



Prevent, Assess, and Respond: A Domestic Violence and
Human Trafficking Toolkit
for Health Centers & Domestic Violence Programs

- a companion to www.ipvhealthpartners.org -



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 groundbreaking model professional, education and response programs, cutting edge advocacy and sophisticated technical assistance. The HRC offers a wealth of free materials that are appropriate for a variety of public and private health professions, settings and departments.

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Prevent, Assess, and Respond: A Domestic Violence Toolkit for Health Centers & Domestic Violence Programs

Intimate partner violence (IPV) and human trafficking (HT) are public health problem of epidemic proportions.

- Domestic violence/sexual assault (DV/SA) is a key social determinant of health and impacts your patients: at least 1 in 4 women have experienced IPV¹ and 1 in 7 men have been the victim of severe physical violence by an intimate partner.² LGBTQ communities experience violence at similar or higher rates to that of heterosexual women.^{3 4 5 6 7 8}
- Human trafficking is also widespread: 88% of sex trafficking survivors had some contact with health care while being exploited.⁹

Health centers are key to violence prevention.

Use this toolkit to build a comprehensive and sustainable response to DV/SA and human trafficking in partnership with DV/SA advocacy programs (social service organizations) to:

- Improve how your health center identifies and responds to DV/SA and promotes prevention, and
- Develop proactive partnerships with local DV/SA advocacy programs to address the health needs of patients and connect them to health centers for care.

1. 2010 CDC National Intimate Partner and Sexual Violence Survey <https://www.cdc.gov/violenceprevention/nisvs/>

2. 2010 CDC National Intimate Partner and Sexual Violence Survey <https://www.cdc.gov/violenceprevention/nisvs/>

3. Breiding MJ, Smith SG, Basile KC, Walters ML, Chen J, Merrick MT. Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization—National Intimate Partner and Sexual Violence Survey, United States, 2011. *MMWR* 2014; 63(SS-8): 1-18.

• http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf

4. Landers S, Gilsanz P. The health of lesbian, gay, bisexual, and transgender (LGBT) persons in Massachusetts. Massachusetts Department of Public Health; 2009.

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

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

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

8. Grant, J., Mottet, L., Tanis, J., Harrison, J., Herman, J., and Keisling, M. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf

9. Laura J. Lederer and Christopher A. Wetzel, The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities, *Annals of Health Law* Volume 23, Issue 1 (Winter, 2014). <https://www.globalcenturion.org/wp-content/uploads/2014/08/The-Health-Consequences-of-Sex-Trafficking.pdf>

Health centers and DV/SA advocacy programs are natural partners given their shared mission to improve the health, wellness, and safety of their clients. Tools developed specifically for DV/SA advocacy programs to promote partnerships with health centers are also offered. Research indicates that IPV, sexual violence and stalking disproportionately impact women and experience severe health consequences.¹² Therefore this toolkit primarily focuses on women, however the recommended interventions can be applied and adapted for men. The terms Intimate Partner Violence (IPV), Domestic Violence (DV) and Domestic and Sexual Assault (DV/SA) will be used interchangeably throughout this toolkit. Quotes from health centers and DV/SA agencies featured in this toolkit have been used with permission.

“When health center leadership commits to the system-wide integration of care, including developing formal partnerships with community based social service organizations to address intimate partner violence, we find they are better positioned to improve health outcomes for the patients they serve.” - Judith Steinberg, MD, MPH, Chief Medical Officer, Bureau of Primary Health Care, Health Resources and Services Administration

What are the health and financial consequences of DV/SA, and human trafficking?

- Health consequences can be severe. The long term impact of DV/SA includes physical injuries, chronic health and mental health issues, and high risk health behaviors.¹⁰ See this [infographic](#) on the health impact of violence.
- The long-term health impact of human trafficking can include back pain, stomach pain, dizziness, chest/heart pain, and respiratory problems.^{11 12}
- DV/SA is [costly](#) and interferes with quality of care. Read more about [DV/SA health costs and utilization](#).
- The U.S. Preventive Services Task Force [recommends screening and brief counseling for intimate partner violence \(IPV\)](#), currently a required women’s preventive service covered ebenefit.
- [Evidence-based interventions](#) exist and [preventive service codes](#) can be used to bill for brief intervention and counseling.
- The U.S. Centers for Disease Control and Prevention [defines intimate partner violence \(IPV\)](#) as physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner.
- The [Trafficking Victims Protection Act of 2000](#) defines human trafficking as exploitation of a person through the use of force, fraud, or coercion to obtain a labor or sex act. For minors, sex trafficking is defined as any commercial sex act with a minor under age 18.

¹⁰ www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html

¹¹ Ottisova, L., Hemmings, S., Howard, L., Zimmerman, C., & Oram, S. (2016). Prevalence and risk of violence and the mental, physical, and sexual health problems associated with human trafficking: An updated systematic review. *Epidemiology and Psychiatric Sciences*, 25(4), 317-341. doi: 10.1017/S2045796016000135

¹² Siân Oram et al. “Human Trafficking and Health: A Survey of Male and Female Survivors in England,” *American Journal of Public Health* 106, no. 6 (June 1, 2016): pp. 1073-1078.

Why Health Centers?

Given their enormous reach and overarching goals to promote health and safety, health centers are uniquely positioned to be leaders in violence prevention across the U.S. One in 13 people nationwide rely on a [HRSA-funded health center](#) for their health care needs.¹³ [Locate a health center](#) near you. Many health centers have already partnered with DV/SA organizations to implement health interventions with promising results to achieve better health outcomes for patients.

Between 2014-2016, 10 health centers and 10 DV/SA programs across the country participated in the [Improving Health Outcomes Through Violence Prevention Pilot Project](#) to identify promising ways to promote the health and safety of patients. The U.S. Department of Health and Human Services, Health Resources and Services Administration, and the Administration for Children and Families funded this project, in collaboration with Futures Without Violence, who provided training and workflow redesign support. Under this pilot, health centers and partnering DV/SA programs tested all steps to address and respond to DV/SA. This pilot has since evolved to become [Project Catalyst](#), a national project to foster leadership and collaboration between DV/SA advocates and health professionals at the state and territory level. Key findings are distilled here into actionable steps for other health care providers, administrators, DV/SA advocates, and community partners to easily adapt for their own settings.

