WOMEN'S HEALTH CARE CLINIC
OUTREACH & EDUCATION PROGRAM

LOS ANGELES BIOMEDICAL RESEARCH INSTITUTE
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INTIMATE PARTNER VIOLENCE / DOMESTIC VIOLENCE PROTOCOL

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PREVALENCE OF INTIMATE PARTNER VIOLENCE AND REPRODUCTIVE COERCION

Intimate partner violence (IPV) is prevalent and it is critical that it be integrated into the family planning setting:

- Approximately 1 in 4 women have been physically and/or sexually assaulted by a current or former partner
- 1 in 5 women in the US has been raped at some point in their lives, and half report being raped by an intimate partner
- 1 in 4 abused adolescent females report that their male partner was trying to get them pregnant
- Close to 400,000 adolescent girls, **every year**, experience serious physical and/or sexual dating violence
- An estimated 2 in 5 adolescent females seen in clinic settings have experienced IPV, and 21% report sexual victimization
- Adolescents who experience IPV are more likely to:
    - Start having sex before age 15
    - Have multiple partners
    - Have a current sexually transmitted infection (STI) or history of a STI
    - Not use condoms correctly or consistently
    - Choose partners who engage in high-risk sexual behavior
    - Use drugs and/or alcohol before sex
- In family planning clinics, more than half (53%) of women seen reported physical and/or sexual IPV
- IPV dramatically increases risk for unplanned pregnancies
- 17% of abused women reported that a partner prevented them from accessing health care
- 29% of women attempting suicide are battered women
- 38% of murdered women are murdered by their partners
- Women in abusive relationships experience acute and chronic health issues, and have a complex medical history outside of black eyes, bruises and broken bones

The American College of Obstetricians and Gynecologists (ACOG) recommends that women and adolescent girls are routinely screened for reproductive and sexual coercion. Women who talk to their provider about the abuse are <u>4 times more likely</u> to use an intervention.

TYPES OF ABUSE AND DEFINITIONS

(as defined by the Futures without Violence and the Family Violence Prevention Fund)

Intimate Partner Violence embodies a variety of forms of abuse, including:

- Physical Abuse
- Sexual Abuse /Assault and Reproductive Coercion
- Verbal Abuse
- Emotional / Psychological Abuse
- Financial Abuse

(Refer to the Power and Control Wheel enclosed in the IPV/DV Protocol for specific examples of IPV and different forms of abuse)

Intimate Partner Violence:
"…a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and threats."

"…a pattern of repeated acts in which a person physically, sexually, or emotionally abuses another person whom they are dating or in a relationship with."

- Occurs in heterosexual and same-sex relationships
- Behaviors are aimed at establishing control by one partner (teen or adult) in the relationship over the other partner

Adolescent Relationship Abuse:
"…a pattern of repeated acts in which a person physically, sexually, or emotionally abuses another person whom they are dating or in a relationship with."

- Occurs in heterosexual and same-sex relationships
- One or both partners is a minor
- Repeated controlling and abusive behaviors—not a single isolated event—that aim to maintain power and control in a relationship
- Examples:
    - Explicit attempts to impregnate female partner against her will
    - Controlling outcomes of pregnancy
    - Forced sexual activity
    - Forced sex without a condom
    - Threats/acts of violence if partner doesn't agree to have sex
    - Intentionally exposing partner to a STI/HIV

Reproductive Coercion:
"…involves behaviors that a partner uses to maintain power and control in a relationship related to reproductive health."

- Occurs in heterosexual and same-sex relationships
- Examples:
    - Explicit attempts to impregnate female partner against her will
    - Controlling outcomes of pregnancy
    - Forced sexual activity
    - Forced sex without a condom
    - Threats/acts of violence if partner doesn't agree to have sex
    - Intentionally exposing partner to a STI/HIV

Birth Control Sabotage:
"Active interference with contraceptive methods by a partner in an intimate or dating relationship."

- Occurs in adult and adolescent relationships
- Examples:
    - Hiding, withholding or destroying pills
    - Breaking a condom on purpose
    - Refusing to pull-out when that is the agreed upon method
    - Pulling out the ring
    - Tearing off the patch

Pregnancy Pressure:
"Involves behaviors that are intended to pressure a partner to get pregnant when she does not want to be."

- Examples:
  - *I'll leave you if you don't get pregnant*
  - *I'll have a baby with someone else if you don't get pregnant*
  - *I'll hurt you if you don't agree to become pregnant*
  - Getting pregnant so partner will stay with her

Pregnancy Coercion:
"Involves threats or acts of violence if a partner does not comply with the perpetrator's wishes regarding the decision of continuing with or terminating a pregnancy."

- Examples:
  - Forcing a woman to carry to term by making threats or with violence
  - Forcing a partner to terminate against her will
  - Injuring a partner in a way that she may have a miscarriage

MANDATORY REPORTING

Who is a mandated reporter for domestic violence?

- We are ALL mandated reporters
- Any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or clinic or other facility operated by a local or state public health department who provides medical services for a physical condition

What is mandated?

- Child abuse – mandatory reporting laws for child abuse is much more inclusive than DV reporting laws
- Physical abuse, assault
- Sexual abuse, sexual assault, rape
- Sexual exploitation
- Statutory rape
  - State definition: sexual intercourse with a minor under 18, other than spouse
  - Sexual intercourse between a minor under 14 years and a partner >14 years or older, irrespective of consent
  - Sexual intercourse between minor who is 14 or 15 years and a partner who is >21 years, irrespective of consent

What is mandated for child abuse?

- Non-accidental physical injury upon a child
- Sexual abuse
  - Coerced sexual touch & sexual assault
  - Rape
  - Child pornography
  - Sexual exploitation & human trafficking
- Preparing, selling, distributing obscene matter, or employment of minor to perform obscene acts
- Neglect
- Willful harming or endangering of health of a child
- Unlawful corporal punishment

- Lewd and lascivious acts or touching
    - A child under force, violence, duress or fear
    - A child under 14, if the person is ≥ 14 years, irrespective of consent
    - A child who is 14 or older, if the person is at least 10 years older (24 years +) irrespective of consent
    - A child who is 15, if the other person is at least 10 years older (25 years +), irrespective of consent

What is triggers a report?

- Reporting is mandated if you:
    - Have knowledge of abuse
    - Have observed abuse
    - Have **strong, reasonable suspicion** of abuse –physical evidence on the body of the victim
- If the health practitioner "provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is":
    - "suffering from any wound or other **physical injury** inflicted by his or her own act or inflicted by another…" where the injury is by means of a firearm", and/or
    - "suffering from any wound or other **physical injury** inflicted upon the person where the injury is the result of assaultive or abusive conduct."
- Under these guidelines by California law, this means that only physical and sexual abuse are reportable *(see below)*
- By law, these guidelines stand regardless of the gender or sexual orientation of the victim or perpetrator –*Section 11163.2 of the Penal Code ("Domestic Violence and Mandatory Reporting Law")*

What is not reportable?

