Massachusetts Medical Society Committee on Violence Intervention and Prevention

# Intimate Partner Violence

## *The Clinician's Guide to Identification, Assessment, Intervention, and Prevention*

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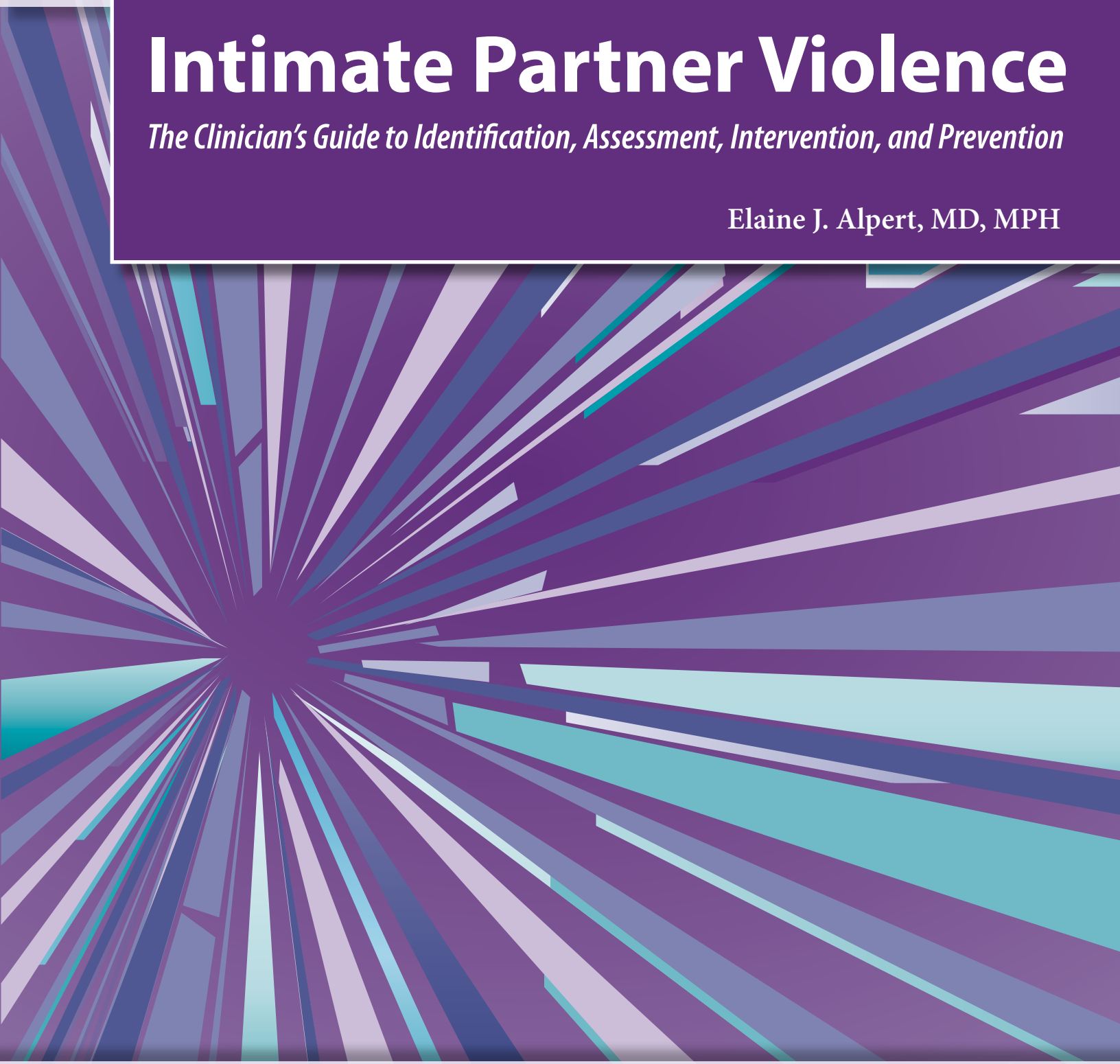

6th edition

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# Preface

The Massachusetts Medical Society (MMS) is pleased to release the sixth edition of its guidebook on intimate partner violence: *Intimate Partner Violence: the Clinician's Guide to Identification, Assessment, Intervention, and Prevention*. The "MMS IPV Guidebook" continues to be widely regarded by physicians and other clinical health care providers as a key resource for up-to-date knowledge and practical advice about this important and prevalent health issue.

The guidebook's first edition, published in 1992, was designed as a quick reference guide for use by physicians and medical students in the Commonwealth of Massachusetts. Updated editions were published in 1996, 1999, 2004, and 2010.

In addition to updates and expansions made throughout the text and references, the sixth edition (2015) represents a major rewrite of the guidebook in the following areas:

- The target audience has been expanded beyond physicians and medical students to include physician assistants, nurse practitioners, nurses, midwives, and other clinical health care providers
- The guidebook has been formatted to permit easy adaptation and customization for use, with permission, in other states as well as internationally
- The content has been organized to enable Massachusetts-based physicians and other health care providers to attain — and remain compliant with — recently enacted Commonwealth of Massachusetts legislation requiring periodic continuing professional education about domestic violence and sexual violence (https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter260 [within this Chapter, see Section 9, Chapter 112, Section 264])
- A discussion of the Affordable Care Act (www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm) and its provisions regarding intimate partner violence assessment and response is included
- New or expanded sections about the impact of adverse childhood experiences and toxic stress on both brain development and adult health, and about principles of trauma-informed care are included
- Active web links to relevant, respected local, statewide, and national resources have been incorporated into the text and references

The purpose of this guidebook is to provide information and guidance for clinically-practicing health care professionals (e.g., physicians, physician assistants, and advanced practice nurses) when screening, identifying, assessing, and responding to patients at risk for abuse. Additional health care providers from a wide variety of training backgrounds, as well as advocates and others in domestic violence, sexual assault, and child protection agencies, can also benefit from the material offered within.

Because health care professionals are often the first and sometimes the only trusted people abused individuals may encounter, they can play a crucial role in the coordinated community response to violence across the lifespan.

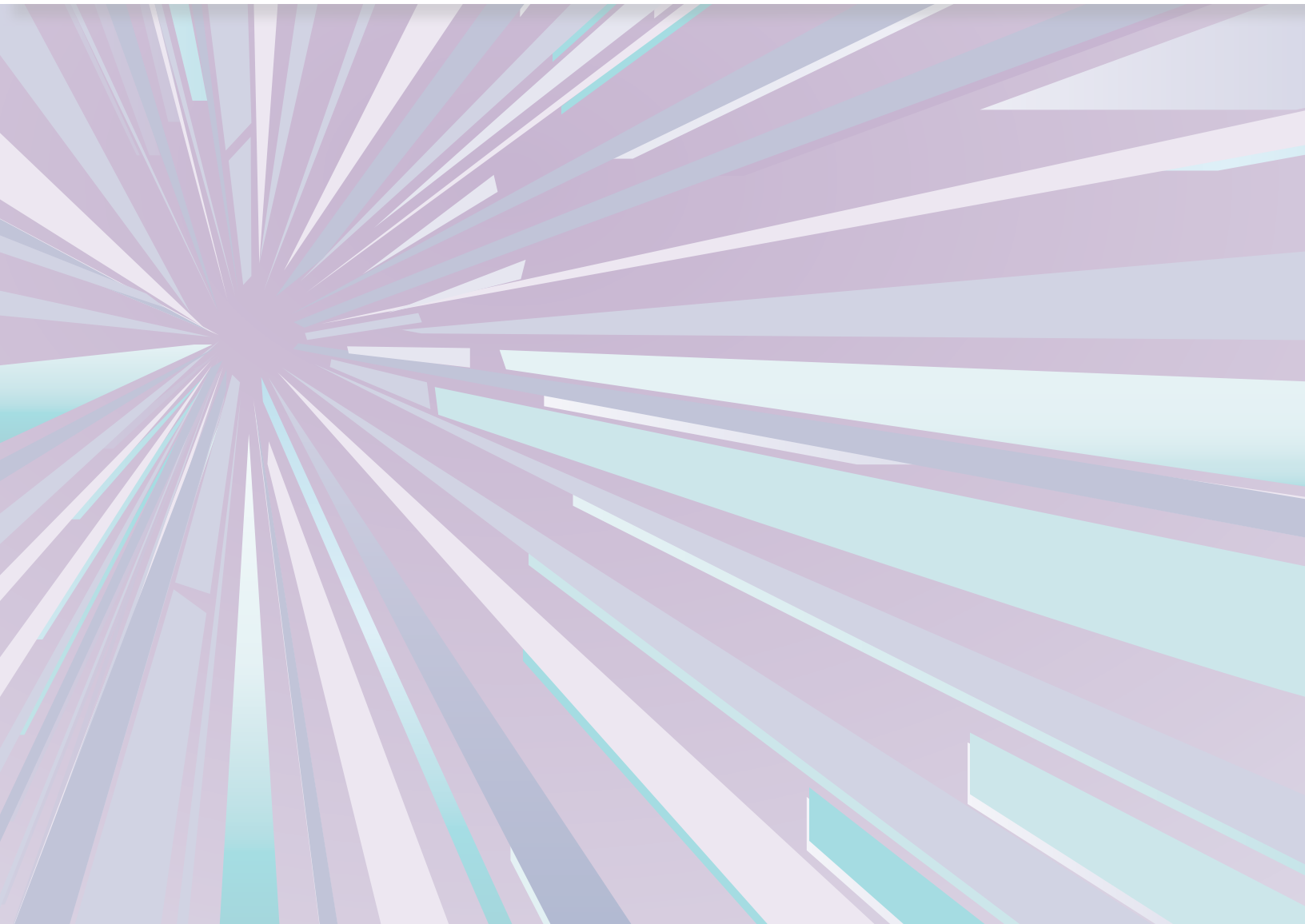
# Acknowledgments

The author gratefully acknowledges the assistance and input of members of the Massachusetts Medical Society Committee on Violence Intervention and Prevention, the Massachusetts Medical Society Alliance, and Jane Doe Inc. — the Massachusetts Coalition Against Sexual Assault and Domestic Violence. In addition, trusted colleagues including Kevin Ard of Massachusetts General Hospital and Harvard Medical School; Nancy Durborow of the National Network to End Domestic Violence (retired); Annie Lewis-O'Connor of Brigham and Women's Hospital; Brigid McCaw of Kaiser Permanente; Elizabeth Miller of the University of Pittsburgh; Tina Nappi, Independent Consultant; Hanni Stoklosa of Harvard Medical School and Harvard School of Public Health; Joanne Timmons of Boston Medical Center; and numerous other academic and community experts contributed critical peer review for this volume. The judicious editorial support of William S. Marsh Jr. is also gratefully acknowledged.

Since 1992, when its still-ongoing Campaign Against Violence began, the Massachusetts Medical Society has remained in the forefront of education, support, and innovation about violence and abuse across the lifespan. This guidebook is but one of several components of a larger Initiative on Violence Prevention. The ongoing support and active collaboration of MMS membership, staff, and leadership is gratefully acknowledged. In particular, heartfelt thanks are extended to MMS Manager of Public Health Outreach Candace Savage, and to Misty Horten, Jay Leonard, and Chris Iacono from Premedia and Publishing Services for their invaluable assistance in ensuring the professional design and publication of this guidebook.

Finally, a debt of enormous gratitude is owed to countless patients and survivors whose courage, honesty, and resilience continue to be a source of education, admiration, and inspiration.

# Introduction



This guidebook is designed to help physicians and other practicing health care professionals improve their ability to identify and respond to patients who have experienced intimate partner violence (IPV), or who may be at risk of abuse. Also referred to as domestic violence, spousal abuse, partner violence, and battering, among numerous other terms, IPV has complex individual, social, and cultural underpinnings, with acute health effects and ongoing medical sequelae that are seen regularly in clinical practice.

Nearly every health care professional is called upon to care for patients who:

- Are at risk for IPV or other types of abuse in interpersonal relationships
- Were exposed to abuse or its effects during childhood or at other times over their lifespan
- Are currently in an abusive relationship
- Are coping with long-term effects of prior abuse

Asking the right questions in order to "diagnose" IPV during the course of routine clinical care is a necessary — albeit insufficient — task for health professionals in clinical practice. Far more important than making the "correct" diagnosis is developing expertise in engaging patients in conversations about healthy relationships as well as acquiring and refining skills that can be used to identify, assess, document, and respond to victimized individuals using a trauma-informed perspective that embodies genuine empathy, compassion, and respect.

To this end, addressing IPV optimally requires health professionals to practice in a trauma-informed and culturally-responsive manner, to know how to access expert advice and referrals both from within and outside the health care system, to manage time efficiently, and to communicate empathically while maintaining appropriate professional boundaries. Finally, it is also important to attend to the emotional needs and physical safety of patients, staff, and one's self at all times.

Because physicians and other health care providers are often the first and sometimes the only trusted professionals survivors of abuse and violence may encounter, they can play a crucial role in breaking the cycle of violence and working toward both safety and prevention.

The goals of this guidebook are to:

- Describe the varied clinical presentations and behavioral dynamics seen in IPV
- Provide comprehensive, health care-focused guidance about IPV identification, response, and prevention in a compact and efficient format
- Present resource information and outline referral procedures for identified as well as at-risk patients
- Summarize peer-reviewed and other respected reports that support clinical practice
- Provide an efficient mechanism to comply with applicable laws, regulations, and policies regarding continuing professional education
- Introduce opportunities to engage in ongoing education, collaboration, and leadership in the field

# RADAR

The acronym RADAR, developed by the MMS in 1992 and described in the figure below, summarizes the steps clinicians can take to use their personal "RADAR" to help identify and respond to patients at risk for, or affected by, intimate partner violence.

**R**emember to ask routinely about IPV as a matter of routine patient care.

**A**sk directly about violence with such questions as "At any time, has a partner hit, kicked, or otherwise hurt or frightened you?" Interview your patient in private at all times.

**D**ocument findings related to suspected intimate partner violence in the patient's chart.

**A**ssess your patient's safety. Is it safe to return home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.

**R**eview options with your patient. Know about the types of referral resources in your community (e.g., shelters, support groups, legal advocates). See pages 61 to 76 of this guidebook for specific resource listings.

# Definition and Spectrum

## *Definition*

IPV can be defined as a deliberate and purposeful pattern of coercive control perpetrated by someone who is currently, or was previously, in a dating or intimate relationship with another person. The perpetrator and abused individual may be married, separated, divorced, or single; in a heterosexual or same-sex relationship; or may self-identify as male, female, transgender, gender nonconforming, or as a member of another gender or sexual minority (GSM).* They may currently live together, have lived together in the past, or have never cohabited. Particularly in the case of adolescents, a relationship need not be long or substantive for abuse to become apparent; patterns of coercive control can arise even in relationships that outside observers might consider to be a new or casual. Physical violence may or may not be present at any given time.

*Expanded discussions of gender and sexuality-related terms and definitions can be found at www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf and http://itspronouncedmetrosexual.com/2013/01/a-comprehensive-list-of-lgbtq-term-definitions.

## Spectrum

IPV is but one component of the larger problem of family violence, which also includes child abuse and neglect, abuse between siblings, elder abuse, and some forms of sexual assault. In addition, those who are victims of either domestic or international human trafficking, particularly in situations where sexualized coercion is a component, share many features in common with non-trafficked individuals coping with IPV, and may even identify their trafficker as a "boyfriend" or other romantic partner.*

Included within the spectrum of IPV is a broad range of coercive behaviors, including:

- Actual or threatened physical assault
- Sexual violence and exploitation (including but not limited to attempted and completed rape)
- Psychological abuse (including intimidation, threats, and systematic degradation)
- Economic control
- Social isolation
- Restriction of access to medical care
- Destruction of keepsakes, property, medications, or other personal possessions
- Spiritual abuse
- Maltreatment of dependents including children, other family members, and animals/pets

These behaviors can occur in any combination, in sporadic episodes or chronically, and can extend over months, years, or even decades.

Although a common presenting complaint in the health care system (particularly in acute or emergency medical settings), physical violence tends to occur less frequently than many other forms of abuse, such as psychological manipulation, social isolation, and threats — all of which are deliberate and purposeful acts intended to undermine the survivor's independence and self-determination while reinforcing the perpetrator's control and dominance in the relationship. Physical assault, when it does occur, is almost always preceded or accompanied by one or more of the other forms of coercive control listed above. Abused individuals tend to act in response to the overall pattern of intimidating behaviors rather than to a single episode or solitary event.

*The Massachusetts Medical Society published an in-depth guidebook about identifying and responding to human trafficking, through the lens of health care, entitled *Human Trafficking: Guidebook on Identification, Assessment, and Response in the Health Care Setting* (2014). This guidebook can be accessed and downloaded at www.massmed.org/humantrafficking at no cost or ordered in hard copy format. Contact dph@mms.org for hard copy order information.

Some manifestations of IPV are considered criminal acts; for example, threats or acts of physical violence, as well as many forms of sexual assault. Other types of abuse, such as the destruction of keepsakes and some forms of intimidation or social isolation, may not be illegal *per se*, even though they can result in long-term and often severe adverse health effects. In this regard, IPV cases might come to the exclusive attention of the health care system, bypassing the legal and criminal justice systems altogether.

## Incidence and Prevalence

Precise incidence and prevalence estimates are difficult to obtain for a variety of reasons, including differing definitions, methodological challenges, and survivor reluctance to disclose due to threats, fear, shame, insufficient awareness, cultural norms, and risk of arrest, incarceration, or deportation for unrelated issues. Regardless, experts agree that IPV is prevalent throughout every facet of society and also is seen in every type of medical setting and specialty.

Recognizing the need for robust, ongoing, representative statewide and national surveillance data about IPV, sexual violence, and stalking that would capture not only incidence and prevalence statistical trends but also the patterns, characteristics, impact, and health consequences of victimization, the U.S. Centers for Disease Control and Prevention (CDC-P) developed the National Intimate Partner and Sexual Violence Survey (NISVS) in 2010.[1] Key findings of this ongoing random digit dial telephone survey are analyzed and reported yearly.

Highlighting the pervasiveness and impact of the problem of abuse in relationships, the most recent (2011) NISVS incidence, prevalence, and impact data for IPV are summarized in the table on the following page republished from the 2011 report (reproduced with acknowledgement of source and with permission).[2]

Of note, NISVS data elucidate incidence and prevalence data that are high (and in some cases roughly equivalent) for U.S. women and men. While a deeper analysis of these complex data is beyond the scope of this guidebook, it is, nonetheless, critical to note that the *impact* of victimization is far greater (on average four times greater) for women, compared to men.

For those interested in exploring NISVS data and its implications in greater detail, full and summary reports as well as state-specific tables can be accessed through the NISVS website at www.cdc.gov/violenceprevention/NISVS/index.html. The actual survey questions can be viewed at http://stacks.cdc.gov/view/cdc/24726.