Follow these essential steps to integrate a response to IPV and HT in your health center:

1. **Build partnerships** between health centers and local DV/SA programs.
2. **Prepare your practice** by implementing a new or updated DV/SA and HT policy to identify and respond to survivors in partnership with community based DV/SA programs, and promote prevention.
3. **Adopt the simple evidence-based intervention** to educate all patients about the connection between IPV and HT and their health and engage them in strategies to promote wellness and safety.
4. **Train providers and all staff** on the impact of DV/SA and HT on health outcomes, and how to assess and respond in collaboration with community based DV/SA programs.
5. **Evaluate and sustain your progress** as part of continuous quality improvement.

¹³ <https://bphc.hrsa.gov/about/healthcenterprogram/index.html>

1. Build Partnerships - For Health Providers

Include DV/SA advocates as part of your multidisciplinary care team/approach

"We developed a system where women who have been facing violence...can come to [our health center] and we help them to navigate the system. We have a primary partner for DV referral and support, DC SAFE, a crisis center in DC. [The health center] doesn't provide any DV crisis intervention, but we navigate them to DC Safe. And also when DC Safe deals with a client that needs health care or long term support, they also navigate back to us. Clients that need long term support because they're dealing with some legal issues...like immigration, or immigration status adjustment...we can also help these women so they're not standing alone."

- Suyanna Barker, DrPH Community Health Action Department Director, La Clinica del Pueblo (Washington, DC)



Domestic and Sexual Violence (DV/SA) advocates offer support, safety planning and coaching to address other social determinants of health

Local and state DV/SA programs are integral partners to a successful team-based response to DV/SA and HT. Many DV/SA partners are equipped to provide supportive services such as translation, transportation, and legal support which mirror the enabling services offered by health centers. DV/SA programs exist in many communities in which health centers are located and DV/SA advocates can offer a range of support to survivors identified in health centers. Such confidential patient support may include information on healthy and unhealthy relationships; emotional support; emergency and long-term safety planning; and supports related to other social determinants of health including housing, food insecurity and employment as well as court and legal advocacy. DV/SA programs can provide [similar services to HT survivors](#) as well. Domestic violence coalitions, local domestic violence programs, tribal domestic violence programs, and culturally-specific community-based organizations are an integral part of any coordinated healthcare and social service response to DV/SA and HT.

Reach out to your local DV/SA program! [Find a domestic violence program](#) near you, or contact your [state/territory DV coalition](#) or [tribal DV coalition](#).

DV/SA advocates can connect their clients to primary health care.

Partnerships promote access to health care for survivors of violence because they may have been prevented from seeking care by their abusive partners or traffickers. In one study 17% of abused women reported that a partner prevented them from accessing health care compared to 2% of non-abused women.¹⁴

DV/SA programs are in a unique position to reach clients as they come in for relationship and safety support. They can:

- inquire about clients' health and help-seeking on intake forms;
- identify whether the client has a primary health care provider and offer referrals to partnering health centers, informing clients about health center services and sliding scale fees;
- offer onsite basic support such as contraception, pregnancy, and sexually transmitted infection (STI) testing; and
- some DV/SA programs have partnered with community health centers to offer more robust health services onsite at DV/SA programs

Health centers participating in the Improving Health Outcomes Through Violence Prevention Pilot Project found that establishing formal partnerships, including memoranda of understanding (MOUs), with community based DV/SA programs, as well as other organizations that support survivors of violence, was crucial to providing **trauma informed care** for survivors.

“One of our most important accomplishments was having our [domestic violence] advocate on site and available for a warm hand-off and regular communication from the advocate for updates and education” - Keri Scott, former Director of Quality, The Rinehart Clinic, (Wheeler, OR)

¹⁴ 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.



Build Partnerships: Domestic Violence/Sexual Assault Advocates

Receiving Warm Referrals from Health Partners

Serving as the primary referral from your partnering health center increases patients' access to DV/SA services. Offer trainings and continuing education with the health center to introduce your agency's services and staff, along with the dynamics, prevalence, and health impact of IPV and HT. Trainings for your partner will better equip providers and staff to address and respond to IPV and HT at their health center.

Providing Health Services

Promote survivor health at your agency by offering important health services such as reproductive health resources, pain medication, and rapid HIV testing. Reflect a culture of health for your clients and staff through wellness classes, healthy food options, and info on health coverage and care. Another way that DV/SA advocates can promote health is by talking with survivors about reproductive coercion and offering reproductive health services like pregnancy tests, contraception, and condoms.

See our full toolkit on [“Supporting Survivor Health in Domestic Violence Programs”](#)

Also see: [“Promoting Health Advocacy in Domestic Violence Programs”](#)

“Noemi [patient advocate at Mariposa Health Center] and Mercedes [domestic violence advocate at Catholic Community Services] have come together to not just provide single advocacy on the DV side...but also advocacy on the client care/health side. They enhanced [available] resources, they broadened those support circles...and in a small community you definitely need as much as help as you can get because sometimes the resources are slim to none.” -Lisa Silva, Program Director, Catholic Community Services (Sierra Vista, AZ)

Tools to Build a Successful Partnership

Memorandum of Understanding (MOU): It is critical for health centers and DV/SA programs to form solid partnerships in anticipation of future needs. Roles and responsibilities of each organization should be clearly identified; establishing an MOU is one of the best tools to use.

[Sample MOU](#)

[Tips on how to partner with DV/SA programs](#)

[Case Study: Oregon Guide to Health Care Partnerships](#)

2. Prepare Your Practice

There are six steps to prepare your practice:

- ◇ Build buy-in for your DV/SA program
- ◇ Support staff in addressing their own experiences of violence
- ◇ Create or update policies or protocols on DV/SA
- ◇ Measure quality improvement
- ◇ Enhance the clinic environment by displaying patient and provider tools
- ◇ Document and code

Build buy-in for your DV/SA program: You will need support from all staff levels of your health center to create a sustainable and effective response to IPV and HT. This includes CEOs, Board Members, clinicians, peer educators, and billing and front desk staff. Identify one or more champions for your program to build and maintain buy in. Consider engaging a leader from the staff level and one from the provider level to lead and manage changes. This toolkit provides the designated champions all of the necessary tools to support their engagement.

[Sample slide presentation](#) for CEOs and Board Members on why health centers should create a response to DV/SA and the steps to get started.

[Sample workflow](#) that outlines each staff person's role – from the front office to the exam room -- in responding to DV/SA.

[Sample blog posts](#) for October Domestic Violence Awareness Month and April Sexual Assault Awareness Month

Supporting staff:

Creating a trauma informed health setting is a critical first step in building a response to IPV. Trauma informed workplaces recognize the needs of both clients and employees. Taking into account the high prevalence rates of IPV, it is likely that some health center employees are also personally affected by IPV and others will experience vicarious trauma.

