



Integrating Health Services into Domestic Violence Programs

Tools for Advocates

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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.



INTRODUCTION

Integrating onsite health assessment and primary health services into domestic violence programs provides an important resource for clients to access health care, resources and information. In addition, it provides an opportunity for domestic violence programs to create a culture of wellness and develop a more comprehensive array of services for their clients and staff.

Advocates are in a unique position to intervene and reduce health consequences related to domestic violence (DV):

- Good health is an important step to healing from DV.
- Entering DV programs may be the first time survivors have had space to address health and wellness.
- Advocates have the opportunity to implement time-sensitive interventions to prevent unplanned and unwanted pregnancy. A focus study conducted by the National Domestic Violence Hotline found that 25% of callers had experienced reproductive coercion, pointing to the importance of talking to survivors about the availability of emergency contraception (see Appendix H for more information).
- Advocates can be members of the health care team, acting as liaisons with health providers.

There is no “one size fits all” model for delivering health services in domestic violence programs. There are many models for providing health services in DV programs, ranging from integrating reproductive coercion assessment into shelter intake, to creating full-scale onsite clinics. Each community should consider their specific needs, resources, and potential challenges. Getting feedback from stakeholder groups (e.g. advocates, health care providers, and other community partners) will help ensure that you shape a program that is responsive to survivors’ needs and practical for providers. In addition, it is important to review the existing policies and protocols related to health and domestic violence that your program may have, and update them as needed.

Although many program elements will vary, there are some key components to building successful health services into DV programs:

- Training for advocates on the connection between health and domestic violence
- Cross-training between health providers and domestic violence advocates
- Developing DV program policies with feedback and guidance from health care partners
- Developing relationships with local health care providers and offering warm referrals to those services
- Maintaining an up-to-date health resource and referral list
- Creating a supportive environment by displaying educational materials and posters about the connection between experiencing abuse and negative health outcomes
- Ensuring that culturally relevant resources are available

Included in the appendices are sample forms and protocols that have been adapted from the work done in a wide range of DV programs from around the country exemplifying these service delivery models, as well as resources Futures Without Violence has developed as part of ongoing



work with other states building DV advocacy-based health programs. Links to other resources are also included in this toolkit.

General Health Resources

- Creating a Health Care Resource Sheet
- Birth Control Education Handout
- The Affordable Care Act & Women's Health Fact Sheet
- Impact of new Federal health coverage rule for domestic and sexual violence advocates Memo
- FAQ: Implementation of IPV Screening and Counseling Guidelines
- Online toolkit: www.healthcaresaboutIPV.org

Resources for DV Programs Addressing Reproductive Health

- Focus Survey Summary: Reproductive Coercion Reports by Callers to National Domestic Violence Hotline Survey
- *Did you know?: Sexual and Intimate Partner Violence Affects Your Health* (sample client education brochure created by Ohio Domestic Violence Network)
- *Frequently asked questions about making over-the-counter medication available in domestic violence and sexual assault programs* (information sheets for advocates)
- Excerpt from Rose Brooks Center's Strategic Plan (Kansas City, MO)
- Sample MOU between reproductive health and DV program
- Sample Reproductive Coercion Protocol

Creating a Shelter-Based Health Clinic

- Guidelines for Shelter-Based Health Care Clinic
- Emergency Contraception Information (for advocates)
- Emergency Contraception Checklist (for advocates)
- Daily Patient Sheet (for health care providers)
- Goals and Priorities While in the Shelter form (for health care providers or advocates)
- Shelter-Based Health Care Clinic Progress Note (for health care providers)
- Follow Up Needed Sheet (for health care providers)

This toolkit is not intended as a comprehensive guide to building health services in DV programs, but provides a basic introduction and sample tools. There are many innovative programs around the country working to integrate health services into DV programs, including Rose Brooks Center in Kansas City, MO (see attached PowerPoint for an overview of their work), Washington State's support to Pregnant and Parenting Teens and Women Program, Haven in Warsaw, VA and the Texas Council on Family Violence. We encourage DV programs embarking on health work to contact these programs for their perspective and expertise. Futures Without Violence will continue to share additional tools as they become more widely available.

APPENDICES

(All documents are included on the trainer's DVD)

- A. Reproductive Health Quality Assessment/Quality Improvement Tool
- B. Creating a Health Care Resource Sheet
- C. Sample Reproductive Coercion Protocol
- D. Sample Intake Health Form
- E. Sample Guidelines for Shelter-based Health Care Clinic
- F. Sample Memorandum of Agreement between health and DV program
- G. Birth Control Education Handout
- H. Focus Survey Summary: Reproductive Coercion Reports by Callers to National Domestic Violence Hotline Survey
- I. *Did you know?: Sexual and Intimate Partner Violence Affects Your Health* (sample client education brochure created by Ohio Domestic Violence Network)
- J. *Frequently asked questions about making over-the-counter medication available in domestic violence and sexual assault programs* (information sheets for advocates)
- K. Excerpt from Rose Brooks Center's Strategic Plan
- L. The Affordable Care Act & Women's Health Fact Sheet
- M. Impact of new Federal health coverage rule for domestic and sexual violence advocates Memo
- N. FAQ _Implementation of IPV Screening and Counseling Guidelines
- O. Example of *Did You Know Your Relationship Affects Your Health?* safety cards (English and Spanish)

BIBLIOGRAPHY

DVD

Integrating Health Services into Domestic Violence Programs: A Video Training Series

- 1) Part 1: Redefining Safety Planning to Include Emergency Contraception
- 2) Part 2: Redefining Safety Planning to Include Emergency Contraception
- 3) Making the Connection



HOW TO USE THIS TRAINERS CURRICULUM

This curriculum has been designed for domestic violence programs and is focused on developing staff skills and broadening their thinking through interactive exercises and activities.

There are several factors that will influence the length of your training when you use these slides. Factors include:

- 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

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 *Did You Know Your Relationship Affect Your Health?* materials

Intended audience:

This curriculum was designed for advocates working in domestic violence programs.

Participant familiarity with reproductive and sexual coercion:

Participants receiving this training should have a basic understanding of reproductive health. However, there is considerable variability among domestic violence programs in terms of how much training advocates and staff have received. Family Planning providers at local clinics and reproductive health programs are an excellent resource to contact for reproductive health training and information.

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). Speakers' 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 by either 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:

- We strongly suggest working with another trainer as a team. Ideally this team would include a domestic violence advocate and reproductive 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.
- Curriculum includes 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 can be extended.

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 practice trainings 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 the Trainer’s Curriculum and PowerPoint slides
 - DVD: Integrating Health Services in DV Programs: A Video Training Series
- *Did You Know Your Relationship Affect Your Health?* Safety Cards
- 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
- 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 sync 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.



Important notes for Trainers:

- Due to the high prevalence of intimate partner violence, reproductive and sexual 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 intimate partner violence, reproductive and sexual coercion, and their effects on women are sensitive topics that can be emotional regardless of whether a person has had any direct experiences with abuse.
- Invite health care providers from your local/regional reproductive health program/clinic to participate in the training. They can provide the latest information on resources, contact information, and invaluable insights into the topics being discussed. Including reproductive health providers in your training can help to build partnerships between domestic violence advocates and local health care providers.
- It is also advisable, whenever possible, to have a domestic and sexual 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 learn 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"), 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. When 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.



**Health
Assessment as
Safety Planning:
Integrating
Reproductive
Health into
Domestic Violence
Programs**



Health Assessment as Safety Planning: Integrating Reproductive Health into Domestic Violence Programs

Overview

The purpose of this training is to help the learner understand how integrating health services into domestic violence (DV) programs and addressing reproductive health as part of DV advocacy services can make a difference in the lives of clients. This training makes the case for advocates – showing how discussions of reproductive health are critical components of safety planning.

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.

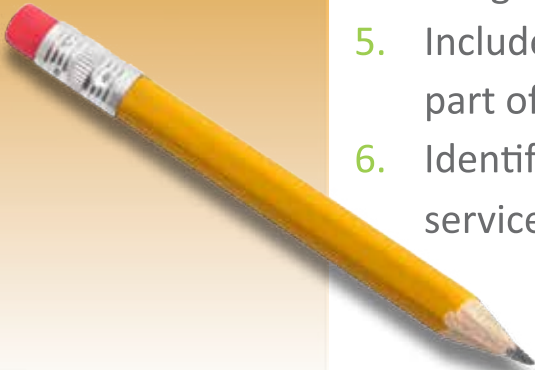
It is important to include elements of interactivity (group discussion, video vignettes, role plays, etc.) for optimal adult learning and to avoid overloading the participants with didactic material. We suggest that you schedule **AT LEAST 1** break during the training, with an opportunity to stretch, eat, and socialize. Remember that this is difficult content and participants will need a “breather.”



Learning Objectives

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

1. Explain the impact of domestic violence (DV) on reproductive health outcomes
2. Define reproductive coercion
3. Create partnerships with local reproductive health programs
4. Assess the readiness of your DV program to integrate health services
5. Include assessment for reproductive coercion as part of DV advocacy services
6. Identify tools and resources to integrate health services into DV programs



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Notes to Trainer: Read the learning objectives aloud.



Workshop Guidelines “Ground Rules”

- Because domestic violence is so prevalent, assume that there are survivors among us
- Be aware of your reactions and take care of yourself first
- Respect confidentiality
- “Step Up, Step Back”
- Please turn off your phones, laptops, etc.
- Others?



Notes to Trainer: 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 a follow-up can occur.

Comfort Meter: 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”



QUESTION:

How comfortable am I talking to my clients about reproductive and sexual health issues?

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Estimated Activity Time: 2-3 minutes

Notes to Trainer: 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 comfort level right now with talking to clients about reproductive health—and if he or she feels comfortable asking questions, offering basic information about reproductive health needs and making referrals.
3. Discuss how the goal at the end of today’s session is that each person has personally moved that needle towards the ‘totally 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.

Advocates identified the following barriers:

- Outside of my scope of work, how is this related?
- Discomfort with initiating conversations with clients about sexual and reproductive health
- Not knowing what to do about positive disclosures
- Lack of time

Health care providers identified the same barriers to addressing DV/SA!



Notes to Trainer: This Train the Trainer toolkit is designed to address the barriers identified by advocates in the field.

Large group discussion: What might get in your way when addressing reproductive health?

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

Redefining Safety Planning

Part I



The following video clip demonstrates some concerns advocates may feel when asked to address reproductive health needs of clients sometimes encountered.

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Estimated Activity Time: 3 minutes to watch video

Notes to Trainer: Introduce the video. Be sure to note that this video was developed in partnership with both domestic violence advocates and reproductive health providers. It includes real life comments and experiences that were encountered as domestic violence programs began addressing reproductive health issues as part of safety planning.

Discussion questions are listed on the next slide.



Video Debrief

- Can you see yourself or your colleagues being resistant to the idea of doing assessments of reproductive coercion?
- What are other barriers or concerns advocates might have that were not raised in the video?
- Do you think that the advocate did a good job articulating the relevance and need for offering emergency contraception to clients? What else could she have added?



Estimated Activity Time: 10 minutes to discuss video

Notes to Trainer: For some participants, this video may be the first time they have heard about the concept of addressing reproductive health as part of domestic violence advocacy services. Give some space for general comments and reactions to the video before moving to the discussion questions. Make sure to not only discuss what was done right but also have a discussion about what could be done better and/or how these “training” conversations might be incorporated into discussions in their workplace.

Family Planning/Reproductive Health Programs



- Located in local health departments, free clinics, community health centers and other settings.
- Most funded through Title X Family Planning Program (enacted 1970 as part of Public Health Service Act), which, by law, gives priority to low-income families.
- Assist individuals in determining the number and spacing of their children and promote positive birth outcomes and healthy families as well as healthy reproductive and sexual health.



You do not have to be an “expert” in family planning, but it is important to know who to contact if participants have questions you can’t answer.

The U.S. Department of Health and Human Services hosts the Title X website, that answers basic questions about federally funded family planning programs: <http://www.hhs.gov/opa/title-x-family-planning/>.