- Abuse that did not leave a wound or physical injury
    - Verbal or emotional /psychological abuse
    - Financial abuse
- Prior physical abuse where there is no current physical wound or injury
- The patient has a physical injury that appears to be the result of abusive conduct - but the patient is not currently seeking medical services to treat a physical condition
- California law states that "a mutual affray between minors" is not reportable child abuse
    - Defined as "a consensual fight on equal terms"; i.e. *"we got into it"*
    - Reporting of "mutual affray" is subject to interpretation and essentially a judgment call

SCREENING GUIDELINES AND ASSESSMENT STRATEGIES

1. Create a safe environment for assessment and disclosure

- Have a safe, private place to interview patients/clients
- Always interview the patient alone first before bringing in her guest (partner, parent, friend)
- Always discuss limits of confidentiality PRIOR to doing assessment, and report as necessary
- Establish trust and rapport with the patient
- Display educational materials addressing IPV and reproductive coercion in waiting rooms, cubicles, exam rooms, hallways and patient bathrooms

2. **Develop partnerships with local domestic violence organizations and a referral list to offer as a resource for patients**

3. **Integrate in the patient visit a routine assessment for IPV and reproductive coercion, often and regularly**

   In the patient chart:

   - Include questions on intake forms and medical history form to inquire about possible IPV
   - Example questions to include:
     - *"Do you feel safe in your home?"*
     - *"Do you feel safe in your relationship?"*
     - *"Do you feel you have control to make decisions about birth control and pregnancy?"*
     - *"Has anything frightening happened to you in the last 6 months?"*
     - Probe for more information based on responses to questions on medical history form regarding hospitalization, surgery, partner history and partner involvement, etc.

   In person:

   - Notice the patient, notice her face, her body and any possible physical signs of abuse
   - Listen for cues in her responses, communication style and behavior
   - Pay attention to her non-verbal communication and body language
   - Normalize the conversation.
     - *"Because domestic violence is so common, we talk to all our patients about healthy relationships."*
     - *"We started talking to all our patients about healthy relationships."*
   - Ask key questions and ask open-ended questions.
     - *"Are you happy in your relationship?"* versus *"Tell me about your relationship."*
     - *"What are some of the things you are uncomfortable with in your relationship?"* versus *"Anything bad in your relationship?"*
   - Use the Safety Card Intervention *(see below)*

4. **Safety Card Intervention - Guidelines for successful use**

   What is it?

   - A simple, evidence-informed intervention
   - Brochure-based assessment that can be easily added to what is already being done
   - Suitable for adult and adolescent counseling
   - Provides a script for providers and clinic staff to ask key questions
     - *"Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be?"*
     - *"Does your partner refuse to wear condoms when you ask?"*
     - *"Are you afraid your partner will hurt you if you tell him you have an STI and he needs to be treated?"*
   - Teaches patients how to access contact information for future reference
   - Outlines safety planning, risk reduction, and support services
   - Available for free on www.futureswithoutviolence.com in English and Spanish

How to use it?

Intervention Elements: The 4 C's

- Confidentiality: ALWAYS review limits of confidentiality before starting this or any screening intervention
- Conversation: Normalize the discussion
- Card: Go through the safety card, focusing on the panels that are most relevant to the patient's circumstances
- Connect: Connect to a warm referral (a domestic violence agency with which the clinic already has an established relationship)

How often**?**

- At least once annually and with each new partner
- If a patient has multiple repeat visits for pregnancy testing, emergency contraception, STI testing–consider these situations as clinical indicators to assess more frequently

When?

- During any reproductive health visit
- All initial and annual visits
- Refill visits – notice signs of birth control sabotage if there are continual signs of misuse of method, loss of method or other unusual occurrences
- Pregnancy test visits and abortion visits, especially continual repeat pregnancy test visits
- STI/HIV test visits, especially continual repeat STI visits

Where?

- In a private setting
- ALWAYS interview the patient alone first

5. Educate and promote prevention

- Integrate the conversation about healthy relationships into counseling
- Give her examples of what a healthy relationship looks like:
  - You feel respected
  - You are treated with kindness
  - You can be with your friends when you want
  - You can wear what you want
  - You feel safe and your boundaries are respected
  - You feel supported, even when you disagree
  - You go only as far as you want with touching, kissing or doing anything sexual
  - You feel comfortable speaking up especially about controlling behavior from your partner (like too many texts or phone calls)
  - You feel happy, at peace and safe
  - Healthy relationships are now and not something you hope for
  - Healthy relationships are important for our health and wellbeing

INTERVENTION STRATEGIES

Intervention for intimate partner violence is complex and a variety of factors must be considered:

- Is the abuse a past incident or a new incident of abuse?

- Is it verbal/emotional abuse, physical abuse, or sexual abuse?
- What is the severity of the abuse?
- Is the patient disclosing the abuse (a single incident or reoccurring) or is it suspected by the clinician?
- Are there others in the home whose safety may be compromised?
- Does the patient want assistance at this time?
- What are the laws regarding mandatory reporting?

The steps for intervention depend on these factors. Although the breadth and depth of each encounter can vary tremendously, effective intervention can be implemented through the same steps.

1. Review confidentiality, the limits of confidentiality and mandatory reporting laws with the patient
2. Provide a safe and supportive environment for the patient
3. Gather necessary information
4. Provide information and clinical care to the patient, as applicable
5. Make the report
6. Create a follow-up plan

(Please refer to the IPV Checklist for Clinicians for more details on all the necessary steps for an intervention)

1. <u>Review Confidentiality, Limits of Confidentiality and Mandatory Reporting</u>

Although confidentiality is discussed with the patient at the beginning of the visit, once an incident of abuse is disclosed—whether a one-time or recurring—it is important that the patient clearly understands the limits of confidentiality. Often times, explaining confidentiality and its limits is an important component to creating a safe space for a patient to disclose. It is critical that all staff, especially providers, understand the current mandatory reporting laws. Even if the patient does not disclose abuse and there is a strong suspicion of abuse or physical findings that clearly indicate abuse, reporting is mandatory and required by law. Helping the patient to understand this prior to assessment is fundamental to building trust. It also provides her with all the information she needs in order to make decisions.

An example of a clear and simple way to discuss confidentiality and its limits with a patient is:

> *"Everything we talk about today is confidential, which means it will remain private, between you and me, unless you share with me that someone is hurting you, you are hurting someone, or you are hurting yourself. Then I will have to share that information to get you help. Do you understand what this means? Are you ok with this?"*

2. <u>Provide a safe and supportive environment</u>

The first stage of the counseling process is directed toward establishing a relationship built on support, trust and mutual respect. Creating a safe and supportive environment is especially essential for implementing effective screening, reporting and prevention strategies for IPV. If a patient does not feel safe, she will not disclose and she will not ask for help. Setting the stage for a safe environment happens in a variety of ways:

a. Verbal and non-verbal communication
b. Non-judgmental and nurturing cues
c. Creating a safe and welcoming physical space (patient waiting room, exam room, etc.)
d. The clinic policies set in place to ensure confidentiality

a. <u>Verbal and non-verbal communication</u>

Your communication style immediately sets the tone for establishing rapport and mutual respect with a patient. Communication, both verbal and non-verbal, indicate to the patient whether or not you are listening deeply, you are open to the information she shares, and the patient feels safe to express without being judged. Familiarize yourself with effective and active listening skills, and practice this level of communication on a regular basis.