Develop policies and implement training specific to health center employees:

- Visit <http://www.workplacesrespond.org/> to view an online toolkit for building workplace responses to IPV, including a tool that allows customization of a protocol for staff exposed to violence.
- Also see a [presentation for staff](#) on vicarious trauma and self-care strategies.
- See this wellness guide: [“Just Breathe: A Guide to Wellness”](#)

“At the beginning of our IPV work we first offered information and resources for employees on vicarious trauma, including developing a support group just for staff, and because of that we were able to build staff resiliency before addressing IPV with patients.”

—Sara Gavin, LMFT, LPCC, Director of Behavioral Health, CommuniCare Health Centers (Woodland, CA)

Create or update policies and protocols on DV/SA and HT: It is critical to establish or update your protocol on DV/SA and HT by identifying roles and responsibilities for staff, establishing a policy to see patients alone, and implementing uniform standards for documentation and reporting. Examples of adaptable protocols from health centers from across the U.S. are featured below.

View [sample Health Center IPV Protocols](#) that you can adapt for your own setting, and this toolkit for developing a [protocol on human trafficking](#).

View a [video vignette](#) on the importance of seeing patients alone for part of every visit.

“A key success for us in supporting survivors was helping the health center establish a ‘see patients alone’ policy”

—Emily Fanjoy, Health Programs Project Coordinator, Tillamook County Women’s Resource Center (Tillamook, OR)



Quality Improvement: Work with your quality improvement staff or committee to establish a baseline assessment of the quality of care currently provided to survivors of IPV and HT. Identify appropriate tools to measure progress such as the following [Quality Assessment/Quality Intervention \(QA/QI\) tool](#). Complete the tool at initial IPV and HT program implementation, at the 6 month mark, and again as needed to measure change, address barriers, and evaluate sustainability. The QA/QI tool can also help inform the development of your protocol.

Enhance the clinic environment by displaying patient and provider tools: Research shows that creating a supportive environment helps survivors feel more comfortable talking about violence.¹⁵ [Hang posters](#) in lobbies and exam rooms with IPV prevention and health messages; stock [safety cards](#) in exam rooms and bathrooms; and [consider other culturally appropriate patient and provider tools](#).

Documentation and Coding: Be sure to train providers and the billing team on how to document and code for DV/SA as well as how to implement important privacy protections for what information gets shared about IPV. Current Procedural Technology (CPT) and International Classification of Diseases (ICD) codes are available for age appropriate counseling and risk factor reduction interventions as well as codes to record assessment and counseling for IPV.

- [Coding and Documentation for Domestic Violence](#)
- [Privacy Principles for Protecting Survivors of Domestic Violence](#)
- [Recommendations for Documentation](#)
- [Considerations for Explanation of Benefits](#)
- [Insurance Discrimination Against Victims of Domestic Violence](#)

15 Chang JC, Decker MR, Moracco KE, Martin SL, Peterson R, Frasier PY. (2005). Asking about intimate partner violence: advice from female survivors to health care providers. *Patient Education and Counseling*, 59:141-147

3. Adopt the Evidence-Based Intervention

What works? Educate all patients about the connection between IPV and HT and their health and engage them in strategies to promote wellness and safety. The following are evidence-based steps that a multi-disciplinary care team can take to educate all patients on IPV and HT, while also promoting prevention. *This approach has also been adapted to use via [telehealth during COVID-19](#).*

Use the **“CUES”** intervention

- 1) **C**onfidentiality: Know your state’s reporting requirements and share any [limits of confidentiality](#) with your patients. [Always see the patient alone](#) for at least part of the visit so that you can bring up relationship violence safely.
- 2) **U**niversal Education + **E**mpowerment: Give each patient two [safety cards](#) to start the conversation about relationships and how they affect health. Open the card and encourage them to take a look. Make sure patients know that you’re a safe person for them to talk to.
- 3) **S**upport: Though disclosure of violence is not the goal, it will happen--know how to support someone who discloses. Make a warm referral to your local domestic/sexual violence partner agency or national hotlines (on back of all safety cards). Offer health promotion strategies and a care plan that takes surviving abuse into consideration.

Why universal education? It is important to use universal education in clinical settings, the strategy used to talk to *all* adult female-identifying and LGBTQ patients, and adolescent patients about the health consequences of IPV and HT. Even when asked directly by skilled providers, women may not disclose abuse for reasons including distrust and concern for subsequent violence.^{16, 17} Combining universal education on IPV and HT (regardless of a disclosure on any screening tool) with brief trauma-informed harm reduction strategies and warm referrals is beneficial to patients. Following these steps help to increase safety, reduce violence, and improve clinical and social outcomes.

¹⁶ Bair-Merritt MH, et al. Primary care-based interventions for intimate partner violence. Am J Prev Med 2014;46(2):188-94. McCloskey LA, et al. Assessing intimate partner violence in health care settings leads to women’s receipt of interventions and improved health. Public Health Rep 2006;121(4):435-44.

¹⁷ Miller E, et al. A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. Contraception 2011;83(3):274-80. Rhodes KV, et al. Interventions for intimate partner violence against women: clinical applications. JAMA 2003;289(5):60

Use the safety card intervention: Universal education is aided by the use of [safety cards](#). The evidence-based safety card tool was developed to help clinicians and DV/SA advocates open conversations about IPV and HT and healthy relationships with their clients. Because survivors may choose not to disclose abuse for a variety of reasons, universal education ensures that patients receive information regardless of disclosure, promoting primary prevention. With the support of FUTURES' safety cards and other patient education materials, survivors of IPV and HT do not have to disclose abuse in order to receive help.

“FamilyCare Health Center has seen a large increase in disclosures of IPV since we’ve implemented universal education with the safety card. And we noted that our DV/SA advocacy partner, Branches was quite full in the month after we held the training on addressing and responding to IPV.” - Kat Cadle Adams, PsyD Psychologist, FamilyCare Health Center (Scott Depot, WV)

“We combined [screening] with using [the safety card] and taking that universal education approach – we aren’t really trying to get patients to disclose. We’ve done a good job in getting providers to understand that that’s not [as] important, and the social workers are reinforcing that. We feel like we’re doing more prevention and less of putting out a fire.” - Diane Sorensen, LCSW Medical Social Worker, Eastern Iowa Health Center (Cedar Rapids, IA)

Tools to Promote Universal Education:

[Safety Cards](#): Multi-lingual and population specific patient education cards. The resources panel may be localized by adding in a local DV/SA hotline number, health center logo, or other local resources for support.