Available Services

- Physical exams: pelvic exams, breast exams, etc.
- Contraception and sterilization
- STI testing and treatment
- Pre-conception counseling and management
- Sexuality and healthy relationship counseling and education

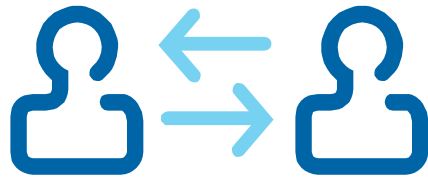


Notes to Trainer: Before presenting, contact your local family planning programs to get more information about the specific services available in your community. Add or delete services listed, as appropriate.

If possible, bring brochures, cards, or other outreach materials for training participants, so that participants can contact their local family planning programs directly. In addition, you can invite a representative from the local family planning program to talk about the services they offer.

Creating Partnerships

Family planning clinics and domestic violence advocacy programs play unique but equally important roles in helping achieve positive health outcomes and promoting healthy relationships. Our goal is collaboration and cross-referrals between these programs.



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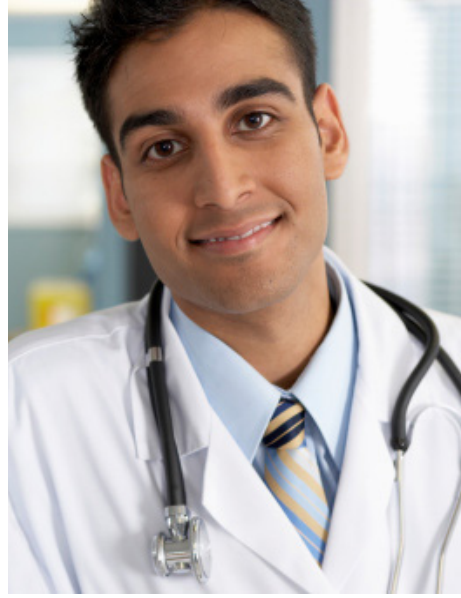
Notes to Trainer: It is important to stress the importance of creating partnerships with local family planning providers to ensure safe, effective and compassionate services are available to victims/survivors in both health and domestic violence programs. Just as health care providers have a role in preventing and responding to domestic violence in the clinical setting, advocates can offer important health information as part of their ongoing work with survivors.



Providers Want to Partner with DV Advocates to Better Serve Their Clients

“[Our family planning] clinics are establishing productive and authentic partnerships with domestic violence centers. At last, we are getting the training and tools we need to address a fairly common but serious problem that has always been with us but has seldom received the attention it deserves.”

*Joe Fay, Statewide Coordinator
Alliance of Pennsylvania Councils*



This is a quote from a *Project Connect* leadership team member in Pennsylvania. He has been working in family planning for many years, and has seen instances of reproductive coercion, but was unsure how to respond. The patient safety cards and partnerships with local DV advocates has improved their clinical response to violence against women.



17% of abused women reported that a partner prevented them from accessing health care

compared to **2%** of non-abused women

(McCloskey et al, 2007)

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These statistics reinforce how important it is to address health needs when women enter domestic violence programs – it may be the first time in a long time that they have had access to services.

- In this study by McCloskey et al. (2007), 2027 women outpatients across five different medical departments housed in 8 hospital and clinic sites completed a written survey. 59% of participants were white, 38% were married, and 22.6% were born outside of the U.S. Nearly 14% of the women disclosed recent IPV and 37% confirmed ever being in a violent relationship.
- 17% of women who had been physically abused by an intimate partner in the past year reported that their partner did not allow them to access health care or interfered with their health care compared to 2% of non-abused women.
- Women with interfering partners were significantly more likely to report having poorer health (OR=1.8)

McCloskey LA, Williams CM, Lichter E, Gerber M, Ganz ML, Sege R. (2007). Abused women disclose partner interference with health care: an unrecognized form of battering. *Journal of General Internal Medicine*, 22(8):1067-1072.



How is this related to your work?

- Good health is part of healing from domestic and sexual violence
- Entering a DV program might be the first place in a long time that health needs are addressed
- DV programs are in a unique position to intervene and reduce health consequences related to experiencing violence



Integrating onsite health assessment and primary health services into domestic violence programs provides an important resource for clients to develop medical homes and access resources and information. In addition, it provides an opportunity for domestic violence programs to create a culture of wellness and develop a more comprehensive array of services for their clients and staff.

Advocates are in a unique position to intervene and reduce health consequences related to experiencing violence. Long term relationships with clients.

- Screening and brief counseling for IPV as a covered preventive health service
- Increased training requests
- Increased referrals
- New partnerships



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One focus of health reform, known as the Patient Protection and Affordable Care Act (ACA), was an increased emphasis on women's preventive care. On August 1, 2012, a new Federal rule administered by the Department of Health and Human Services went into effect requiring free cost-sharing (without co-payments or deductibles) for eight preventive health services in select new, non-grandfathered health plans, including ***screening and counseling for domestic and interpersonal violence***.

The inclusion of screening and counseling for domestic violence as 1 of 8 *covered* women's preventative health services acknowledges DV as an important health issue. This coverage – if implemented in partnership with domestic violence advocates – offers an historic opportunity to reach thousands more women and children not currently being helped. It may also mean that:

- Providers will need training and resources to help them perform these services safely and effectively.
- There may be an increase in referrals from health care systems for DV advocacy services.
- In addition, advocates may benefit from more accessible health services, including home visitation, for the women in their programs with increased collaboration.

Please Note: For states where they have not expanded Medicaid, most providers in public health programs who bill Medicaid will NOT be reimbursed for screening and counseling. For more information on ACA and tools to respond, go to www.healthcaresaboutIPV.org.



Intimate Partner Violence and Reproductive Coercion: Making the Connection

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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 section 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.



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

(Miller, 2010; Sarkar, 2008; Goodwin et al, 2000; Hathaway, 2000)



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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.

Hathaway et al. (2000) analyzed data from a population-based survey (Behavioral Risk Factor Surveillance System) in Massachusetts to examine the association between IPV and unintended pregnancy. Among women experiencing IPV who had been pregnant in the past 5 years, approximately 40% reported that the pregnancy was unwanted, as compared to 8% of other women.

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.

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.

Hathaway JE, Mucci LA, Silverman JG, Brooks DR, Mathews R, Pavlos CA. (2000). Health status and health care use of Massachusetts women reporting partner abuse. *American Journal of Preventive Medicine*, 19(4): 302-307.

You Know the Stats!

1 in 4 U.S. women
and
1 in 5 U.S. teen girls
report having
experienced physical
and/or sexual partner
violence.



(Black et al, 2011; Silverman et al, 2001)



Notes to Trainer: These statistics will likely look familiar to participants – we mention it in all trainings so that participants understand the scope of the problem of violence against women.

Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens R. (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.

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: 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 abuse and teen pregnancy. However, few teen pregnancy programs address the connection between abuse and pregnancy risk, or recognize the identification of one of these risks as a clinical indicator to screen for the other. It may be interesting for the participants to consider what we associate with teen pregnancy from the media.

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.



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)



Note to Trainer: Remind participants that this statistic demonstrates that we can't assume that 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 women in abusive relationships, the threat of harm is often 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 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 explanation 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 a low risk for STIs.

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.

“ 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. ”

(Miller et al, 2007)

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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 young people 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.





What are some other ways a intimate partner can interfere with a woman's birth control?



Estimated Activity Time: 3 minutes

Notes to Trainer: Ask participants to give some examples they have seen in their DV programs. Responses may include examples of condom refusal, pregnancy pressure, forced sex, etc. Proceed to the next slide which provides examples of birth control sabotage and highlight any examples that were not identified by participants.

Tactics Include:

- Destroying or disposing contraceptives (pills, patch, ring)
- Impeding condom use (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 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.

Sex Used As a Tool of Power and Control

“ I'm not gonna say he raped me... he didn't use force, but I would be like, "No," and then, next thing, he pushes me to the bedroom, and I'm like, "I don't want to do anything," and then, we ended up doin' it, and I was cryin' like a baby, and he still did it. And then, after that... he got up, took his shower, and I just stayed there, like, shocked... ”

(Miller et al, 2007)



Notes to Trainer: Review this quote with the audience. Ask, do you think this woman was raped? (Nearly 100 percent of your audience will say yes).

Then say, let's look at the very first thing she said here — *"I'm not going to say he raped me..."* This kind of response is common among women in relationships — who sometimes have consensual sex with partners and who at other times experience sex like what is described here.

This illustrates why it is important to ask about specific behaviors using other words beyond "rape". It allows the woman to self identify with what happened to her.

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.

Making the Connection



The following animated video clip introduces viewers to the definition and prevalence of reproductive coercion, as well as the role that health care providers can have in identification and response.



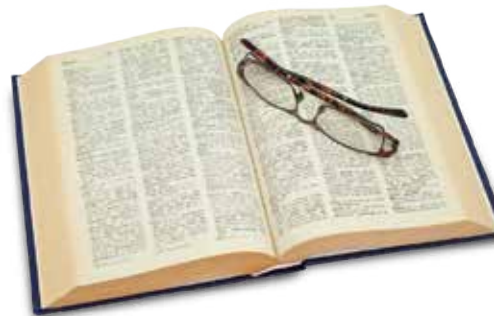
Estimated Activity Time: 3 minutes to watch video

Notes to Trainer: This video gives participants a brief overview of reproductive coercion, and the health care provider's role in its prevention and intervention. If time allows, after the video, ask if participants have any questions or have general reactions/feedback to the video.



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

- 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



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?"

Reproductive coercion 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

Ask the group: "How many of you have talked to clients who have experienced this?"

National DV Hotline Survey: Reproductive Coercion is Common Among DV Survivors

3,169 callers responded and 25% answered yes to:

- Has your partner or ex-partner ever told you not to use birth control?
- Has your partner or ex-partner ever tried to force you or pressure you to become pregnant?
- Has your partner or ex-partner ever made you have sex without a condom so you would become pregnant?



Reproductive coercion is common among women accessing DV services. In a phone survey administered by the National Domestic Violence Hotline, a quarter of the callers disclosed experiencing reproductive coercion.

More information on the survey can be found at: <http://www.thehotline.org/2011/02/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion/>

Hotline Callers Made the Connection



“He knows I don’t want to have another child; I’ve told him before. He says it will be ok, we will get a house soon. Thank God I got my period yesterday, but he was furious.

If you hadn’t asked me those questions, I wouldn’t have thought of it like that. I wouldn’t have thought that he was a manipulative person. I really wouldn’t.”



This quote is from one of the callers to the National Domestic Violence Hotline in response to the focus survey on reproductive coercion referenced in the previous slide.

What Role Can Your Program Play?

Family Planning Programs are vital to reducing unintended pregnancy and reducing reproductive control.

Can we say the same about DV programs?

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Note to Trainer: Give participants a few minutes to think about this question. Increasingly, the importance of having reproductive health care providers address reproductive coercion and DV in their programs is being recognized.

Given the extensive evidence that DV and unintended pregnancies often co-occur, How can DV programs increase their capacity to address the reproductive health needs of their clients?

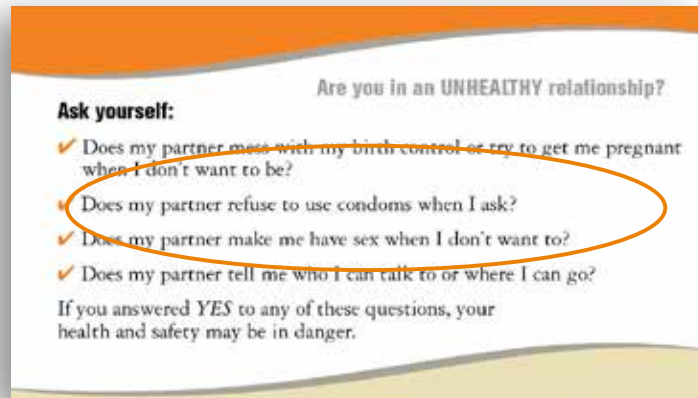
Both DV advocates and reproductive health providers play important roles in supporting the health and safety of their clients.



How Can Advocates Use This Card?

Reproductive Health Safety Card

- Modeled after DV safety cards
- Asks key questions
- Used as a prompt for staff and a safety card for clients



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Notes to Trainer: Give the participants a few minutes to review the card. Then open up the discussion to hear how they might incorporate this card into their work during intakes, in support groups, as part of counseling/case management, during prevention education sessions, etc.