(Refer to the WHCCOEP Patient Education & Counseling Protocol for more information on counseling skills and active listening)

- Use non-judgmental communication
  - Be aware of your facial expressions, gestures, movement, initial reactions, verbal responses
  - Notice non-verbal cues from patient
- Practice active listening
  - Sit square, facing the client, with an open posture
  - Maintain appropriate and culturally-sensitive eye contact
  - Remove barriers between you and the patient
  - Utilize active listening tools
    - Parroting
    - Clarifying
    - Summarizing
    - Empathic responses: "*It sounds like this is very difficult for you."*
- Stay present with your patient and minimize distractions
- Speak the patient's language
  - In the patient's language she is most comfortable speaking and understanding
  - Use simple, clear, non-medical terms that she uses understands: *"vaginal lips"* versus *"labia"*

b. <u>Non-judgmental and Nurturing Cues</u>

Being non-judgmental is a moment-to-moment practice. Overtime and with experience, being nonjudgmental will flow naturally through your communication, body language, and tone. IPV is traumatic and disclosing IPV is frightening. Be nonjudgmental and nurturing as much as humanly possible. By doing so, you will exude compassion, cultivate a deeper trust with the patient, support her healing process, facilitate her safety, and empower her actions moving forward as she seeks help.

- Be non-judgmental in your communication
  - Be aware of your facial expressions, gestures, movement, initial reactions, verbal responses
  - Notice non-verbal cues from client
  - *"Why"* versus *"How come"*
- Normalize the conversation
  - *"Because abuse is so common, I talk to all my patients about unhealthy relationships."*
  - *"A lot of people feel that way…*"
- Get comfortable talking about healthy and unhealthy relationships
- Be patient-centered
  - Non-coercive
  - Ask, don't tell
  - Focus on the client's goals, behaviors, thought-patterns, etc.
  - Meet her where she is at
- Reinforce her growth and progress

- *"It's so wonderful that you came in today."*
- *"You did such a powerful thing for yourself and children when you talked to the counselor at the shelter."*

- Acknowledge and validate the patient:
  - *"You don't deserve the abuse and it is not your fault."*
  - *"I am concerned for your safety (and the safety of your children)."*
  - *"You are not alone and there is help available."*
- Educate, do not give advice
- Utilize valuable referrals
- Understand when you are beyond your scope of expertise and skills, and offer resources for those areas

c. <u>Creating a safe and welcoming physical space</u>

The physical room where the interview and counseling take place can be a subtle but powerful and effective tool that supports the patient-provider relationship, as well as IPV screening, reporting and prevention. If you have not done so already, objectively stroll through each patient room at your site—the waiting room, the front desk, the office, the exam rooms, the patient bathroom, etc. Imagine yourself as the patient and notice what surrounds you in that space. How does the energy in the room feel? What are you looking at on the walls, ceiling, windows, TV? What reading materials are available in the room? What is the underlying message of patient education displayed in the room? Are your culture, ethnicity and language portrayed in the room? Does the room feel warm and welcoming?

- Maintain clean and clear patient rooms with a positive atmosphere
  - If possible, use colors and décor that feels welcoming, comfortable and relaxing
  - Clear patient areas of clutter, which energetically feels stressful, and sends a message to the patient that you are unprofessional and disorganized which can cause her to feel unsafe
- Provide a safe, quiet and private place to interview patients
  - If possible, interview patients in a room with a door that closes, otherwise, create as much privacy in patient areas as possible
  - Play background music to absorb sounds and surrounding conversations
- Display culturally-competent educational materials addressing IPV and reproductive coercion in waiting rooms, cubicles, exam rooms, hallways and patient bathrooms
  - Chose materials that speak to different cultures and ethnicities
  - Display materials in various languages that are prevalent at your site

d. <u>The policies set in place to ensure confidentiality</u>

This has already been discussed extensively, but additional tips include:

- Always discuss limits of confidentiality PRIOR to doing assessment
- Create a patient room that is private so the patient feels that what she says in the room cannot be heard outside of that room
- Have a policy in place to ALWAYS interview the patient alone first before inviting her guest into the room (partner, parent, friend, etc.)
- Have a script and protocol in place for when a patient guest is resistant or possibly even hostile towards the patient being interviewed alone
  - *"It is so great that you came today with your wife and that you are supportive of her health. I can tell you really care about her. We have a strict clinic policy that we always interview the patient alone first. Let us take 5 minutes and then I'll come out so you can join us."*

3. Gather information

Appropriate staff will gather information for the medical record, and essentially the report. This will include personal/subjective data (information stated by the patient) and clinical/objective data (physical exam, laboratory tests, etc.).

The patient's history includes:

a. Chief complaint: elicit and record precise details of the abuse, including relevant trauma history and relationship of abuse to any concurrent medical symptoms
b. Past medical history/review of symptoms: ask about and record any history, both related and unrelated to the domestic violence
c. Sexual history: document any incidents of sexual assault, partner history, sexual behaviors, lack of barrier protection, STIs, unplanned pregnancy, abortions, miscarriages and ability to use birth control
d. Medication history: document any relationship between the abuse and the use of psychoactive, analgesic or other medications
e. Relevant social history: document relationship to abuser, living arrangement, abuser's access to patient, patient's immediate safety, and patient's support system

Be as detailed and specific as possible. Whenever possible use the patient's exact words and language. For example: "*Jimmy, my husband, hit me in the eye with his fist."* or *"My boyfriend, Randy, called me a fat whore and slapped me in the face because I was 15 minutes late getting home from work."*

Ask key questions—refer to the Safety Card for effective, evidence-informed questions and scripts. You want to be appropriately nosey. The more information you obtain, the more you can help the patient. To get more information, use open-ended questions as much as possible rather than close-ended questions, to get more information

- *"Do you feel safe at home?"* (closed-ended question)
- *"Tell me about your relationship with your husband."* (open-ended question)

Document the date, time and location of an incident. Include any names or descriptions of witnesses. Also include if there were threats made, use of weapons or objects (knife, open or closed fist, etc.) and patient's appearance or demeanor.

If patient gives her permission to go for a SART exam with a trained/certified SART practitioner, the appropriate police department will assist with setting that up. Do **not** perform pelvic exam if patient desires SART and follow-up (this can be done if patient has not menstruated or had coitus since the incident).

The process of successfully establishing trust with the patient and completing the interview in a safe space will ultimately facilitate the next step without causing additional trauma: the physical exam.