[CUES Intervention graphic](#)

[Telehealth, COVID-19, IPV, and Trafficking: Increasing Safety for People Surviving Abuse](#)

Additional Tools:

[Survivor Health Brochure](#): Trauma-informed health care tips for those who have survived childhood or adult violence or abuse and have difficulty going to their nurse practitioner, doctor, physician assistant, dentist, or other health care providers.

Clinical guidelines for [reproductive](#) and [adolescent](#) health settings.

To learn more [contact the National Health Resource Center on Domestic Violence](#).

4. Train Providers and All Staff

Promote team-based care by training the entire health center

Health centers participating in the [Improving Health Outcomes Through Violence Prevention Pilot Project](#) found that training all staff—from the front desk to physicians—promotes team-based care and was a key part of their success in sustaining a comprehensive response to IPV and HT. Training all staff also increases awareness of workplace policies and support available to employees facing IPV and HT.

Before introducing health center staff to IPV and HT assessment, universal education and response (mentioned above) related to patients, first educate staff on IPV and HT resources and referrals specific to employees. A partnering DV/SA advocate may help develop a workplace policy; offer training to health center staff; facilitate a wellness/resiliency staff support group; or serve as a primary referral for staff requesting support. They may also help offer education on the dynamics of IPV and HT; vicarious trauma; self-care; and discuss institutional supports that help promote staff resiliency.

Key elements of clinical training:

- The health center’s commitment to IPV and HT system change, goals and timeline;
- Introduction of partnering local DV/SA advocate(s) and DV/SA advocacy services available to employees and clients;
- Vicarious trauma and staff self-care;
- IPV and HT dynamics and prevalence;
- Physical and emotional health impact of abuse and trafficking;
- Case examples to build clinical skills on how to offer universal education on healthy and unhealthy relationships and trafficking;
- Assessment for IPV and HT and harm reduction strategies including warm referrals to local DV/SA programs; and
- Information on documentation, reporting (as needed) and quality improvement.



A partnering DV/SA advocate may help deliver such training and education, in collaboration with IPV and HT leaders at the health center, or other expert trainers.

“We have complete revamped our intake process. Because of the conversations from the training that we have had we dramatically increased the number (and effectiveness) of questions about health. We’re looking at our clients’ needs holistically. We’re sending the clients a message that it’s safe to talk about those issues here.” –Maria Cancel, LMHC, Brockton Neighborhood Health Center (Brockton, MA)

Tools to Train Staff:

The following tools were designed to support health centers get started by holding a training (ideally one **3.5 hour training** or two **1.75 hour trainings**). Tools include PowerPoint decks, short video vignettes, fact sheets and clinical guidelines.

- PowerPoint training decks for health center and DV/SA programs:
 - [Trauma-Informed Approaches to Address IPV and HT in Community Health Centers](#)
 - [Integrating Health Services into DV Agencies and Community-Based Organizations](#)
 - [HIV and Ryan White dually-funded programs](#): Includes an HIV-specific PowerPoint training deck, fact sheet, safety card, and other resources
- [Training videos for health settings](#)
- [CUES Intervention Graphic](#)
- National trainings such as the biennial [National Conference on Health and Domestic Violence](#) offer training and education opportunities for health center staff and DV/SA advocates.

5. Evaluate and Sustain Your Progress

Include IPV and HT as health center quality improvement goals

Conduct Quality Improvement and Create Sustainable Programs:

Monitor quality of care by revisiting your Quality Assessment/Quality Improvement (QA/QI) tool, mandating training for all new staff and offering refresher training annually for all staff. Support staff as they implement the new IPV and HT protocol through case consultations in morning huddles and reflective supervision. As your program advances, consider evaluating the impact your partnerships have on health outcomes of clients and conduct data review with other measures already collected and assess for opportunities to align efforts with other existing priorities. Also work to integrate prompts and resources into your electronic health record and monitor your health IT systems to ensure privacy protections are being enforced to keep patient data safe and secure. Every year, revisit partnerships, policies, and formal memoranda of understanding (MOUs), with community-based DV/SA programs, as well as other or new organizations to support survivors of violence, with an aim to ensure crucial partnerships are in place to provide trauma-informed care to survivors.



“Implementing morning huddles and changes to our EHR have helped us to focus on how we can consistently support IPV survivors.”- Abner Santiago, LPC, Behavioral Health Consultant, La Comunidad Hispana (Kennett Square, PA)

Tools to support sustainability and quality improvement:

- [Quality improvement tools for health centers and DV/SA programs](#)
- [Coding and Documentation for Domestic Violence](#)
- [Privacy Principles for Protecting Survivors of Domestic Violence](#)
- [Reflective supervision questions](#)
- [Safeguarding health information in explanation of benefits](#)

By doing this work, health centers are demonstrating their commitment to patient-centered care by helping to prevent IPV and HT before they begin and by recognizing the impact IPV and HT have on health. Working together and coordinating efforts with community-based DV/SA programs help reduce isolation and improve health and safety outcomes for survivors. Our vision is a future without violence that provides education, safety, justice, and hope for all.

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Supporting Survivors and Staff During COVID-19

Health Providers and DV Advocates are Lifelines

IPV, sexual assault, child abuse, and human trafficking are on the rise during COVID-19 because many families and survivors are staying home, or are isolated from support systems. Systemic health and economic inequities are also increasing vulnerability for communities of color and LGBTQ communities. Health professionals and DV advocates are in a unique position to coordinate their care both virtually and in-person to meet a survivor's safety planning and health care needs, and to promote prevention. Read more about the [impact of COVID-19 on survivors](#).

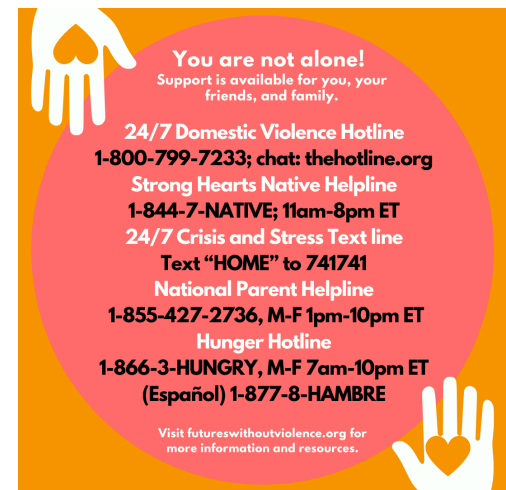


Providing Universal Education on IPV/HT During COVID-19

Health providers can address and respond to IPV and human trafficking during this public health emergency by making sure that all patients are getting access to important resources without having to disclose experiences of violence. See resources below (and infographic to the right) for more information on how to provide universal education on relationship violence during virtual visits in a way that is safer for patients and ensures that everyone gets access to supportive services - even if it is not safe for them to talk about what they are experiencing.