Other published studies indicate current or recent IPV in:

- Four (4) to 14% percent (current incidence) of women seen for general medical care in office or clinic practice settings[3,4]
- A substantial proportion of women who attempt suicide[5,6]
- As many as 20% of pregnant and postpartum women[7]
- More than half of the mothers of abused children[8]

## TABLE 1. Lifetime and 12-month prevalence of intimate partner violence victimization, by sex of victim and time period — National Intimate Partner and Sexual Violence Survey, United States, 2011

| | Women | | | | | | Men | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Lifetime | | | 12-month | | | Lifetime | | | 12-month | | |
| | %* | (95% CI) | Estimated no. of victims† | %* | (95% CI) | Estimated no. of victims† | %* | (95% CI) | Estimated no. of victims† | %* | (95% CI) | Estimated no. of victims† |
| Rape | 8.8 | (7.8–9.8) | 10,574,000 | 0.8 | (0.5–1.2) | 922,000 | 0.5 | (0.3–0.8) | 572,000 | —‡ | — | — |
| Completed forced penetration | 5.6 | (4.8–6.5) | 6,770,000 | — | — | — | — | — | — | — | — | — |
| Attempted forced penetration | 2.8 | (2.2–3.5) | 3,368,000 | — | — | — | — | — | — | — | — | — |
| Completed alcohol- or drug-facilitated penetration | 3.8 | (3.1–4.5) | 4,558,000 | 0.5 | (0.3–0.8) | 618,000 | — | — | — | — | — | — |
| Other sexual violence | 15.8 | (14.6–17.1) | 19,082,000 | 2.1 | (1.6–2.6) | 2,476,000 | 9.5 | (8.4–10.8) | 10,828,000 | 2.1 | (1.7–2.7) | 2,442,000 |
| Made to penetrate | 0.3 | (0.2–0.5) | 374,000 | — | — | — | 3.6 | (2.9–4.5) | 4,151,000 | 0.8 | (0.6–1.2) | 962,000 |
| Sexual coercion | 9.2 | (8.3–10.3) | 11,156,000 | 1.5 | (1.1–1.9) | 1,752,000 | 4.0 | (3.3–4.8) | 4,554,000 | 0.9 | (0.7–1.3) | 1,044,000 |
| Unwanted sexual contact | 6.4 | (5.6–7.3) | 7,711,000 | 0.6 | (0.4–1.0) | 776,000 | 2.4 | (1.9–3.1) | 2,771,000 | — | — | — |
| Noncontact unwanted sexual experiences | 8.5 | (7.6–9.6) | 10,311,000 | 0.9 | (0.6–1.2) | 1,043,000 | 4.1 | (3.4–5.0) | 4,686,000 | 0.8 | (0.5–1.3) | 929,000 |
| Physical Violence | 31.5 | (29.9–33.2) | 38,028,000 | 4.0 | (3.2–4.8) | 4,774,000 | 27.5 | (25.8–29.3) | 31,331,000 | 4.8 | (4.0–5.8) | 5,452,000 |
| Slapped, pushed, shoved | 29.7 | (28.1–31.4) | 35,872,000 | 3.7 | (3.0–4.5) | 4,447,000 | 25.5 | (23.8–27.2) | 28,992,000 | 4.4 | (3.6–5.3) | 4,983,000 |
| Slapped | 18.9 | (17.6–20.4) | 22,864,000 | 1.7 | (1.2–2.3) | 2,056,000 | 19.5 | (18.0–21.1) | 22,216,000 | 2.7 | (2.1–3.5) | 3,072,000 |
| Pushed/shoved | 27.3 | (25.7–28.9) | 32,955,000 | 3.1 | (2.5–3.9) | 3,736,000 | 18.3 | (16.9–19.9) | 20,849,000 | 3.2 | (2.6–4.0) | 3,641,000 |
| Any severe physical violence | 22.3 | (20.8–23.9) | 26,928,000 | 2.3 | (1.8–2.9) | 2,752,000 | 14.0 | (12.7–15.5) | 15,985,000 | 2.1 | (1.6–2.7) | 2,374,000 |
| Hurt by pulling hair | 9.4 | (8.4–10.6) | 11,397,000 | 0.9 | (0.6–1.3) | 1,088,000 | 2.6 | (2.1–3.3) | 3,014,000 | — | — | — |
| Hit with a fist or something hard | 13.2 | (12.0–14.4) | 15,881,000 | 1.2 | (0.8–1.8) | 1,471,000 | 10.1 | (9.0–11.4) | 11,506,000 | 1.5 | (1.1–2.1) | 1,695,000 |
| Kicked | 6.7 | (5.8–7.6) | 8,033,000 | 0.4 | (0.2–0.7) | 494,000 | 4.6 | (3.8–5.4) | 5,190,000 | 0.5 | (0.3–0.8) | 555,000 |
| Slammed against something | 15.4 | (14.2–16.8) | 18,638,000 | 1.3 | (1.0–1.8) | 1,614,000 | 2.5 | (2.0–3.1) | 2,836,000 | 0.4 | (0.2–0.7) | 455,000 |
| Tried to hurt by choking or suffocating | 9.2 | (8.2–10.3) | 11,120,000 | 0.7 | (0.5–1.2) | 896,000 | 0.7 | (0.5–1.1) | 814,000 | — | — | — |
| Beaten | 10.5 | (9.5–11.7) | 12,719,000 | 0.7 | (0.4–1.0) | 795,000 | 2.3 | (1.8–3.0) | 2,654,000 | — | — | — |
| Burned on purpose | 1.2 | (0.8–1.7) | 1,423,000 | — | — | — | 0.3 | (0.2–0.6) | 384,000 | — | — | — |
| Used a knife or gun | 4.2 | (3.5–5.0) | 5,101,000 | — | — | — | 2.3 | (1.8–3.0) | 2,661,000 | — | — | — |
| Stalking | 9.2 | (8.2–10.3) | 11,149,000 | 2.4 | (1.9–3.0) | 2,883,000 | 2.5 | (1.9–3.3) | 2,822,000 | 0.8 | (0.6–1.2) | 940,000 |
| Psychological aggression** | 47.1 | (45.3–48.8) | 56,807,000 | 14.2 | (12.9–15.5) | 17,091,000 | 46.5 | (44.6–48.4) | 52,937,000 | 18.0 | (16.5–19.6) | 20,471,000 |
| Expressive aggression | 39.0 | (37.3–40.8) | 47,118,000 | 9.7 | (8.6–10.8) | 11,677,000 | 31.0 | (29.3–32.8) | 35,330,000 | 9.1 | (8.1–10.2) | 10,314,000 |
| Coercive control | 39.9 | (38.2–41.6) | 48,140,000 | 10.4 | (9.3–11.6) | 12,552,000 | 40.4 | (38.5–42.3) | 45,964,000 | 15.4 | (14.0–17.0) | 17,571,000 |
| Contact sexual violence,§ physical violence, or stalking with intimate partner violence-related impact†† | 27.3 | (25.8–28.9) | 32,996,000 | NA | NA | NA | 11.5 | (10.3–12.8) | 13,080,000 | NA | NA | NA |

Abbreviations: CI = confidence interval; NA = not assessed.

*Percentages are weighted.

†Rounded to the nearest thousand.

‡Estimate not reported; relative standard error > 30% or cell size ≤20.

**Psychological aggression includes expressive aggression (such as name calling, or insulting or humiliating an intimate partner) and coercive control, which includes behaviors that are intended to monitor, control, or threaten an intimate partner.

§Contact sexual violence by an intimate partner includes rape, being made to penetrate a perpetrator, sexual coercion, and unwanted sexual contact perpetrated by an intimate partner.

††Includes experiencing any of the following: being fearful, concerned for safety, any post-traumatic stress disorder symptoms, injury, need for medical care, need for housing services, need for victim advocate services, missed at least 1 day of work or school, and contacting a crisis hotline. For those who reported being raped, it also includes having contracted a sexually transmitted infection or having become pregnant. Intimate partner violence–related impact questions were assessed in relation to specific perpetrators, without regard to the time period in which they occured, and asked in relation to any form of intimate partner violence experienced (sexual violence, physical violence, stalking, expressive aggression, coercive control, and control of reproductive or sexual health) in that relationship. By definition, all stalking incidents result in impact because the definition of stalking requires the experience of fear or concern for safety.

Data indicate that the vast majority of IPV survivors are women in heterosexual relationships. In addition, abuse is also known to occur against men in heterosexual relationships, women and men in same-sex relationships, transgender, gender nonconforming, and other GSM individuals.

## Key Behavioral Dynamics

Although abuse may become evident suddenly, an abusive act is rarely an isolated event. In fact, relationships that ultimately become abusive usually begin very differently — characterized, at least at the outset, by tenderness, romance, promise, and love —not violence. Abusive behaviors tend to develop gradually and progressively over time as the perpetrator enforces more and more control over the abused individual's independence and actions. Once a power-coercive dynamic develops, abuse often increases in frequency and severity over time.

While the overall dynamics of power, control, manipulation and coercion remain remarkably similar across relationships, each individual relationship tends to have its own unique abuse pattern or "fingerprint." Within relationships, abuse can be predominantly physical, sexual, psychological, verbal, spiritual, and/or economic, although patterns tend to evolve over time as circumstances change within individual relationships.

With rare exceptions, abusive behavior is directed exclusively at the intimate partner (and sometimes the partner's children or other dependents), and is deliberately well-hidden from others.

Abuse is generally one-way, although survivors may strike back in self-defense or in other ways, in response to their partner's violence.[9] Even in situations in which violent acts are committed by both parties, the impact of violent behavior is much more deleterious to the victimized party than to the perpetrator, as the survivor's independence, autonomy, health, and safety become progressively compromised over time.

Those who are abused in relationships may not "look" battered. In fact, there may be no physical evidence of abuse at the time of the clinical encounter with the patient. Conversely, those who perpetrate abuse generally do not seem outwardly menacing or mean. In fact, some abusers come across as particularly charming and disarming.

Victimized individuals often assume responsibility and internalize blame for their own abuse upon integrating specific and repeated messages of inadequacy from the abuser. Some survivors believe — or have been told — that they deserve the abuse because of their choice of intimate partner or lifestyle.

Internalization of blame and responsibility may be reinforced by societal, cultural, and media messages that tolerate or even promote negative stereotypes of abused individuals based on gender, race, ethnicity, sexual orientation, gender identity, or social class.

Following a severe incident of physical or sexual violence, the survivor may feel hopeful that caring behavior, apologies, and promises on the part of the perpetrator to "make it up" herald an end to the abuse, and that the situation will improve.

Abuse in a relationship typically results from deliberate and purposeful actions on the part of the perpetrator, rather than from an impulse disorder or anger management problem. When physical violence or threats are occurring in a relationship, anger management and couples counseling strategies are not only ineffective, but also are specifically contraindicated, as these practices can result in an escalation of danger for the survivor. Addressing abuse requires altering the perpetrator's own behavior, rather than focusing on issues related to couples.

Even when disclosure of abuse is prompted by a single, specific incident, an underlying pattern of coercive control often becomes evident over time. Survivors may not become fully cognizant of the overall pattern of the abuse they have suffered until they have attained a safe physical, emotional, and chronological distance from the perpetrator and can "look back" on the entire landscape of the relationship.

Abused lesbian, gay, transgender, gender nonconforming, and other GSM individuals cope — at a minimum — with the same constellation of coercive behaviors faced by heterosexual as well as cisgender survivors, while also grappling with sexual orientation or gender identity-associated bias, harassment, shame, stigma, bullying and at times, outright homophobic and/or trans-related violence in their daily lives. In addition, those who have not come out to their health care providers must also decide whether they want to reveal two potentially sensitive issues simultaneously (abuse as well as sexual orientation or gender identity minority status). These considerations can make abused GSM individuals feel even more vulnerable in the health care setting, which is inherently characterized by unequal power relationships (provider and patient).

Patients often believe that health care providers do not know about or understand what is happening to them, may not take the situation seriously, may not believe them, or might even assign blame to them if abuse is disclosed. Even so, patients generally want to be asked about violence across the lifespan in the context of clinical care, as long as inquiry is done in a confidential, culturally sensitive, nonjudgmental, and trauma-informed manner, and as long as the patient is the one who decides what, how, to whom, and when to disclose.

## Who Is at Greatest Risk?

Any person, anywhere, can be victimized. IPV affects adolescents and adults, women and men, and cuts across all age, racial, ethnic, religious, educational, and socioeconomic strata. However, available research indicates that adverse effects of intimate partner violence appear to be more prevalent in certain groups:[1,10,11]

- Women, particularly those who are single, separated, or divorced
- Adolescents and young adults
- Ethnic minorities
- Non-U.S.-born (immigrant) women
- Gender and sexual minorities (GSM)
- Low-income individuals, particularly those experiencing situational financial distress
- Those whose partners have experienced recent job loss or employment instability
- Those who abuse alcohol or other drugs, or whose partners do

- Women who are pregnant and have been previously abused
- Individuals who have recently sought an order of protection, restraining order, or vacate order
- Those whose partners demonstrate excessively jealous or possessive behavior

## Health Effects

Multiple studies have indicated strong associations between IPV victimization and adverse health outcomes. In addition to physical trauma, survivors may present with a variety of other medical and social health consequences, including perceived poor general health, chronic pain, gynecological problems, gastrointestinal disorders, neurological problems, post-traumatic stress disorder, sleep disorders, anxiety, depression, suicidal ideation, alcoholism other forms of substance abuse, smoking, and unwanted pregnancy.[12,13,14,15] Hathaway et al. also reported that women experiencing IPV have increased rates of health care utilization, indicating that survivors of IPV tend to cluster in health care settings, and thus are likely to be seen frequently by health care providers.[15]

## Obstacles to Leaving: Why Survivors Stay in Abusive Relationships

There are many reasons abused individuals may find it difficult to leave an abusive relationship.

### *Fear*

The abuser may threaten to hurt or even kill his or her partner or take away or hurt the children, other family members, or pets if she or he attempts to leave.

### *Economic and Logistical Constraints*

Abusers often control the financial resources of the household as well as access to telephones, car keys, important documents, medication, and even food, making it exceedingly difficult for survivors to leave if they cannot independently support themselves and their children. Additionally, survivors may not know how to seek shelter or other resources for help and safety, and they may be afraid or embarrassed to ask for assistance.

### *Social Isolation*

Abusers often constrain their partners' ability to communicate freely with friends and family. Prolonged isolation leaves the survivor psychologically dependent on the abuser as the sole source of social and emotional support. Over time, the perpetrator becomes the only person the survivor hears explaining what is happening — and why — within the relationship.

## Feelings of Failure

Many abused individuals are made to feel by the batterer — as well as by others — that they are failures as people, and that they are responsible for having brought on their own abuse. They may view themselves as needing to figure out how to adapt or change in order to halt the abuse or fix what is wrong in the relationship. Reinforced by societal and cultural messages, survivors may also believe that their children deserve a two-parent family, even at the expense of their own safety and well-being.

## Promises of Change

The patient may believe the perpetrator's expressions of remorse about becoming abusive accompanied by subsequent promises that such behavior will never happen again. Some survivors also feel it is somehow their role or responsibility to change or redeem their abusers. While some abused individuals may want the relationship to continue, most are clear about wanting the violence to stop.

## Religion

Religious convictions can act as complex and significant obstacles to leaving. For example, some patients believe that sacrifice in the physical life is to be expected and that the more one suffers in the present life, the greater the reward will be in the next life. Some believe fervently in the commandment to forgive, and in the power and grace when forgiveness is offered for the transgressions of others. Others voice the sentiment that "God would never give me more than I could handle."[16] Others may have made a promise to remain together "'til death do us part" and feel it is sinful to break their vows by ending a marriage. Still others believe that one's present lot in life is the result (be it reward or punishment) for acts committed in a prior life. Finally, while many passages from religious texts espouse peace, love, and mutual respect, other readings can be used to reinforce domination and control.

## Culture

Social, ethnic, and cultural norms and practices can serve as substantial obstacles to leaving an abusive relationship. Some patients may come from cultures where it is virtually unheard of — and even shameful — to leave a marriage, no matter how unsatisfying or dangerous it might be. Leaving an abusive relationship, therefore, would result in even greater social isolation resulting from being ostracized from one's own family, community, and way of life.

## Prior Lack of Intervention

All too often, survivors of abuse are either blamed for the violence or not taken seriously by family, health care professionals, social service providers, and law enforcement authorities, leaving them feeling even more helpless and vulnerable, and discouraging them from seeking further help.

# Patient Barriers to Disclosure

In addition to the personal obstacles survivors face in attempting to leave an abusive relationship, they may also be hesitant to disclose their abuse to anyone — including health care providers.[17,18]

Common barriers to disclosure in the health care setting include:

## *Fear*

Some survivors fear that disclosure to health care providers might result in reports to child protective services, police, employers, or immigration authorities. Others voice concern that in a well-intentioned attempt to help, a health care provider might take matters into his or her own hands and broach the subject with the abusive partner, thus inviting increased danger from an abuser bent on retribution. Still others are apprehensive about disclosure because they fear loss of confidentiality if their medical records are accessed by others, including the perpetrator.

## *Stigma and Shame*

Patients may be reluctant to disclose information about current or past abuse even when specifically asked because of embarrassment, shame, hope that the relationship will improve, or fear of retaliation by the perpetrator. In addition, survivors often feel ashamed about the abuse and want to avoid being stigmatized as someone who is a "victim," weak, or unworthy in the eyes of their health care provider.

## *Assumptions about the Health Care System*

Some survivors may perceive the health care system and its providers as being unwilling or unable to help. Others, unaware of the now well-documented connections between abuse and adverse health effects, don't want to "bother" a health care provider with something they think isn't a strictly medical issue. Patients who are members of racial, ethnic, sexual, or gender minorities, in particular, may perceive traditional health care settings to be out of touch with their own ethnic, religious, or cultural values and thus unable to understand their situation or provide respectful and culturally appropriate assistance. Finally, access to health services other than emergency care is often restricted or completely unavailable for survivors who lack adequate health insurance.

**NOTE:** While not the case in Massachusetts, some states require health care providers to report physical injuries resulting from intimate partner violence. This requirement can potentially act as a further barrier to disclosure. See www.futureswithoutviolence.org/compendium-of-state-statutes-and-policies-on-domestic-violence-and-health-care for state-specific information.

## Language, Culture, and Religion

Those who have difficulty communicating in the provider's spoken language may not be able to disclose because of language barriers, and may fear loss of confidentiality when communicating through a translator. Cultural differences between health care providers and patients may make even well-intentioned efforts by a health professional less relevant to an abused individual's needs. Religious convictions and customs can also influence survivors to remain silent about abuse. In particular, immigrants (discussed below) as well as members of other visible or cultural minorities may feel that disclosing abuse will cast a bad light on their own already oppressed group or community, and may thus choose not to "air dirty laundry" to health care providers or anyone else in the "outside" world.

## Immigration Status

Survivors who are immigrants, both legal and undocumented, may fear being "turned in" by health care personnel. They may fear losing custody of their children or even deportation, which may result in being required to leave their children behind with the abuser, with strangers, or with the child welfare system. They may also fear that disclosure might result in the abuser getting apprehended and eventually deported, especially if the abuser is the sole economic provider for the family. Moreover, some trafficked foreign nationals may be in an arranged or coerced marriage as part of their trafficking exploitation. In some cases, their legal status may be tied directly to the continuation of the marriage, which makes them less likely to disclose harm they may be experiencing.

## Sexual Orientation and Gender Identity

Those who are members of gender and sexual minorities (GSM) may fear being shamed or "outed" if still closeted in regard to their sexual orientation or gender identity. This issue keeps many such individuals out of the health care system entirely, especially if abuse is ongoing and a dismissive, disrespectful, or even hostile response on the part of health care providers is anticipated as a result of disclosure.

## Abuser Threats and Control

Perpetrators employ a range of manipulative and controlling tactics to interfere with a patient's ability to access optimal health care and follow medical instructions. The abuser may accompany the patient to medical appointments, may not allow the patient to be seen alone, or may "take over" the encounter by answering questions directed at the patient. He or she may also go through the patient's belongings (making it unsafe to take home brochures and other educational materials about IPV). The abuser may confiscate or discard both prescription and over-the-counter medications and medical devices as a means of control or "punishment," may not permit medications to be taken as prescribed, or may allow the patient to take medications such as asthma inhalers only as a reward for "good behavior." Abusers also have been known to cancel appointments or prevent the patient from arriving on time, thus making the patient appear to be a "no-show" or noncompliant. All of these perpetrator behaviors can result in the patient feeling unsafe in disclosing abuse in the medical setting.

# Provider Challenges to Providing Effective and Sensitive Care

Some health care providers are reluctant to address intimate partner violence in the context of routine clinical care, citing the factors listed below, elucidated through seminal research by Sugg and others.[19] The timeless work of Sugg and colleagues sheds light on the sensitivity of this issue as a health care topic and the importance of providing state-of-the-art, evidence-based education and training for physicians and other health care professionals.

## *Discomfort with Confronting Issues of Violence and Abuse*

Abuse can be an emotionally difficult topic for health care providers themselves to introduce and address. The health care provider may have personal knowledge of a situation affecting a family member or close friend. Additionally, the clinician may be a survivor — or even a perpetrator — of child, adolescent, or adult physical or sexual abuse. Conversely, a clinician who has no personal experience with violence, abuse, or victimization might find it difficult to relate to or empathize with his or her patients.

## *Feelings of Powerlessness*

Health care providers are trained to be helpers, fixers, and healers. Many clinicians feel powerless to be able to do anything definitive to help the patient, especially if the survivor decides to remain in the relationship or returns after having left. The frustration of not knowing what to say once a disclosure is made and of not seeing prompt or visible "success" (or even improvement) can pose additional challenges, especially for those who have limited experience addressing IPV in the clinical setting.

## *Personal Attitudes and Misconceptions about IPV*

Issues that arise within a family, or between partners or spouses, may be viewed as "private or family matters" that fall outside the purview of medical practice. However, addressing IPV is now considered to be part of standard clinical practice and should be treated in a manner similar to other socially relevant issues that are addressed in the course of everyday care.

## *Office Security and Personal Safety*

Some providers may be reluctant to intervene out of concern for their own personal security and for the safety of their staff. Although reports of health care workers being threatened or injured by partners of abused patients are extremely rare, potential risks to office staff must be considered practically and realistically in any potentially volatile situation. Office staff should be trained on how to recognize and respond to IPV issues, including those related to patient privacy and confidentiality, and how to operate as a member of a larger health care team. Security procedures should be outlined and practiced in the office setting to prepare for potential, albeit rare, emergencies related to IPV.

## Lack of Education or Expertise

Many younger health care providers have received at least rudimentary training about IPV during professional school. Paradoxically, though, this is a completely new topic for many seasoned clinicians. The multifaceted nature of this pervasive problem does not allow it to fit neatly within any one discipline, although sporadic educational offerings can be found at women's health, mental health, and behavioral health conferences and in related journals. This guidebook is designed to help fill some of the educational gaps for clinically practicing health professionals.