Women Want to Talk About Reproductive Health

- Small pilot study in in Pittsburgh, PA
- DV program **started asking all women** about recent unwanted, unprotected sex at intake
- Clients were **overwhelmingly positive** about being asked the questions and knowing that pregnancy tests and EC were available to them onsite.

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Some advocates may be concerned that clients find talking about reproductive health too intrusive, embarrassing, or overwhelming. However, our experience with small pilot studies shows that women welcome the opportunity to discuss their health.



Virginia: Haven

All women are screened for unwanted/forced sex and birth control sabotage upon shelter intake and offered Emergency Contraception to help prevent pregnancy, if needed.



Through *Project Connect*, DV programs had the opportunity to integrate basic health services. One success story is Haven in Virginia. They trained all advocates to do an assessment for reproductive coercion within 24 hours of shelter intake, offered all incoming clients an information sheet about EC, and dispensed EC as needed/requested.

Introducing the Assessment: Sample Script

Many women who come to our program have experienced situations which put them at risk for unwanted or unplanned pregnancies. There is a safe medication called emergency contraception that you can take up to five days after unprotected sex to prevent pregnancy. To better understand who may need or want this medication we review this form with all our clients.



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Notes to Trainer: Read the script aloud. Before advocates introduce the safety card with clients, it is important to normalize the activity. This sample script gives guidance on how to begin the conversation about reproductive coercion assessment at DV program intake. Ask participants how they might adjust it in their work.



Redefining Safety Planning

Part II



The following video clip demonstrates the role advocates can have in addressing the reproductive health needs of their clients



Estimated Activity Time: 5 minutes to watch video

Notes to Trainer: Introduce the video. Be sure to note that it was developed in partnership with both domestic violence advocates and reproductive health providers. It includes real life comments and experiences that were encountered as domestic violence programs began addressing reproductive health issues as part of safety planning.

Discussion questions are listed on the next slide.

Video Debrief

- What did the advocate do well?
- What would you change?
- Can you see yourself or your colleagues integrating the assessment for reproductive coercion, and offering on-site emergency contraception?
- What other questions do you have about the assessment?

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Estimated Activity Time: 7-10 minutes to discuss video

Notes to Trainer: Review questions listed on slide.



“I thought emergency contraception was the abortion pill...”



- Emergency contraceptive pills **prevent** pregnancy by delaying or inhibiting ovulation and inhibiting fertilization.
- Emergency contraceptive pills work **before** pregnancy begins.
- In fact, because emergency contraception helps women **avoid** getting pregnant when they are not ready or able to have children, it can reduce the need for abortion.

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It is important to acknowledge that there is a lot of misinformation about Emergency Contraception. The next two slides address the common myths about EC.

Additional Information About EC

- This medication does **not cause miscarriage**
- It will **not hurt a pregnancy** if you are already pregnant
- It only helps to prevent pregnancy if you have had **recent unprotected sex.**



Visit <http://ec.princeton.edu> for additional information and resources

Notes to Trainer: The website noted on the slide is an important resource to review before the training. You can also refer back to the video vignette, where many of these “myth-busters” were mentioned.

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 emergency contraception.



Women who have intercourse around ovulation should ideally be offered a copper intrauterine device. Women with body mass index $>25 \text{ kg/m}^2$ should be offered an intrauterine device or UPA. All women should be advised to start effective contraception immediately after EC.

Glasier A, Cameron ST, Blithe D, Scherrer B, Mathe H, Levy D, Gainer E, Ulmann A. (2011). Can we identify women at risk of pregnancy despite using emergency contraception? Data from randomized trials of ulipristal acetate and levonorgestrel. *Contraception*, 84(4):363-7.

Glasier AF, Cameron ST, Fine PM, Logan SJ, Casale W, Van Horn J, Sogor L, Blithe DL, Scherrer B, Mathe H, Jaspart A, Ulmann A, Gainer E. (2010). Ulipristal acetate versus levonorgestrel for emergency contraception: a randomised non-inferiority trial and meta-analysis. *Lancet*, 375(9714): 555-62.

What are some other contraceptive methods clients experiencing reproductive coercion might consider?



Handout: Birth Control Education

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Notes to Trainer: When training participants that are both domestic violence and sexual assault advocates, a contraceptive methods handout may be useful to make sure all participants understand in detail the way 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. Ask if there are any questions about these methods and how a partner might interfere with them

Group Discussion



- What makes (you) a good advocate?
- What is the difference between asking about other needs (legal, housing, childcare, etc.) and reproductive health?
- What are the advocacy skills you would be putting to use when asking clients about sexual and reproductive health?
- What is your “worst case scenario” when thinking about discussing sexual and reproductive health with clients?



Notes to Trainer: The goal of this group discussion is two-fold.

1. It gives the participants time to think about how the skills and resources they already employ are directly applicable to incorporating discussions about reproductive coercion. Examples to highlight include listening non-judgmentally, offering support and validation, problem-solving/safety planning, and helping clients access relevant resources.
2. It gives the participants the opportunity to talk about some “what if” scenarios. Common scenarios include the client getting offended by questions about reproductive health, a client bringing up painful/traumatic stories, or the advocate not knowing how to answer a specific question. Troubleshoot some of these scenarios, and remind participants these are situations that can occur while talking about other issues, as well. As advocates, they have the tools, resources, and training to address these difficult situations.

Role Play



- Divide into groups of three. One person is the advocate, one person is the client, one person is the observer
- **Scenario:** A client is coming in for an intake. Introduce the reproductive coercion assessment questions, review the safety card and check in to see if she needs EC
- Discuss as a group – what worked well, what would you change?
- Switch roles so everyone has a chance to practice doing the assessment

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Estimated Activity Time: 15 minutes

Notes to Trainer: Read the instructions on the slide. Stress the importance of introducing the card QUICKLY- in a real interaction there will have been more time for rapport building - assume that has already happened.

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.

Come back together as a group to debrief.

1. Ask the observers to think about the kinds of things that the advocate said that worked well such as how did she/he introduce the card? Did she/he make the discussion comfortable? What would they have liked to see more of?
2. Ask the participants who role played the client how the assessment made them feel.
3. Ask participants who role played advocates if they were comfortable asking these questions. If some of the advocates indicated that they were not comfortable, ask what would help to increase their comfort level.

Strategies: Onsite

- Add health question to intake and case management forms
- Provide information on local family planning services
- Stock pregnancy tests, condoms, and other OTC reproductive health supplies
- “Golden ticket” for appointments at local clinics
- Rx delivery by local pharmacy
- Onsite providers: clinical services &/or health education



Notes to Trainer: In addition to offering onsite EC there are many other ways DV programs can provide reproductive health services to their clients.

- Have flyers, cards, brochures, etc. from the local family planning clinic posted at the shelter and administrative office. Make sure a staff person is responsible for refreshing the information. Simply having the information available creates an environment where women know it is OK to talk about their reproductive health issues with program staff. This is a simple, no-cost strategy.
- Cost can be a barrier to women accessing reproductive health resources. Have a supply on hand of pregnancy tests, condoms, and other items. Think about where they will be stored, how they will be replenished, and how they will be paid for. A local clinic may be able to supply them to you for free. This strategy was implemented by the Maine Project Connect team.
- In some areas, there are long wait times for family planning appointments. By building partnerships with your local clinics, you may be able to negotiate “golden tickets” for expedited appointments. This strategy was implemented by the Texas Project Connect team.
- Medication delivery is another important strategy, especially for women in shelters who are not safe going out into the community. DV programs can set up MOUs with local pharmacies to have medications delivered. A local pharmacy can set up a “credit” for your program so that EC is available and paid for in advance when clients need them. This strategy was implemented by the Virginia Project Connect team.
- Setting up an onsite clinic is the strategy that will require the largest investment. Partner with a local family planning program, medical/nursing school, or other organization to provide onsite health care at regular intervals (most commonly weekly or bi-weekly). These providers can offer a range of services—both reproductive health and primary care. They also have the opportunity to provide health education sessions during support groups, house meetings, etc.

- Co-located advocate at local clinic
- On-call advocate with “backdoor” number
- Advocates trained in health services (translation, navigators, HIV care messengers, etc)



Health interventions can work. If done correctly, screening and counseling by a health provider in collaboration with advocates has been shown to make a difference in health outcomes for victims of violence.

- A number of clinical trials found that when screening is coupled with education, harm reduction and referrals to domestic and sexual assault services, violence can be reduced and the health status of women improved. (Tiwari et al, 2005)
- Women who talked to their health care provider about the abuse were far more likely to use an intervention. (McCloskey et al, 2006)
- At a 2-year follow-up, women who were screened for abuse and given a wallet-sized referral card that included national hotline numbers reported fewer threats of violence and assaults. A majority of the women do not have recurrent abusive relationships and health. (McFarlane et al, 2006)

You can partner with your health providers to promote effective partnerships.

Tiwari A, Leung W, Leung T, Humphreys J, Parker B, Ho P. (2005). A randomized controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG: an International Journal of Obstetrics and Gynaecology*, 1-10.

McCloskey LA, Lichter E, Williams C, Gerber M, Wittenberg E, Ganz M. (2006). Assessing Intimate Partner Violence in health care settings leads to women's receipt of interventions and improved health. *Public Health Reporter*, 121(4):435-444.

McFarlane JM, Groff JY, O'Brien JA, Watson K. (2006). Secondary prevention of intimate partner violence: a randomized controlled trial. *Nursing Research*. 55(1):52-61.

Building Relationships with Local Reproductive Health Programs

- Invite providers to join your community's DV workgroup/ taskforce
- Cross-trainings: Provide a “DV 101” training at your local clinic; invite a provider to do a “reproductive health 101” training for DV program staff
- Schedule regular visits to the family planning clinic to restock your program’s community outreach materials
- Invite providers to do a tour of your program
- Work with clinic staff to plan a Domestic Violence Awareness Month, Health Cares About Domestic Violence, or other community outreach event at the clinic



Notes to Trainer: It is important to build lasting partnerships with family planning programs in order to be able to sustain onsite health services. This slide includes some examples. Ask the participants if they have other ideas or experience working with their local health care providers.

Voices of Advocates

“Once we became aware of [reproductive coercion] it just made sense to change the questions we were asking clients. For our women in shelter having access to medical services in a safe way without looking over their shoulder— it’s part of rebuilding and taking control back. What do these medical resources mean to these women? They are priceless.”



*Sara Sheen, Director of Bridge Program
Rose Brooks Center, St Louis, MO*

Notes to Trainer: This quote is from a director at one of the first DV programs to address reproductive health.



Are You Ready?

- What are the next steps your program can take to integrate reproductive health into its work with survivors?
- What other information or training do you need to become more comfortable with assessing for reproductive coercion?
- Do you know who your local family planning partners are?

Handouts: Reproductive Coercion QA/QI tool and Creating a Health Care Resource Sheet



Estimated Activity Time: 15 minutes

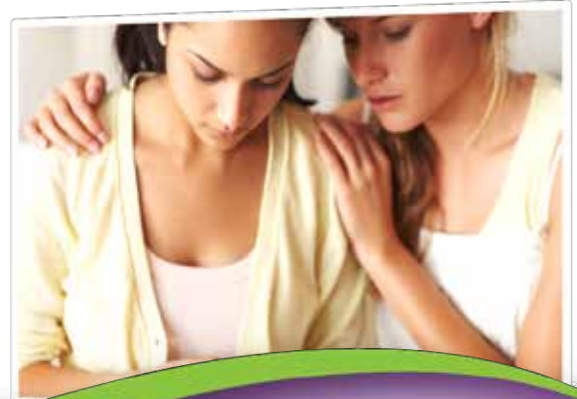
Notes to Trainer: Pass out handouts, “Reproductive Coercion QA/QI tool” and “Creating a Health Care Resource Sheet.”

This training is a call to action for DV programs to address reproductive health. Give participants time to think about next steps – have them take notes on and respond to these 3 questions. If programs send teams of participants, have them sit together and discuss. Participants can share their responses to the questions, and get feedback from you and other group members.

Stories From Survivors

According to the client, her abuser had sabotaged her birth control method in the past, forced her to terminate a pregnancy he didn't want, then forced her to keep a pregnancy that endangered her. ...she said she felt relief to talk to someone about the coercive nature of her husband... she stated, "I'm so glad you asked me that."