Tools to support universal education via telehealth:

- [Telehealth, COVID-19, Intimate Partner Violence, and Human Trafficking: Increasing Safety for People Surviving Abuse](#)
- [You are not alone! \(shareable resource graphic\)](#)
- [COVID-19 Resource Page for Survivors and Families](#)



Community Health Center and Domestic Violence Program Partnerships to Support Survivor Health and Promote Safety During COVID-19

Health centers and DV programs are natural partners given their shared mission to improve the health, wellness, and safety of their patients and clients and to prevent violence before it begins.

Community Health Centers During COVID-19

[Federally-funded community health centers](#) (CHCs) are key partners for domestic violence programs, as they can help promote health access to survivors and others who are most vulnerable to COVID-19.

Most CHCs across the U.S. now offer COVID-19 testing and many offer walk-up or drive-through test options. During COVID-19, the [“Find a Health Center”](#) tool has been updated to allow users to identify nearby health centers and find sites that offer COVID-19 testing. Additionally, the Health Resources and Services Administration (HRSA) has been surveying CHCs in each state to compile [COVID-19 information](#), including information on closures and COVID-19 testing. Lastly, the [Health Center Resource Clearinghouse](#) has a page dedicated to COVID-19 resources for CHCs.

Domestic Violence Programs During COVID-19

For health centers, including DV advocates as part of your multidisciplinary care teams is a crucial step in supporting both staff as well as survivors in your community. Domestic/sexual violence advocacy organizations work with communities to support survivors of domestic and sexual violence and human trafficking in times of crisis and need. DV advocates have the know-how to work with and support all survivors through immediate and long-term safety planning, and making survivors aware of the unique legal, criminal, and housing supports available to them. During COVID-19, DV programs are continuing their services and adapting as needed, included running virtual support groups and modifying shelter accommodations to decrease the risk of transmission of COVID-19. Visit the [National Coalition Against Domestic Violence](#) to find your state/territory coalition and local DV program(s).

Resources:

- [Building Sustainable and Fruitful Partnerships between Community Health Centers and Domestic Violence Advocacy Programs](#)
- [Supporting the Health and Economic Needs of DV/SA/HT Survivors during the COVID-19 Public Health Emergency](#)
- [Shelter in Place, Violence, and the Healthcare Response](#) (webinar recording - For audio call: 866-360-7719 | passcode: 52020)
- [A Hidden Pandemic Behind COVID-19: HRSA Newsletter](#)

Promoting Staff Wellness During COVID-19

Promoting staff wellness in the workplace during COVID-19 is critical, given high rates of stress, little or no access to child care, and increased financial insecurity. Staff wellness is especially important for health providers and advocates, as they are frontline workers.

Tools to Promote Wellness:

- [Resources for Workplaces and Employers](#)
- [Capacitar International: Mindfulness Videos](#)
- [ACEs Aware Webinar - Taking Care of Our Patients, Our Teams, and Ourselves](#)
- [Greater Good Science Center: Well-being Resources for Health Care Professionals](#)
- [Emotional PPE Project: Free Mental Support for Healthcare Workers](#)

FAQ

1. What is Futures Without Violence?

Answer: For more than 30 years, FUTURES has been providing groundbreaking programs, policies, and campaigns that empower individuals and organizations working to end violence against women and children around the world. Striving to reach new audiences and transform social norms, we train professionals such as doctors, nurses, judges, and athletic coaches on improving responses to violence and abuse. We also work with advocates, policy makers, and others to build sustainable community leadership and educate people everywhere about the importance of respect and healthy relationships. Our vision is a future without violence that provides education, safety, justice, and hope. Learn more [here](#).

2. What is the National Health Resource Center on Domestic Violence?

Answer: For more than two decades, the National Health Resource Center on Domestic Violence has supported health care professionals, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence. The center offers personalized, expert [technical assistance](#) via email, fax, phone, postal mail and face-to-face at professional conferences and meetings around the nation. Contact us at health@futureswithoutviolence.org or call 415-678-5500.

3. What is domestic violence?

Answer: Domestic violence is the willful intimidation, physical assault, battery, sexual assault, and/or other [abusive behavior](#) as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, psychological violence, and emotional abuse. The frequency and severity of domestic violence can vary dramatically; however, the one constant component of domestic violence is one partner's consistent efforts to maintain [power and control](#) over the other. Learn more about the dynamics, signs, and prevalence of domestic violence here: <http://www.ncadv.org/learn-more/what-is-domestic-violence>

4. What is sexual violence (also referred to as sexual assault)?

Answer: Sexual violence is defined by the Center for Disease Control as: A sexual act committed against someone without that person's freely given consent. Sexual violence is divided into the following types: Completed or attempted forced penetration of a victim; Completed or attempted alcohol/drug-facilitated penetration of a victim; Completed or attempted forced acts in which a victim is made to penetrate a perpetrator or someone else; Completed or attempted alcohol/drug-facilitated acts in which a victim is made to penetrate a perpetrator or someone else; Non-physically forced penetration which occurs after a person is pressured verbally or through intimidation or misuse of authority to consent or acquiesce; Unwanted sexual contact; Non-contact unwanted sexual experiences

Read more here: <https://www.cdc.gov/violenceprevention/sexualviolence/definitions.html>

5. What is intimate partner violence (IPV)?

Answer: The U.S. Centers for Disease Control and Prevention [defines IPV](#) as physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner.

6. What is trauma?

Answer: Trauma is a normal reaction to an abnormal situation. “Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.” Read more here: <http://www.integration.samhsa.gov/clinical-practice/trauma>

7. What is trauma-informed care?

Answer: The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a trauma-informed approach to care as:

“A program, organization, or system that:

1. Realizes the widespread impact of trauma and understands potential paths for recovery;
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist re-traumatization.