## Professional Isolation

Over time, far too many health care providers, particularly physicians, have been trained to work almost entirely in isolation, calling upon other members of the office, hospital, or community-based health care "team" to tackle discrete, defined tasks, rather than engaging proactively and collaboratively to achieve a positive outcome. Working in isolation is typically far less satisfying on a personal and professional level than working as a member of a productive cooperative or collaborative team, and can also increase the risk of burnout.

Health care providers who are working in isolated or otherwise less than satisfying settings may be less likely to engage in routine inquiry about violence and abuse, and also may be less likely to know what to do when abuse is disclosed. Seeking out ways to prevent or address professional isolation before it occurs can potentially reduce burnout and also make inquiry about abuse more effective and professionally rewarding.

## Time Constraints

Every health care provider is busy, with ever-increasing demands on clinicians' limited time. Time management is addressed later in this guidebook.

**NOTE:** The challenges outlined above can be addressed by practicing according to the principles of routine, empathic, and trauma-sensitive care outlined later in this guidebook. Effective patient care can be easier to accomplish when working as a member of a multidisciplinary or interprofessional health care team.

# Special Populations

## *Intimate Partner Violence and Reproductive Health*

Intimate partner violence is associated with a range of specific reproductive health risks such as restricted access to contraception, unintended and even coerced pregnancy; rapid repeat pregnancy; late or sporadic access to prenatal care; spontaneous abortion; elective (and sometimes coerced) abortion; intrauterine growth retardation; antepartum hemorrhage; premature labor; low birth weight infants; increased risk of injury, particularly to the breasts, abdomen, and genital area; unexplained pain; substance abuse; poor nutrition; and perinatal maternal death.[20] Indeed, IPV against pregnant women appears to be more prevalent than preeclampsia, gestational diabetes, and placenta previa, conditions routinely screened for in prenatal care. Finally, homicide has been shown to be the most common cause of pregnancy-associated maternal death.[21]

The short- and long-term sequelae of abuse to the pregnant woman and her developing child can be far-ranging. Prenatal visits provide access to and continuity of care for reproductive age and pregnant women, and thus represent an excellent opportunity to conduct routine inquiry geared both to early detection and primary prevention of IPV. Patients should be routinely screened for new or ongoing IPV during each and every prenatal visit.

## *Adolescent Relationship (Teen Dating) Violence*

Adolescents can be subject to an array of abusive behaviors, ranging from verbal and emotional abuse to physical abuse, rape, reproductive coercion, and even homicide. Some teens are battered by people with whom they are in a dating relationship, while others are adolescent victims of parental abuse. Teens in dating relationships often confuse jealousy with love. In addition, teens typically lack experience and perspective regarding behaviors that signify a healthy dating relationship. Striving for independence, abused adolescents may be especially reluctant to seek help from authority figures, including health care providers.[22]

Clinicians should reassure teens about the supportive nature of the health professional–patient relationship, and about confidentiality — and its limits — within the health care setting. Physicians and other health care providers should screen adolescents for abuse as outlined on pages 35 to 38, remembering that the abuser may be a parent, other family member, boyfriend, or girlfriend. The teen's knowledge of, and behavior around, violence, coercion, alcohol, drugs, and sexual activity should be assessed. An abused teen especially needs to be told that the battering is not his or her fault and that help is available.

Bullying is a related issue that has gained prominence in recent years. This topic, while of critical importance to adolescent health, is beyond the scope of this guidebook.

## *Violence in Gay, Lesbian, Bisexual, Transgender, and other Gender and Sexual Minority (GSM) Relationships*

The prevalence of IPV in GSM relationships appears to be equal to or greater than that reported in heterosexual relationships.[23] Many lesbian, gay, bisexual, transgender, gender nonconforming, and other GSM individuals do not feel comfortable disclosing their sexual orientation or gender identity to their health care provider and are thus likely to be even more reluctant to disclose abuse. Furthermore, GSM patients who do disclose their sexual orientation or gender identity to medical professionals are rarely asked about intimate partner violence.[24] Barriers to inquiry include gender-related myths — for example, men cannot be victims of abuse, women are never batterers, and same-sex relationships are inherently "equal" because parties are of the same sex.

GSM survivors of intimate partner violence encounter a spectrum of abusive behaviors similar to that of their heterosexual counterparts. Additional obstacles specific to GSM survivors further reduce their opportunities to disclose and discuss abuse. These obstacles include homo- and transphobia and resulting discrimination, including within the health care sector on both individual and institutional levels; potential social consequences of revealing one's sexual orientation or gender identity, such as loss of children and other family relationships, job insecurity, and loss of community standing; fear of police inaction; and further discrimination. There also is a dearth of shelter space and support services for battered gay men, transgender, and gender nonconforming individuals. Lesbian and bisexual women have the option of going to more traditional domestic violence programs that accept women, but staff at many of these programs may not be trained and/or sensitive to working with members of the GSM community who may be abused.

Transgender and gender nonconforming individuals face substantial barriers to accessing help because providers — and the public in general — often understand even less about gender identity and expression than they do about sexual orientation. Health care providers should therefore approach screening, diagnosis, and treatment with special sensitivity to the difficult issues battered GSM patients face.

## *Violence in Diverse Cultures, Immigrant Populations, and Visible Minorities*

IPV is prevalent in every culture and segment of society. Immigrants and other members of visible and non-visible minority cultures are likely to face extra hurdles as they attempt to access available services to achieve safety for themselves, their children, and other dependents. Some survivors may adhere to belief systems and traditions that make it harder for them to perceive their own danger, understand their right to live in safety, know their legal rights and options, or even feel that they can speak to anyone about their situation. Those whose native language is not English may find it especially difficult to communicate in an emotionally nuanced manner with health care providers, advocates, and law enforcement representatives. Regardless of their legal status, many battered immigrants are fearful of becoming homeless, losing their children, or being deported, should their abuse become known. Such individuals may not perceive the health care system to be one they can trust to help direct them toward safety and may therefore suffer in silence.[25]

Health care professionals who are sensitive to the barriers and challenges that immigrants and members of diverse cultures face will be in a better position to establish trusting and confidential relationships with their patients — a crucial step toward both improved medical care and empowerment for those who are in danger.

## Substance Abuse and Intimate Partner Violence

Substance abuse, including excessive alcohol use, is frequently seen in association with many forms of violence and adverse experiences across the lifespan.[26,27,28,29,30,31] This co-occurrence, however, is far more complex than previously thought, with no direct causal relationship. Recent studies indicate that increased rates of substance abuse are seen in survivors of childhood physical and sexual abuse as well as current or past IPV. In most cases, dependence on alcohol or other drugs is construed as a maladaptive yet understandable and even predictable means of coping with current or past trauma. Additionally, some batterers have been reported to encourage or even coerce substance use on the part of their partners as a means to maintain or enforce control, or may sabotage their partner's efforts to achieve and maintain sobriety. Finally, ongoing substance abuse may prolong a survivor's victimization by impairing her/his ability to take proactive steps to achieve safety and independence. Although some studies posit a modest association between alcohol consumption and perpetration of violence within intimate relationships,[30] a detailed discussion of substance abuse and addiction in regard to perpetrators is beyond the scope of this guidebook.

The success of safety planning can be compromised by ongoing drug use, and the success of addiction recovery can be impeded by continued violence. For these reasons, intervention goals for chemically dependent, battered patients should be individualized for each patient, focusing dually on sobriety and safety. For some, substance abuse treatment may be a necessary first step. For others, achieving safety may be key before participating in an addiction recovery program, as achieving sobriety may threaten the batterer's sense of control and place the survivor at risk for escalating violence.

Clinicians should assess for IPV where there is evidence of substance abuse and screen for substance abuse where there is evidence of IPV. In addition, physicians and other prescribing health professionals should weigh carefully the risks and benefits of prescribing controlled substances for symptom relief in patients with chemical dependence.

## Sexual Assault and Intimate Partner Violence

Rape and other forms of sexual assault are highly prevalent in society and are problems of significant medical, public health, and criminal justice importance. Sexual assault is often a component of abusive relationships, although underreporting due to embarrassment, self-blame, and fear make accurate prevalence figures difficult to obtain.

The most recent national surveillance data are from the National Intimate Partner and Sexual Violence Survey (NISVS), accrued in the 2011 calendar year, and summarized in Table 2.[2]

**Table 2. NISVS 2011 Rape and Sexual Violence Data Summary**

| Sexual violence | All Women | All Men | IPV-related (Women) | IPV-related (Men) |
|---|---|---|---|---|
| Rape (lifetime) | 19.3% | 1.7% | 8.8% | 0.5% |
| Rape (12 months) | 1.6% | Too small to calculate | 0.8% | Too small to calculate |
| Other Sexual Violence (lifetime) | 43.9% | 23.4% | 15.8% | 9.5% |
| Other Sexual Violence (12 months) | 5.5% | 5.1% | 2.1% | 2.1% |

These data reveal that the lifetime prevalence of rape is 19.3% for women and 1.7% for men (one-year incidence of 1.6% for women, and insufficient number to calculate for men). The 2011 NISVS data further revealed that 43.9% of women and 23.4% of men experienced other types of sexual assault or violence over the course of their lifetimes (with an annual incidence of 5.5% and 5.1% for women and men, respectively).

Rape reported by women at the hands of a current or former intimate partner was estimated at 8.8% lifetime prevalence and 0.8% annual incidence. In contrast, 0.5% of men reported a lifetime history of rape by an intimate partner, with a number too small to calculate for annual incidence.

Sexual violence does not take place accidentally or impulsively; it is — almost without exception — intentional and often well-planned on the part of offenders, who generally have ample opportunity to choose not to assault. Sexual violence— including that which takes place within current or former intimate relationships — is not about the act of sex *per se*; it is, rather, using sexual acts as a means to assert power, control, and dominance.

Sexual violence can have profound short and long-term effects on physical, psychological, sexual and reproductive health, and overall well-being.[32] Short-term physical effects include direct trauma from acts of sexual violence, such as vaginal or anal bleeding, bruises, scratches, and strangulation injuries. Psychological effects, such as profound feelings of isolation and dissociation, are also seen frequently in the immediate aftermath of a sexual assault. Longer-term effects can include chronic, recurring abdominal pain; headaches; changes in daily routine, eating and sleeping patterns; binging and purging; and anxiety, depression, post-traumatic stress disorder, and suicidal ideation or attempts. Survivors may struggle with additional health consequences related to sexual assault, such as unwanted pregnancy and sexually-transmitted infections, including HIV/AIDS.

In the aftermath of an assault, patient responses can vary from intense distress to calm composure. Some survivors may not trust hospital personnel and may decide to decline forensic evidence collection, which can take several hours to complete and can seem like yet another violation of bodily integrity.

## Responding to Sexual Assault

The health care provider should practice at all times in a trauma-informed manner (pages 43–45) to facilitate validation, support, and appropriate referrals for legal services and supportive counseling.

Specifically, clinicians should practice with unambiguous honesty and sensitivity when working with patients who have been sexually violated, and ensure that confidentiality and privacy are maintained to the fullest extent of applicable law. In particular, a trauma-informed approach emphasizing both sensitivity and patience is critical when the patient agrees to the collection of forensic historical and physical evidence (see "Documentation in the Medical Record," page 41).

The clinician should refrain from asking questions that might sound blaming or judgmental, such as "Why were you wearing that?" or "Why didn't you report this to the police?" Instead, ask nonjudgmentally about what happened, by saying, "Please try and tell me what happened to you." The health professional can encourage contact with a local rape crisis center and appropriate therapeutic and community-based services, even if an assault took place months or years ago. Approaches that are empathic and trauma-sensitive are integral to the recovery and reintegration process for survivors of sexual assault.

## Child Exposure to Intimate Partner Violence

An estimated 8.2 million children are exposed to violence within the home every year.[33] Exposure to violence — including hearing it take place in another room — can be as damaging to children as being abused directly.

Children as young as infants can be affected by family violence, particularly in situations of toxic stress, which adversely affects the developing brains of a young children exposed or subjected to prolonged, severe, and repeated adversity (e.g., physical or sexual abuse, severe neglect, severe duress from extreme poverty, and exposure to violence and trauma in the absence of consistent adult support).[34,35] Witnessing violence affects a child's ability to focus and learn in school, to form healthy peer relationships, and to develop normally. Many of these children have a distorted view of the world — one that is not hopeful, welcoming, or safe. They have a foreshortened, constricted view of their lives, in which they cannot picture themselves as adults, or see a hopeful future for themselves.

Adolescents who grow up in homes where their parents are violent are more likely to be involved with substance abuse and dating violence. Young people who witness family violence are also at greater risk of being physically harmed themselves, especially if they attempt to defend or protect the victim, usually the mother, during an assault.[36,37]

Children, not unlike adults, may find it difficult to talk to anyone about the violence in their lives, and thus risk becoming "silent victims."[38] Interventions that help families achieve a stable and safe home environment can play an important role in protecting all involved.

Pediatric care providers should attend to children's needs for safety and security when assessing the extent and effects of their exposure to violence within the family. Appropriate assessment and intervention can help children learn that violence perpetrated by anyone, including a family member or loved one, is wrong and unacceptable, and that trusted adults are there to help. Efforts such as these can serve as a crucial link to help children cope with and recover from the devastating effects of witnessing intimate partner violence.

## The Link between Child Abuse and Intimate Partner Violence

Child abuse and intimate partner violence are closely linked.[39,40] Although most abused and neglected children do not become victims or perpetrators as adults, research has shown that the vast majority of men in batterer intervention programs report having witnessed the abuse of their mothers or having been physically abused themselves as children.[41] Girls who have been abused or neglected, or who have witnessed the abuse of their mothers, may be more likely to be victimized in their own adolescent or adult relationships. Abused and neglected children are also at greater risk for exhibiting delinquent, violent, and criminal behavior, as well as long-term health problems.[42,43]

Disclosure of IPV may herald a particularly dangerous period for both the abused individual and any dependent children. Therefore, once disclosure is made, particular attention must be paid to the safety and well-being of the children, as well as others, living in a home in which violence is occurring. If a health care professional suspects that there might be physical, sexual, or emotional abuse or neglect of children, he or she, as a mandated reporter, is required by law to contact the child abuse hotline of the state in which the suspected abuse is occurring (see the "Hotline, Shelter, and Referral Resources" section for detailed resource information). If a report to a Child Protective Services (CPS) agency (this agency is called the

Department of Children and Families, or DCF in Massachusetts) needs to be filed, the health care provider should inform the caseworker of his or her suspicion that the mother (or other caregiver) is also being abused. CPS can then consult with specialists in IPV to take action geared toward promoting the safety of both the adult survivor (usually the mother) and the children. In addition, the health care provider should communicate the decision to contact CPS and the reasons for doing so to the survivor. Such a conversation, although at times difficult to initiate, can help establish trust and promote safety for both the survivor and children.

Addressing family violence requires an understanding of the complex interconnections among child abuse and neglect, child exposure to violence, intimate partner violence, and the transmission of violent behavior from one generation to the next. Physicians and other health care providers are therefore in a unique position to protect children from child abuse and from subsequent dysfunction later in life by addressing violence across the lifespan.

## Human Trafficking Presenting as IPV or Sexual Assault

Some patients who disclose IPV may actually meet criteria for human trafficking, even if they don't self-identify as trafficking victims. Traffickers who prey on adolescents, in particular, groom their victims by portraying themselves as their "boyfriends," "daddies," or other romantic partners. In such cases, seduction, gifts, and actions construed as emotional support are used as key tactics of entrapment and manipulation. Once a romantic link is established, the trafficker persuades and then typically coerces the victim to engage in commercial sex acts.

Detailed information about human trafficking can be accessed through MMS's 2014 guidebook, *Human Trafficking: Guidebook on Identification, Assessment, and Response in the Health Care Setting*.

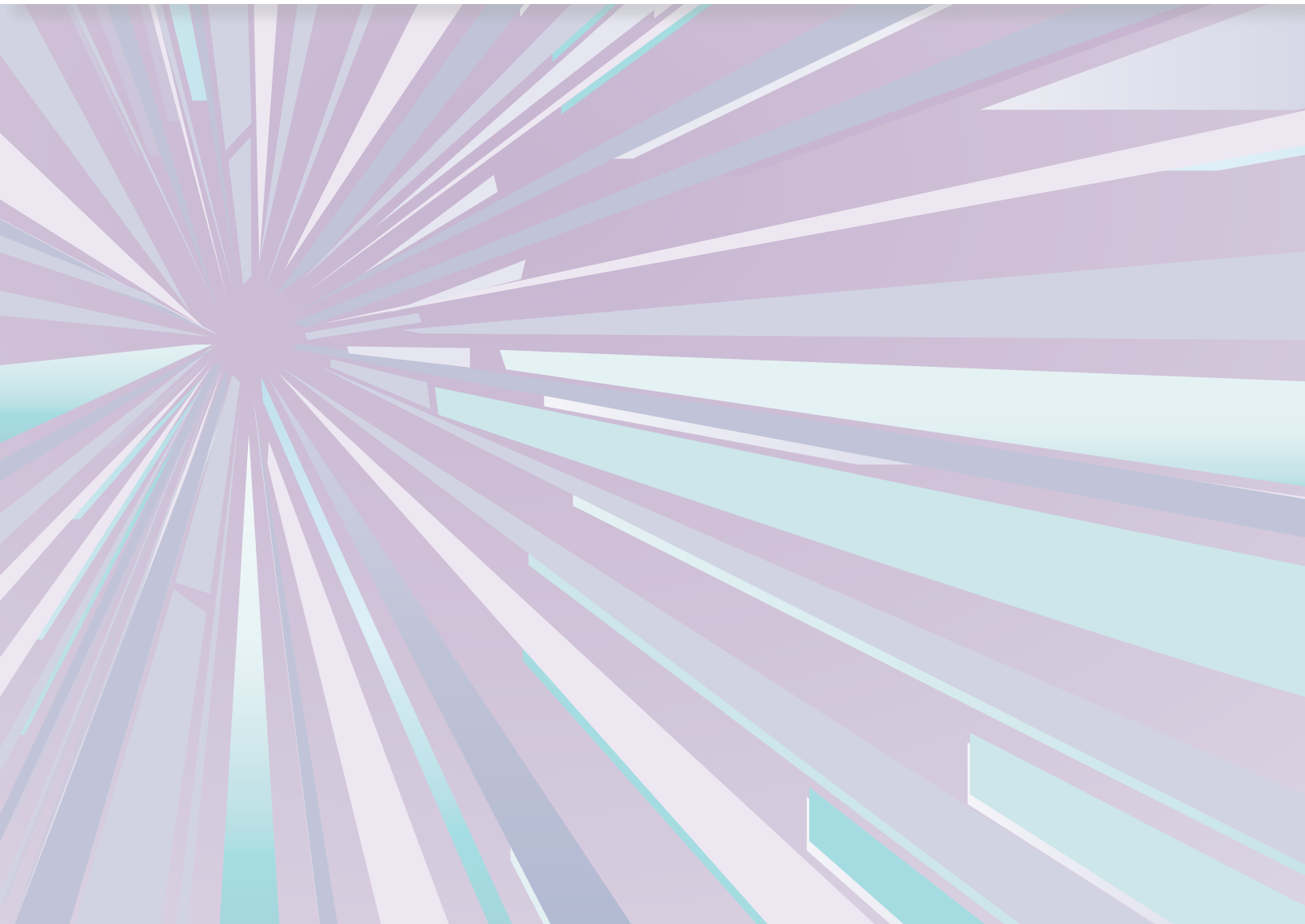
## Elder Abuse

Elder abuse encompasses physical, sexual, financial, and emotional mistreatment or neglect of elders by those in intimate, family, caregiver or other relationships of trust; neglect by others; and self-neglect.[44,45,46] Health care providers can act as pivotal partners in the detection, management, and prevention of elder abuse.

Understanding the dynamics of elder abuse is critical to breaking the intergenerational cycle of abuse. Some abused elders are mistreated in the context of dependency or infirmity. Others come to the attention of clinicians or other providers having been abused for years or even decades. Some elderly individuals exhibit signs and symptoms of current or past IPV. Patients no longer in acute danger can still suffer long-term morbidity from chronic sequelae of past abuse. For elders living independently, fear of being placed in a nursing home and losing autonomy may limit disclosure of abuse.

Physicians and other health care providers who care for elders often enjoy long-term and trusting relationships with their patients. Whenever feasible, clinicians should work as members of multidisciplinary care teams. Health professionals as well as extended care (home care) providers are in a position to observe behaviors and conditions related to abuse and neglect, which can facilitate early intervention for at-risk patients. All health care professionals should remain mindful of their mandated reporter responsibilities as they evaluate elderly at-risk patients (see page 48).

# The Adult Health Effects of Traumatic Exposures and Other Adverse Events During Childhood



A wealth of emerging evidence has made it abundantly clear that adverse events and exposures that occur during childhood can have profound, lifelong effects no only on child development, but also on adult physical and behavioral health. The groundbreaking Adverse Childhood Experiences (ACE) Study was one of the first research studies that elucidated the links between adverse childhood experiences and adult health.

