthy Relationships
- Assessment and Intervention
- Updates about Available Resources

Staff members are required to attend two trainings a year on adolescent relationship abuse and sexual violence related issues. Numerous opportunities for trainings will be provided, both in-person and online.

Confidentiality

Our policy, protocol, and practice surrounding the use and disclosure of health information regarding victims of adolescent relationship abuse and sexual violence respects patient autonomy and confidentiality; serving to improve the safety and health of victims. The Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) apply.

Patient's confidentiality is paramount and must be taken seriously. Therefore, everything discussed with the patient is confidential. Patients should be told that all information is kept private and confidential, unless the patient tells the health care provider they are being hurt by someone, planning on hurting them self (suicidal), or planning on hurting someone else. It is essential to inform patients about mandated reporting requirements.¹

SECTION II: UNIVERSAL EDUCATION—ANTICIPATORY GUIDANCE ON HEALTHY RELATIONSHIPS

This health center is committed to providing information about healthy relationships to all patients. Anticipatory guidance on healthy relationships should occur at least annually and with each new partner. The patient should be seen alone—without partners, parents, or friends present. Every teen regardless of gender or sexual orientation should have the opportunity to talk to their provider about safe, consensual and healthy relationships.

The medical assistants and health educators in the health center will be responsible for ensuring that every patient receives a Hanging Out or Hooking Up safety card. A sample script is provided below:

“We want all of the young people who come to our clinic to know that we care a lot about them being in healthy relationships. We are giving this informational card to all of our patients. Please look this over while you’re waiting to see the clinician.”

The clinician should follow up with the patient during the health visit. **Remember to discuss the limits of confidentiality before reviewing the card.** It is not necessary to review all eight panels. Depending on the type of visit or questions raised during the visit, the clinician can select which panel(s) to focus on. **It is important to discuss the card during the visit rather than simply handing them the card.**

Although NOT the intended goal of universal education, occasionally a patient will make a disclosure of ARA. **Please see Section IV: Documentation and Follow Up for information on steps to take if a patient says s/he is experiencing ARA.**

1 Please note that this section will vary state by state, and should be reviewed by a domestic violence and/or sexual assault advocate familiar with all the mandated reporting laws relevant to exposure to relationship abuse and sexual assault.

SECTION III: DIRECT ASSESSMENT WITH SEXUALLY ACTIVE YOUNG WOMEN

Adolescent relationship abuse is highly prevalent among young women seeking reproductive health care. As a result, the health center's policy is to conduct an **integrated assessment for adolescent relationship abuse and reproductive coercion among all adolescent females presenting for a reproductive health concern.**

Who Shall Conduct Assessment:

Assessments will be conducted by a health care professional who has been:

- Educated about the dynamics of adolescent relationship abuse and sexual violence, the safety and autonomy of abused patients, and cultural competency;
- Trained on how to ask about and intervene with identified victims of abuse; and
- Authorized to record in the patient's medical record.

How to Assess:

- When assessing for RC and ARA utilize a private, safe environment. Separate any accompanying persons from the patient. If this cannot be done, postpone assessing for a follow-up visit.
- Explain the limits of confidentiality prior to assessment; patients should be informed of any reporting requirements or other limits to provider/patient confidentiality.
- When unable to converse fluently in the patient's primary language, use a professional interpreter or another health care provider fluent in the patient's language. The patient's family, friends or children should not be used as interpreters when asking about RC and ARA.
- Introduce the assessment using your own words in a non-threatening, non-judgmental way. *"I talk to all my female patients about how they deserve to be treated in a relationship, especially when it comes to decisions about sex."*
 - Use the *Did You Know Your Relationship Affects Your Health?* safety card to ask questions that are integrated into the reason for the visit.
 - Contraception/birth control options counseling visit: Use "Are you in an UNHEALTHY relationship?" panel
 - Pregnancy testing visit: Use "Who controls PREGANCY decisions?" panel
 - STI testing visit: Use "Is your BODY being affected?" panel
 - Emergency contraception visit: Use "Taking control" panel
- Always follow up disclosures of RC with additional questions about ARA. Please see Section IV: Documentation and Follow Up for information on steps to take if a patient discloses ARA.