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.” Learn more here: <https://www.samhsa.gov/nctic/trauma-interventions>

8. What is vicarious trauma?

Answer: Vicarious trauma happens when we accumulate and carry the stories of trauma—including images, sounds, resonant details—we have heard, which then come to inform our worldview. Learn more here: <http://www.joyfulheartfoundation.org/learn/vicarious-trauma>

9. What is universal education?

Answer: Universal education is the clinical strategy used to educate all patients on healthy and unhealthy relationships, and the health consequences of IPV. This approach differs from screening in that it advocates for all patients to be given information on the health impact of IPV, regardless of whether or not they disclose current or past experiences of violence, thus reaching more patients who may choose not to disclose for a variety of reasons, while also promoting prevention. Universal education should also be coupled with direct inquiry and an offer for a warm referral and available resources for IPV. Read more about our [evidence-based clinical intervention](#). See our [CUES intervention graphic](#) as a visual reminder of the steps of the intervention, which can be posted in your staff break room.

10. What is a warm referral?

Answer: A warm referral, as referred to in the [CUES intervention](#), is a supported referral to DV/SA advocacy services from a health provider, in which the provider is able to offer a patient access to an onsite DV/SA advocate; offer use of the clinic's phone to call a local resource; or offer the name and phone number so they can reach out independently, etc. Complement a warm referral with a brochure or safety card from a local DV/SA agency, if it is safe for the patient to take home. Ideally, the provider has an established relationship with the DV/SA advocacy program and is familiar with the staff and services available, thus increasing the likelihood of the patient following through with the connection.

11. How often should I screen for and offer universal education on IPV?

Answer: It's important to talk to all patients at least once a year or with each new partner about healthy relationships, ones that aren't, and how it affects their health. Ensure that screening questions are accompanied with a discussion about the health impact of IPV and available resources. Because of the higher prevalence of abuse during pregnancy, check in with pregnant women about how their relationship is going at least once a trimester and postnatal.

12. Should I screen and offer universal education to just women or to all patients?

Answer: Everyone deserves to have respectful and caring relationships and anyone can be a victim of intimate partner and sexual violence. LGBTQ people experience IPV at rates similar to or higher than heterosexual women—another reason to talk to all patients about the health impact of IPV and available resources. All patients can benefit from universal education about the health impact of healthy and unhealthy relationships. Because the majority of IPV survivors are women, most health centers begin by offering universal education and screening to just women later expanding to all patients once the practice has been solidified.

13. What screening tool is best to use in our EHR?

Answer: We support a universal education approach—talking to all patients about the health impact of IPV, in addition to asking direct questions about current and past experiences of IPV. Universal education also provides patients with resources of where to get help if they need it, and offering brief counseling and a warm referral to a DV/SA advocate in the event of a disclosure. Universal education can be combined with screening tools that are integrated into the electronic health records (EHRs). The US Preventive Services Taskforce also [recommends a number of screening tools](#), including [Hurt, Insult, Threaten, Scream \(HITS\)](#) (English and Spanish versions); [Slapped, Threatened, and Throw \(STaT\)](#); and [Humiliation, Afraid, Rape, Kick \(HARK\)](#).

14. What is a safety card?

Answer: The Health Resource Center on Domestic Violence, a project of [Futures Without Violence](#) offers a number of multilingual, low-literacy patient education safety cards that provide information on healthy and unhealthy relationships, their impact on health and list national referrals for support. The evidence-based safety card tool was developed to help clinicians and DV/SA advocates open conversations about DV/SA and healthy relationships with their clients. They are typically a 4-5 panel double-sided tool that folds into a 2.5 x 3 inch card (business-card sized). The Health Resource Center on Domestic Violence offers a number of [setting-specific and population-specific safety cards](#).

15. How can I protect survivor privacy and still promote improved health?

Answer: Federal legislation and state and local statutes are crucial to establishing a comprehensive baseline of regulations and protections for the use and disclosure of sensitive electronic information. Health information technology (HIT) developers and vendors also have a role in building the software and hardware necessary to deal with the information in an appropriate fashion.

See these [guiding principles](#) that should be applied by clinicians, administrators, policy makers, and developers when designing, building, or regulating health information systems that will hold or exchange sensitive health information. These principles build on past work to protect information collected in paper health records, and expand the consideration to electronic health records and health information exchanges.

16. What are the health care reporting requirements for IPV in my state, tribe, or U.S. territory?

Answer: See our [Compendium of State and U.S. Territory Statutes and Policies on Domestic Violence and Health Care](#).

17. Domestic Violence and Sexual Assault (DV/SA) programs: What are they and where can I find one?

Answer: Many DV/SA partners are equipped to provide supportive services such as translation, transportation, and legal support which mirror the enabling services offered by health centers. DV/SA programs exist in many communities in which health centers are located and DV/SA advocates can offer a range of support to survivors identified in health centers. Such confidential patient support may include information on healthy and unhealthy relationships; emotional support; emergency and long-term safety planning; and supports related to other social determinants of health including housing, food insecurity and employment as well as court and legal advocacy. Some advocates staff crisis hotlines, run support groups or provide in-person counseling, and some agencies have programs for adolescents and children. In some instances, a community may only have one such program available to support DV/SA survivors and their families. However, other communities may operate both a domestic violence program and a distinct sexual assault program.

The National Hotline on Domestic Violence can help identify local programs and offer safety planning assistance to survivors, concerned family members, or professionals working with clients who need help. The Hotline is staffed by DV/SA advocates available to talk 24/7 at 1-800-799-SAFE (7233) in over 170 languages and online: www.thehotline.org. All calls are confidential and anonymous. There is also a national helpline for Native American communities, the [StrongHearts Native Helpline](http://www.stronghearts.org), 1-844-7NATIVE (1-844-762-8483) Monday through Friday, from 9 am to 5:30 pm CST. The [StrongHearts Native Helpline](http://www.stronghearts.org) is a culturally-appropriate, confidential service for Native Americans affected by domestic violence and dating violence. You may also contact your [state domestic violence coalition](#) or [tribal coalition](#) to find a local domestic violence program near you. Additionally, RAINN (Rape, Abuse & Incest National Network) operates the National Sexual Assault Hotline (800.656.HOPE) and www.rainn.org (with a live chat) in partnership with more than 1,000 local sexual assault service providers across the country.