## Background

The ACE Study is one of the largest investigations ever conducted to examine the links between adverse childhood exposures and later-life health and well-being. The initial ACE Study, funded in large part by the U.S. Centers for Disease Control and Prevention and conducted in the Kaiser Permanente Health Care System (San Diego Health Appraisal Clinic) from 1995 to 1997, involved collection and analysis of data from over 17,000 outpatients.[47,48] Subsequent retrospective and now prospective data collection and analysis have resulted in a veritable treasure trove of data and insights that elucidate the range and depth of adult physical health, mental health, and social welfare effects of adverse or traumatic experiences that took place during childhood. Now in its 15th year, the prospective phase of the ACE Study is ongoing and currently in the midst of additional data collection.

## Methods

As detailed on the CDC website (www.cdc.gov/nccdphp/ace), "Each ACE Study participant completed a confidential survey that contained questions about childhood maltreatment and family dysfunction, as well as items detailing their current health status and behaviors." Ten (10) categories of adverse childhood experiences were assessed: 3 types of personal abuse (major physical abuse, significant emotional abuse, and contact sexual abuse), 2 types of neglect (physical and emotional), and 5 types of major household dysfunction (growing up in a home in which there was: physical violence against a mother or other caretaker; substance abuse by a family member; a family member in prison; absence of one or both biological or adopted parents; and depression, mental illness or suicide completion or attempts in a family member). Positive answers to these questions were then correlated to measures of adult risk behavior, health status, and disease.

## Findings

More than half of the respondents reported at least one adverse experience during childhood. A graded, or proportional, relationship was found between the number of adverse childhood experiences (the "ACE score"), the frequency of identifiable health risk factors for leading causes of death, and subsequent adult health and social welfare problems. To date, hundreds of peer-reviewed articles have been published about the ACE Study and its implications for physical health, mental health, and social welfare in adults.

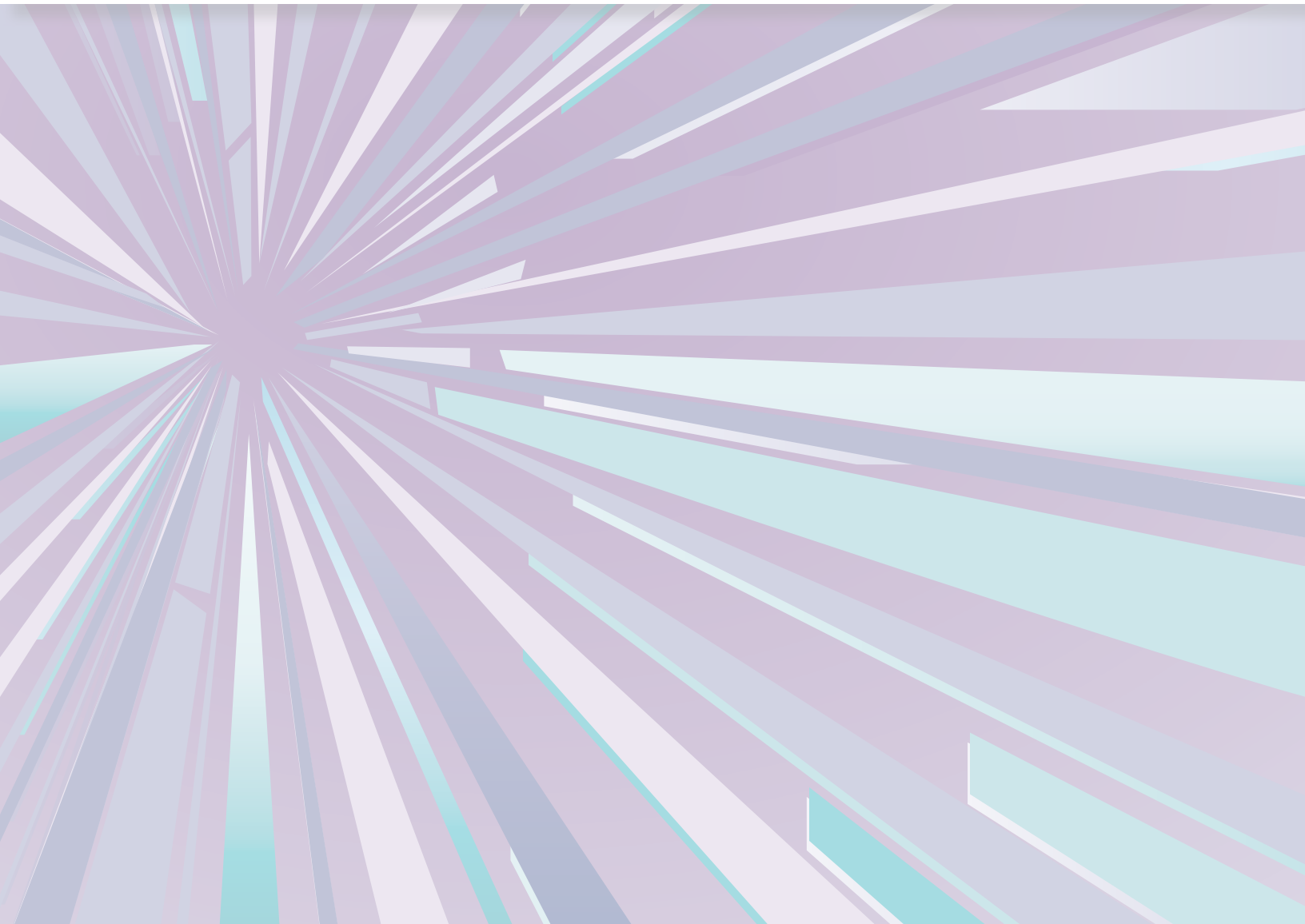
A 14-minute video summary of the ACE Study, focusing on its development, methodology, and major findings is now available courtesy of the Academy on Violence and Abuse (www.avahealth.org) and can be viewed directly through this link: www.avahealth.org/ace_study/ace_study_dvd_institutional_license/ace_study_summary_14.html.

## Implications

The ACE Study has ushered in a new era of inquiry and understanding regarding the pervasive adverse consequences of traumatic childhood experiences on adult health and social welfare, and of the health effects of violence across the lifespan. The wealth of emerging evidence speaks to the importance of addressing trauma during childhood as a critically important underlying contributor to multiple adult health problems. Even more important, however, is that the ACE Study represents a clarion call for improving adult health by focusing on (1) primary prevention of child physical and sexual abuse, (2) preventing intimate partner violence, (3) preventing or addressing substance abuse, and (4) preventing toxic stress and therefore promoting normal brain development in children.

Health care providers who seek to understand their patients' current and past experiences of victimization, as well as their sources of resiliency and support, can better address current health problems that arise from past abuse, and to foresee — and therefore potentially prevent — the occurrence of future health problems. As noted by Chamberlain, since many of the consequences of exposure to violence are not immediate and can occur decades after the trauma, there are multiple opportunities for prevention of adverse health outcomes over a patient's lifespan once a history of abuse is elicited[49] (see www.vawnet.org/applied-research-papers/print-document.php?doc_id=301).

# Assessment for Abuse from a Lifespan Perspective



The evidence base supporting the utility of routine assessment for IPV within the health setting is evolving rapidly.[50,51,52] This emerging scholarship also documents a lack of harm when inquiry is undertaken in an empathic, compassionate, respectful, and trauma-informed manner.[52] In addition, an increasing number of leading medical organizations and family violence experts recommend that physicians and other health care professionals not only inquire about IPV in the course of routine care of all adolescent and adult patients, but also reconceptualize inquiry *away* from mere screening and *toward* encompassing a broader assessment within health care of potential victimization across the lifespan.* This new focus on lifespan assessment incorporates attention to the following factors:

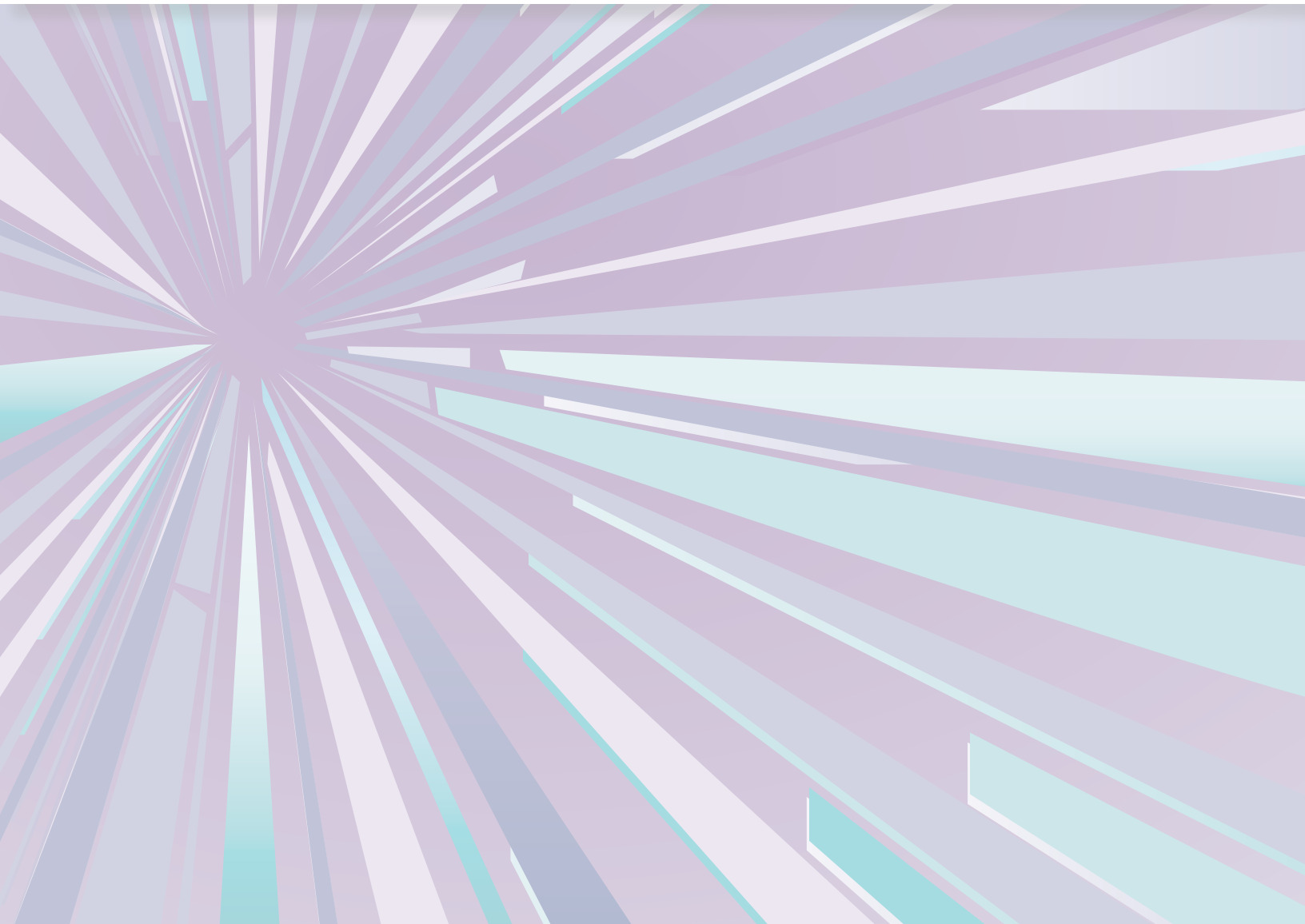
- The neurobiology of toxic stress during both brain development and throughout adulthood
- Genetic and environmental risk and resilience factors
- Effectiveness of intervention and prevention strategies
- The appropriate role of physicians and other health care professionals in collaborative care
- Updated (2013) recommendations from the U.S. Preventive Services Task Force
- Joint Commission on Accreditation of Hospitals Organization standards and accreditation requirements
- Provisions of the Patient Protection and Affordable Care Act (see separate discussion pages 27–28)

The arguments supporting routine inquiry in the health care setting about violence across the lifespan have become abundantly clear over the last decade. In its 2004 National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings, Futures Without Violence (formerly the Family Violence Prevention Fund) summarized research on the benefits of routine assessment. This report stated that, "Universal and regular, face-to-face screening of women by skilled health care providers markedly increases the identification of victims of IPV, as well as those who are at risk for verbal, physical, and sexual abuse."[53] A separate consensus statement, Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health, describes routine inquiry about IPV as "a primary starting point to improve the medical practice approach to intimate partner violence… with a focus on early identification of all families and victims of intimate partner violence whether or not symptoms are immediately apparent."[54]

Given the prevalence of IPV,[1] evidence that survivors of IPV are seen frequently by health care providers, and research findings that abuse occurring at any age can lead to health problems that can extend decades into the future, nearly every health care provider can expect to see patients who are either grappling with an abusive relationship or suffering from its intermediate or long-term health effects.

*Organizations and entities that recommend routine inquiry for intimate partner violence include the American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Congress of Obstetricians and Gynecologists, Futures Without Violence, the Institute of Medicine, and the National Coalition Against Domestic Violence.

# Affordable Care Act Provisions Concerning Intimate Partner Violence



The Patient Protection and Affordable Care Act, commonly referred to as the "Affordable Care Act" (ACA) or "Obamacare," enacted by Congress and signed into law by President Barack Obama in March 2010, includes a number of provisions related to women's health that expand access to preventive care, including specific provisions related to "interpersonal and domestic violence screening and counseling" (see www.acf.hhs.gov/sites/default/files/fysb/aca_fvpsa_20131211.pdf).

Specifically, beginning in August 2012, the ACA has required most health care plans to cover, without copayment or other cost sharing, eight recommended preventive services for women of childbearing age, including screening and counseling for interpersonal and domestic violence (see inset below).

### WOMEN'S PREVENTIVE SERVICES COVERED WITHOUT COST-SHARING UNDER THE AFFORDABLE CARE ACT

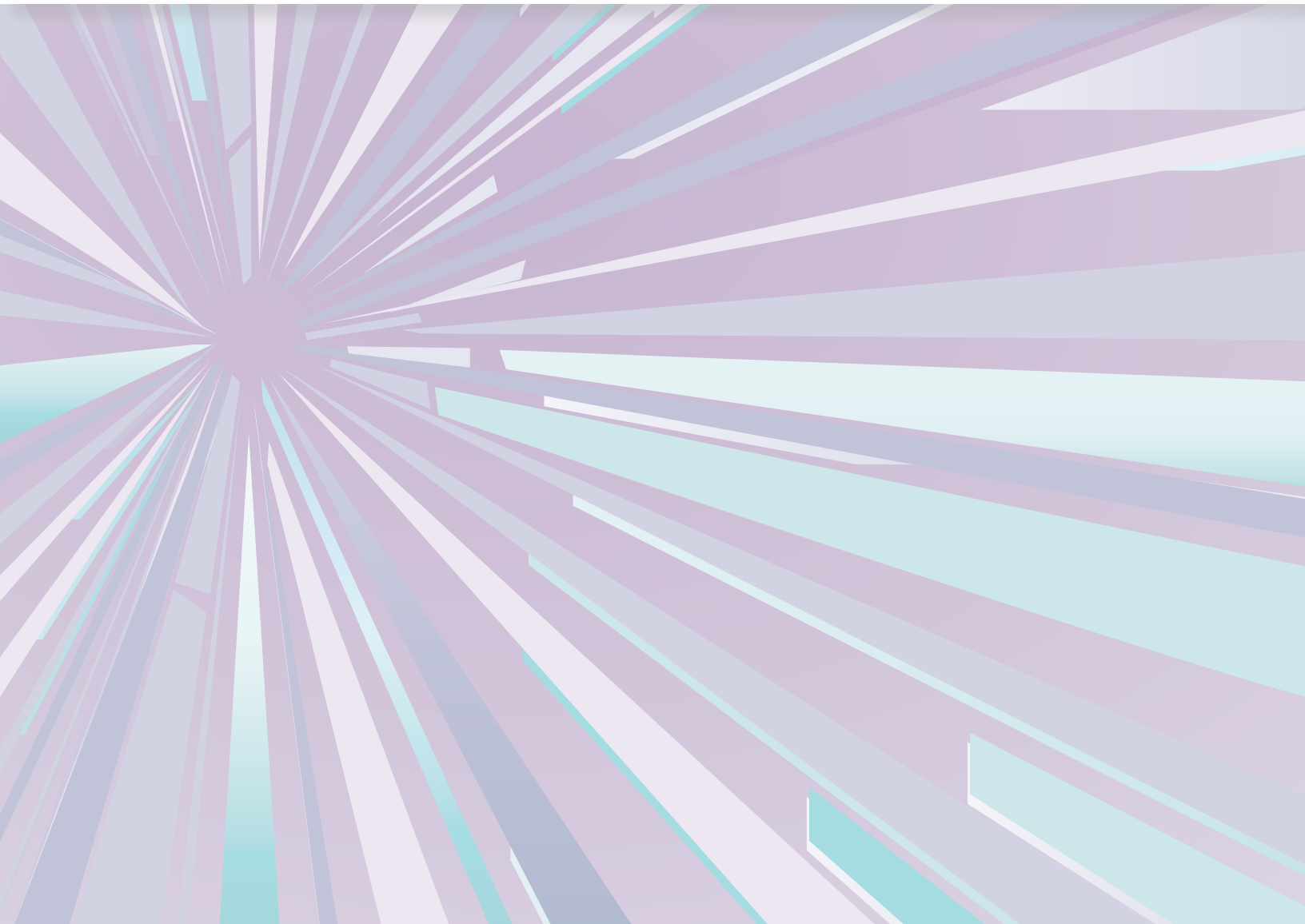
1. Well woman visits (annual preventive care visit)
2. Gestational diabetes screening
3. HPV DNA testing
4. STI counseling
5. HIV screening and counseling
6. Contraception and contraceptive counseling
7. Lactation support, supplies, and counseling
8. Interpersonal and domestic violence screening and counseling

It should be noted that the ACA provisions regarding interpersonal and domestic violence are a coverage requirement, and not a screening requirement. These provisions represent a guarantee of payment for services rendered, with an underlying implied expectation that sexual and domestic violence screening and counseling should be considered standard practice. The term "screening" is broadly defined and thus is left largely to the discretion of individual providers and health plans. The term "counseling" refers to the provision of basic information and referrals to community-based agencies or other appropriate resources.

Under the ACA, screening and counseling for IPV can be provided at least once a year (but may be offered more frequently for individual patients), and can take place in any health care setting.

*Additional information about the IPV provisions of the ACA can be found at www.healthcaresaboutipv.org/wp-content/blogs.dir/3/files/2013/11/FAQs-Implementation-of-IPV-Screening-and-Counseling-Guidelines.pdf.

# Time Management



Physicians and other health care providers may be reluctant to engage in inquiry and identification because they feel they have insufficient opportunity to screen and respond given the multiple responsibilities and time constraints they face in daily practice. Judicious time management, however, can permit both universal inquiry and targeted follow-up.

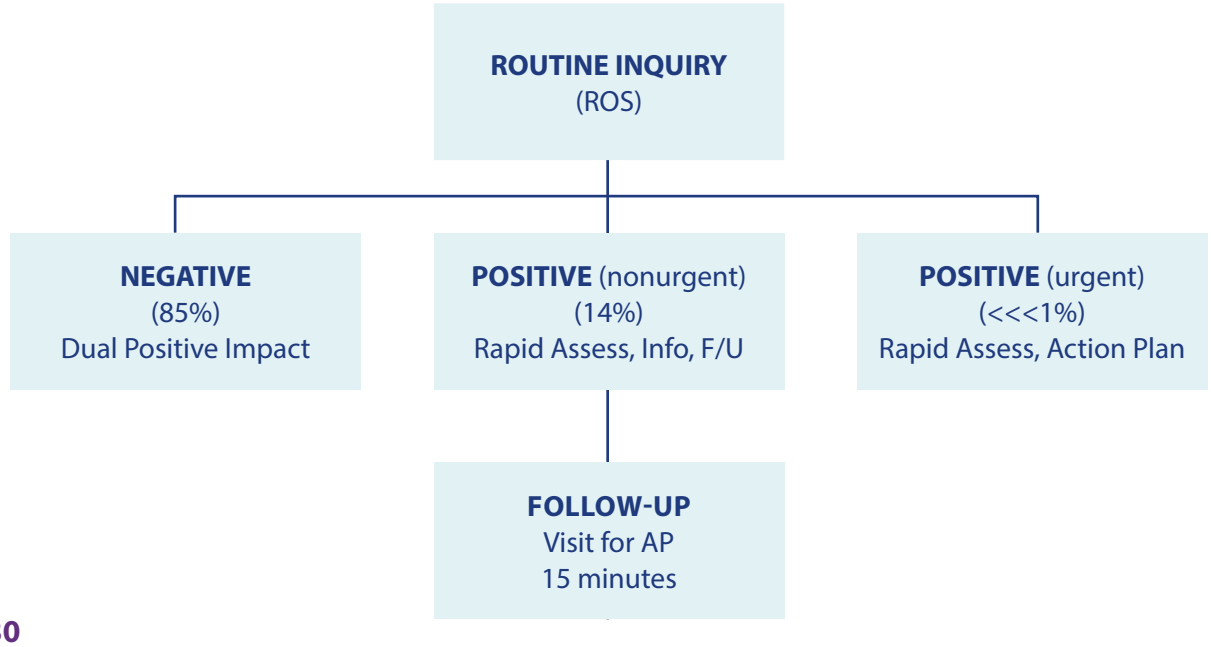
As can be seen in the diagram (Figure 1A), most health care providers inquire routinely about common medical conditions such as angina pectoris. The provider generally asks, "Have you experienced pain, pressure, or discomfort upon exertion?" The likelihood of a positive response will, of course, vary depending on the patient mix and field of practice. Most patients, however, will answer "no" to this question. The question and its accompanying response normally take no more than 10 seconds of a clinician's time, yet two important tasks are accomplished, yielding a "dual positive impact" as illustrated in the figures below: (1) the health care provider is reassured that angina pectoris is not occurring, or at least is rather unlikely; and (2) the patient becomes aware that should such symptoms arise, the provider is concerned, knowledgeable, and able to respond.