4. Provide information and clinical care

The physical exam requires recording the precise details of findings related to abuse, including using an injury body map *(enclosed in IPV/DV Protocol)*. Consider taking pictures with a forensic ruler *(enclosed in IPV/DV Protocol)*, if appropriate, and if the patient gives consent. Describe any injuries by size, color, texture, and location. Document in the chart any screening for sexually transmitted infections, as well as any other lab/diagnostic tests that are performed.

Be sure to assess the patient's safety, and potential for harm to her and others in the household (children, other family members, etc.). If there is a significant risk for suicide, keep the patient safe and in the healthcare setting until an emergency psychiatric evaluation is arranged.

When the assessment indicates domestic abuse and the patient does **not** disclose or **denies** abuse, document your reasons for concern:

- *"Physical findings are not concurrent with patient's statements."*
- *"Patient presents with indications of possible physical abuse."*

Throughout the visit there are opportunities to provide valuable information. Utilize teachable moments to offer additional information and education that may be helpful to the patient. Examples include:

- *"Domestic violence is common and happens in every community."*
- *"This is not your fault. You did not do anything wrong."*
- *"Violence typically doesn't just happen once. Once it starts, it usually does not stop, and tends to get worse over time."*
- *"Did you know that your relationship can impact your health?"*
- *"Let's create a personalized safety and wellness plan for you."*

5. <u>Make the Report</u>

The location of the abusive incident determines which police department takes the report. This is important for time management. Make contact with the appropriate police department as soon as the assessment has been made. Having a good relationship with law enforcement agencies is helpful but how long it takes to send personnel to take the report often is the slowest part.

- County of Los Angeles Sheriffs (unincorporated areas or if location is unknown jurisdiction)
- City Police Department (i.e. Torrance, Long Beach)

General guidelines for making a report:

- Make a telephone report to the appropriate law enforcement agency or Child Protective Services as soon as possible
- Complete and submit the appropriate forms for the type of abuse
    - Report on Injury or Suspected Abuse Form - within 2 working days to the same law enforcement dept. *(enclosed in IPV/DV Protocol)*
    - Child Abuse Report Form - within 36 hours to Child Protective Services
- The agency with which the report is filed is responsible for "cross-reporting" with other appropriate agencies (i.e. law enforcement)

Making a report can be a long and time-consuming process, not only for the provider, but for the entire clinic staff. It is not common that making a report takes an average of 2-3 hours or longer. It is advantageous to have a clinic policy or procedure in place for when a report is being made to support the remainder of the day and clinic flow. It is critical to remember that even though making a report is time-consuming and disruptive to clinic flow, it is extremely important and mandatory. Having clinic policies and procedures in place, in conjunction with regular staff training ensures that reports will be made correctly, and all information is documented properly and thoroughly.

Be aware of the potential consequences of making a report:

- Increased risk for retaliation by partner or perpetrator may cause immediate danger to patient
- Deteriorated sense of trust of the provider
- Decreased health care utilization by patient

- Providers' fear may prevent them from screening and providing care and referral

6. <u>Make a Follow-Up Plan</u>

What happens after a police report is made is important for not only basic patient follow-up, but also for helping to create a sense of completion and safety for the patient. A follow-up plan can include a multitude of items, including:

- All patients with a current intimate partner violence incident, or history of DV, should be offered a follow-up appointment
  - *"I would like to make a follow-up appointment in a few weeks to see how you're doing. Would you like to make an appointment today?"*
- At every visit following an assessment of domestic violence/abuse, it is important to review the medical history, and address any new episodes of abuse, safety, coping skills and options.
  - *"Have you told any friends or family about the abuse?"*
  - *"Has there been increase or worsening of the abuse?"*
  - *"I am concerned about your health, your safety."*
  - *"How are you coming along on your safety plan?"*
  - *"Have you made any changes?"*
- Safety assessment and plan *(see Domestic Violence Personalized Safety Plan enclosed in the IPV/DV Protocol)*
- Assure the patient confidentiality from her abuser
  - *"Is there a safe way for us to contact you?"*
  - *"No one has access to your test results without your written permission."*
  - *"We will not disclose to anyone that you were seen at the clinic."*
- Make a referral to the shelter/advocate that the clinic is partnered with for emergency housing, counseling, legal assistance and general crisis/trauma support *(refer to the DV & Family Counseling Referral List enclosed in the IPV/DV Protocol)*
  - If possible, follow-up with referral to DV organization
- Treatment for STIs and acute medical problems, as applicable
  - Follow-up for testing in 3 months for STI testing
- Emergency contraception, if applicable
- Discrete contraception, if applicable

SUPPORTING AND TRAINING CLINIC STAFF

It has been emphasized throughout this protocol that creating a safe and supportive environment for patients is critical to the entire assessment process. The more assessment happens in the clinic setting, the more intimate partner violence can be prevented, and identified early. In order for this process to occur routinely and effectively, it is imperative that a safe and supportive environment is also created for staff.

Assessing intimate partner violence, witnessing injuries and wounds on the body of a patient, and hearing the gruesome and traumatic personal stories from patients can trigger emotions, memories and a variety of reactions from staff. Make sure everyone on staff is aware of who to talk to when they are triggered by a patient visit, or if they simply need to debrief between patients or at the end of the day.

Integrating effective IPV screening into routine clinic visits is ultimately set in motion through staff training and establishing clinic policies and procedures. It is effective to slowly adapt new policies for

IPV screening, and provide adequate staff training for each new administrative, programmatic and clinical addition made. Staff training is a fundamental step for newly integrating IPV screening, and providing annual staff training on IPV is also key. Supporting staff to become more comfortable and knowledgeable with identifying IPV, discussing IPV and healthy relationships, and understanding mandatory reporting will create stronger, more effective outcomes in IPV screening and prevention.

Maintaining a written protocol for IPV screening and reporting is also a critical and strategic component to supporting staff in feeling more comfortable with IPV as well as with their role as counselors and mandated reporters. Have protocols and all appropriate forms and tools (forensic ruler, camera, etc.), compiled together in one central location that is easily accessible to all staff. Necessary forms may include an IPV checklist, DV referral list, and referral forms, safety plan and law enforcement contact information. It is important that the protocol and all related forms are reviewed and updated on an annual basis.

Given the prevalence and nature of IPV and DV, there is no doubt that routine screening must be integrated into all clinic settings. With the many proven effective strategies and tools outlined in this protocol, this level of effective service integration between healthcare and domestic violence support can be made possible, and clinic staff can respond to these issues in a healthy and helpful way.