- As reported by an advocate with a Virginia DV program



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The slide features an excerpt from a case study from an advocate in Virginia participating in qualitative research about DV programs integrating reproductive health services into their programs.

The full case study is below:

This client also came to us from a medical facility. She was released from [XYZ] Behavioral Center after suffering from anxiety and suicidal thoughts. She was also eight months pregnant with twins; they were fathered by her abuser. Again, the medical concerns were being addressed immediately, as she was released from a medical facility. When I asked her about her husband and if he had shown any sexually coercive behaviors, she began calling out a litany of transgressions. According to the client, her abuser had sabotaged her birth control method in the past, forced her to terminate a pregnancy he didn't want, then forced her to keep a pregnancy that endangered her. This client has MS and was not able to take her medications for fear that it would harm the babies. We talked about options if she goes back to him and options if she decides to leave the relationship for good. She verbalized that she felt relief to talk to someone about the coercive nature of her husband. The few people she had in her life for support didn't see those behaviors as problematic or abusive, even when she had to stop her MS medications. I got the feeling that her family saw this as typical and acceptable behavior from a husband and it was her job to accommodate him. She stated, "I'm so glad you asked me that."

National Health Resource Center on Domestic Violence



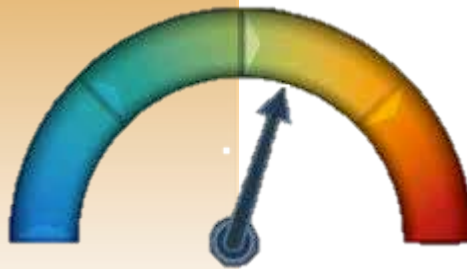
- For free technical assistance and tools including:
 - Safety cards
 - Training curricula
 - Clinical guidelines
 - State reporting law information
 - Documentation tools
 - Pregnancy wheels
 - Posters
 - Online toolkit:
www.healthcaresaboutipv.org



Notes to Trainer: For more information and program support, contact the National Health Resource Center on Domestic Violence, a project of Futures Without Violence (Futures). Safety cards, posters, clinical guidelines and pregnancy wheels are available from the Futures' 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/>.

Revisit the Comfort Meter: Where Am I Now?

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



QUESTION:

How comfortable am I talking to my clients about reproductive and sexual health issues?

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Estimated Activity Time: 2-3 minutes

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

1. Tell participants to take out the sheet of paper they used for their “Comfort Meter” at the beginning of the session.
2. Ask participants to take a minute to think about their comfort level now with talking to clients about reproductive and sexual coercion now that they have completed the training—and if he or she feels comfortable asking questions and getting a “yes” as the answer.
3. 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.

Thank You!



Notes to Trainer: 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. Be sure to include your contact information, so participants can contact you for further information or questions.

Appendices



INTEGRATING HEALTH SERVICES INTO DOMESTIC VIOLENCE AND SEXUAL ASSAULT PROGRAMS

Quality Assessment/Quality Improvement Tool

The following quality assessment tool is intended to provide Domestic Violence/Sexual Assault (DV/SA) programs with some guiding questions to assess how well they may be addressing the health needs of DV/SA survivors. This includes addressing clinical and mental health concerns as well as access to health services. 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 the state-wide effort to improve the integration of health services delivery into DV/SA programs. 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, without identifying specific programs). We will ask your program to complete the tool one more time in about 6 months time.

We hope that this tool will help provide guidance on how to enhance your DV/SA program's capacity to address the health and healthcare needs of survivors.

PROGRAM: _____ **DATE:** ____ / ____ / ____

Completed by (title only) _____

ASSESSMENT METHODS	YES	NO	N/A	DON'T KNOW
Does your program have a written intake form to ask survivors about:				
• Medical concerns				
• Mental health concerns				
• Reproductive and Sexual Coercion (birth control sabotage, pregnancy pressure, STI/HIV risk)				
• Health insurance				
• Last physical				
• Immunizations				
• STI/HIV testing				
• Current medications				
• Allergies				
In addition to asking about the clients' health, does the intake form include an assessment of their <i>children's health</i> ?				
Are there specific prompts on the intake form to encourage staff to assess for <i>sexual assault</i> and the need for emergency clinical services?				
Are there any scripts or sample questions that staff can use on your assessment forms to ask clients about <i>reproductive coercion</i> ?				
Is there a private place in your program to screen and talk with clients about health concerns?				

INTEGRATED ASSESSMENT	YES	NO	N/A	DON'T KNOW
Are clients assessed for depression?				
Are clients assessed for suicidality?				
Are clients assessed for substance abuse?				
Additional mental health or clinical conditions?				
INTERVENTION STRATEGIES	YES	NO	N/A	DON'T KNOW
Does your staff have:				
Scripted tools/instructions about what to say and do when a client discloses a medical concern?				
Scripted tool/instructions on how to assess for suicidality with clients who disclose depression?				
Scripted tool/instructions on how to assess for the need for emergency contraception?				
A protocol for connecting a client to urgent medical services?				
A connection to a clinical service provider for clinical questions?				
A clear protocol for what types of situations require urgent clinical assessment?				
Does your program have resource lists that:				
Identify clinical referrals/resources for clients who need medical care?				
Identify referrals/resources for clients who need mental health care?				
Includes a contact person for each referral agency?				
Has a staff person who is responsible for updating the list?				
Are these lists updated at least once a year?				
NETWORKING & TRAINING	YES	NO	N/A	DON'T KNOW
Has your staff had contact with representatives from any of the following types of clinical service providers in the past year?				
Women's health services				
Mental health services				
Children's health services				
Urgent care services				
Other clinical services				
Is there anyone on your staff who is especially skilled/comfortable dealing with medical and mental health issues?				
Do new hires receive training on assessment and intervention for medical and mental health issues during orientation?				
Does your staff receive booster training on assessment and intervention for medical and mental health issues (as these relate to DV/SA) at least once a year?				



SELF-CARE AND SUPPORT	YES	NO	N/A	DON'T KNOW
Does your program have a protocol for what to do when a staff person is experiencing intimate partner violence?				
Does your program have a protocol for what to do if a perpetrator is on-site and displaying threatening behavior or trying to get information?				
Does staff have the opportunity to meet and discuss challenges and successes with cases involving complex medical and/or mental health problems?				
DATA & EVALUATION	YES	NO	N/A	DON'T KNOW
Does your program track medical and mental health needs of clients?				
Does your program track medical and mental health referrals made on behalf of clients?				
Does your program conduct an annual review and update of all protocols addressing survivor health and healthcare needs?				
Does your program do any type of consumer satisfaction surveys or client focus groups that ask clients' opinions about assessment and intervention strategies for health related concerns?				
Does your program provide regular (at least annual) feedback to staff about their performance regarding assessment and referrals for survivors' health and health care related concerns?				
EDUCATION AND PREVENTION	YES	NO	N/A	DON'T KNOW
Does your program provide information to clients on how violence can impact their health?				
Does any of the information that you provide to clients address healthy relationships?				
Does your program sponsor any client or community education to talk about the impact of domestic violence and/or sexual assault on health?				
ENVIRONMENT & RESOURCES	YES	NO	N/A	DON'T KNOW
Are there any brochures/cards or other information about the health impact of DV and/or SA available on site?				
Are there any posters about reproductive health and health care displayed at your site?				
Are materials available specific to LGBTQ relationship abuse and health concerns?				
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?				

CREATING A HEALTH CARE RESOURCE SHEET

Call your local public health programs and find out what services are offered:

- ☐ Family planning (contraceptives, pregnancy testing, abortion services/referrals, STI and HIV testing and treatment)
- ☐ Prenatal care
- ☐ Mammograms
- ☐ Pediatrics
- ☐ Immunizations
- ☐ Primary care
- ☐ Dental services
- ☐ Adolescent-specific services (i.e. teen clinic)
- ☐ Services/outreach to LGBT community
- ☐ Home visitation
- ☐ Nutrition services (WIC, SNAP, etc.)
- ☐ Community education/outreach
- ☐ Other:

What languages are spoken?

Do they have any other culturally specific programs?

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

Are there evening hours?

What forms of payment/insurance are accepted?

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.



REPRODUCTIVE COERCION PROTOCOL INTAKE: SHELTER

Definition: Reproductive coercion involves behaviors that a partner uses to maintain power and control in a relationship related to reproductive health. Examples of reproductive coercion include:

- Explicit attempts to impregnate a female partner against her will
- Controlling the outcomes of a pregnancy
- Coercing a partner to engage in unwanted sexual acts
- Forced non-condom use
- Threats or acts of violence if a person doesn't agree to have sex
- Intentionally exposing a partner to a STI/HIV

While these forms of coercion are especially common among women experiencing physical or sexual violence by an intimate partner, they may occur independent of physical or sexual violence in a relationship and expand the continuum of power and control that can occur in an unhealthy relationship.

To guide the conversation about Reproductive Coercion, here are some suggested assessment questions:

1. Are you concerned you may be pregnant?
 - Provide Family Planning Clinic information (same day appointment - woman must schedule appointment).
 - *Provide pregnancy test*
 - Positive-refer to family planning for options counseling.
 - Negative-refer to family planning (long acting contraception).
2. Is someone messing with your birth control?
 - Refer to Family Planning Clinic for education on long acting contraceptive methods and contraceptive management.
 - Disseminate the Safety Cards *Hanging out or Hooking up?* and *Did You Know Your Relationship Affects Your Health?*
3. Have you had unwanted sex in the last 72 hours?
 - Provide information on Emergency Contraception (EC).
 - Provide Sexual Assault information/referral per Shelter protocol.
 - Emergency contraception is a safe and effective back-up method of birth control that can prevent pregnancy after unprotected/unwanted sex.



Family Planning Clinic

- Provide Family Planning Clinic phone number and hours.
- Appointment required - same day appointments available.
- Women and men can purchase ECs.
- Women or men will need to complete paperwork.
- Sliding fee scale based on family size and income (zero to \$45).

At the Counter

- There is no age restriction to access ECs.
- No government issued ID is required.
- Only women can buy them.
- There needs to be a trained pharmacist available.
- You have to ask the pharmacists or clerk for them (cost \$35-\$45).

Over the Counter

- You need to be 17 or older to get them.
- Government issued ID is required.
- Men and women can purchase them.
- Any pharmacist or clerk can sell them to you.
- You don't have to fill out any paperwork.
- You have to ask the clerk or pharmacists for them, they are not on the shelves.
- Call your local pharmacy to find out more about Emergency Contraception availability. (Cost \$35-\$45).

4. Are you concerned about an STI and HIV?
 - Refer to Family Planning Clinic for testing (same day appointment - woman must schedule appointment)
5. Would you like to talk to a female nurse practitioner about your reproductive health needs or contraception?
 - Refer to Family Planning Clinic for testing (same day appointment - sheltered victim of abuse must schedule appointment).
 - **If it is unsafe for the woman to leave the shelter and services are necessary follow protocol** (to be developed with clinical staff).
6. Disseminate the Safety Cards *Hanging Out or Hooking Up?* and *Did You Know Your Relationship Affects Your Health?*



EMERGENCY CONTRACEPTION INFORMATION FOR SHELTER STAFF/VOLUNTEERS

If a shelter resident is concerned about being pregnant, feels as though her significant other is attempting to make her pregnant against her will, or has had sex against her will in the last 5 days and is interested in emergency contraception, then shelter staff/volunteers can follow the checklist below. Please place checkmarks in the boxes as each item is completed.

1. When a woman tells shelter staff or volunteers she is concerned about possibly being pregnant, staff or volunteers should give the woman the Emergency Contraception Checklist. ☐
2. After the woman has filled out the checklist, the staff or volunteer should review the sheet to be sure the woman is older than 17 years of age ☐, the woman is not pregnant ☐, and that the woman meets the criteria for emergency contraception (the shelter resident must have checked yes to at least one questions in question number 2 (two) on the Emergency Contraception checklist) ☐.
3. Shelter staff or shelter volunteers must see documentation of the shelter resident that confirms she is 17 years of age or older. ☐
4. Once the resident's age has been confirmed the staff should ask if the resident is interested in taking emergency contraception. ☐
5. If the resident answers yes, then the staff can get the emergency contraception medication for the resident.
☐ Yes, the resident was given emergency contraception.
☐ No, the resident was not interested in taking emergency contraception at this time.