Should the patient respond "yes" to a general inquiry about angina pectoris, however, the physician or other health care provider will engage in a series of questions designed to determine if the condition is of new onset or unstable. Assuming this is not the case, the clinician will likely place the patient on an aspirin and/or nitrate regimen, order an ECG and perhaps a stress test, and arrange to see the patient in follow-up. Such an encounter should take no more than two to three minutes.

On rare occasion, a patient will present for evaluation of unstable cardiac symptoms, or an emergent condition will be uncovered during the course of a more routine evaluation. In such a situation, emergency procedures will need to be instituted, which can take a moderate to substantial amount of time. Using the above logic, the average health care provider can both inquire routinely about angina and manage his or her time wisely, using a targeted follow-up appointment to address less-than-emergent problems in greater detail.

### Figure 1A. Time Management in Office Practice

Routine inquiry about common medical conditions, such as angina pectoris (AP)



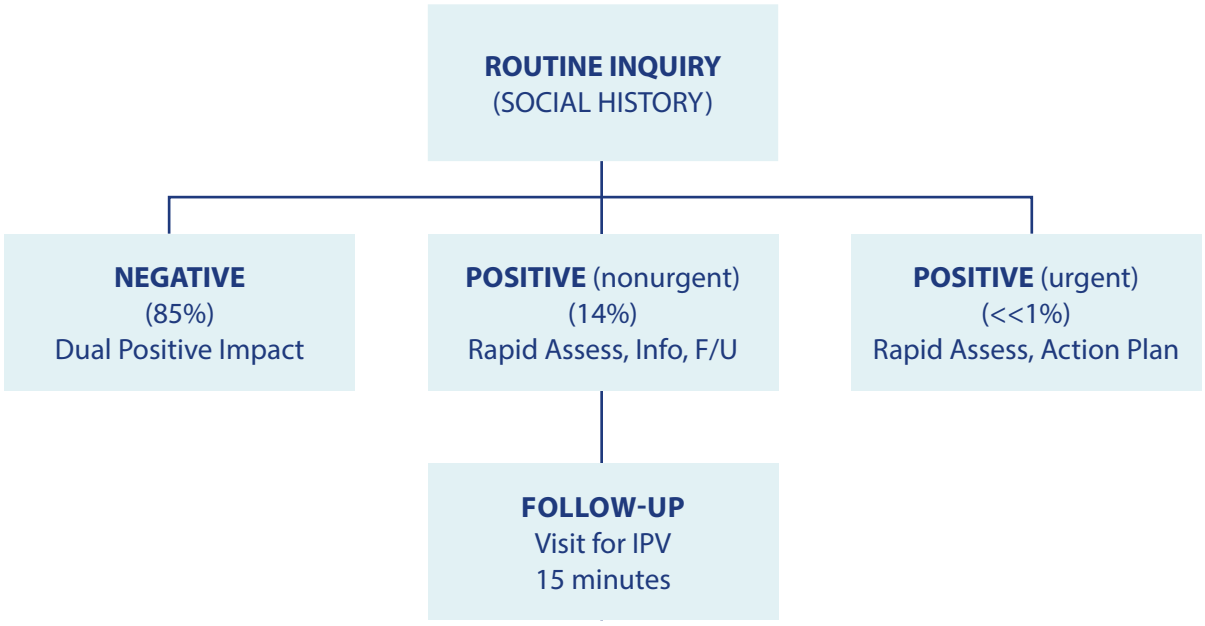
Similar logic can be employed in assessing for intimate partner violence (Figure 1B). Asking about IPV (usually as part of the social history) should take no more than 10 seconds and will produce similar beneficial effects: the clinician is reassured that the patient is not at risk for family violence (or that the patient, if affected, is not ready or able to disclose at that time), and the patient is made aware that the medical office is a safe place, and that the health care provider is concerned, knowledgeable, and able to respond should IPV become an issue at any time in the future.

Typically, relatively few patients have a current history of IPV. Most of those who do, despite dealing with a difficult situation, are not in acute danger at the time of the health care visit. Should the patient disclose victimization, the provider should conduct a brief danger assessment, offer information including how to access relevant websites, hotlines, and local advocacy services. Convey concern and support for the patient, and arrange to see the patient in follow-up to discuss the abuse and resource and referral options in greater detail. Similar to the case of stable angina pectoris on the previous page, such an encounter should encompass approximately two to three minutes.

Only rarely will the health professional be confronted with a patient in extreme danger or with emergent needs. In this situation, as in the case of new onset or unstable angina, a true medical emergency exists and urgent action will need to be taken.

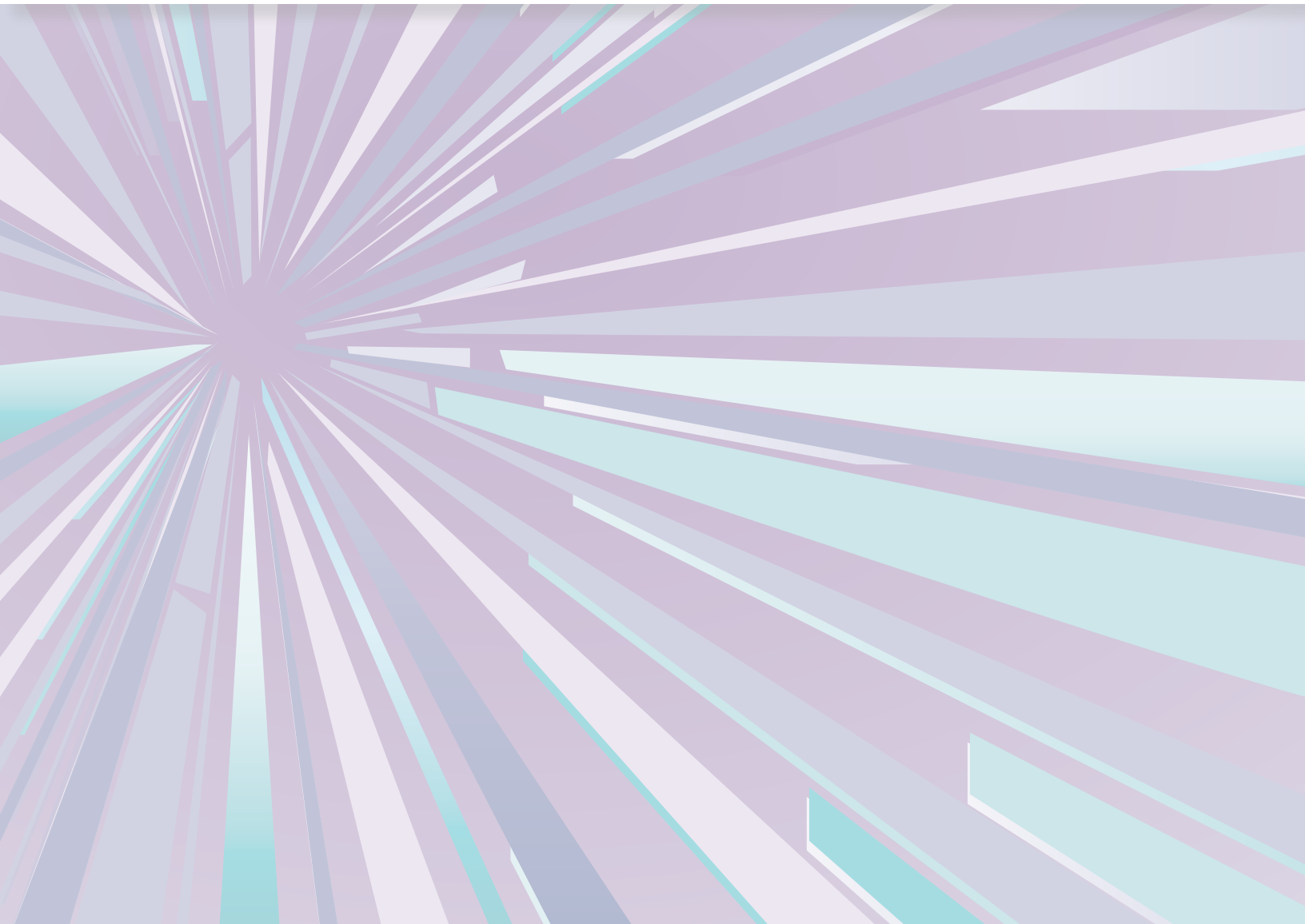
### Figure 1B. Time Management in Office Practice

Routine inquiry about intimate partner violence (IPV) screening




Routine inquiry for IPV therefore should not add substantially to the health care provider's time commitments, and it may ultimately save time by allowing the clinician to budget time proactively while building trust and rapport.

# Clinical Evaluation



All aspects of clinical evaluation and response, including inquiry, identification, assessment, and intervention, should be approached as part of a collaborative, multidisciplinary team, rather than in isolation. The health care team consists not only of the clinician and related office or hospital staff, but also of social workers, chaplains, administrative support staff, security personnel, and others as appropriate to the setting and situation. Beyond the health care sector, community-based experts, including advocates, educators, members of the faith community, police and other law enforcement representatives, and many others can work together to create a comprehensive "coordinated community response." A "trauma-informed care" approach should be utilized at all times.

## Trauma-Informed Care

Patients who have been abused, including within family or intimate relationships, may find medical encounters to be both distressing and anxiety provoking. Evaluations such as dental and gynecological exams, and even seemingly innocuous encounters such as blood pressure checks and abdominal palpation can trigger intense reactions of anxiety, dread, and avoidance. In view of the documented prevalence of IPV and other forms of interpersonal violence and the paucity of visible signs or definitive disclosures in most cases, physicians and other health care providers should approach the care of all patients using principles of "trauma-informed care," treating all patients as if they were potential abuse survivors.

Also known as trauma-sensitive care or trauma-aware care, trauma-informed care is, in many respects, the behavioral health equivalent of universal precautions for communicable diseases. Similar to routine precautions to prevent the transmission of blood-borne and other bodily fluid infections during medical procedures, clinicians who embody trauma-informed care practices assume the possibility of current or past abuse in *all* patients and act accordingly. Schachter et al.[55] outline nine principles of trauma-sensitive practice:

1. Respect
2. Patience (or taking time)
3. Rapport
4. Sharing information
5. Sharing control
6. Respecting boundaries
7. Fostering mutual learning
8. Understanding nonlinear healing
9. Demonstrating awareness and knowledge of interpersonal violence

## Clinical Presentations

Patients want their health care providers to inquire about violence and abuse during the course of routine and emergency clinical care. Survivors are more likely to disclose a history of abuse if the clinician is perceived to be knowledgeable, nonjudgmental, respectful, and supportive.[56, 57] Although recent research in this area is difficult to identify, and although preferences may vary among individual patients, the gender of the clinician does not appear to be an important factor in the willingness of most patients to disclose or discuss abuse.[58]

Patients with a current or past history of abuse may show no obvious signs or symptoms of medical or psychological distress, underscoring the importance of routine inquiry by physicians and others on the interprofessional health care team. Some, however, may present with signs and symptoms, or "red flag indicators," including:

- **PHYSICAL TRAUMA:** any acute injury, particularly lacerations, contusions, dislocations, fractures, head injury, or findings consistent with attempted strangulation (e.g., facial petechiae, laryngeal edema)
- **STRANGULATION INJURIES** occur far more commonly than previously thought. Visible signs of strangulation may be far more difficult to detect in darker-skinned patients than in those with fairer skin tones
- **GYNECOLOGICAL PROBLEMS:** genital lacerations and contusions, sexually transmitted infections (including HIV/AIDS), rape and sexual assault, unintended pregnancy, rapid repeat pregnancy, abortion complications
- **SOMATIC DISORDERS:** headache, chest pain, abdominal pain, pelvic pain, back pain, fatigue, eating disorders, functional gastrointestinal disorders
- **LOCALIZED OR GENERALIZED NEUROLOGICAL FINDINGS:** altered mental status, seizures, motor or sensory deficits, memory problems
- **BEHAVIORAL/PSYCHIATRIC ISSUES:** anxiety, depression, hypervigilance, panic, dissociation during medical procedures, history of suicidal ideation or attempts, substance abuse
- **SOCIAL RED FLAGS:** frequent missed appointments, delayed presentation for care, seeming "non-compliance" with medical instructions
- **PARTNER RED FLAGS:** excessively attentive or jealous companion, partner who insists on accompanying patient into the examining room, partner who speaks for the patient or to whom the patient turns for approval when answering questions

The above list encompasses only some of the most commonly reported red flags for abuse seen in the health care setting. Patients who present with these or similar indicators should be assessed routinely, as described below. In addition, more probing questions, asked in a trauma-informed manner, may illuminate the underlying cause of the patient's distress.

## Patient Interviewing Techniques

All adolescent and adult patients should be queried routinely and periodically about IPV. The patient should be interviewed in private, without the partner, children, other relatives, roommates, or friends present. A history of previous trauma, chronic pain complaints, psychological distress, or other red flag indicators should be sought from direct history or from the medical record.

## *Framing Inquiry as a Routine Component of the Health Care Encounter*

Before asking specific questions about IPV, it is best to frame inquiry as a routine component of everyday clinical practice. In addition to introducing the issue of violence in relationships by displaying posters, brochures, and help cards in the waiting room, examining room, and lavatories, the health care provider should introduce the issue using a nonjudgmental framing statement. Sample framing statements include:

- "Violence can be a problem in many people's lives, so I now ask every patient I see about trauma or abuse they may have experienced in a relationship."
- "Many patients I see are coping with an abusive relationship, so I've started asking about intimate partner violence routinely."

Once the issue is framed, even a single question, asked routinely and nonjudgmentally in the course of the social history, can substantially increase the detection rate of IPV in office practice and can facilitate the patient's sense of safety in disclosing a history of abuse.

Here are some examples of questions that can be adapted as needed to individual practices:

- "What do you enjoy or value most in your relationship? What would you change if you could?"
- "At any time, has a partner hit, kicked, threatened, or otherwise hurt or frightened you?"
- "Has a partner ever choked or strangled you?"
- "Has a partner ever made you view or participate in a sexual practice that made you uncomfortable or that you didn't want?"
- "Every couple has conflicts — what happens when you and your partner have a disagreement? Do conflicts ever turn into physical fights or make you afraid for your safety?"
- "I have seen patients in my practice who have been intimidated, threatened, or even hurt by someone they love. Might this be happening to you?"
- "Do you ever feel afraid of your partner?" Or, "Are there times that your partner has worried or scared you?"
- "Do you feel safe in your relationship?"

Although clearly a more general question, the suggestion below can empower a patient to discuss concerns that might be related to violence or trauma, but might not be revealed with more specific lines of questioning:[16]

- "Is there anything going on either currently or in the past that you feel has affected your health or that you feel I should know about in taking care of you?"

Should the patient disclose abuse in response to any of the above questions, or if abuse is suspected even in the absence of clear disclosure, selected follow-up questions, asked sensitively in a safe, confidential, and trauma-informed manner, can help determine the extent of potential abuse and the possible risk to the patient. Examples of follow-up questions include:

- "How were you hurt (or made to feel afraid)?"
- "Has this happened before?"

- "When did it first happen?"
- "How badly have you been hurt in the past?"
- "Have you needed to go to an emergency room for treatment?"
- "Have you ever been threatened with a weapon or has a weapon ever been used on you?"
- "Have you ever tried to get a legal order of protection against a partner?"
- "Have your children ever seen or heard you being threatened or hurt?"
- "Have your children ever been threatened or hurt by your partner?"
- "What have you tried to do to keep yourself (and your children or other dependents) safe?"
- "Do you know how you can get help if you are hurt or afraid?"

It is helpful to ask adolescent patients questions such as these:

- "Have you begun to date?"
- "Has your boyfriend/girlfriend ever threatened to hurt you or have you ever threatened to hurt him/her?"
- "Are you ever afraid of your boyfriend/girlfriend?"
- "Have you ever had a pushing or shoving fight with a boyfriend/girlfriend?"
- "Have you ever gotten hurt from a fight with a boyfriend/girlfriend?"
- "Have you begun to have sex?"
- "Has anyone ever forced you to have sex when you didn't want to?"
- "Have you been able to confide in or talk to anyone else about this?"

## Guidelines When Language Translation Is Required

When language barriers are present, the services of a trained, professional translator or interpreter should be obtained. Professional medical interpreters normally receive regular training about patient privacy and confidentiality, particularly in regard to highly sensitive issues such as abuse and violence. Compromising the quality or safety of translation may result in missed opportunities to intervene, and can place survivors in increased danger, especially if casual or accompanying interpreters are used in place of professional translators.

Health care providers should refrain from allowing accompanying persons (e.g., friends, relatives including children, or others) to serve as interpreters, as these individuals might be the abusers themselves, their friends or associates, or might unintentionally compromise confidentiality by disclosing what they have heard to third parties. Moreover, stigma and shame might impede disclosure if a translator from the patient's own local community is relied upon for language interpretation.

Accessing professional translation services may be more difficult in remote health care settings or in areas with limited resources. Even when there is a professional interpreter available in a small community, the interpreter's ties to the local community may still pose a risk for survivors. In such instances, or in the absence of appropriate professional interpreters, remote telephone interpretation services should be sought.

### Caveats

As important as it is to ask the right questions, it is equally important to refrain from asking questions in a manner that might frighten or intimidate a patient, increase a patient's sense of humiliation or shame about possible abuse, or be interpreted as blaming the abused individual for the situation.

Keep in mind:

- Most abused individuals do not identify themselves as "victims" or as "battered" *per se* because of the perception of helplessness, shame, and worthlessness associated with such value-laden terms. Therefore, avoid using such terms during the course of clinical care. Instead, acknowledge the patient's feelings, experiences, and perspectives by mirroring his or her word choices, or alternatively, use words like "hurt," "frightened," or "mistreated."
- Do not inquire about abuse in the presence of the partner, friends, or family members.
- Do not break patient confidentiality by disclosing any information or discussing your concerns with the patient's partner — even if the partner is a patient of the practice as well.
- Never ask a patient what he or she did to bring on the abuse.
- Do not ask the patient why he or she has not left the partner.