18. What is the Domestic Violence Resource Network (DVRN)?

Answer: The [Domestic Violence Resource Network](#) (DVRN) is funded by the U.S. Department of Health and Human Services and funds a network of organizations working to improve the country's response to domestic violence. In addition to funding two national resource centers, [National Resource Center on Domestic Violence](#) and [National Indigenous Women's Resource Center](#), the DVRN also funds three culturally-specific resource centers. These include:

- [Casa de Esperanza](#), the national resource center for working with Latinx communities. Casa de Esperanza offers a [webinar series](#) on topics such as "[Trauma Informed and Culturally Specific Practice with Latin@ Survivors](#)" and "Safety Planning for Immigrant Survivors of Domestic and Sexual Violence."
- [Asian & Pacific Islander Institute on Gender-Based Violence](#), which offers training and technical assistance for survivors in Asian & Pacific Islander communities. Their [resource library](#) has culturally-specific materials available for various forms of gender-based violence that are prevalent in Asian & Pacific Islander communities.
- [Ujima](#), the National Center on Violence Against Women in the Black Community, which offers training and technical assistance and educational resources for prevention and responding to domestic, sexual, and community violence in the Black community.

Five special issue resource centers:

- [Battered Women's Justice Project Criminal and Civil Justice Center](#)
- [National Clearinghouse for the Defense of Battered Women](#)
- [National Council of Juvenile and Family Court Judges](#)
- [National Health Resource Center on Domestic Violence](#)
- [National Center on Domestic Violence, Trauma, & Mental Health](#)

In addition, the DVRN supports the [National Domestic Violence Hotline](#), and the [National LGBTQ Institute on Intimate Partner Violence](#).

19. Do you provide training onsite?

Answer: As a national program, we are unable to provide onsite trainings, but contact us at health@futureswithoutviolence.org to see how we can best support your training needs. The Health Resource Center on Domestic Violence offers a number of [training curricula and other tools](#) to facilitate trainings in addition to hosting a biennial annual [National Conference on Health and Domestic Violence](#) and an ongoing webinar series, where you can learn more about promising practices and research in the field.

20. What resources are available for American Indian/Alaska Native (AI/AN) communities?

Answer: The National Health Resource Center on Domestic Violence offers a number of resources tailored specifically for American Indian and Alaska Native (AI/AN) communities, including safety cards, posters, and a Promising Practices Report. Learn more about our [work with AI/AN communities](#), and [order hard copies and download PDFs](#) of our materials. See also www.niwrc.org, the National Indian Resource Center Addressing Domestic Violence and Safety for Indian Women.

There is also a national helpline specifically for Native American survivors of domestic violence or dating violence, the [StrongHearts Native Helpline](#), 1-844-7NATIVE (1-844-762-8483) Monday through Friday, from 9 am to 5:30 pm CST. [Indian Health Services](#) also has a protocol for [Intimate Partner Violence](#).

21. What resources are available for Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) and Gender-non-conforming (GNC) communities?

Answer: The National Health Resource Center on Domestic Violence offers a number of resources tailored specifically for LGBTQ/GNC communities, including safety cards and posters. Learn more about our resources for working with [LGBTQ/GNC communities](#), and [order materials](#).

Also get more information at the [LGBTQ DV Capacity Learning Center at The NW Network](#).

22. What languages are your materials in, and what culturally-specific resources do you offer?

Answer: [The National Health Resource Center on Domestic Violence](#) has developed materials to meet the unique needs of all individuals and families. Culturally-specific resources include patient safety cards, posters, fact sheets and reports, and some are multi-lingual. For example:

- [American Indian/Alaska Native](#) safety cards (3 versions), posters, a care giver/parent brochure, fact sheet, and promising practices report. See also the FAQ entry for resources for [American Indian/Alaska Native \(AI/AN\)](#) communities.
- [Lesbian Gay Bisexual Transgender Queer](#) (LGTBQ) and Gender-Nonconforming (GNC) safety cards (English and Spanish) and a poster. See also the FAQ entry for resources for [LGBTQ and GNC](#) communities.
- General health safety card in five languages commonly spoken in [Hawaii](#) (Chinese, Chuukese, Hawaiian, Marshallese, and Tagalog).
- [Spanish](#) language safety cards, posters, and brochures.
- General health safety card in [Tagalog](#) for a national audience, as well as a guide for [organizing a community-based response to domestic violence](#), using the Filipino community as a model.
- General health safety cards in [Arabic and Farsi](#).
- General health safety card, reproductive health safety card, adolescent health, and LGBQ safety cards in [Armenian](#), [Chinese](#), and [Korean](#).
- Safety card for [high school and college-aged Muslims](#).

See all culturally-specific tools [here](#).

23. What resources do you have for rural or remote communities?

Answer: Rural and remote communities have unique needs related to distance, isolation, inclement weather, and access to services and emergency responses, among others. A 2011 study published in the Journal of Women’s Health found that 22.5% of women in small rural areas and 17.9% in isolated areas reported being victims of intimate partner violence, compared to a national average of 16.1%.^{*} Futures Without Violence contributed to the [Violence and Abuse in Rural America Guide](#) that addresses the wide range of abuses that may take place in rural communities. FUTURES also offers an archived webinar: [Collaborating to Address Trafficking in Rural Communities: Lessons from the Field](#), and the manual, [Building the Rhythm of Change: Developing Leadership and Improving Services Within the Battered Rural Immigrant Women’s Community](#). View additional resources for [American Indian/Alaska Native communities](#) and a [partnership model for rural areas](#).

^{*}Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural Disparity in Domestic Violence Prevalence and Access to Resources. Journal of Women’s Health, 20(11), 1743-1749. doi:10.1089/jwh.2011.2891

24. What does it mean to be a *survivor of domestic violence/sexual assault (DV/SA)*?

Answer: The terms ‘victim’ or ‘survivor’ may be used to refer to a person who has experienced or is experiencing domestic violence/sexual assault (DV/SA). Some organizations or individuals use the terms interchangeably while others feel that the terms ‘victim’ and ‘survivor’ have very different connotations. It is important for providers to let individuals label their own experience and to mirror this language. We largely use the term ‘survivor’ in this toolkit.

25. Where can I find more information on programs addressing human trafficking and its health impact, as well as intervention and support strategies?

Answer: [Human trafficking](#) has severe [adverse effects](#) on the health, well-being, and human rights of millions of vulnerable adults and young people in the U.S. and globally. Learn more about [FUTURES' programs, policies, and initiatives](#) working to prevent and respond to human trafficking.

Learn more about trafficking among American Indian women and girls in Minnesota in the [Shattered Hearts](#) report from the [Minnesota Indian Women's Resource Center](#). View this [webinar](#) for more information on addressing trafficking in rural communities.