INTAKE HEALTH FORM

(This form is designed to be used with all clients upon intake into an advocacy program.)

Program Intake Date: _____

Many women who come to our program have experienced situations putting them at risk for unwanted or unplanned pregnancies. There is a safe medication that you can take called emergency contraception (some call it the “morning-after pill”) up to five days after unprotected sex to prevent pregnancy. To better understand who may need or want this medication we give this form to all our clients.

1. Is unwanted or unplanned pregnancy a concern for you at this time?
- ☐ No, this is not a concern for me. (If this is not a concern, you have completed the survey)
 - ☐ Yes, this is a concern for me. (If yes, please continue with form)
 - ☐ I am unsure whether I am pregnant or not and would like help getting a pregnancy test.
(Please let the advocate know this is what you need help with today)

2. What is your age? _____

3. First day of your last period _____ Was it normal? ☐ Yes ☐ No

If your last period was missed or light or has become irregular, it's a good idea to take a pregnancy test just to make sure you aren't pregnant before considering taking emergency contraception

4. Have you had unprotected sex (without condoms or any form of birth control) in the past 5 (five) days? ☐ Yes ☐ No
- a) Have you had sex in the last 5 days and experienced a condom breaking, being pulled off, falling off, or staying in you? ☐ Yes ☐ No
 - b) Have you forgotten to take your birth control (birth control pills, change your Nuva Ring, etc.) in the last 5 days? ☐ Yes ☐ No
 - c) Do you feel like your current partner is trying to get you pregnant when you don't want to be? ☐ Yes ☐ No
5. Please check the box below once you have read the side effects that can happen when taking emergency contraception:

Common side effects: Nausea, vomiting, feeling tired, dizziness, headache and abdominal pain

- ☐ **Yes, I have read and understand the common side effects that can happen when taking emergency contraception.**



6. Please check the box below once you have read the information below about emergency contraception.

Anyone thinking about taking emergency contraception should know the following information:

- a) If you vomit within 1-2 hours of taking emergency contraception, you will need another dose of the medication and may need to consider getting a prescription for a medication to help prevent you from vomiting again.
- b) If your next expected period is more than 1 (one) week late, you should take a pregnancy test.
- c) Emergency contraception does not protect you from sexually transmitted infections (STIs) and if you feel like you are or have been at risk for STIs you should seek testing at your primary care doctor or the health department.
- d) You may want to consider a long acting reversible method of birth control like the IUD or Implanon methods that are less likely to be forgotten or be tampered with by your partner. For more information on this subject please see Futures Without Violence's Safety Card - *Did You Know Your Relationship Affects Your Health?*

☐ **Yes, I have read and understand the information about emergency contraception.**

I would like a referral or access to emergency contraception today.

☐ **Yes** ☐ **No** ☐ **Unsure**

Thank you for answering these questions. Please give it back to your advocate so he or she can better understand what your needs are.

(Advocates — Please complete this section)

Futures Without Violence Safety Card *Did You Know Your Relationship Affects Your Health?* should be offered to all clients—even if they aren't experiencing reproductive coercion—so they know how to help a friend or family member if it is an issue for her.

Futures Card Given? ☐ **Yes** ☐ **No**

Health Care referral for EC given or access to EC provided? ☐ **Yes** ☐ **No**

SAMPLE GUIDELINES FOR SHELTER-BASED HEALTH CARE CLINIC

XYZ Women's Shelter

What health care services will be provided at the clinic?

- The clinic will provide counseling on Emergency Contraception (EC), and dispense EC as appropriate, as well as make referrals to local sexual and reproductive health services.
- The clinic will provide pregnancy testing and referrals to local sexual and reproductive health services.
- The clinic will provide general health screening forms for the women and their children who come into the shelter and seek the services of the clinic.
- The clinic will help identify the client's health needs.
- The clinic will facilitate referrals to appropriate treatment/management of the identified needs. The HCM will maintain an updated the list of local health services.
- The clinic and shelter staff will work in collaboration to provide travel vouchers, accompaniment, and childcare as needed and if available.
- The clinic will **not** provide primary care services, offer lab services or provide medications, other than EC. The shelter-based clinic will **not** manage episodic healthcare needs.

Will these women and children need to sign separate consent forms prior to being seen in the clinic?

No

When will the healthcare clinic function?

The healthcare clinic will function every Tuesday from 4-7pm. This specific time frame may vary with shelter resident census and with different volunteers.

Who will manage the healthcare clinic during hours of operation?

A nurse care manager (NCM), who volunteers his/her time, will manage the clinic during the hours of operation. Each week a state-licensed registered nurse, nurse practitioner or physician will be available to manage the clinic.

What documentation tools will be utilized at the shelter-based healthcare clinic?

- Daily Patient Sheet: Documentation of who was seen, their age, needs, referrals made on a daily basis.
- Goals and Priorities While in the Shelter form: Allows clients to determine what is their highest ranking priority while in the shelter. The NCM and the client can then review this form and determine appropriate management plans.



- XYZ Women's Shelter-based Health Care Clinic Progress Note: Allows the NCM to document information from the client visit.
- Follow Up Needed Sheet: Allows NCM to document if a follow up with client is necessary and what steps have been taken to achieve this follow up visit in the clinic.

How will the women and children's information be managed/stored at the shelter?

The room the shelter has set aside as the clinic will have a locked storage system for client charts, which will remain locked at all times. Only clinical staff will have access to the records, NOT shelter staff.

Can clients access EC if the clinic is closed?

Clients will be able to access EC during an appointment at the shelter-based healthcare clinic **OR** from an advocate who has completed the 4-hour Reproductive Health training (the list of trained advocates is updated regularly by the Program Manager), if the clinic will not be open within the 5-day window after unprotected sexual intercourse. Please see the attached EC information and checklist.



DAILY PATIENT SHEET

[illegible]

GOALS AND PRIORITIES WHILE IN THE SHELTER

Please circle a numbered response (1-5) for the statements below:

Scale:					
1-not important	2-slightly important	3-fairly important	4-important	5-very important	
Finding a job	1	2	3	4	5
Financially supporting myself	1	2	3	4	5
Making sure I'm in good physical health	1	2	3	4	5
Making sure I'm in good mental health	1	2	3	4	5
My personal safety	1	2	3	4	5
If you have children: Making sure my child is in good physical health	1	2	3	4	5
If you have children: Making sure your child is in good mental health	1	2	3	4	5

Adapted from the VCU Institute for Women's Health-Shelter Based Health Project, 2008.
Virginia Project Connect Team

SHELTER-BASED HEALTH CARE CLINIC PROGRESS NOTE

Name: _____ DOB _____

For Child/Mother's Name: _____ DOB _____

XYZ Women's Shelter-based Health Care Clinic

Progress Notes

DATE	NOTES

Adapted from: the Wald Clinic at House of Ruth, 2009.
Virginia Project Connect Team



FOLLOW-UP NEEDED SHEET

FOLLOW-UP NEEDED

Name and DOB	Date of visit	Reason for follow up (brief)	Follow-up effort begun	Done	Left Shelter

SAMPLE MEMORANDUM OF AGREEMENT

This document constitutes an agreement between *XYZ Domestic Violence Program* and *ABC Family Planning Association*

The purpose of this agreement is to outline the relationship between the *XYZ Domestic Violence Program* and *ABC Family Planning Association* which serves the purposes of identifying women exposed to reproductive coercion and increasing access to appropriate health care for women through the helpline, shelter intake, outreach, and the dissemination of safety cards and other educational information by *XYZ Domestic Violence Program*. The *ABC Family Planning Association* provide universal education on healthy relationships, and through clinical assessment will make referrals to the *XYZ Domestic Violence Program*.

Description of Activities

XYZ Domestic Violence Program agrees to participate in a collaborative process for increasing the number of consumers in need who receive family planning services. In the referring role, *XYZ Domestic Violence Program* agrees to participate in the following activities between _____ and _____:

- Attend partner orientation meetings.
- Attend training on family planning services, emergency contraception and contraception.
- Attend periodic check-in meetings (via phone or in person) to make sure the education and referral process is clear and efficient throughout the duration of this agreement.
- Complete an annual self-assessment of the partnership between *XYZ Domestic Violence Program* and *ABC Family Planning Association* agencies by the end date of this agreement.
- Do due diligence in referring the targeted population to family planning services for the duration of this agreement.

ABC Family Planning Association agrees to provide education and resources to *XYZ Domestic Violence Program* on reproductive health services, reproductive coercion, contraception, emergency contraception, same day appointments for clinical services and onsite clinical services if appropriate for sheltered victims of abuse. *ABC Family Planning Association* agrees to provide 25 pregnancy tests for each of the two shelters.

The return of two signed copies of this agreement to the *XYZ Domestic Violence Program* constitutes acceptance of all of the terms of this agreement.

Signature: _____ Date: _____
Executive Director
XYZ Domestic Violence Program

Signature: _____ Date: _____
President and CEO
ABC Family Planning Association

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.

FOCUS SURVEY SUMMARY

Reproductive Coercion Reports by Callers to NDVH

Overview

Between Monday, August 16, 2010 and Sunday, September 26, 2010, female callers to the Hotline who were identified as Victims/Survivors of Intimate Partner Violence were invited to participate in a survey on pregnancy coercion and birth control sabotage.

The six-week survey was completely voluntary, confidential and anonymous. It consisted of four questions that were asked at the end of calls, after advocates provided advocacy and referral services and were screened for safety. Callers who were in immediate danger or needed to be connected to a program immediately were not asked to participate in the study.

The survey was prompted by selecting the caller type: Victim/Survivor: IPV, and entering the gender of caller as female. Completing the survey was a required field and the caller application would not close without an answer being entered.

After advocacy and referral services were provided, Advocates invited callers to participate in the survey with an introduction that included the following information:

A lot of women who call us tell us that they are made to do things sexually that they do not want to do, or are pressured to become pregnant even if they don't want to be. We want to understand how often women are experiencing this so we can try to prevent this from happening to others. If you are willing to answer this four question survey, I'd like to ask some questions about things that may have happened to you in your sexual or dating relationship. Would you mind answering our four-question survey?

Focus Survey Questions

There are three possible answers: Yes, No, and No Answer. No Answer covered several possible situations, including caller refused, question not asked, caller didn't know, etc.

- Has your partner or ex-partner ever told you not to use any birth control (like the pill, shot, ring, etc.)?
- Has your partner or ex-partner ever tried to force or pressure you to become pregnant?
- Has your partner or ex-partner ever taken off the condom while you were having sex so that you would get pregnant?
- Has your partner or ex-partner ever made you have sex without a condom so that you would get pregnant?

Supporting the Caller after the Survey

Advocates were provided the following guidelines for responding to callers who identified some aspects of reproductive coercion in their responses to the survey questions:

- *Please be aware that if callers identify that they've experienced some or all of these forms of coercion and control, you may spend a few minutes supporting and safety planning with the caller around these issues.*



- *Offer support and validation.*
- *Suggest that the caller can contact her health care provider (or women's health clinic) to get on birth control her partner can't interfere with. This will vary by individual and depend on how her partner monitors her use of birth control.*
- *Emergency contraception (EC) is available to prevent unplanned pregnancy after unprotected sex; talk to a healthcare provider about this option.*
- *If caller identifies that she has contracted an STI, safety plan with her around safe partner notification. This may mean speaking to her health care provider or the county health department about anonymous options. It could also mean safety planning with her around how she can increase her safety once her partner has been notified.*
- *Thank the caller for sharing their experiences with us. We hope to use this information to help prevent this from happening to others.*

Focus Survey Results

- **Overall Participation Rate = 31% of female callers who identify as Victim/Survivor: IPV**
- **3169 callers participated in the survey by answering all or some of the four questions between August 16, 2010 and September 26, 2010**

Has your partner or ex-partner ever told you not to use any birth control (like the pill, shot, ring, etc.)?

Of the 3169 callers who answered this question, 25% responded yes.

Has your partner or ex-partner ever tried to force or pressure you to become pregnant?

Of 3166 callers who answered this question, 25% responded yes.

Has your partner or ex-partner ever taken off the condom while you were having sex so that you would get pregnant?

Of 3103 callers who answered this question, 16% responded yes.