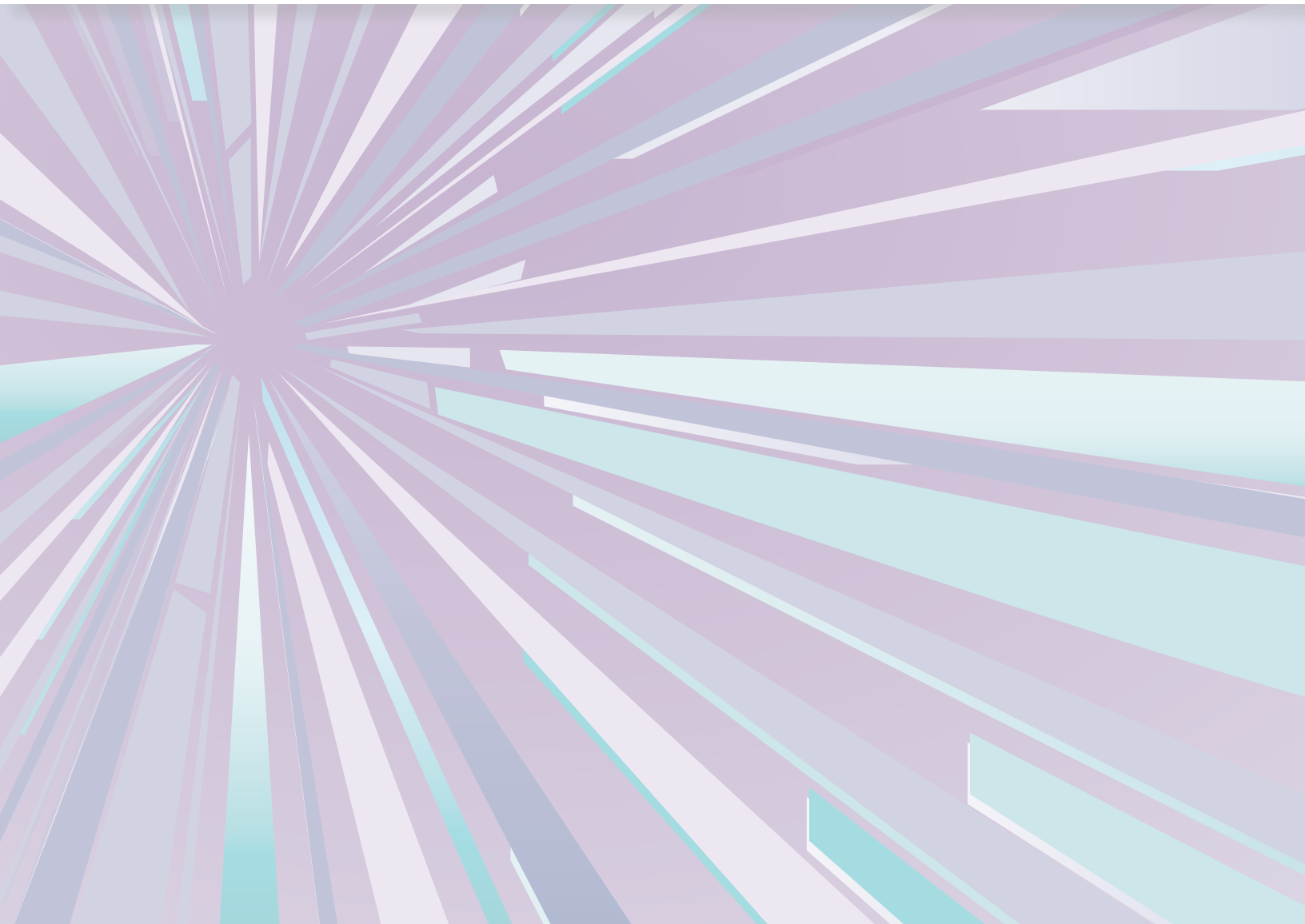
## Physical Examination

Be highly suspicious of IPV when any of these physical findings are noted:

- Any evidence of injury, especially to the face, torso, breasts, or genitals (N.B.: a careful head, neck and skin exam is essential to assessing for physical injury)
- Ligature neck marks, hand/finger-shaped neck marks, or other evidence of strangulation
- Bilateral or multiple injuries
- Delay between onset of injury and presentation for care
- Patient's explanation inconsistent with injury pattern
- Prior use of emergency services on multiple occasions for trauma or other care
- Unexplained chronic pain symptoms
- Psychological distress (e.g., anxiety, depression, sleep disorder, suicidal ideation)
- Evidence of rape or sexual assault
- Pregnant woman with any injury, particularly to the abdomen or breasts; vaginal bleeding; or decreased fetal movement

Although abused individuals may sustain life-threatening physical injuries, they often suffer less obvious effects that may be harder to "diagnose" yet can be quite debilitating.

# Intervention



# Guiding Principles of Intervention

Once IPV is disclosed, the health care provider's role is to document, assess, and refer as indicated, keeping in mind the four classic guiding principles of intervention developed originally by Warshaw et al. for Futures Without Violence (formerly the Family Violence Prevention Fund):[59]

## *Survivor Safety*

All aspects of patient assessment, documentation, safety planning, communication, intervention, and follow-up must be conducted with the utmost concern for the immediate and long-term safety of the survivor and her or his dependent children. The clinician should ask him- or herself, *Is what I am asking/doing/recommending going to help my patient become safer, or at least not place the patient at risk for further harm?*

## *Survivor Autonomy*

The batterer's controlling and intimidating behavior restricts the abused individual's ability to make informed, independent choices about his or her life. Facilitating the patient's autonomy is key to restoring a sense of purpose and well-being for survivors of IPV and can facilitate readiness to take proactive steps toward independence and safety.

## *Perpetrator Accountability*

IPV occurs because of the perpetrator's behavior and actions, not the survivor's. It thus follows that the problem of violence in the relationship, and therefore the need to take definitive steps to end the violence is the perpetrator's responsibility. This guiding principle recognizes the importance of holding perpetrators fully accountable for their own behavior and rejects victim blaming, "problems in the relationship," and other excuses offered by the offender as explanations or justification for the abuse that has occurred.

## *Advocacy for Social Change*

As health care professionals and systems grapple with the complex issues involved in understanding and responding to violence across the lifespan, the need to collaborate with others in health care, as well as those in law enforcement, education, the faith community, the business sector, public policy makers, and society-at-large, becomes evident. Health professionals can serve as critical partners in efforts to identify, and ultimately prevent, intimate partner violence.

# Provider Action Steps

Once IPV has been disclosed in the health care setting, action steps include:

- Documenting findings in the medical record
- Assessing for danger and initiating safety planning
- Providing information, validation, and support
- Making appropriate health care-based and community referrals that address the patient's needs
- Assuring timely and appropriate follow-up

## *Documentation in the Medical Record*

Relevant historical and physical findings should be documented carefully in the medical record, using matter-of-fact, written descriptions as well as sketched or photographic images. The patient's historical account, symptoms, and signs should be recorded accurately and nonjudgmentally, indicating "domestic violence" or "intimate partner violence" as a finding, diagnosis, or problem whenever appropriate. Free-hand or stick-figure sketches and/or labeled photograph(s) can serve as important supplements to written descriptions. Consent for photographic documentation should be obtained from the patient prior to taking photographs. Images should be dated, signed, and denoted as "unaltered" in the medical record.

Documentation in the medical record can be a source of invaluable information should the patient seek legal redress from the batterer. In addition, as vigorous criminal prosecution of domestic assault increases, accurate and legible medical records might be able to substitute for the clinician's personal testimony in court.

### Special Considerations in Documenting Sexual Assault

Following a sexual assault, many forms of forensic evidence can be collected up to five days after the crime occurs. Physical evidence that can be used for medical assessment and possible criminal prosecution should be obtained using a state-approved sexual assault evidence collection kit, which can be found in most hospital emergency departments. The forensic examination and accompanying evidence collection should be conducted by a certified forensic examiner in a standardized setting, whenever possible.

An increasing number of hospital emergency departments utilize the services of Sexual Assault Nurse Examiners (SANEs) who have specific training in forensic nursing, evidence collection, and crisis counseling. SANE programs have been shown to[60,61]

- Promote the proper collection of forensic evidence
- Facilitate provision of post-assault medical care (e.g., emergency contraception as well as HIV and other STI prophylaxis)
- Improve both reporting to police and the subsequent filing of charges

- Increase conviction rates and yield longer average sentences for offenders
- Facilitate comprehensive community-based referrals for survivors
- Improve psychological recovery for survivors
- Challenge prevailing social norms about rape and other forms of sexual assault

In an increasing number of states, including Massachusetts, medically trained rape crisis advocates typically accompany SANEs to provide support, information, and follow-up guidance to survivors. Recent research has shown that compared to services by SANEs alone, SANE nurse/rape crisis advocate response pairs further increase the provision and quality of post-rape medical care, increase reporting to police, and improve patient perceptions of experiences with both medical personnel and law enforcement. Thus, while SANE services provide vital improvements in post-rape evaluation and care, SANE-advocate partnerships yield even greater incremental benefits.[62]

Should a patient who has been sexually assaulted contact the health care provider's office before presenting to the emergency department, he or she should be told to refrain from showering, bathing, or douching before presenting for forensic evaluation. Rape survivors should be instructed to put all clothes worn during the assault in a paper bag and bring them to the closest SANE site or, if difficult to access, to the nearest hospital for use, as appropriate, in forensic evidence collection.

## *Danger Assessment and Safety Planning*

### Danger Assessment

Once a patient has disclosed being in a threatening or violent relationship, the health care provider can help assess risk or danger, begin a discussion about safety planning, and offer referrals as appropriate. Detailed safety planning is best done by, or in conjunction with, a trained and certified domestic violence advocate from a local advocacy organization. Health care providers who choose to engage independently in developing safety plans with patients are encouraged to accrue additional skills-based training in IPV assessment and response.

The most important determinants in assessing risk are the patient's level of fear and his or her own appraisal of both immediate and future safety needs. However, since some patients may minimize, deny, or be unfamiliar with the danger of their situations, the following indicators of escalating risk should be explored with the patient:

- An increase in the frequency or severity of threats or assaults
- Increasing or new threats of homicide or suicide by the partner
- The presence or availability of a firearm or other lethal weapon
- New or increasingly violent behavior outside the relationship by the perpetrator

## Safety Planning

To develop a safety plan, the patient's level of danger and the resources needed to flee suddenly must be assessed. The safety plan should include a place to go (friends, family, or emergency shelter); necessities for daily living such as cash, credit and debit cards; personal documents; car keys; medications; diapers (as needed); and changes of clothing. If an order of protection (restraining order) has been issued, the patient should carry a copy of it at all times. Inform the patient that local domestic violence programs provide free and confidential services and that trained advocates from these programs can provide essential information and support regarding the following:

- Learning about available options
- Legal rights
- Police and court procedures for protective orders
- Emergency shelter and safe house availability
- Support groups and other valuable community-based resources

Encourage the patient to call a local, statewide, or national hotline. The statewide hotline in Massachusetts is called SafeLink and can be reached at (877) 785-2020. The National Domestic Violence Hotline number is (800) 799-SAFE (7233).

Provide a private space for the patient to make telephone calls if the patient wishes to place these calls from the safe setting of the health care office. Calling a hotline in no way commits the patient to a course of action, but can better inform and empower her or him to make educated decisions.

Quite often, the same information needs to be provided to patients more than once.

# *Information, Validation, Support, and Medical Treatment*

The act of displaying information about IPV is an intervention in itself, as it conveys the message that the health care provider and office staff know and care about this issue. In addition, since some patients coping with abuse have not yet elected to disclose their situation to their health care providers, making information widely available can benefit even those who have not yet been identified in the health care setting.

Posters, brochures, and other information about IPV can be displayed prominently in waiting rooms, examination rooms, lavatories, and other appropriate locations. Small "take-away" materials such as pamphlets, help cards, and tear-off information sheets that display local resource and hotline information should be made available in "private" locations, such as lavatories, so that patients can access information without fear of being scrutinized by others.

Patients who are coping with an abusive relationship appreciate and can benefit from information, validation, and support from trusted sources — especially from health care providers. Those who are not ready to leave an abusive relationship should be assured that the health care provider — and the health care system as a whole — stands ready to work on their behalf without judgment and over time. Even when immediate results are not apparent, patient education efforts and supportive messages are not only valued, but also specifically remembered by patients as critical keys to safety and recovery.

## Information

Helpful educational messages for patients experiencing abuse include:

- "Intimate partner violence is common."
- "Physical violence is only one part of IPV."
- "Abuse usually increases in frequency and severity over time."
- "Children can be affected by (1) being physically hurt and (2) witnessing or hearing abuse."

## Validation

Validating statements include the following:

- "There is no excuse for domestic violence."
- "You most certainly are not to blame."
- "The abuse you have suffered is not your fault."
- "No one deserves to be abused."
- "You do not deserve to be hit or hurt. You deserve better."
- "How difficult this must be for you."
- "You are not alone."

## Safety

Statements that convey concern for the patient's safety include:

- "I am concerned about your safety and well-being."
- "Help is available."

### Follow-up

Follow-up is particularly important, as this conveys a powerful message to patients that their concerns are both valid and also appropriate to address in the medical setting. Statements that leave the door open for future encounters with clinicians and others in health care include:

- "You have choices."
- "As your situation changes, I (or my office, hospital, health center) will help you by providing information, support, and referrals."

### Confidentiality

Statements about confidentiality are not only educational, but also can be of critical importance to patients. Communicating honestly about how abuse-related information will be both included and secured within the medical record, and about limits to confidentiality that may be imposed by applicable state reporting requirements, is essential. To this end, early on in the health care encounter, it is often helpful to make a clarifying statement such as:

- "Everything we discuss here is strictly confidential to the fullest extent possible under the law. I will not discuss your situation with your partner or anyone else without your knowledge and consent, unless required to by law."

### Medical Treatment

Comprehensive medical treatment in cases of IPV involves not only treating acute injuries, but also arranging comprehensive primary care for patients who lack access to regular medical care. Referral for mental health services may be indicated, but couples or marriage counseling is absolutely contraindicated if the situation is volatile or if violence or other forms of coercion are active or ongoing.

## *Resources and Referrals*

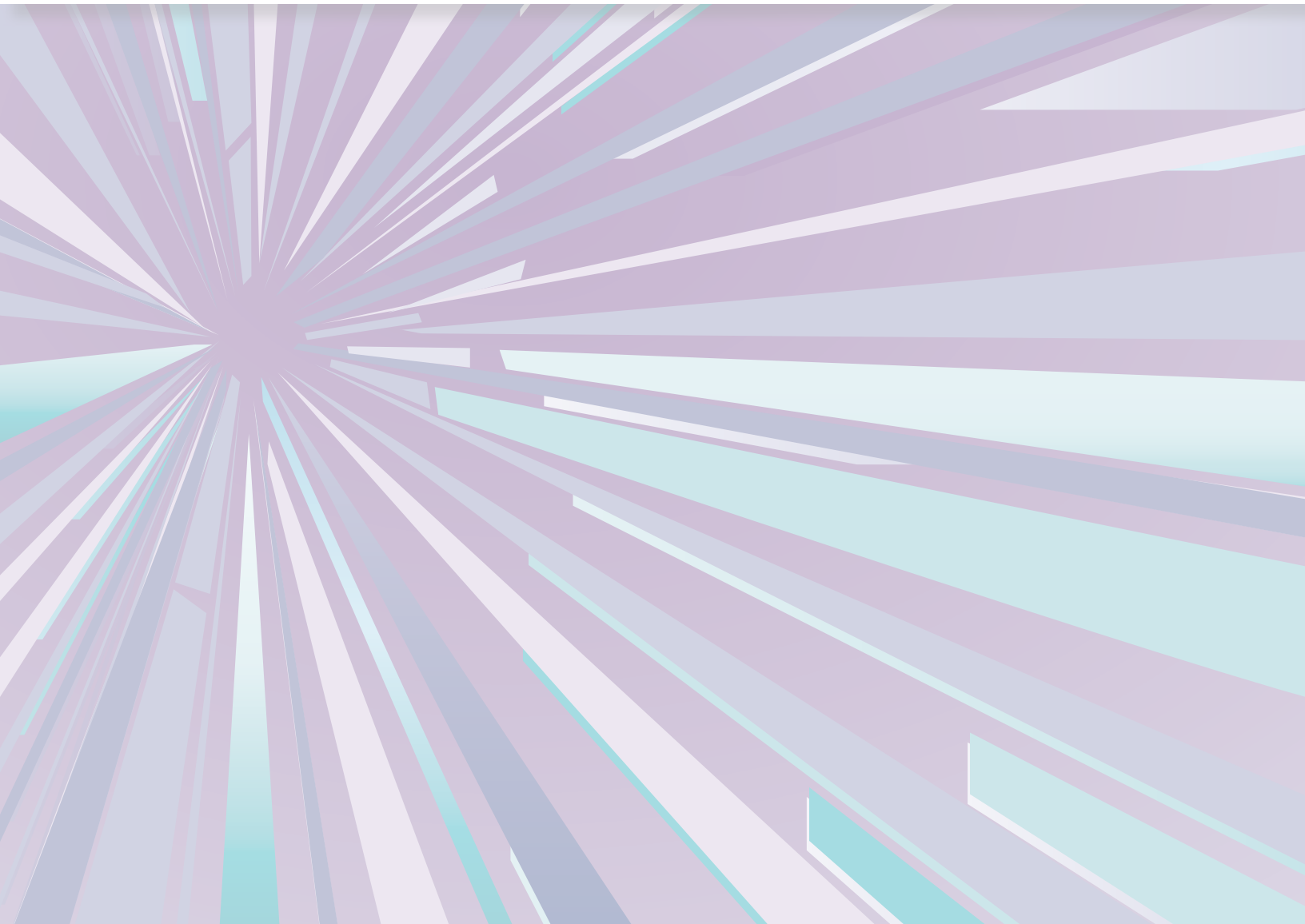
The clinician should review options with the patient and make appropriate referrals to community-based domestic violence advocacy and support services, mental health providers, legal advocates, social service providers, and others. Referrals should be offered in keeping with the patient's wishes, priorities, and cultural preferences. Before giving written information to patients, it is best to ask if the patient feels it is safe to take information home. If the patient feels it is unsafe to do so, she or he should be provided a private space in which this material can be read, integrated, and potentially even memorized.

For most complex conditions seen in the health care setting, referrals are made to medical or surgical experts with advanced medical training in a particular subspecialty. In contrast, referrals for patients experiencing IPV are generally made to domestic violence advocates and other nonmedical experts, some of whom may have unique and invaluable expertise yet limited formal education. Making referrals outside the health care system and relying on those whose expertise derives from practice-based evidence rather than evidence-based practice, represents a sometimes challenging yet critical step for health care providers engaged in supporting survivors of violence and abuse.

Particularly in light of the many prevention-focused priorities of the Affordable Care Act, compiling and making available a local resource list can prove to be valuable for the patient and time-saving for the health care provider. Resource information should be compiled and kept updated for referral to the following services:

- Support groups, advocacy, safety planning, and other services offered by domestic violence agencies
- Legal assistance
- Services for children, elders, and other dependents
- Mental health counseling services
- Social welfare services
- Housing relocation assistance
- Emergency shelter and transition home services
- Chaplaincy/spiritual assistance
- Job-training services
- Other referrals as appropriate to the individual situation

# Mandated Reporting in Massachusetts



Although there is no statute in Massachusetts requiring that domestic abuse against competent adult individuals be reported to authorities, there are circumstances in which health care providers are required to make reports. If a provider has a reasonable basis to believe that a child, elder, or disabled patient is suffering as a result of abuse, a report must be made to the appropriate agency (see below). If such a situation arises, the health care provider should explain to the patient the reasons for filing the report, along with assurances that the need to file a report in no way implies judgment or blame. Attempts should also be made to assist the patient in locating resources that will help ensure the safety of both the abused individual and at-risk family members if there is a fear of or reason to suspect retaliation by the perpetrator.

Under Massachusetts law, health care providers who fail to comply with mandated reporting responsibilities may be subject to disciplinary action, fines, or civil liability.

Questions regarding the legal aspects of mandatory reporting can be directed to the Massachusetts Medical Society, Office of General Counsel, at (781) 434-7520 or (800) 322-2303, ext. 7520.

## Child Abuse

Reports of suspected maltreatment of individuals under 18 years of age should be filed with the Department of Children and Families Child-At-Risk Hotline, (800) 792-5200.

## Elder Abuse

Reports of suspected elder maltreatment (including self-neglect) should be filed by contacting the Elder Abuse Hotline, (800) 922-2275.

## Abuse of Disabled Persons

Reports of suspected abuse of individuals with mental or physical disabilities should be filed with the Disabled Persons Protection Commission at (800) 426-9009.