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APPENDIX

NCDSV Power and Control Wheel

NCDSV Domestic Violence Personalized Safety Plan

WHCCOEP Domestic Violence, Sexual Assault and Family Counseling Services Referral List

WHCCOEP Intimate Partner Violence Checklist for Clinicians

Suspicious Injury Report Form

Injury Location Chart (Body map)

Forensic Ruler

DV Referral Form for Interval House

Safety Cards for Intervention (Futures Without Violence)

Power and Control Wheel

Physical and sexual assaults, or threats to commit them, are the most apparent forms of domestic violence and are usually the actions that allow others to become aware of the problem. However, regular use of other abusive behaviors by the batterer, when reinforced by one or more acts of physical violence, make up a larger system of abuse. Although physical assaults may occur only once or occasionally, they instill threat of future violent attacks and allow the abuser to take control of the woman's life and circumstances.

The Power & Control diagram is a particularly helpful tool in understanding the overall pattern of abusive and violent behaviors, which are used by a batterer to establish and maintain control over his partner. Very often, one or more violent incidents are accompanied by an array of these other types of abuse. They are less easily identified, yet firmly establish a pattern of intimidation and control in the relationship.

Developed by:
Domestic Abuse Intervention Project
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NATIONAL CENTER
on Domestic and Sexual Violence
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Domestic Violence Personalized Safety Plan

Name: _____ Date: _____

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I d not have control over my partner's violence, I do have a choice about how to respond to him / her and how to best get myself and my children to safety.

STEP 1: Safety during a violence incident. *Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.*

I can use some of the following strategies:

A. If I decide to leave, I will _____. *(Practice how to get out safely. What door, windows, elevators, stairwells, or fire escapes would you use?)*

B. I can keep my purse and car keys ready and put them *(location)* _____ in order to leave quickly.

C. I can tell _____ about the violence and request that she or he call the police if she or he hears suspicious noises coming from my house.

D. I can teach my children how to use the telephone to contact the police, the fire department, and 911.

E. I will use _____ as my code with my children or my friends so they can call for help.

F. If I have to leave my home, I will go to _____. *(Decided this even if you don't think there will be a next time.)*

G. I can also teach some of these strategies to some or all of my children.

H. When I expect we're going to have an argument, I'll try to move to a place that is low risk, such as _____. *(Try to avoid arguments in the bathroom, garage, kitchen, near weapons, or in rooms without access to an outside door.)*

I. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he / she wants to calm him / her down. I have to protect myself until I / we are out of danger.

STEP 2: Safety when preparing to leave. *Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving a relationship.*

I can use some or all of the following strategies:

A. I will leave money and an extra set of keys with _____ so I can leave quickly.

B. I will keep copies of important documents or keys at _____.

C. I will open a savings account by _____, to increase my independence.

D. Other things I can do to increase my independence, include: _____

_____

E. I can keep change for phone calls on me at all times. I understand that if I use my telephone credit card, the following month's phone bill will show my batterer those numbers I called after I left. To keep my phone communications confidential, I must either use coins, or I might ask to use a friend's phone card for a limited time when I first leave.

F. I will check with _____ and _____ to see who would be able to let me say with them or lend me some money.

G. I can leave extra clothes or money with _____.

H. I will sit down and review my safety plan every _____ in order to plan the safest way to leave the residence. _____(*domestic violence advocate or friend's name)* has agreed to help me review this plan.

I. I will rehearse my escape plan and, as appropriate, practice it with my children.

STEP 3: Safety in my own residence. *There are many things that a woman can do to increase her safety in her own residence. It may be impossible to do everything at once, but safety measures can be added step by step.*

Safety measures I can use:

A. I can change the locks on my doors and windows as soon as possible.

B. I can replace wooden doors with steel / metal doors.

C. I can install security systems, including additional locks, window bars, poles to wedge against doors, an electronic system, etc.

D. I can purchase rope ladders to be used for escape from second floor windows.

E. I can install smoke detectors and fire extinguishers from each floor of my house / apartment.

F. I can install an outside lighting system that activates when a person is close to the house.

G. I will teach my children how to make a collect call to me and to _____ *(name of friend, etc.)* in the event that my partner takes the children.

H. I will tell the people who take care of my children which people have permission to pick up my children and that partner is not permitted to do so. The people I will inform about pick-up permission include:

_____ *(name of school)*

_____ *(name of babysitter)*

_____ *(name of teacher)*

_____ *(name of Sunday-school teacher)*

_____ *(name[s] of others)*

I. I can inform _____ *(neighbor)* and _____ *(friend)* that my partner no longer resides with me and that they should call law enforcement if he / she is observed near my residence.

STEP 4: Safety with an Order of Protection. *Many batterers obey protection orders, but one can never be sure which violent partner will obey and which will violate protective orders. I recognize that I may need to ask law enforcement and the courts to enforce my protective order.*

The following are some steps I can take to help the enforcement of my protection order:

A. I will keep my protection order _____ *(location). Always keep it on or near your person. If you change purses, that's the first thing that should go into the new purse.*

B. I will give my protection order to law enforcement departments in the community where I work, in those communities where I visit friends or family, and in the community where I live.

C. *There should be county and state registries of protection orders that all law enforcement departments can call to confirm a protection order.* I can check to make sure that my order is on the registry. The telephone numbers for the county and state registries of protection orders are: _____ (county) and _____ (state).

D. I will inform my employer; my minister, rabbi, etc.; my closest friend; and _____ that I have a protection order in effect.

E. If my partner destroys my protection order, I can get another copy from the clerk's office.

F. If law enforcement does not help, I can contact an advocate or an attorney and file a complaint with the Chief of Police Department of the Sheriff.

G. If my partner violates the protection order, I can call 911 or law enforcement and report the violation.

STEP 5: Safety on the job and in public. *Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family, and co-workers can help to protect women. Each woman should carefully consider which people to invite to help secure her safely.*

I might do any or all of the following:

A. I can inform my boss, the security supervisor, and _____ at work.

B. I can ask _____ to help screen my telephone calls at work.

C. When leaving work, I can _____.

D. If I have a problem while driving home, I can _____.

E. If I use public transit, I can _____.

F. I will go to different grocery stores and shopping malls to conduct my business and shop at hours that are different from those I kept when residing with my battering partner.

G. I can use a different bank and go at hours that are different from those I kept when residing with my battering partner.

STEP 6: Safety and drug or alcohol use. *Most people in this culture use alcohol. Many use mood-altering drugs. Much of this is legal, although some is not. The legal outcomes of using illegal drugs can be very hard on battered women, may hurt her relationship with her children, and can put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. Beyond this, the use of alcohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him / her an excuse to use violence. Specific safety plans must be made concerning drugs or alcohol use.*

If drug or alcohol use has occurred in my relationship with my battering partner, I can enhance my safety by some or all of the following:

A. If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.

B. If my partner is using, I can _____ and / or _____.

C. To safeguard my children I might _____.

STEP 7: Safety and my emotional health. *The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life takes much courage and incredible energy.*

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

A. If I feel down and am returning to a potentially abusive situation, I can _____ _____.

B. When I have to communicate with my partner in person or by telephone, I can _____ _____.

C. I will try to use "I can …" statements with myself and be assertive with others.

D. I can tell myself, "_____" whenever I feel others are trying to control or abuse me.

E. I can read _____ to help me feel stronger.

F. I can call _____ and _____ for support.

G. I can attend workshops and support groups at the domestic violence program or _____ to gain support and strengthen relationships.