Has your partner or ex-partner ever made you have sex without a condom so that you would get pregnant?

Of 3130 callers who answered this question, 24% responded yes.

Trends and Anecdotes

Some callers reported their partners pressuring & coercing them into becoming pregnant & then forcing them to abort the pregnancy. For many this seemed to be an element of emotional abuse and control.

Several victims reported that their partners seemed to disregard health risks they might experience. One caller reported her partner pressuring her to reverse a tubal ligation so that she would become pregnant despite the health risks (including death). Another reported that she could not use hormonal birth control because of a medical condition, yet her partner refused to wear condoms to prevent pregnancy.

Many callers reported that asking the focus survey questions really helped them understand their partner's behavior as part of the power and control they were experiencing in their relationship.

Quotes from callers:

"He knows I don't want to have another child; I've told him before. He says it will be ok, we will get a house soon. Thank God I got my period yesterday, but he was furious."

"If you hadn't asked me those questions [from the focus survey], I wouldn't have thought of it like that. I wouldn't have thought that he was a manipulative person. I really wouldn't."

"My boyfriend wants to have babies and settle down. He doesn't want me to use birth control and says it's a decision we're both supposed to make and so I have to hide it. Every month he asks 'How come you aren't pregnant? It's been two months.' I feel I can't have a say in this relationship. I have to take it behind his back. I can't even close the bathroom door because he says 'You're taking the pill. Keep it open.' It's a lot of pressure. I feel it's my body, it's my life; I don't feel anyone should control my body." Caller- Age 23

"My sister didn't want to get pregnant but she had no choice. And she got pregnant again as soon as the first baby was 9 months old. She's 13 weeks pregnant now and she and the kids are double-locked in the house and never allowed out."

Recommendations for Press Releases

Caller confidentiality, anonymity, and safety are always prioritized over data collection, particularly when it comes to focus surveys. Our caller application collects basic demographic and caller situation information but nothing identifying. When we report on caller situations or anecdotes, we find that the following words best describe our reports: accounts, descriptions, caller situations, issues/experiences described/shared by callers, caller narratives, etc. We avoid language that might imply we record confidential and identifying information.

In addition, we prefer the word 'surveying' to 'screening' callers. We've learned from previous media issues around our focus surveys that 'survey' seems to be the best description of our process, and in general, screening is not a fitting description of how we respond to caller needs in the context of our crisis intervention work. We generally refer to that aspect of our work as an assessment of needs and safety concerns/risk factors.



Sexual and Intimate Partner Violence can have a serious impact on a woman's reproductive health

Survivors are at a higher risk of experiencing:*

- ~ Invasive cervical cancer and pre-invasive cervical neoplasia
- ~ Urinary tract, vaginal, and sexually transmitted infections including HIV
- ~ Irregular menstrual cycles
- ~ Pain during sex, dysmenorrhea and vaginitis
- ~ Pelvic inflammatory disease
- ~ Chronic pelvic pain syndrome
- ~ Bladder infections
- ~ Vaginal and anal tearing
- ~ Sexual dysfunction
- ~ Gynecological problems



What is Intimate Partner Violence? Sexual Violence? Reproductive Coercion?

Intimate Partner Violence is:

A pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners.

Sexual Violence is:

Any physical contact of a sexual nature without voluntary consent. Sexual assault can take place by **anyone, anywhere**. This includes an intimate partner.

Reproductive Coercion is:

Behaviors that a partner uses to maintain power and control in a relationship related to reproductive health. This includes: birth control sabotage, pregnancy pressure, pregnancy coercion, and forcing sex without a condom.

For More Information:

Ohio Domestic Violence Network
www.odvn.org 1-800-934-9840

Ohio Alliance to End Sexual Violence
www.oaesv.org 1-888-866-8388

The National Domestic Violence Hotline
www.thehotline.org 1-800-799-SAFE



The comprehensive resource on domestic violence

Did you know?



Sexual and Intimate Partner Violence Affects Your Health

How could violence affect my health?



Sexual and intimate partner violence is a traumatic experience. After experiencing a traumatic event a person goes through a wide range of normal emotional and psychological

responses. These reactions are NORMAL reactions to ABNORMAL events.

Trauma also impacts how people think and the ways in which they process and understand information. It can make everyday tasks such as organizing, remembering details, or concentrating seem overwhelming.

Our bodies often express what we cannot express verbally so traumatic memories are often transformed into physical outcomes. Chronic danger and anticipation of violence places survivors at an increased risk for any of the following conditions.

Emotional and Psychological Reactions to Trauma*

- ~ Grief, guilt or shame, denial, fear, despair, hopelessness, depression
- ~ Mood swings, emotional outbursts, spontaneous crying
- ~ Exaggerated startle response, hyper-alertness or hyper-vigilance
- ~ Anger or irritability, panic, increased need for control
- ~ Emotional detachment, emotional numbing, diminished interest in activities
- ~ Difficulty concentrating and making decisions, confusion
- ~ Disorientation, uncertainty, suspiciousness
- ~ Nightmares, flashbacks, distressing dreams, self blame

*Please note: these lists are not exhaustive. If you are experiencing any ailment or symptom, talking with someone who has knowledge of trauma recovery can help survivors sort out the emotional aftermath of sexual or intimate partner violence. You can also consult a doctor for treatment,

Physical Manifestations of Trauma*

- ~ Arthritis, asthma, stroke
- ~ Headaches and migraines
- ~ Back pain and chronic pain
- ~ Gastrointestinal problems
- ~ High cholesterol, heart disease and heart attack
- ~ Depressed immune function
- ~ Eating problems, substance abuse, self harmful behavior
- ~ Physical problems that doctors cannot diagnose
- ~ Sexual difficulties



FAQ

Frequently asked questions about making over-the-counter medication available in domestic violence (DV) and sexual assault (SA) programs

Q: Can our DV and dual advocacy programs make over-the-counter medication*, pregnancy tests, and emergency contraception available to women and their children using our program services?**

*non-prescription

**non-prescription for 16 and under (as of June 10, 2013), available for purchase without age restrictions when manufacturing and labeling changes. Check with your local pharmacy.

A: Yes! The good news is that we can remove barriers and give women access to over the counter medication for themselves and their children in our programs.

Things to consider

Offering

When you **offer** a first aid kit to someone who has cut themselves, the adult chooses whether or not to use what you are offering. You are not ordering them to use a Band-Aid, just offering. By letting folk know that you have Tylenol, aspirin, children's cough syrup, pregnancy tests or emergency contraception available, you are simply providing information, not directing someone to use any of these items.

Dispensing

"Dispensing" has a particular legal implication and refers to prescription drugs.* Letting someone know that you have over-the-counter medication available if they feel the need for it is not the same as *dispensing* medication. The woman is choosing to take Tylenol or give her child cough syrup; it is her choice. DV and dual programs are neither prohibited from nor directed to make over-the-counter medication available to our program participants according to state codes (see WAC 388-61A-0560). Our WAC requires programs to have a secure way to store medications with immediate access to the program participant (see WAC 388-61A-0570).

**Drug dispensing: the preparation, packaging, labeling, record keeping, and transfer of a prescription drug to a patient or an intermediary, who is responsible for administration of the drug. --Mosby's Medical Dictionary, 8th edition (2009).*



Controlling

Survivor-centered, empowerment-oriented programs want to **avoid** controlling survivors' medications; that is why our WAC specifies that individuals must have secure storage and ready access to their medications. Survivors should be in control of their own and their children's medicine. But when we make it difficult for survivors to have immediate and timely access to over-the-counter medication that they may need, we are controlling their choices, and failing to offer a full range of options for responding to abuse and making one's own choices. It is okay to expand a survivor's control and choices over her own and her children's health by safely making available over-the-counter medications – just as you would make available a Band-Aid, Ace bandage or ice for a wound. Increasing the ease with which a survivor can make choices about over-the-counter medications can impact her life beyond her interaction with your program. In particular, making emergency contraception available in a timely manner can give a survivor the chance to prevent an unintended pregnancy.

Q: What do some programs do?

A: Programs around the state have implemented many different and creative ways of meeting the medication and contraception needs of survivors.

Examples

Provide sample sizes of Tylenol, ibuprofen, aspirin or cough medicine.

Offer the larger-size item and ask for people to take what they need and return the item immediately.

Let program participants know that the programs have pregnancy tests and emergency contraception on site (don't wait until someone asks).

Give everyone an individual lock box for storage of over-the-counter medication, and prescription medication.



Q: What are the relevant WACS?**A: WAC 388-61A-0560**

What first aid supplies must I approve? “You must keep first-aid supplies on hand and accessible to clients residing in shelter for immediate use. First-aid supplies must include at a minimum the following: First-aid instruction booklet, band-aids, sterile gauze, adhesive tape, antibiotic ointment single use packets, antiseptic wipe single use packets, hydrocortisone ointment single use packets, roller bandage, thermometer (nonmercury/nonglass), and nonlatex gloves. In instances where an adult or child has ingested a potentially poisonous chemical or substance, you must call the Washington Poison Center for further instruction.” [Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0560, filed 10/27/10, effective 11/27/10.]

WAC 388-61A-0570

What are the requirements for storing medications? “(1) Clients residing in shelter must be provided with a means to safely and securely store, and have direct and immediate access to, their medications such as individual lock boxes, lockers with a key or combination lock, or a similar type of secure storage.(2) All medications, including pet medications and herbal remedies, must be stored in a way that is inaccessible to children.” [Statutory Authority: Chapter 70.123 RCW. 10-22-040, § 388-61A-0570, filed 10/27/10, effective 11/27/10.]



SAMPLE: INCLUDING LANGUAGE ABOUT REPRODUCTIVE HEALTH SERVICES AS PART OF DOMESTIC VIOLENCE ADVOCACY

From Rose Brooks Center (Kansas City, MO) Strategic Plan

CRITICAL ISSUE #3 – QUALITY OF SERVICES

- How will we provide the highest quality of services to the people we serve?

GOAL 3: Create and maintain an inclusive, accessible environment for all individuals by strengthening agency's commitment to accessibility and responsiveness.

Objective 3.5: Improve responsiveness to survivors experiencing sexual violence and reproductive coercion. (community partners, education, working with youth, interventions, etc)

Strategies:

1. Increase staff comfort and confidence in screening for sexual violence and reproductive coercion
2. Identify the barriers and strategies for increasing staff comfort and confidence
3. Develop script on how to frame our screening questions
4. Staff role play on how they discuss sexual violence and reproductive coercion with survivors
5. Integrate assessment for sexual violence and reproductive coercion into our core training
6. Prevention - additional training for Children's Program staff-started dialog, want to add in to our core Sexual Assault unit Project SAFE and the Teen Empowerment group. Need technical assistance from internal experts.

For more information, contact:

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Director of Community Programs

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The Affordable Care Act & Women's Health

In 2011 and 2012, 71 million Americans with private health insurance gained access to preventive services with no cost sharing through the Affordable Care Act. Under non-grandfathered health plans, beginning for plan years that began on or after August 1, 2012, preventive services such as mammograms, cervical cancer screenings, and others, are covered with no cost sharing. (A non-grandfathered health plan refers to a plan in place when the Affordable Care Act was enacted that has not been changed in specified ways). In addition, certain recommended preventive services are free for people on Medicare.

The Affordable Care Act makes women's health a priority by expanding access to preventive care. Recognizing that women are more likely to need preventive health services but often have less ability to pay for these services, the Department of Health and Human Services adopted new Guidelines for Women's Preventive Services in August 2011. These guidelines allowed 47 million women to gain guaranteed access to eight additional preventive services without paying more at the doctor's office. In addition to coverage for an annual well-woman preventive care visit, the following recommended preventive services are included in the HHS guidelines¹, and are covered without cost-sharing under non-grandfathered plans:

Maternal Health

- **Gestational diabetes screening:** This screening is for women 24-28 weeks pregnant, and those at high risk of developing gestational diabetes, which can develop into Type II diabetes. Children of women with gestational diabetes are at significantly increased risk of being overweight and insulin-resistant.
- **Breastfeeding support, supplies, and counseling:** Pregnant and postpartum women enrolled in non-grandfathered plans have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment. Breastfeeding is one of the most effective preventive measures to promote the health of mothers and children.