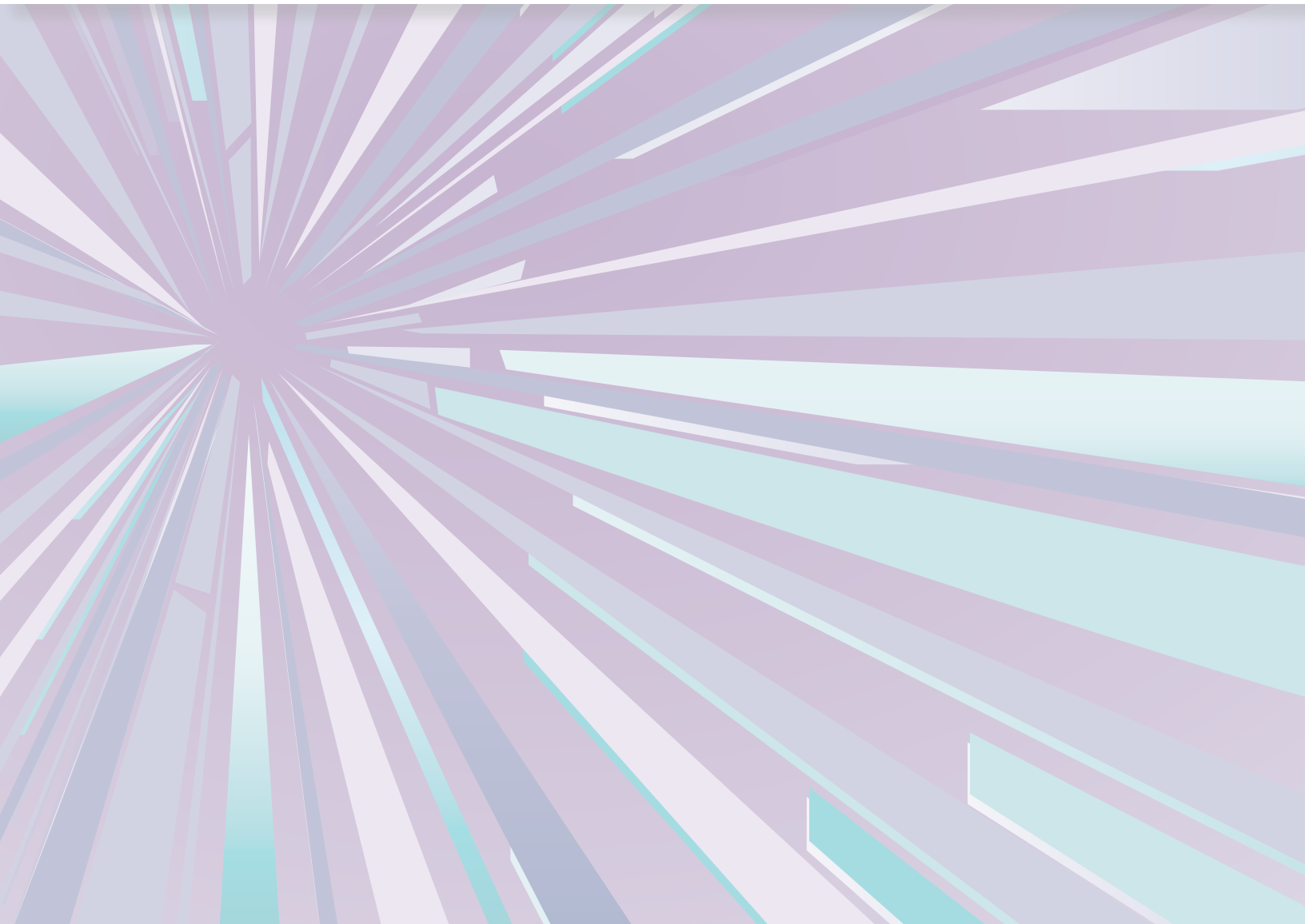
## Rape or Sexual Assault

In addition to the reporting requirements above, when attending, treating, or examining a survivor of rape or sexual assault, the provider must report the case by filing a Provider Sexual Crime Report to the Massachusetts Executive Office of Public Safety and Security and to the police department of the city or town in which the rape or sexual assault occurred.*

The clinician must file this anonymous report regardless of the age of the patient. The patient's name, address, or any other identifying information *are not included in this required report*.

*See www.sapr.mil/public/docs/laws/massachusetts.pdf for detailed guidance.

# The Roles of the Patient and the Health Care Provider



## The Patient's Role

The patient's role is to decide what, how, and to whom to disclose if violence or abuse is present, and to make independent, autonomous decisions about what to do on a go-forward basis. Only the patient can decide if and when it is safe or desirable to leave an abusive situation, and when the economic and emotional resources to support that decision are in place.

## The Health Care Provider's Role

Working as a member of an interprofessional health care-based team, the health care provider's role is to is to use RADAR in the health care setting to aid in identifying, assessing, and responding to those at risk for, or affected by, violence in relationships.

**R**emember to ask routinely about IPV as a matter of routine patient care.

**A**sk directly about violence with such questions as "At any time, has a partner hit, kicked, or otherwise hurt or frightened you?" Interview your patient in private at all times.

**D**ocument findings related to suspected intimate partner violence in the patient's chart.

**A**ssess your patient's safety. Is it safe to return home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.

**R**eview options with your patient. Know about the types of referral resources in your community (e.g., shelters, support groups, legal advocates). See pages 61 to 76 of this guidebook for specific resource listings.

Keep in mind that obtaining a disclosure is not the only goal of inquiry. In fact, regardless of whether a disclosure has been made, the very act of having been asked about violence and abuse in an empathic, trauma-sensitive manner can prove to be a life-changing intervention in and of itself.

Once a disclosure *is* offered, documentation made, and an initial danger assessment completed, intervention steps by the health care provider can be staged over subsequent visits and triaged according to patient preference and medical need. Specifically, the provider should:

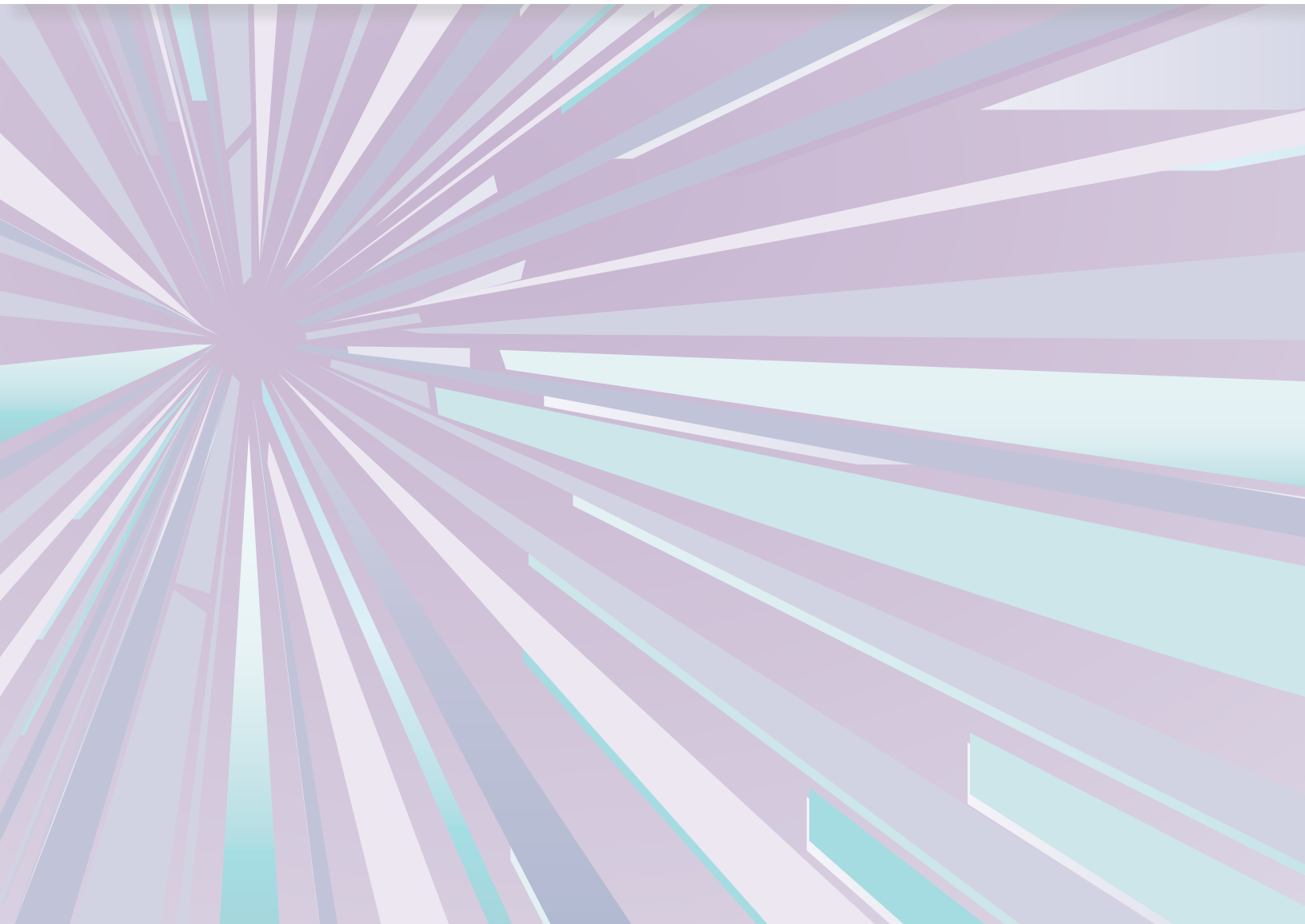
- Reframe the perpetrator's behavior as unacceptable and possibly illegal
- Place responsibility for the violence unequivocally on the perpetrator
- Validate the patient's courage and resilience in coping with abuse that has occurred
- Document findings carefully and nonjudgmentally in the medical record
- Assess for danger
- Initiate safety planning
- Diagnose and treat specific injuries and medical problems related to ongoing or past victimization
- Arrange for evaluation and management of mental health needs for both survivors and dependent children
- Discuss safer sex practices and protection against both sexually transmitted infections and unintended pregnancy
- Discuss the pros and cons of prescribing potentially sedating medications that could impair the survivor's ability to respond quickly to a dangerous situation
- Evaluate the need to file a mandated report to the appropriate agency for children, elderly, or disabled patients
- Refer the patient as appropriate to advocates and other community-based direct service experts (local, statewide, or national hotlines and domestic violence programs can be used as sources for referrals)
- Assure follow-up for both the presenting complaint and for comprehensive primary care

## *Assuring Follow-up*

Although not part of the RADAR acronym, assuring appropriate follow-up is helpful — if not essential — for both patient and provider. From the patient's perspective, clinician follow-up about IPV on subsequent visits reinforces caring, support, and trust, making ongoing communication more open and less stressful. From the health care provider's perspective, assuring follow-up reinforces the provider-patient relationship, makes subsequent patient care more efficient and satisfying, and also promotes ongoing health professional education and expertise.

**IMPORTANT NOTE:** A patient who remains in a dangerous or potentially dangerous relationship should not be labeled as a "treatment failure" or "noncompliant." Choosing not to leave usually reflects the survivor's constrained resources, or her or his reasonable assessment of available options and safety needs.

# Prevention



# Public Health in the Office Setting

This guidebook's focus on intimate partner violence as a health care and public health issue is congruent with two important public health-focused principles:

- Addressing conflict by using intimidation and violence impairs individual, family, community, and societal health and well-being
- Primary prevention is generally more proactive, efficient, cost-effective, and beneficial than efforts intended to respond to damage that is already done

Health care providers can communicate prevention-focused messages, especially about healthy relationships, effectively in the course of routine or emergency practice. Health care providers and affiliated office staff who model competence and concern about preventing IPV can inspire patients to address these difficult issues from positions of strength and resilience.

There are many ways to bring effective primary and secondary prevention into the office setting. Posters, brochures, and resource cards can be displayed prominently in waiting and examination rooms and in private areas such as lavatories. Office staff can receive periodic in-service training about IPV, referral resources, protocols, and office safety procedures.

# Health Care Providers as Change Agents in a Larger Community Response

The clinician's job should not be restricted to the examining room or hospital ward. Health professionals typically are highly respected in the community. Their opinions are sought out and given great credence, and their influence as role models and community leaders is clear.

Clinicians can leverage their positions of leadership and respect by joining community coalitions; advocating for improved services, laws, and practices; and modeling respectful, nonviolent behavior. In short, health care providers can very effectively "teach peace" in the course of their professional and personal activities.[63] The public health role of the health professional as leader, advocate, and change agent is arguably as important as the more traditional, historical role that focuses almost exclusively on providing clinical care for individual patients.

## *Legal Issues*

Although health care providers are rarely involved in IPV-related legal proceedings, some familiarity can be helpful. Once abuse is identified, the provider should refer the patient to a trained advocate who can explore options, assist with safety planning, and make other appropriate referrals, including to legal advocacy and law enforcement experts. Although proper documentation in the patient's medical chart can provide invaluable information for subsequent legal proceedings, such information can only be provided to outside sources if requested in writing by the patient or in response to a legally enforceable order (e.g., a subpoena).

# Orders of Protection (Restraining Orders)

Under the Massachusetts Abuse Prevention Act (General Laws, chapter 209A), any person who is suffering from abuse by a present or former family or household member or dating partner may obtain an emergency, temporary, and/or permanent restraining order against the abuser. Abuse is defined by the statute as "(a) attempting to cause or causing physical harm; (b) placing another in fear of imminent serious physical harm; or (c) causing another to engage involuntarily in sexual relations by force, threat, or duress."

- Orders can be obtained through any district, superior, or probate and family court, as well as the Boston Municipal Court.
- Upon request, the survivor's address can be impounded and kept confidential from the abuser.
- The court may order the abuser to refrain from further abuse, to have no further contact with the abused individual, and/or to vacate and remain away from the survivor's residence and workplace. Any violation of such an order is a criminal offense, and police must arrest the abuser if there is probable cause to believe that such an order has been violated.
- The court may elect to issue orders awarding temporary custody and support of any children, as well as other orders deemed appropriate to a particular case. These orders are enforceable through civil contempt proceedings.
- A court may also order the immediate surrender of any firearms the abuser possesses, as well as the immediate suspension of licenses or permits to possess firearms. Violation of such a surrender order is also a criminal offense.

Four types of orders of protection, or restraining orders, are available to a person seeking relief from abuse:

## *Emergency Restraining Order*

When court is not in session, including at night and on weekends, an emergency restraining order can be obtained by calling the police who will then contact an on-call judge. The judge will determine if a substantial likelihood of immediate danger of abuse has been demonstrated, and if so, issue an emergency order. A formal complaint requesting a temporary order should then be filed by the victim when the court is next in session.

## *Temporary Restraining Order*

When court is in session, a temporary restraining order can be obtained by filing a complaint in the appropriate court to request protection from abuse. The victim must inform the judge of the nature of the abuse, the identity of the abuser, and indicate the kind of relief that is sought. Where a substantial likelihood of immediate danger of abuse has been demonstrated, a court may issue such an order without prior notice to the abuser.

## Permanent Restraining Order

Upon issuance of a temporary restraining order and notice to the alleged abuser, a court hearing is scheduled within 10 business days, at which time the alleged abuser has an opportunity to present his or her version of events. After this hearing, if the judge determines that sufficient evidence of abuse has been presented, he or she may extend the order for an additional period of time up to one year. The order can be further extended thereafter as deemed necessary to protect the abused individual.

Whenever possible, the survivor should be accompanied during this process by an advocate from a local domestic violence or other victim services agency, from the district attorney's office or the court, or by a friend or trusted family member.

All temporary and permanent restraining orders are entered into the Massachusetts Domestic Violence Registry, where they can be accessed by judges and the police for future reference.

## Harassment Prevention Order

Under the Massachusetts Act Relative to Harassment Prevention Orders (General Laws, chapter 258E), a harassment prevention order is available to a person who has been stalked, sexually assaulted, or harassed, but who does not have a substantial dating relationship with the harasser. A person may qualify for this type of order if (1) she or he is a target of three or more acts of harassment that are meant to and do indeed cause fear, intimidation, or destruction of or abuse to property; (2) she or he suffered one act of forced sexual relations; or (3) she or he is a victim of a crime that falls within a specific set of crimes as laid out in this law.

Under this law, the court may order the harasser to:

- Refrain from abusing or harassing the injured party
- Refrain from contacting the victim, unless authorized by the court
- Remain away from the sufferer's household or workplace
- Pay the person monetary compensation for the losses suffered as a direct result of the harassment

# Criminal Complaints

Most criminal complaints are initiated by the arrest of an alleged batterer by the police. However, a criminal complaint can also be sought through the clerk's office of the local district court. An abused individual filing for a restraining order must be provided with information about the availability of criminal complaint proceedings.

The criminal complaint process sends a clear message to the batterer that domestic abuse is considered a serious crime for which criminal penalties, including fines and a jail sentence, may be imposed. Upon conviction, an abuser may be required to take part in a batterer intervention program as a condition of sentencing.

It bears noting that once a criminal complaint is issued, the local district attorney's office, and not the crime victim, has the responsibility and authority for the prosecution of the criminal case.

There are a variety of criminal charges that are often brought in domestic violence cases, including:

- Violation of a restraining order
- Assault
- Assault and battery
- Assault or assault and battery with a deadly weapon
- Breaking and entering
- Trespassing
- Threats
- Sexual assault
- Stalking

## Stalking Law

The Massachusetts Stalking Law (General Laws, chapter 265, section 43) provides that any person who "willfully and maliciously engages in a knowing pattern of conduct or series of acts" that seriously alarms or annoys a person and makes a threat intended to place the person in imminent fear of death or bodily injury shall be punished by a fine or imprisonment, or both. One purpose of the Stalking Law is to allow for prosecution of those batterers who are obsessed with their victims and continue to harass them even after the victim has ended the relationship.

While not every violation of a restraining order would qualify as stalking, a person convicted of stalking in violation of a restraining or vacate order is subject to a mandatory prison term of at least one year.

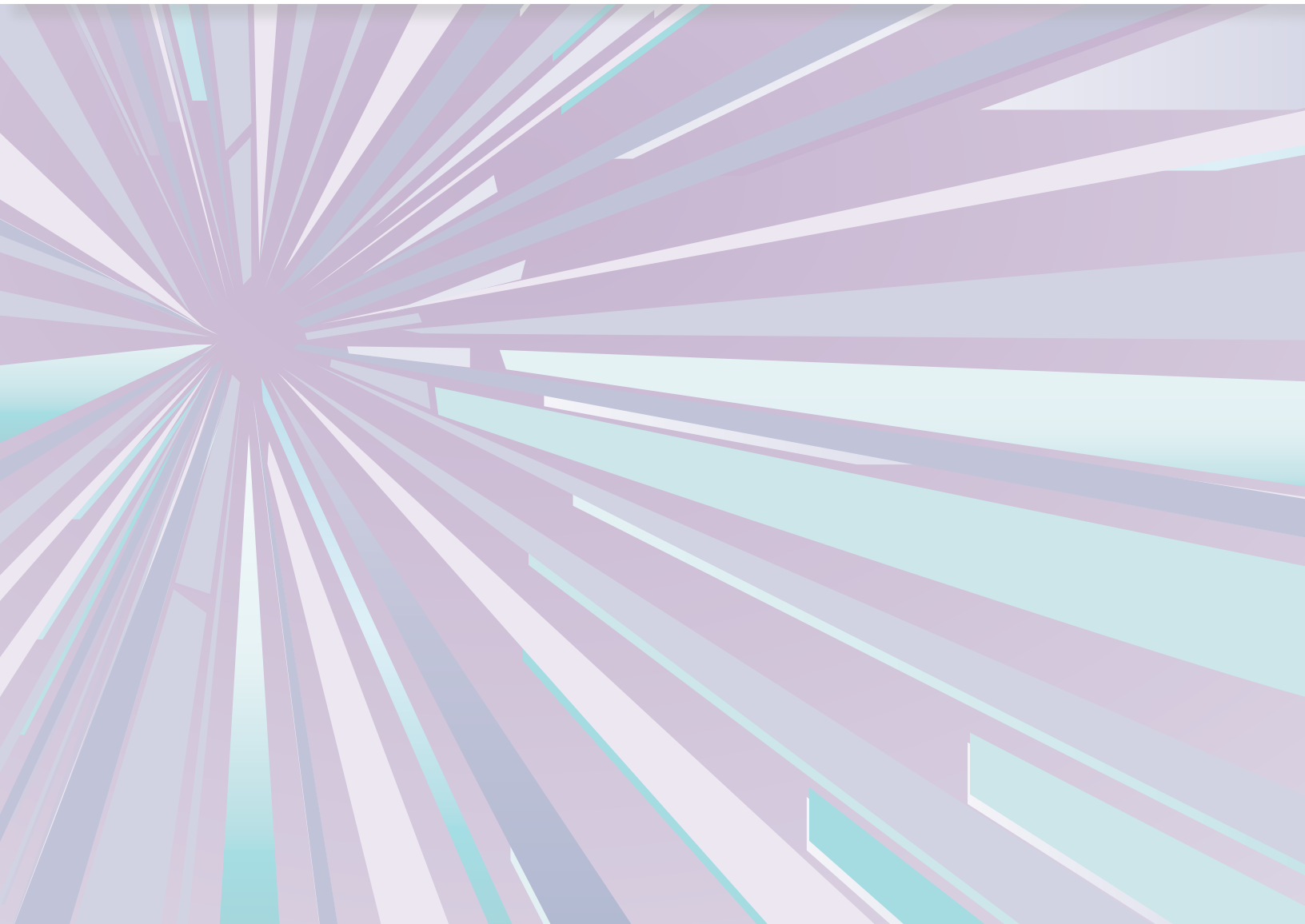
## Child Custody Presumption Law

The Massachusetts Presumptive Custody Law (General Laws, chapter 208, section 31A), requires a court issuing a temporary or permanent child custody order to "consider evidence of past or present abuse toward a parent or child as a factor contrary to the best interest of the child." An abusive parent is defined as one who has committed either: (1) a pattern of abuse — including causing, attempting to cause, or placing the other parent or child in fear of imminent bodily injury; or (2) a serious incident of abuse — causing, attempting to cause, or placing the other parent or child in reasonable fear of imminent serious bodily injury, including causing the other parent to engage involuntarily in sexual relations.

If the court finds sufficient evidence of abuse, the law creates a rebuttable presumption that child custody should not be awarded to the abusive parent. It is then up to the abusive parent to present sufficient evidence to rebut the presumption or prove that a custody award to the abusive parent would be in the child's best interest.