Health professionals can play a significant role in early intervention of human trafficking and reducing the profound suffering it causes. The U.S. Department of Health and Human Services [SOAR](#) training program helps health care and social service providers identify and respond to survivors of human trafficking. [HEAL Trafficking](#) also takes a public health perspective to ending trafficking and [provides trainings for healthcare professionals](#) on addressing and responding to survivors of trafficking.

FUTURES also has resources that address human trafficking:

- The [adolescent health safety card](#) and the [reproductive health safety card](#) integrate information on trafficking
- Webinar: [Collaborating with Community-based Organizations and Faith-based Communities to Address Trafficking](#)
- Webinar: [Legal Aspects of Human Trafficking for Health Providers](#)
- Webinar: [Collaborating to Address the Needs of Trafficked Survivors with Disabilities](#)

Reach out to the [National Human Trafficking Hotline](#) if you or someone you know is a victim of human trafficking and also for more information on the prevalence of trafficking and how to get involved.

26. What is the health impact of IPV?

Answer: IPV has serious implications for health and wellbeing of its survivors. As the leading cause of female homicides and injury-related deaths during pregnancy, IPV also accounts for a significant proportion of injuries and emergency room visits for women. IPV is a significant yet preventable public health problem that affects millions of people regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death. Women who have been victimized by an intimate partner and children raised in violent households are more likely to experience a wide array of physical and mental health conditions including frequent headaches, gastrointestinal problems, depression, anxiety, sleep problems, and Post Traumatic Stress Disorder (PTSD). Despite these alarming facts, a critical gap remains in the delivery of comprehensive health care to women. For more information, visit <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html>

27. What are strangulation and traumatic brain injury (TBI) and how do they relate to violence, abuse and fatality risk?

Answer: Traumatic Brain Injuries (TBIs) are a common form of physical violence that are often repeated. The Centers for Disease Control ([CDC](#)) [defines a traumatic brain injury \(TBI\)](#) as a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head, or penetrating head injury. Studies show a range of 40%-91% of women experiencing intimate partner violence (IPV) have incurred a TBI due to a physical assault.[1] Strangulation is one of the most common forms of TBI that survivors of violence and abuse experience, and more than two-thirds of survivors are strangled at least once, with the average being 5.3 times per victim[2]

Other common forms of TBI that survivors experience are blunt force blows to the head that can cause concussions, such as being slammed against a wall, or being shaken so hard that the brain hits the wall of the skull. Non-fatal strangulation is an important risk factor for homicide of women. [3] Visit the [Training Institute on Strangulation Prevention](#) for more information on the health impact of strangulation.

While immediate TBI physical repercussions may not always be obvious, TBI can cut off oxygen to the brain hours or days following an injury, and victims can die from TBI hours or days after the assault.[4] That's why it's important for both domestic violence advocates and health care providers to talk to their clients and patients about any form of head injuries they may have experienced. Health care providers can ask patients about recent or past head injuries, and advocates can add questions to their intakes form to assess for TBIs. Advocates can also keep in mind while safety planning the potential cognitive and behavioral impact that TBIs can have. The "[HELPS](#)" [Screening Tool for Traumatic Brain Injury](#) is a helpful screening tool to assess for TBIs, which is designed for professionals who are not TBI experts. The "HELPS" tool also describes potential cognitive, behavioral, and physical symptoms of TBIs, as well as recommendations for working with women who have TBIs. The [Danger Assessment Tool](#) helps to determine the level of danger an abused woman has of being killed by her intimate partner. It is free, available to the public, and is available in English, Spanish, Portuguese, and French Canadian.

The [Ohio Domestic Violence Network](#) (ODVN) developed educational resources for survivors and advocates on TBIs and strangulation. The [Has Your Head Been Hurt](#) educational card provides information on injuries related to TBIs and strangulation, links to emotional and cognitive symptoms, and highlights the warning signs of life-threatening injuries. [The Invisible Injuries Booklet](#) is a companion tool for the [Has Your Head Been Hurt](#) card, to assist domestic violence programs in accommodating the needs of survivors who have experienced head injuries and to identify possible follow-up care or evaluation. ODVN's work on TBIs and intersections with domestic violence was featured in [this report from the U.S. Government Accountability Office](#), which led to the U.S. Department of Health & Human Services to agree to coordinate among its agencies to better address TBIs related to domestic violence.

See also this [graphic of strangulation signs and symptoms](#), from the [Training Institute on Strangulation Prevention](#).

[1] Jacquelyn C. Campbell, PhD, RN, FAAN,¹ Jocelyn C. Anderson, PhD, RN,^{1,2} Akosoa McFadgion, PhD, MSW, Jessica Gill, PhD, RN,⁴ Elizabeth Zink, MS, RN, Michelle Patch, MSN, APRN-CNS, ACNS-BC, Gloria Callwood, PhD, RN, FAAN,⁵ and Doris Campbell, PhD, ARNP, FAAN, The Effects of IPV and Probable Traumatic Injury on Central Nervous Symptoms. *Journal of Women's Health* (2018) <https://www.liebertpub.com/doi/abs/10.1089/jwh.2016.6311?src=recsys&>

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[4] Training Institute on Strangulation Prevention. (2017). Health Issues Result from Strangulation – Training Institute on Strangulation Prevention. [online] Available at: <http://www.strangulationtraininginstitute.com/health-issues-result-from-strangulation>

28. What is the impact of the COVID-19 public health emergency on survivors of domestic violence, sexual assault, and human trafficking?

Answer: COVID-19 has had tremendous impacts on people surviving violence and those who are most vulnerable to abuse and exploitation. With stay at home orders in place across much of the U.S., survivors are now likely to be stuck at home with the person(s) causing them harm and now have less access to support networks. This isolation, along with increased stress and financial instability, put survivors more at risk for violence in their homes.[i] Additionally, high unemployment rates can impact survivors' financial independence, which in turn can make them more dependent on the person(s) causing them harm and make them more vulnerable to exploitation. Communities of color and LGBTQ communities are particularly vulnerable to exploitation, especially during COVID-19.[ii]

Black and brown communities have been disproportionately impacted by COVID-19.[iii] Deaths among black communities nationally is almost twice the percentage of the national population they represent.[iv] This can both be attributed to higher rates of lower-paying and less secure jobs due to systemic inequities, and also social determinants of health, which has led to higher rates of chronic health issues in black communities.[v] For survivors of color, these systemic inequities and increased likelihood of underlying health conditions can further exacerbate the impact of COVID-19.

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Health centers are key to violence prevention

get more at:

ipvhealthpartners.org

online toolkit for community health centers and
domestic violence agencies

resources | information | partnership



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