Sexual Health

- **STI counseling:** Sexually active women enrolled in non-grandfathered plans have access to annual counseling on sexually transmitted infections (STIs), which can reduce risk behaviors in patients.
- **HPV DNA testing:** Women aged 30 and above enrolled in non-grandfathered plans have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of Pap smear results. Early screening, detection, and treatment can help to reduce cervical cancer prevalence.
- **HIV screening and counseling:** Sexually active women enrolled in non-grandfathered plans have access to annual HIV screening and counseling. Access to HIV testing is critically important for women nationally; of the over 280,000 women living with HIV in 2009, it is estimated that 15% were unaware that they were HIV-positive.
- **Contraception and contraceptive counseling:** With the exception of employees of certain religious organizations, women of childbearing age enrolled in non-grandfathered plans have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider.

Intimate Partner Violence

- **Interpersonal and domestic violence screening and counseling:** Screening and counseling for interpersonal and domestic violence will be covered for all adolescent and adult women. According to the CDC, more than 1 in 3 women (36%) have experienced rape, physical violence and/or stalking by an intimate partner in her lifetime. Identifying current or past violence can help prevent further abuse and lead to improved health status.

In addition to covering the cost of screening and counseling for intimate partner violence, the Affordable Care Act has several provisions that will benefit survivors of domestic violence.



How the Affordable Care Act Benefits Domestic Violence Survivors

By making insurance affordable and easier to obtain, the Affordable Care Act allows survivors of domestic violence access to services to treat chronic health conditions often associated with abuse, and referrals to resources to prevent further violence. Additionally, it helps women who feel trapped in abusive relationships due to economic dependency, which can include health insurance through their partner, to leave that partner and seek safety. Here are some key changes to health coverage that will benefit domestic violence survivorsⁱⁱ:

Prohibits Pre-Existing Condition Exclusion Based on Domestic Violence History

- Beginning on January 1, 2014, the Affordable Care Act will prohibit insurance companies, health care providers, and health programs that receive federal financial assistance from denying coverage to women based on many factors, *including being a survivor of domestic or sexual violence*.
- Before this protection, seven states allowed insurers to deny health coverage to domestic violence survivors, and only 22 states had enacted adequate domestic violence insurance discrimination protections.

Exempts Survivors of Domestic Violence from Penalty Fee for Not Having Insurance

- Starting in 2014, most people must have health coverage or pay a fee known as the “individual shared responsibility payment.” If you can afford health insurance but choose not to buy it, you must pay this fee.
- Survivors of domestic violence who have recently experienced abuse are not required to pay the fee; they qualify for a hardship exemption.

Requires Coverage of Mental Health & Substance Abuse Disorder Treatment

- The Affordable Care Act will require most health insurance plans on the Health Insurance Marketplace to cover mental health and substance use disorder services. Under the Affordable Care Act, non-grandfathered health plans must cover preventive services like depression screening for adults and behavioral assessments for children at no cost. Starting in 2014, most plans will not be able to deny patients coverage or charge more due to pre-existing health conditions, including mental illnesses.
- Mental health coverage will significantly benefit survivors. According to the CDC, 63% of female victims of intimate partner violence experienced at least one symptom of Post-Traumatic-Stress-Disorder (PTSD), and research shows that intimate partner violence is a major risk factor for depression, deliberate self-harm, and suicide.

Increases Support for Native Survivors

- The Affordable Care Act established a new program for behavioral health in the Indian Health Service (IHS) that addresses violence and abuse, expanding treatment and prevention for Native survivors, their children and partners.

To learn how to sign up for health insurance in the Health Insurance Marketplace, visit:

www.healthcare.gov

To learn more about coverage for mental health and substance abuse disorder treatment, visit:

www.mentalhealth.gov

ⁱUnless otherwise stated, all information on women’s preventive services retrieved from:
<http://www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html>

ⁱⁱUnless otherwise stated, all information on how ACA benefits domestic violence survivors retrieved from:
<http://www.healthcaresaboutipv.org/wp-content/blogs.dir/3/files/2012/09/ACA-and-DV-final.pdf>

For more information, please contact the Division of Family Violence Prevention and Services at:
www.acf.hhs.gov/fvpsa or 202-401-5319. Updated: **December 2013**.



IMPACT OF NEW FEDERAL HEALTH COVERAGE RULE FOR DOMESTIC AND SEXUAL VIOLENCE ADVOCATES

This memo provides background on a new Federal health rule that could have an impact on domestic and sexual violence programs, such as increased training requests from health providers, increased opportunities for new partnerships with health providers, and increased referrals. In addition to summarizing the new rule, the memo will provide:

- FAQ information on how advocates can prepare for the implementation of the new rule, and
- Links to resources developed and available to help advocates effectively respond.

Background of new Federal rule on health insurance coverage of domestic and interpersonal screening and counseling:

Health reform, known as the Affordable Care Act (ACA), made many changes that are being implemented on different timetables. One focus was an increased emphasis on women's preventive care. On August 1, 2012, a new Federal rule administered by the Department of Health and Human Services will take effect to require free cost-sharing (without co-payments or deductibles) for eight preventive health services in select new, nongrandfathered health plans, **including screening and counseling for domestic and interpersonal violence**. This service is defined as screening for including past violence and abuse and includes young women/adolescents which studies show have the highest rates of violence. In practice, many women may eventually be asked about domestic and interpersonal violence by their Ob-gyn during their annual, well-woman exam along with the other women's preventive health services. This change in practice will likely evolve over time as plans learn about the recommendations and prepare their practices to provide such services.

What does the rule mean by "interpersonal and domestic violence"?

- When DHHS issued this rule, they referred to a definition by the Institutes of Medicine which described interpersonal and domestic violence, including intimate partner violence and childhood abuse, as a pattern of coercive behaviors that may include progressive social isolation, deprivation, intimidation, psychological abuse, childhood physical abuse, childhood sexual abuse, sexual assault, and repeated battering and injury. These behaviors are perpetuated by someone who is or was involved in a familial or intimate relationship with the victim.

Is this a requirement for all insurance plans?

- Currently, this only applies to new health plans and plans that are not "grandfathered plans." A Kaiser Family Foundation survey on employer-sponsored health insurance plans found that 44% of plans would be required to follow the new federal rules

Department of Health and Human Services Rule: Screening and counseling for interpersonal and domestic violence as preventive service for women. Screening and counseling involve elicitation of information from women and adolescents about current and past violence and abuse in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems.



about women's preventive health coverage. However, the percentage of women covered will continue to gradually grow over time. Health exchange plans will comply in 2014, and it seems clear from FAQ issued by the U.S. Department of Health and Human Services in February 2012 that preventive health services, including women's preventive health services, will be included.¹

Is this a new requirement for providers to screen for IPV or for insurers to cover the costs?

- These are guidelines for insurance companies to cover the cost of this service as opposed to a requirement of all providers to deliver the service.

How will this impact domestic and sexual violence programs?

- *Could result in increased training requests:* Unlike some of the other recommendations (i.e. access to contraception, mammograms, prenatal care, contraception, etc.) this recommendation is provider driven and we know that providers need training and resources to help them perform this services safely and effectively. The Health Resource Center on Domestic Violence (HRC) has tools available for you to help train providers www.HealthCaresAboutIPV.org and can also provide technical assistance.
- *Could result in increased referrals:* We anticipate that changes in practice will take time, and that increases in referrals to your programs may not be immediately apparent.
- *Could result in the need to respond to manage unintended consequences* (i.e. providers reporting issues, providers not disclosing limits of confidentiality, poorly trained providers): Without adequate training or systems changes to protect the patients' safety and privacy, some patients may be put at risk. State domestic violence coalitions can leverage their partnerships to help providers think about unintended consequences. The National Health Resource Center on Domestic Violence invites you to join us by working at the national and state level to address these concerns and by sharing stories of success or challenges so we can address these potential consequences.
- *Could result in important new partnerships:* This coverage -- if implemented in partnership with domestic and sexual violence advocates -- can offer a historic opportunity to reach thousands more women and children not currently being helped. In addition, advocates may benefit from more accessible health services, including home visitation, for the women in their programs with increased collaboration.

What can domestic and sexual violence programs do?

- Be aware of the new recommendations and how they may impact their programs.
- Call or email the National Health Resource Center on Domestic Violence staff with Futures Without Violence if you would like technical assistance on how respond or to prepare or materials to respond to any requests for training that may occur (415.678.5500; health@futureswithoutviolence.org)
- Provide health care programs brochures on services in your community as well as a link to your websites.
- Reach out to the health programs in your community to offer training and support, or refer them to the National Health Resource Center on Domestic Violence (HRC) for patient and provider resources and online training. This is a prime opportunity for victim advocates to visit their local

1 <http://cciio.cms.gov/resources/files/files2/02172012/ehb-faq-508.pdf>.



medical providers and talk about the services/training they offer and how this connects to the new health coverage rule. At a minimum, someone in a program leadership position or a medical advocate may send a letter to local health providers articulating how the victim advocacy program can support the new health rule and name some program contacts. The HRC can help draft a template letter to enable this type of advocate outreach to providers. Contact your state domestic violence program for technical assistance or additional support with a link to a national list of state coalitions; we suggest the National Resource Center on Domestic Violence link to access a list: <http://www.vawnet.org/links/state-coalitions.php>.

How can the National Health Resource Center on Domestic Violence (HRC) help?

We can provide training resources, patient and provider tools and technical assistance: The HRC has a number of resources for providers, patients and advocates. Please see www.HealthCaresAboutIPV.org

- Free training tools
- Free patient and provider tools
- Technical assistance
 - Webinars for coalitions and programs
 - In person training or calls
 - Working group to inform HRC activities
 - Partnering on policy briefs
- Online toolkit

Why should local domestic and sexual violence programs who have limited resources get involved with this new health coverage change?

- *Opportunity to reach more women:* Health care providers are seeing large numbers of women and girls experiencing violence (up to 50% of patients or clients in some health and public health programs). These same women may not be aware of domestic and sexual violence services, and this new recommendation provides an opportunity to improve their health and safety.
- *Health interventions can work:* If done correctly, screening and counseling by a health provider in collaboration with advocates have been shown to make a difference in health outcomes for victims of violence. A number of clinical trials found that when screening is coupled with education, harm reduction and referrals to domestic and sexual assault services, violence can be reduced and the health status of women improved.² Women who talked to their health care provider about the abuse were *far more* likely to use an intervention.³ At a 2-year follow-up, women who were screened for abuse and given a wallet-sized referral card that included national hotline numbers reported fewer threats of violence and assaults. A majority of the women do not have recurrent abusive relationships and health care costs go down after abuse ends.⁴ In another

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- 2 Tiwari, A., Leung, W., Leung, T., Humphreys, J., Parker, B., & Ho, P. (2005). A randomized controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG: an International Journal of Obstetrics and Gynaecology*, 1-10.
 - 3 McCloskey, L.A., Lichter, E., Williams, C., Gerber, M., Wittenberg, E., & Ganz, M. (2006). Assessing Intimate Partner Violence in Health Care Settings Leads to Women's Receipt of Interventions and Improved Health. *Public Health Rep.* 2006 Jul-Aug; 121(4): 435-444.
 - 4 McFarlane, Judith M.; Groff, Janet Y.; O'Brien, Jennifer A.; Watson, Kathy; 2006. *Nursing Research*. 55(1):52-61

study with an onsite IPV advocate, screening and brief counseling resulted in a decline in IPV and significantly lower scores for depression & suicide ideation.⁵

- *Opportunity for prevention:* In addition to health providers providing early intervention referrals, health providers can be prevention messengers and provide anticipatory guidance to young women on what is a healthy relationship and how to recognize early warning signs for them and their friends and family. As an example, adolescent health settings would likely begin with a focus on universal education about healthy relationships for all patients and with follow-up direct assessments for those at risk or those in relationships.
- *May eventually result in new funding streams:* In the future, we will work with other national parterres, governmental agencies and the advocacy community to strongly urge new funding streams to better support the services provided by domestic violence advocates; one goal is that health insurance plans will reimburse advocates for victims referred for counseling and services through this new rule. In the meantime, it is a prime opportunity to reach victims earlier to improve their safety and provide prevention messages on healthy and unhealthy relationships.

What does the HRC tell providers are the key elements of a clinical response?