STEP 8: Items to take when leaving. *When women leave battering partners it is important to take certain items. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.*

Money: Even if I never worked, I can take money from jointly held savings and checking accounts. If I do not take this money, he / she can legally take the money and close the accounts.

Items on the following lists with asterisks (*) are the most important to take with you. If there is time, the other items might be taken, or stored outside the home. These items might best be placed in one location, so that if we have to leave in a hurry, I can grab them quickly. When I leave, I should take:

* Identification for myself
* My birth certificate
* School and vaccination records
* Checkbook, ATM card
* Keys – house, car, office
* Medications
* Welfare identification, work permits, green cards
* Children's birth certificates
* Social Security cards
* Money
* Credit cards
* Driver's license and registration
* Copy of protection order

Passport(s), divorce papers

Medical records – for all family members

Lease / rental agreement, house deed, mortgage payment book

Bank books, insurance papers

Address book

Pictures, jewelry

Children's favorite toys and / or blankets

Items of special sentimental value

Telephone numbers I need to know:

Police / sheriff's department (local) – 911 or _____

Police / sheriff's department (work) _____

Police / sheriff's department (school) __ _____

Prosecutor's office _____

Battered women's program (local) _____

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

County registry of protection orders _____

State registry of protection orders _____

Work number _____

Supervisor's home number _____

I will keep this document in a safe place and out of reach of my potential attacker.

Review date: _____

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Intimate Partner Violence Checklist

☐ 1. Explain the limits of confidentiality regarding anything discussed with the patient.

☐ 2. Know and then explain mandatory reporting laws (see Family and Intimate Partner Violence Manual, Mandatory Reporting, Section 6).

☐ 3. History (whenever possible use patient's own words "Jimmy, my husband, hit me in the eye.")

a. Chief complaint: elicit and record precise details of the abuse including relevant trauma history and relationship of abuse to any concurrent medical symptoms
b. Past medical history/review of symptoms: ask about and record any history related to domestic violence
c. Sexual history: document any sexual assault, lack of barrier protection, STDs, unplanned pregnancy, abortions, miscarriages and ability to use birth control
d. Medication history: document any relationship between the abuse and the use of psychoactive, analgesic or other medications
e. Relevant social history: document relationship to abuser, living arrangement, abuser's access to patient

☐ 4. Physical Exam: record precise details of findings related to abuse, including using a body map (see form in front of Family and Intimate Partner Violence Manual). If patient gives her permission to go for a SART exam with a trained/certified SART practitioner, the appropriate police department will assist with setting that up. Do not perform pelvic exam if patient desires SART and follow-up (this can be done if patient has not menstruated or had coitus since incidence.

☐ 5. Laboratory/diagnostic procedures

a. Urine pregnancy test, if appropriate
b. Test for appropriate sexually transmitted diseases

☐ 6. Police report: where the incident took place (jurisdiction) determines which police department would take the report. This is important for time management.

a. County of Los Angeles Sheriffs (unincorporated areas or if location is unknown jurisdiction)
b. Torrance Police Department

☐ Options/ Plan

a. Assess and record patient's risk for suicide, homicide, potential for serious harm or injury
b. Treatment for STDs and acute medical problems
c. EC
d. Contraception
e. Referral to IPV/DV hotline, shelter, legal assistance and counseling
f. Follow-up for testing in 3 months for STD testing
g. Validation of worth, not being at fault, importance of reporting, need for follow-up testing
h. Safety assessment and plan
i. Assurance of confidentiality

☐ Return appointment given for results.

CALIFORNIA EMERGENCY MANAGEMENT AGENCY

SUSPICIOUS INJURY REPORT

CalEMA 2-920 (4/1/09)

STATE OF CALIFORNIA

INFORMATION DISCLOSURE

This form is for law enforcement use only and is confidential in accordance with Section 11163.2 of the Penal Code. This form shall not be disclosed except by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by this report. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts. The person making this report shall not be required to disclose his/her identity to their employer (PC 11160).

Part A: PATIENT WITH SUSPICIOUS INJURY

1. PATIENT'S NAME (Last, First, Middle)	2. BIRTH DATE	3. GENDER ☐ M ☐ F	4. SAFE PHONE NUMBER ( )

5. PATIENT'S RESIDING ADDRESS (Number and Street / Apt – **NO P.O. Box)** City State Zip

6. PATIENT SPEAKS ENGLISH ☐ Y ☐ N – Identify language spoken: _____	7. DATE AND TIME OF INJURY Date: Time: ☐ am ☐ pm ☐ Unknown

8. LOCATION / ADDRESS WHERE INJURY OCCURRED, IF AVAILABLE – Check here if unknown: ☐

9. PATIENT'S COMMENTS ABOUT THE INCIDENT – Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ ADDITIONAL PAGES ATTACHED

10. NAME OF SUSPECT – If identified by the patient	11. RELATIONSHIP TO PATIENT, IF ANY

12. SUSPICIOUS INJURY DESCRIPTION – Include a brief description of physical findings and the final diagnosis. ☐ ADDITIONAL PAGES ATTACHED

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. LAW ENFORCEMENT AGENCY NOTIFIED BY PHONE (Mandated by PC 11160)	14. DATE AND TIME REPORTED Date: Time: ☐ am ☐ pm

15. NAME OF PERSON RECEIVING PHONE REPORT (First and Last)	16. JOB TITLE	17. PHONE NUMBER ( )

18. LAW ENFORCEMENT AGENCY RECEIVING WRITTEN REPORT (Mandated by PC 11160)	19. AGENCY INCIDENT NUMBER

Part C: PERSON FILING REPORT

20. EMPLOYER'S NAME	21. PHONE NUMBER ( )

22. EMPLOYER'S ADDRESS (Number and Street) City State Zip

23. NAME OF HEALTH PRACTITIONER (First and Last)	24. JOB TITLE

25. HEALTH PRACTITIONER'S SIGNATURE:	26. DATE SIGNED:

CALIFORNIA EMERGENCY MANAGEMENT AGENCY

SUSPICIOUS INJURY REPORT

CalEMA 2-920 (rev 4/09)

STATE OF CALIFORNIA

Instructions To The Health Practitioner

Penal Code Section 11160 *mandates* the following regarding suspicious injuries:

- Internal procedures established to facilitate reporting and apprise supervisors and administrators of reports shall be consistent with the reporting requirements of PC Section 11160. The internal procedures shall not require any employee who must make a report to disclose his or her identity to the employer.
- Report suspicious injuries to your local law enforcement agency by telephone **immediately**, or as soon as practically possible.
- Submit the required completed written report to your local law enforcement agency *within two working days of discovering a suspicious injury,* whether or not:
  1. The person has expired;
  2. The injury was a factor contributing to the person's death; or
  3. Evidence of the conduct of the perpetrator is discovered during an autopsy.
- Use this standard form or a form, developed and adopted by another state agency, that otherwise fulfills the requirements of this form, (see "Exceptions to using this form" below).
- Two or more health practitioners with knowledge of a suspicious injury may mutually select a team member to make the telephone report and one written report signed by the selected team member. A team member who knows that the selected team member has not made the telephone call or submitted the written report shall make the report(s).
- No supervisor or administrator shall impede or inhibit the required reporting duties, and no person making a report pursuant to this section shall be subject to any sanction for making the report.