SECTION IV: DOCUMENTATION OF ASSESSMENT AND FOLLOW-UP

For **every** assessment, the following should be documented in the patients' chart:

- Confirmation that the assessment occurred, or the reason why it did not, and what follow-up actions were taken to ensure that assessment will occur at a future visit
- The patient's response
- Documentation of resources provided, such as safety cards
- Referrals provided

This data will be checked quarterly for compliance by our Management Information Systems professional.

Positive Assessment

- Be supportive of the patient with statements such as:
 - *No one deserves to be abused.*
 - *There is no excuse for relationship abuse.*
 - *You are not alone; there are people you can talk to for support.*
 - *Is there anything else I can do to help?*
- Let the patient know that you will help regardless of whether s/he decides to remain in or leave the abusive relationship.
- Refer the patient to the local Domestic Violence Advocate
- Offer to call the advocate with patient
- Refer the patient to our clinic's social worker/counselor (if available)
 - If the social worker/counselor is in, call directly at _____ (add local phone number here).
 - If the social worker/counselor is out of the office, fill out an orange referral form. Follow up with the social worker/counselor to ensure that the patient has been contacted.
- If the patient does not wish to speak with an advocate
 - Ask if you can make a written referral.
 - Tell the patient that s/he can always call or make a return visit for support or information.
 - Review safety planning information with patient.
 - Provide patient with a safety card with relevant phone numbers and hotline numbers.
- Safety planning
 - Ask: "Do you feel you are in immediate danger?," if s/he answers yes, find out if the person they fear is present at the clinic. If the person is at the clinic,
 - Call security at _____ (add local phone number here). Explain the situation, inform them you are at the clinic and ask them to enter the back door.
 - The goal is to keep everyone safe and not alarm anyone in the waiting room.
 - Our code for employees that security has been called is "Dr. Jones is needed in room X."
 - Call the domestic violence advocate at _____ (add local contact number) for further danger assessment and to discuss next steps.

- Offer to call the police, if s/he would like to press charges.
- Explain to the patient that documentation of past and future incidents with a medical facility or law enforcement may be beneficial to her/him in the event s/he takes legal action in the future.

Please note: If written information is given to the patient, it should be able to fit in his/her pocket and done so only if the patient feels safe accepting it.

Suspected But Unconfirmed ARA

There may be situations in which you suspect ARA is occurring, but the patient does not disclose. ***Remember:*** Disclosure is NOT the goal; increasing safety and decreasing isolation IS. Simply having conversations about RC and ARA lets patients know that this clinic is a safe place to talk about ARA, if they choose to. Research tells us that many adolescent patients do not disclose to health care providers and rely on their peers for information and support. Therefore, it is critical that we offer safety cards to EVERY patient.

Patient-centered Mandatory Reporting

It is critical that you understand our State laws related to confidentiality and minor consent, physical and sexual abuse, and child abuse. Please refer to our clinic's confidentiality policy and child abuse reporting policy; the same conditions apply.

REMEMBER: Many forms of RC and ARA do not meet the legal requirements for mandatory reporting to child protective services and/or law enforcement.

While the language in the mandated reporting laws state that the person who becomes aware of the abuse should report 'immediately' to the relevant authorities, the focus should **always** be on the care and safety of the young person first. **After** the reason the young person was seeking care has been addressed (such as treatment for a possible STI), the provider should remind the young person of the limits of confidentiality discussed at the start of the visit, then inform the patient of the requirement to report.

Law Enforcement Intervention

Inform the victim that in the event s/he elects to take legal action in the future, a law enforcement report on record may help their case. If the patient wishes to make a report to the law enforcement, and is not in immediate danger:

- Assist her/him in contacting the Police Department Domestic Violence Unit at _____ (add local number).
- For support during the police interview, offer to stay in the room with the patient until the DV/SA advocate has arrived.
- Medical reports may be given to the officer only with the written consent from the patient.
- Document that a police report was made and obtain the officer's name and badge number.

This policy is to be reviewed and updated by the Clinic Manager on an annual basis.

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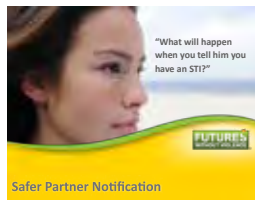
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Module 6: Building Bridges Between Adolescent Health and Domestic Violence Advocacy

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Module 7: Preparing Your Program: Supporting Staff Exposed to Violence and Trauma

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NOTES





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