- Review limits of confidentiality
- Brochure based assessment
- Connect to and address related health issues
- Trauma informed support & validation
- Supported referral
- Trauma informed reporting (when required)
- Documentation and privacy
- (Please see online toolkit at www.HealthCaresAboutIPV.org for more information)

What is HRC telling health providers about working with advocates?

Research has shown that brochure based interventions are effective and providers find that a brief intervention that uses a safety card and includes a referral to a local domestic violence or advocacy support agency is simple and effective. Providers can help patients connect with an advocate to work on a safety plan and additional services such as housing, legal advocacy and support groups/ counseling. HRC staff regularly train providers that this can be done with this simple phrase:

- “If you are comfortable with this idea, I would like to call my colleague at the local program (fill in person’s name) who is really an expert in what to do next and she can talk with you about supports for you and your children from her program...”

We encourage health providers that if they do not already have a relationship with a local domestic violence program, to provide a ‘warm’ referral to the National Domestic Violence Hotline (800.799.SAFE), the National Sexual Assault Hotline (800.656.HOPE), or the National Dating Violence Helpline (866.331.9474). This can be done by saying:

- “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 too

5 Coker AL, Smith PH, Whitaker DJ, Le B, Crawford TN, Flerx VC. Effect of an in-clinic IPV advocate intervention to increase help seeking, reduce violence, and improve well-being. *Violence Against Women*. 2012;18:118-131.

– or can just be there to listen if you need to talk...”

By asking and offering support, harm reduction strategies and referrals, health care providers can significantly improve the health and safety of victims of abuse.

How about concerns/questions on confidentiality and reporting?

- Regarding confidentiality, we suggest that advocates inform survivors, ahead of time if possible, that their doctors may ask questions about domestic violence. If such a meeting is able to happen in advance, advocates can ask survivors if there are any confidential concerns that she/he would like to discuss ahead of time to prepare. Advocates must remember to stress to health care providers the importance of seeing patients alone, even if the patient has a support person who appears to be a friend or relative of the same sex (as this “support person” could be an abusive partner).
- Because reporting requirements are different in each state and territory and implementation can vary county by county, in all of HRC materials and training, we train providers about the need to understand their state law and when reporting is required, they should disclose the limits of confidentiality prior to screening. Scripts are available to help providers disclose limits of confidentiality with a patient before screening, and can be accessed through the resources listed at the end of this memo as a review of the state statutes on reporting.
- If providers do need to make a report, there are several ways they can be supportive to the patient, including informing the patient of their requirement to report, explaining what is likely to happen when the report is made, asking the patient if she is willing to call an advocate to develop a safety plan in case of retaliation, and make the report with the patient.

RESOURCES AVAILABLE

The National Health Resource Center on Domestic Violence through Futures Without Violence has developed many resources aimed at health providers that advocates can use as they build partnerships and provide training to meet the goals of this new rule. Among the tools, safety cards can be given to patients or placed in the practice, and HRC is completing online learning modules on the overview of intimate partner violence, preparing a health practice, and confidentiality. Training resources are currently available and more are being developed on specific settings and specialties such as mental health, reproductive health, urgent care, pediatrics, adolescent health, STI/HIV, and home visitation. See below for example tools:

- National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization In Health Care Settings
- Reproductive Health and Partner Violence Guidelines: An Integrated Response to Intimate Partner Violence and Reproductive Coercion
- Healthy Moms, Happy Babies: A Train the Trainers Curriculum on Domestic Violence, Reproductive Coercion and Children Exposed for Home Visitation programs
- Hanging Out or Hooking Up? Guidelines for Responding to Adolescent Relationship Abuse in Adolescent Health settings
- Safety cards for adolescent health, reproductive health, primary care and home visitation programs
- Training tools and videos, posters and other provider tools
- *Compendium of State Statutes and Policies on Domestic Violence and Health Care:*

<http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf>.

- Confidentiality protocols

For More Information on Domestic Violence:

For more information, tools and resources on domestic violence, including medical advocacy, please see the National Resource Center on Domestic Violence and Pennsylvania Coalition Against Domestic Violence:

- <http://www.pcadv.org/>
- <http://www.nrcdv.org/>

For Information on Sexual Assault:

For more information tools and resources on sexual assault please see the National Sexual Violence Resource Center and the Pennsylvania Coalition against Rape:

- <http://www.nsvrc.org/>
- <http://www.pcar.org/>

For Information on Domestic Violence, Trauma and Mental Health:

- <http://www.nationalcenterdvtraumamh.org/>

Additional Memo's for Advocates on Health and DV

- Memo on how the Affordable Care Act may impact victims of Domestic Violence:
[http://www.futureswithoutviolence.org/userfiles/file/HealthCare/ACA and DV final.pdf](http://www.futureswithoutviolence.org/userfiles/file/HealthCare/ACA%20and%20DV%20final.pdf)
- Memo for advocates partnering with public health programs:
http://www.futureswithoutviolence.org/userfiles/file/HealthCare/public_health_partnerships_with_advocates.pdf

Additional Resources to Help Facilitate Screening and Counseling

- AHRQ Innovations Solution: "Family Violence Prevention Program significantly improves ability to identify and facilitate treatment for patients affected by domestic violence," (profile of Kaiser Permanente Northern California's Family Violence Prevention Program)
<http://www.innovations.ahrq.gov/content.aspx?id=2343>.

The HRC is funded by the Family Violence Prevention and Services Program at the U.S. Department of Health and Human Services. For over 16 years, the Center has provided free technical assistance and web-based and in-person training at 415.678.5500 or health@futureswithoutviolence.org.



IMPLEMENTATION OF ACA SCREENING AND BRIEF COUNSELING RECOMMENDATIONS FOR DOMESTIC VIOLENCE AND INTIMATE PARTNER VIOLENCE (DV/IPV)

Frequently Asked Questions

Updated: September 2013

Q: Who is eligible to receive screening and brief counseling for DV/IPV?

A: Today, all people insured by new private insurance plans are eligible to receive screening and brief counseling for DV/IPV with no cost sharing (plans that existed before the Affordable Care Act was signed in to law are exempt). Beginning in 2014, all people insured in the new health insurance marketplace will become eligible; as likely all Medicaid beneficiaries enrolled in Alternative Benefit Plans will also be eligible.

Q: What exactly does HHS say that screening for DV/IPV is?

A: The federal guidance states “screening may consist of a few, brief, open-ended questions. Screening can be facilitated by the use of brochures, forms, or other assessment tools including chart prompts. One option is the five-question *Abuse Assessment Screening* tool available here: www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf, page 22.

Another option is brochure based assessments that have been shown to be effective:
www.healthcaresaboutipv.org/tools/brochure-based-screening*

The full federal guideline can be found at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

Q: What exactly does HHS say that the counseling requirement includes?

A: The federal guidelines say that “counseling provides basic information, including how a patient’s health issues may relate to violence and referrals to local domestic violence specialists when patients agree to referrals. Easy-to-use tools such as patient brochures, safety plans, and provider educational tools, as well as training materials, are available through the HHS-funded Domestic Violence Resource Network, including the National Resource Center on Domestic Violence (www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services/programs/centers).”

The full federal guidelines can be found at: www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

Providers and advocates can also go to www.healthcaresaboutipv.org for tools and resources or contact Futures Without Violence for assistance at health@futureswithoutviolence.org or call 415-678-5500, or visit the website.

Q: Who will decide how the screening and counseling provision will actually work and what is required?

A: All insurers are mandated to offer screening and brief counseling for DV/IPV. The new guidelines provide information for what must be covered and places few limits restricting the full implementation of this important provision. Individual insurers will determine exactly what will be covered and how the benefit will be administered. State Insurance Commissioners and Medicaid Directors (as well as other key state officials) will play an important role in helping to define the benefit.

Q: How often can a woman receive screening and brief counseling for DV/IPV?

A: At least once a year. The guidelines place no restrictions or limits on the number of visits that can be covered. It does explicitly say that more than one well-woman visit can be covered in order to receive all necessary preventive services if a provider feels it is necessary. It will be up to individual plans to decide if they want to offer more frequent screening specifically for the screening and brief counseling for DV/IPV.

For example, screening may occur during the well-woman visit but professional health organizations also recommend assessment during other types of reproductive, mental and adolescent health visits.

Q: Where should the screening take place?

A: There are no limits as to where the screening must take place. The guidance suggests that the well-woman visit include all women's preventive health services. The plans will determine the settings for the provision of the screening.

However, it is a critical safety issue that screenings occur alone with no other family or friends present during the assessment.

Q: Who can receive reimbursement for providing screening and brief counseling for DV/IPV?

A: The guidelines referenced above do not provide any details on who can receive reimbursement for providing screening and brief counseling. It will be up to individual insurers under the scope of state law to determine who can provide screening. This will apply to all private plans and, in 2014, those plans in the health insurance marketplace.

In other words, it is possible for a wide range of providers, including traditional medical providers, mental health counselors, and more, to become eligible for reimbursement for providing screening and counseling. But it will be up to the plans, under the scope of state law, to make those determinations.

No guidance was provided on what codes to use when assessment and counseling occurred. Some provider groups are exploring using preventive medicine service codes 99381-99397 which include age appropriate counseling/anticipatory guidance/risk factor reduction interventions. There are also separate codes (99401-99412) for counseling provided separately, at a different encounter on a different day, from the preventive medicine examination. For more information, see the Preventive Medicine Services Codes.



Q: Which states will qualify for the 1% FMAP increase for providing all preventive health services including screening and brief counseling?

A: Recent guidelines details how the federal financial incentive to states to offer preventive services to Medicaid beneficiaries will work. If a state offers preventive health services without cost sharing, they get a 1% bump in the amount of federal money (the FMAP) the program gets.

To get the extra 1% FMAP, states must offer all Medicaid beneficiaries—whether services are provided on a fee-for-service, managed care, or alternate benefit plan package—preventive health services without cost sharing. Each state must choose if they want to do this and file a state plan amendment.

The services that must be covered for the 1% FMAP (Federal Medical Assistance percentage; or the share of additional federal money a state will receive) include screening and brief counseling for DV/IPV, a USPSTF recommended service. Unfortunately, due to a drafting error in the ACA, states are not required to cover the package of women's preventive health services to receive the FMAP bonus.

The full federal guidelines on this policy can be found at:
www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-002.pdf

**Comments in italics provide additional information not included in DHHS recommendations or further guidance.*

For more information, please visit www.futureswithoutviolence.org/health or contact health@futureswithoutviolence.org or 415-678-5500.



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.

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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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Fundado en parte por el Departamento de Salud y Servicios Humanos de EE. UU. para la Oficina de la Salud de la Mujer (Subsidio #1 ASTWH110023-01-00) y la Administración de Niños, Jóvenes y Familias (Subsidio #90EV0414).

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The American College of
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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.

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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

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

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

- ✓ 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?

Ask yourself:

Is your BODY being affected?

- ✓ 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 an UNHEALTHY 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 a HEALTHY relationship?

Ask yourself:



vacía para que su pareja no sepa.
paquete y ponerlos en un sobre o botella de píldoras
sexuales sin protección para evitar un embarazo. Se pueden sacar de su
Anticonceptivos de emergencia (unos le llaman la píldora de la mañana siguiente) se puede tomar hasta cinco días después de tener relaciones
su pareja no los sienta.
un embarazo hasta por 10 años. Los hilos se pueden cortar para que
El DIU es un dispositivo de seguro que se pone en el útero y evita
implante anticonceptivo o inyección anticonceptiva).
que usted pueda controlar (como el dispositivo intrauterino (DIU),
Hable con su proveedor de atención médica sobre anticonceptivos

anticonceptivo, o se niega a usar condones:
Si su pareja le hace tener sexo, se entremete o altera su
mantenense conectado a través de un niño, aun cuando eso no es lo que usted desea.
Su pareja puede ver el embarazo como una forma de mantenerse en su vida y

Tomando Control:

de ITS/VIH, embarazos no deseados, y lesiones graves.
Si respondió SI a cualquiera de estas preguntas, puede estar en riesgo

- ✓ ¿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?

Pregúntese:

¿Está siendo afectado la su CUERPO?

- ✓ ¿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.

Pregúntese:

¿Está en una relación ENFERMIZA?

- ✓ ¿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.

¿Está en una relación SANA?

Pregúntese:

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