Exceptions To Using This Form

Other state reporting mandates pre-empt the use of this form to report suspicious injuries, as follows:

Incident	Form	Source of Form
Physical Child Abuse	SS 8572	Call California Department of Justice at (916) 227-3285.
Dependent Adult / Elder Abuse	SOC 341	Online: http://www.dss.cahwnet.gov/pdf/SOC341.pdf or contact your local County Adult Protective Services Dept.
Sexual Assault – Adult*	CalEMA 2-923*	Online: www.CalEMA.ca.gov under Plans and Publications or call Cal EMA at (916) 324-9100.
Sexual Assault – Child*	CalEMA 2-925* CalEMA 2-930*	

*Use these forms to conduct a forensic examination of the victim. Otherwise, use this Suspicious Injury Report form.

Definitions

Health Practitioner – Provides medical services to a patient for a physical condition that he/she reasonably suspects is a suspicious injury as listed below, and is employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department.

Suspicious Injury – Includes any wound or other physical injury that either was:

- Inflicted by the injured person's own act or by another where the injury is by means of a firearm, OR
- Is suspected to be the result of *assaultive or abusive conduct* inflicted upon the injured person.

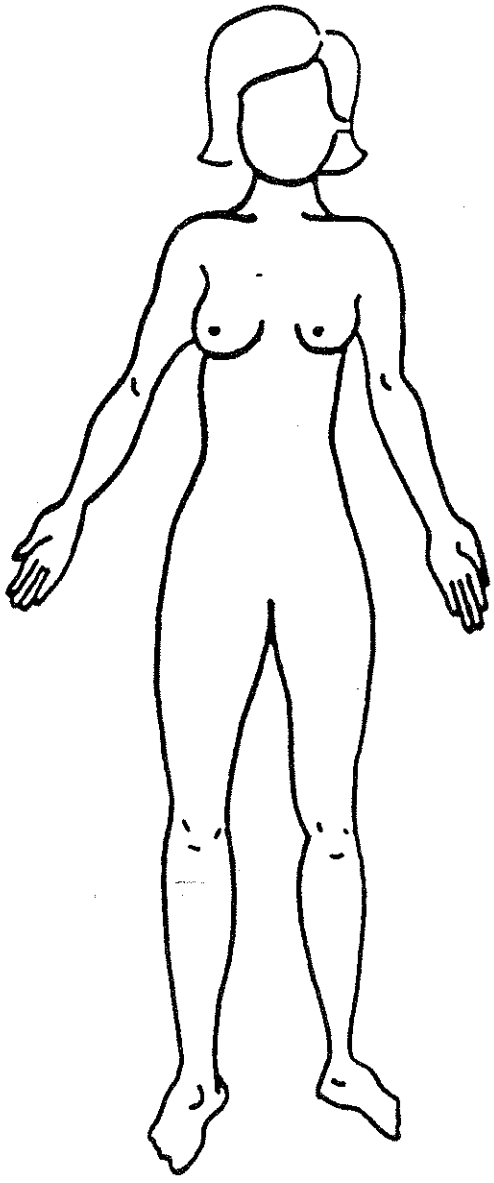
Injury – Shall not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restricted dangerous drug.

Assaultive / Abusive Conduct – includes committing, or an attempt to commit, any of the following Penal Code violations:

- Abuse of spouse or cohabitant
- Aggravated mayhem
- Administering controlled substances or anesthetic to aid in the commission of a felony
- Assault with a stun gun or taser
- Assault with a deadly weapon, firearm, assault weapon or machine gun, or by means likely to produce great bodily injury
- Assault with intent to commit mayhem, rape, sodomy, or oral copulation
- Battery
- Child abuse or endangerment (including Statutory Rape)
- Elder abuse
- Incest
- Lewd and lascivious acts with a child
- Murder
- Manslaughter
- Mayhem
- Oral copulation
- Procuring any female to have sex with another man
- Rape
- Sexual battery
- Sexual penetration
- Sodomy
- Spousal rape
- Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure
- Torture CAL

Injury Location Chart

Indicate, with arrow from description to body, where injury was observed. Indicate number of injuries of each type in space provided.



ENCOUNTERS:

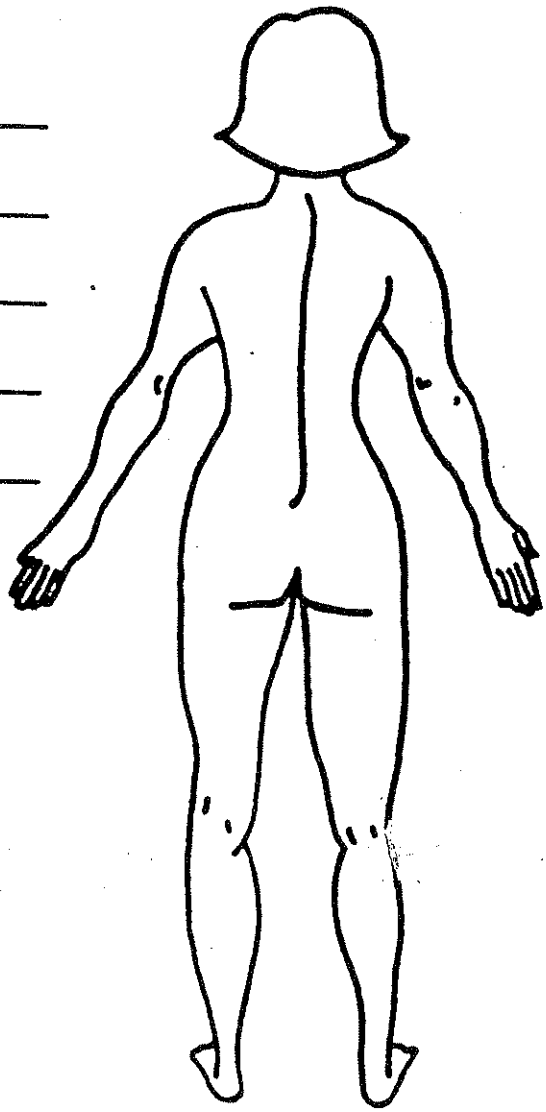
Cuts_____ Punctures_____

Bites_____ Abrasions_____

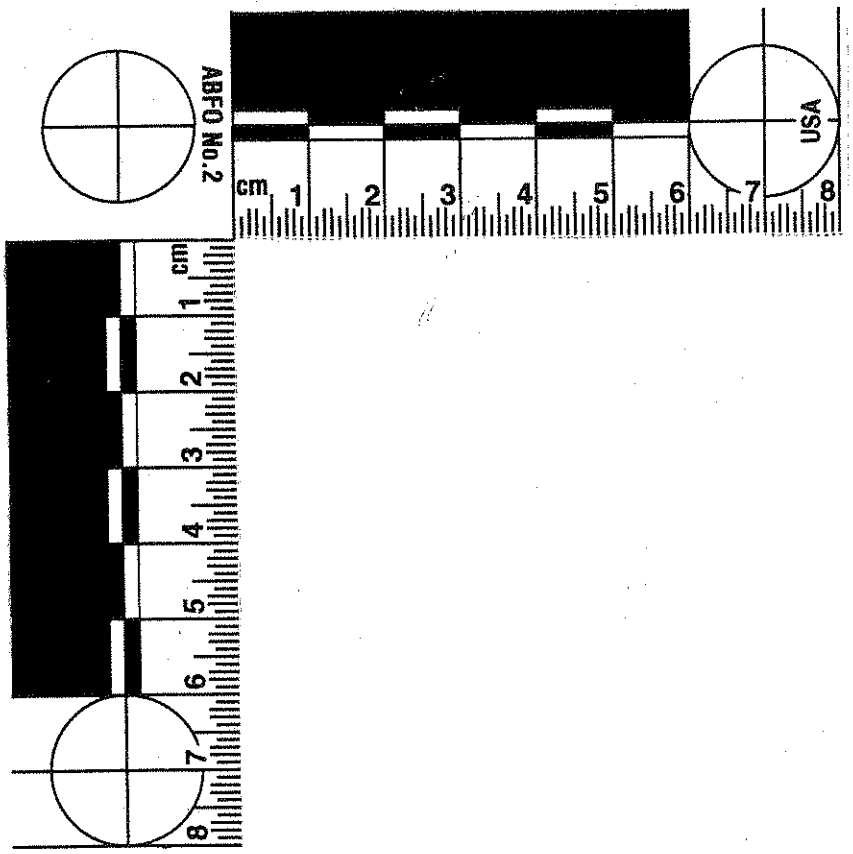
Bruises____ Bleeding_____

Burns____ Dislocations____

Bone Fractures_____



Mark and describe all bruises, scratches, lacerations, bite marks, etc.



CSI CRIME SCIENCES INC
An Invitro Sciences Inc. Company
1874 Hwy 20E Unit2, Fonthill ON LOS 1E6
905-892-1800 FAX 905-892-4359
www.crimesciences.com

Interval House **Fax**: (562) 596-3370 **Email:** admin@intervalhouse.org
Attn: Adriana/Sharon **Phone**: (562) 594-9492 **24-hr Hotline**: (562) 594-4555

DOMESTIC VIOLENCE PATIENT REFERRAL/OUTCOME FORM

Patient's First Name **Last Name** **DOB**

Address **City** **State** **Zip Code**

Preferred Language
- ❑ English
- ❑ Spanish
- ❑ Other:_____

Gender Identity
- ❑ Male
- ❑ Female
- ❑ Other _____

Best Phone Number To Call: ⑧ **Home Phone** ⑧ **Cell Phone** ⑧ **Other**

( ) - _____

Best Time(s) To Contact: _____

Is it safe to leave a message? ⑧ **Yes** ⑧ **No**

Other Phone Notes: _____

Services Requested from Interval House:
- ❑ Counseling
- ❑ Legal Assistance
- ❑ Emergency Shelter
- ❑ Rental Assistance
- ❑ Resource & Referral
- ❑ _____
- ❑ _____

Services Receiving/Received as a result of referral:
- ❑ Counseling
- ❑ Legal Assistance
- ❑ Emergency Shelter
- ❑ Rental Assistance
- ❑ Resource & Referral
- ❑ _____
- ❑ _____

Notes from Referring Provider (if applicable):

Contact Information of Referring Provider:

Name: _____ Phone: _____ Email: _____

Outcome from Interval House after Referral:

IH staff: _____ Date outcome report sent: _____

How is my health being affected?

Ask yourself:

- ✔ Are you over-eating and gaining weight?
- ✔ Do you often find yourself depressed or anxious?
- ✔ Do you have frequent headaches and/or chronic back or abdominal pain?
- ✔ Have you been diagnosed with hypertension or heart disease?

Any of these health problems may be the result of chronic stress from an abusive relationship. Making these connections can help you take steps towards better health.

How are your children doing?

Studies show that children who live in homes where their mother has been hurt are more likely to experience learning disabilities, behavior problems, drug and alcohol abuse, or even repeat abusive behavior as adults. But, children can also get through the hard times and here are some ways you can help:

1. Let them know it isn't their fault.
2. Keep an open door for when your child is ready to talk.
3. If your child is anxious or has behaviors that concern you, consult a pediatrician or counselor. Connect them to children's programs available in domestic violence programs.

FUTURES WITHOUT VIOLENCE™

Formerly Family Violence Prevention Fund

FuturesWithoutViolence.org

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).

If you are being hurt by your partner, it is NOT your fault. You deserve to be safe and healthy.

Call the National Domestic Violence Hotline for toll-free, 24/7 support with:

safety planning, housing options, and local referrals.

1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

Call 911 if you are in immediate danger.

Are you in a HEALTHY relationship?

Ask yourself:

- ✔ Is my partner willing to communicate openly when there are problems?
- ✔ Does my partner give me space to spend time with other people?
- ✔ Is my partner kind and supportive?

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 physical and mental health, longer life and better outcomes for your children.

Are you in an UNHEALTHY relationship?

Ask yourself:

- ✔ Does my partner shame me or humiliate me in front of others or in private?
- ✔ Does my partner control where I go, who I talk to, and how I spend money?
- ✔ Has my partner hurt or threatened me, or forced me to have sex?

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

Here are some proven steps you can take to help you cope and improve your health.

1. Talk with someone supportive that you trust about what's going on.
2. If it is safe, write about the pain you have experienced.
3. Reduce your stress through deep breathing and exercise.
4. Talk to your health care provider about things you may be doing to help you cope, such as: over-drinking, using drugs, or over-eating and support for next steps.

If your safety is at risk, here's how you can protect yourself:

1. Call 911 if you are in immediate danger.
2. Prepare an emergency kit for a situation where you have to leave suddenly (keys, money, legal and important documents, medicines, social security numbers, bank account information etc.) Call a domestic violence hotline for additional help planning.
3. Develop a safety plan with your children, including people they can call in an emergency including 911.
4. Talk to your health care provider, who can provide you with a private phone to call for help.

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).

FUTURES WITHOUT VIOLENCE®

FuturesWithoutViolence.org

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

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

Are you in a HEALTHY relationship?

Ask yourself:

- ✔ 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.*

Are you in an UNHEALTHY relationship?

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.

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.

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.