If ordering visitation to an abusive parent who has been denied custody, the court must provide for the safety and well-being of the child and the abused parent through supervision or other means.

# Help for Health Professionals

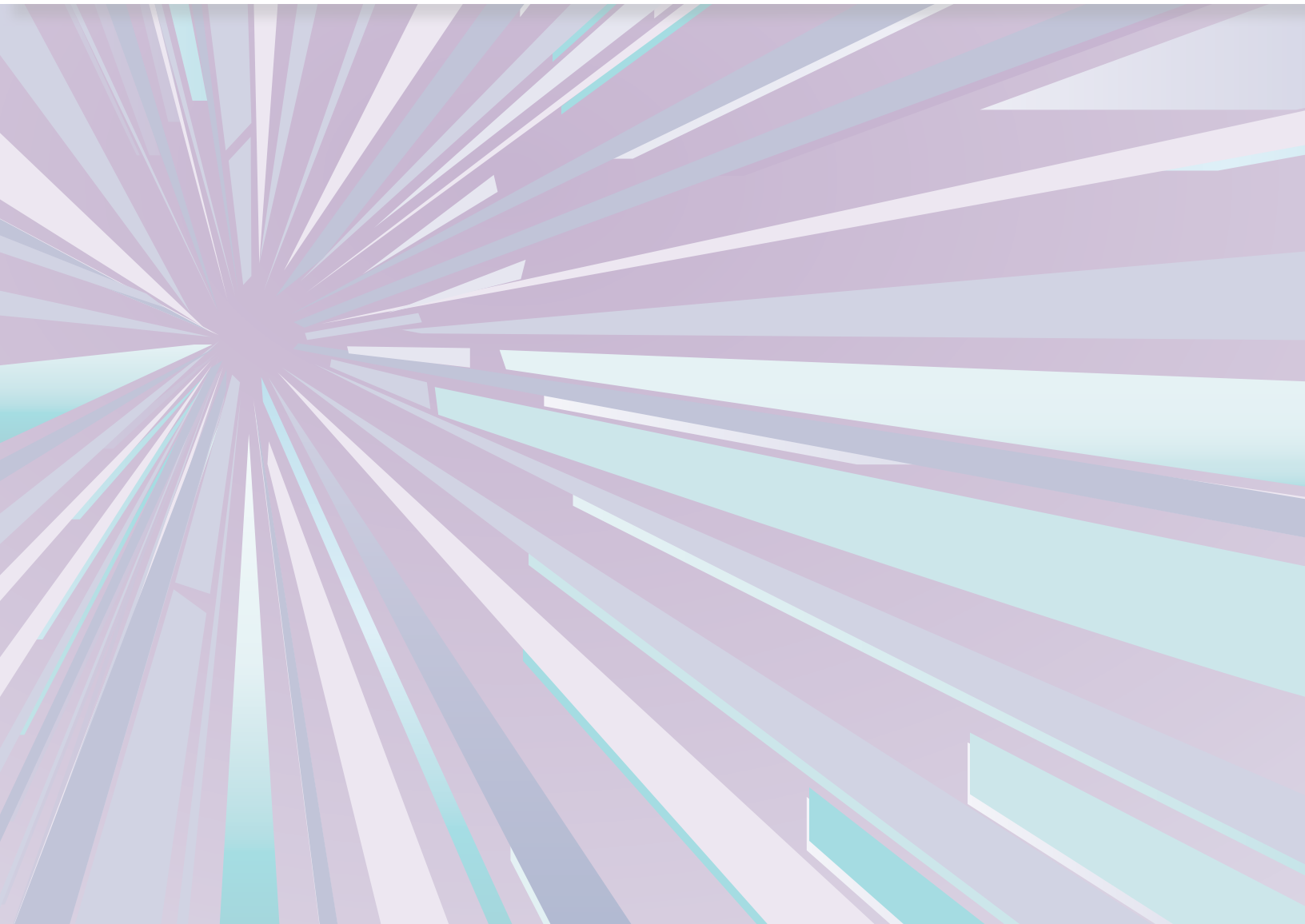


Individual physicians and other health care professionals may themselves have been victimized as children or as adults, or may currently be in an abusive relationship as a survivor or as a perpetrator. Those whose lives have been affected by abuse are urged to seek help from a hotline or direct service organization or from a trusted colleague, therapist, family member, or other source of support.

SafeLink, the Massachusetts statewide domestic violence hotline at (877) 785-2020, or the National Domestic Violence Hotline at 1-800-799-SAFE (7233) can provide key help and support at any time of day or night. In addition, 911 should be called in case of emergency.

Confidential referral for Massachusetts physicians and their families who are in need of help as survivors or as perpetrators can be obtained by calling Physician Health Services, Inc., a corporation of the Massachusetts Medical Society, at (800) 322-2303, ext. 7404, or (781) 434-7404.

# Hotline, Shelter, and Referral Resources



The health care provider may be the only trusted professional a patient experiencing abuse encounters. It is therefore critical to have the best information readily available to assist patients.

This list below includes many, but not all, of the existing resources in Massachusetts that provide support and services for survivors of IPV. The Massachusetts Medical Society website, www.massmed.org, and the Jane Doe, Inc. website, www.janedoe.org, contain additional information.

Web resources with a national focus are listed at the end of this section.

| HOTLINE AND CRISIS RESOURCES | | |
|---|---|---|
| **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| Massachusetts Statewide Domestic Violence Hotline (SafeLink) | (877) 785-2020 | www.casamyrna.org/safelink-home |
| National Domestic Violence Hotline | 1-800 799-SAFE (7233) | www.thehotline.org |
| National Human Trafficking Resource Center Hotline | (888) 373-7888 | http://traffickingresourcecenter.org |
| National Sexual Assault Hotline | 1-800-656-HOPE (4673) | https://rainn.org/get-help/national-sexual-assault-hotline |
| Asian Task Force against Domestic Violence | (617) 338-2355<br>multi-lingual | www.atask.org |
| The Network/La Red | (617) 742-4911 | tnlr.org |
| Llámanos: Statewide Spanish Rape Crisis Hotline | (800) 223-5001 | www.ywworks.org |
| GLBT National Help Center | (888) 843-4564 | www.glbthotline.org |
| GLBT National Youth Talkline | (800) 246-7743 | www.glbthotline.org/youth-talkline.html |
| National Teen Dating Abuse Helpline | (866) 331-9474<br>TTY 866-331-8453 | www.loveisrespect.org |
| Police Emergency | 911 | |

| HEALTH CARE-BASED COMPREHENSIVE ADVOCACY PROGRAMS | | |
|---|---|---|
| **ORGANIZATION/LOCATION** | **TELEPHONE** | **WEBSITE** |
| Center for Violence Prevention and Recovery<br>Beth Israel Deaconess Medical Center<br>*Boston* | (617) 667-8141 | www.bidmc.org/violenceprevention |
| C.A.R.E. (Coordinated Approach to Recovery and Empowerment) Clinic<br>Brigham and Women's Hospital<br>*Boston* | (617) 525-9580 | |

| | | |
|---|---|---|
| Domestic Violence Program<br>Boston Medical Center<br>*Boston* | (617) 414-7734 | www.bmc.org/traumasurgery/injuryprevention/patients-caregivers.htm#domestic-violence-program |
| HAVEN<br>Massachusetts General Hospital<br>*Boston* | (617) 724-0054 | www.mghpcs.org/socialservice/programs/haven |
| Passageway<br>Brigham and Women's Hospital<br>*Boston* | (617) 732-8753 | www.brighamandwomens.org/about_bwh/communityprograms/our-programs/violence/passageway.aspx |
| Family Safety Project<br>Steward/Holy Family Hospital<br>*Methuen* | (978) 989-0607, ext. 12 | www.holyfamily-hospital.org/HF-Family-Safety-Project |
| DV/Sexual Assault Program<br>Newton-Wellesley Hospital<br>*Newton* | (617) 243-6521 | www.nwh.org/community-health-resources/domestic-and-sexual-violence-services |
| Crossroads<br>North Shore Medical Center and HAWC<br>*Salem, Beverly, Gloucester, Lynn* | (978) 744-8552<br>(800) 547-1649 — hotline | http://hawcdv.org/services/hospital-advocacy |
| Family Advocacy Center<br>Baystate Mary Lane Hospital<br>*Springfield* | (413) 794-5555 | www.baystatehealth.org/about-us/community-programs/health-initiatives/family-advocacy-center |
| Hilltown Safety at Home<br>Hilltown Community Health Centers<br>*Worthington and Huntington* | (413) 559-8039 | www.hchcweb.org/Hilltown-Safety-at-Home.html |

**MASSACHUSETTS-BASED IPV ADVOCACY SERVICES**

**BOSTON AREA**

| MUNICIPALITY | PROGRAM NAME | TELEPHONE | WEBSITE |
|---|---|---|---|
| Boston | Casa Myrna | (877) 785-2020 | www.casamyrna.org |
| Cambridge | Transition House | (617) 661-7203 — hotline | www.transitionhouse.org |
| Chelsea | HarborCOV | (617) 884-9909 | www.harborcov.org |
| Jamaica Plain | Elizabeth Stone House | (617) 427-9801 | www.elizabethstonehouse.org |
| Jamaica Plain | Finex House | (617) 288-1054 (also TTY) | www.finexhouse.org |
| Somerville | Respond, Inc. | (617) 623-5900 | www.respondinc.org |

| SOUTH OF BOSTON | | | |
|---|---|---|---|
| **MUNICIPALITY** | **PROGRAM NAME** | **TELEPHONE** | **WEBSITE** |
| Attleboro/ Taunton | New Hope, Inc. | (800) 323-4673 — hotline | www.new-hope.org |
| Brockton | Family and Community Resources | (508) 583-6491 | www.fcr-ma.org |
| Brockton/Quincy | A New Day | (508) 588-2045<br>(508) 588-8255 — hotline | www.healthimperatives.org/anewday |
| Fall River | SSTAR, Inc. Women's Center | (508) 675-0087 | www.sstar.org/womens-center |
| Fall River/ New Bedford | The Women's Center | (508) 672-1222<br>(508) 996-3343<br>(508) 999-6636 — hotline | www.thewomenscentersc.com |
| Plymouth | South Shore Women's Resource Center | (508) 746-2664<br>(888) 746-2664 — hotline | www.thesswrc.org |
| Quincy | DOVE (Domestic Violence Ended) | (617) 770-4065<br>(617) 471-1234 — hotline | www.dovema.org |
| **CAPE COD AND THE ISLANDS** | | | |
| **MUNICIPALITY** | **PROGRAM NAME** | **TELEPHONE** | **WEBSITE** |
| Falmouth | Cape Cod Center for Women | (774) 763-2222<br>(508) 564-7233 — hotline | www.capecodshelter.org |
| Hyannis | Independence House | (508) 771-6507<br>(800) 439-6507 — hotline<br>TTY (508) 771-6782 | www.independencehouse.org |
| Nantucket | A Safe Place, Inc. | (508) 228-2111 — hotline<br>TTY (508) 228-7095 | www.asafeplacenantucket.org |
| Martha's Vineyard | CONNECT to End Violence | (774) 549-9667<br>(508) 696-7233 — hotline | www.mvcommunityservices.com/programs-and-services/connect-to-end-violence |
| **NORTH OF BOSTON** | | | |
| **MUNICIPALITY** | **PROGRAM NAME** | **TELEPHONE** | **WEBSITE** |
| Lawrence/ Haverhill | YWCA of Greater Lawrence | (978) 682-3039<br>(844) 372-9922 — hotline | www.ywcalawrence.org/programs-services/domestic-violence |
| Lawrence | Supportive Care | (978) 686-1300 | www.supportivecaredv.org |

| | | | |
|---|---|---|---|
| Lowell | Alternative House | (978) 454-1436<br>(888) 291-6228 — hotline | www.alternative-house.org |
| Newburyport/ Amesbury | Jeanne Geiger Crisis Center | (978) 454-1436<br>(978) 388-1888 — hotline | www.jeannegeigercrisiscenter.org |
| Salem | HAWC (Healing Abuse Working for Change) | (800) 547-1649 — hotline | www.hawcdv.org |
| Salisbury | Portal to Hope | (781) 338-7678 | www.portaltohope.org/new |
| **WEST OF BOSTON** | | | |
| **MUNICIPALITY** | **PROGRAM NAME** | **TELEPHONE** | **WEBSITE** |
| Framingham | Voices against Violence | (800) 593-1125<br>TTY (508) 626-3686 | www.smoc.org/voices-against-violence.php |
| Greenfield | NELCWIT (New England Learning Center for Women in Transition) | (413) 772-0871<br>(413) 772-0806 — hotline | www.nelcwit.org |
| Holyoke | Womanshelter/ Compañeras | (413) 536-1628<br>(877) 536-1628 — hotline | www.womanshelter.org |
| Leominster | Spanish American Center | (978) 534-3145 | www.spanishamericancenter.org |
| Newton | The Second Step | (617) 965-3999 | www.thesecondstep.org |
| Northampton | Safe Passage | (413) 586-1125<br>(413) 586-5066 — hotline<br>TTY (888) 345-5282 | www.safepass.org |
| Pittsfield | Elizabeth Freeman Center | (413) 499-2425<br>(866) 401-2425 — hotline | www.elizabethfreemancenter.org |
| Springfield | YWCA of Western Massachusetts | (413) 732-3121<br>(413) 733-7100 and<br>(800) 796-8711 — hotline and TTY | www.ywworks.org |
| Waltham | REACH Beyond Domestic Violence | (781) 891-0724<br>(800) 899-4000 — hotline | www.reachma.org |
| Webster/South County | New Hope | (800) 323-4673 — hotline | www.new-hope.org |
| Worcester/ Leominster | BWR (Battered Women's Resources) and Daybreak | (508) 791-3181<br>(508) 755-9030 — hotline | www.ywcacentralmass.org/domestic-violence/services |

| MASSACHUSETTS-BASED RAPE CRISIS AND SEXUAL ASSAULT SERVICES<br>*(Also see www.mass.gov/eohhs/docs/dph/com-health/violence/rape-crisis-center-list.pdf)* | | | |
|---|---|---|---|
| **BOSTON AND ROUTE 128 AREA** | | | |
| **MUNICIPALITY** | **PROGRAM NAME** | **TELEPHONE** | **WEBSITE** |
| Cambridge | Boston Area Rape Crisis Center | (800) 841-8371 — hotline | www.barcc.org |
| **NORTH OF BOSTON** | | | |
| **MUNICIPALITY** | **PROGRAM NAME** | **TELEPHONE** | **WEBSITE** |
| Lawrence | YWCA of Greater Lawrence | (978) 682-3039<br>(877) 509-9922 — hotline | www.ywcalawrence.org |
| Lowell | The Center for Hope and Healing | (800) 542-5212 | www.chhinc.org |
| Lynn | YWCA North Shore Rape Crisis Center | (781) 477-2313<br>(800) 922-8772 — hotline<br>TTY (978) 686-8840 | www.ywcansrcc.org |
| **SOUTH OF BOSTON** | | | |
| **MUNICIPALITY** | **PROGRAM NAME** | **TELEPHONE** | **WEBSITE** |
| Attleboro/ Taunton | New Hope | (800) 323-4673 — hotline | www.new-hope.org |
| Brockton/Quincy | A New Day | (508) 588-2045<br>(508) 588-8255 — hotline | www.healthimperatives.org/anewday |
| Fall River/ New Bedford | The Women's Center | (508) 672-1222<br>(888) 839-6636 | www.thewomenscentersc.com |
| Fall River/ New Bedford | Women's Center/SSTAR | (508) 675-0087 | www.sstar.org/womens-center |
| **CAPE COD AND THE ISLANDS** | | | |
| **MUNICIPALITY** | **PROGRAM NAME** | **TELEPHONE** | **WEBSITE** |
| Hyannis | Independence House, Inc. | (508) 771-6507<br>(800) 439-6507<br>TTY (508) 771-6782 | www.independencehouse.org |
| Martha's Vineyard | CONNECT to End Violence | (774) 549-9667<br>(508) 696-7233 — hotline | www.mvcommunityservices.com/programs-and-services/connect-to-end-violence |
| Nantucket | A Safe Place | (508) 228-2111 — hotline<br>TTY (508) 228-7095 | www.asafeplacenantucket.org |
| **WEST OF BOSTON** | | | |
| **MUNICIPALITY** | **PROGRAM NAME** | **TELEPHONE** | **WEBSITE** |
| Amherst | Center for Women and Community | (413)-545-0883<br>(888) 337-0800 — hotline<br>TTY (413) 577-0940 | www.umass.edu/ewc |
| Framingham | Voices against Violence | (800) 593-1125<br>TYY (508) 626-8686 | www.smoc.org/voices-against-violence.php |

| | | | |
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| Greenfield | NELCWIT (New England Learning Center for Women in Transition) | (413) 772-0871<br>(413) 772-0806 — hotline | www.nelcwit.org |
| Milford | Wayside Valley Rape Crisis Center | (508) 478-6888, ext. 106<br>(800) 511-5070 — hotline | www.waysideyouth.org/OurServices/WaysideMilford/TraumaInterventionServices.aspx |
| Pittsfield | Elizabeth Freeman Center | (413) 449-2425<br>(866) 401-2425 — hotline | www.elizabethfreemancenter.org |
| Springfield | YWCA Western MA | (413) 732-3121<br>(413) 733-7100 and<br>(800) 796-8711 — hotline and TTY | www.ywworks.org |
| Webster/ South County | New Hope | (800) 323-4673 — hotline | www.new-hope.org |
| Worcester | Pathways for Change (Rape Crisis Center of Central MA) | (800) 870-5905 | www.centralmasspfc.org |

| SERVICES FOR THE GENDER AND SEXUAL MINORITY (GSM) COMMUNITY | | |
|---|---|---|
| Boston Police, Liaison to the Gay, Lesbian, Bisexual Community | (617) 635-4855 | www.cityofboston.gov/contact/default.aspx?ID=153 |
| GLBTQ Domestic Violence Project | (800) 832-1901 — hotline | www.glbtqdvp.org |
| GLBT National Help Center | (888) 843-4564 | www.glbthotline.org |
| GLBT National Youth Talkline | (800) 246-7743 | www.glbthotline.org/youth-talkline.html |

| SERVICES FOR BATTERED MEN | | |
|---|---|---|
| **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| Violence Recovery Program | (617) 927-6250 | http://fenwayhealth.org/care/behavioral-health/vrp |

| MASSACHUSETTS NON-EMERGENCY RESOURCES | | |
|---|---|---|
| **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| Jane Doe Inc.<br>Monday–Friday, 9AM–5PM, for other than crisis services | (617) 248-0922 | www.janedoe.org |
| Victim Compensation and Assistance Division, Office of the Attorney General | (617) 727-2200, ext. 2160 | www.mass.gov/ago/public-safety/resources-for-victims/victims-of-violent-crime/victim-compensation.html |
| Information (for phone numbers of local domestic violence shelters and services) | 411 | |

| MANDATED REPORTING | | |
|---|---|---|
| **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| Elder Abuse<br>Executive Office of Elder Affairs | (800) 922-2275 | www.mass.gov/elders/service-orgs-advocates/protective-services-program.html |
| Disabled Persons Protection Commission | (800) 426-9009<br>TTY (888) 822-0350 | www.mass.gov/dppc |
| Department of Children and Families (Child-at-Risk Hotline) | (800) 792-5200 | www.mass.gov/eohhs/gov/departments/dcf/child-abuse-neglect |

| LEGAL ADVOCACY RESOURCES | | |
|---|---|---|
| **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| Cambridge and Somerville Legal Services | (617) 603-2700 | www.gbls.org/impact-advocacy/cambridge-somerville-legal-services |
| Greater Boston Legal Services | (617) 371-1234<br>(800) 323-3205 | www.gbls.org |
| Harvard Legal Aid Bureau | (617) 495-4408 | www.harvardlegalaid.org |
| Mass Legal Services | | www.masslegalservices.org |
| Mass Legal Help | | www.masslegalhelp.org |

| VICTIM ASSISTANCE PROGRAMS AND COURT LISTINGS | | | |
|---|---|---|---|
| Massachusetts SAFEPLAN civil court advocacy program | | www.mass.gov/mova/safeplan/safeplan-agencies-and-courts/ | |
| MA Court System (forms and filing information) | | www.mass.gov/courts/forms/restrain-harass-forms-gen.html | |
| **BARNSTABLE COUNTY** | | | |
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Hyannis*<br>Serving: Barnstable Probate and Family Court, Barnstable District Court, Falmouth District Court, and Orleans District Court | Independence House | (508) 771-6507 | www.independencehouse.org |
| **BERKSHIRE COUNTY** | | | |
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Pittsfield*<br>Serving: Berkshire Probate and Family Court, Northern Berkshire District Court (North Adams), and Southern Berkshire District Court (Great Barrington) | Elizabeth Freeman Center | (413) 499-2425<br>(866) 401-2425 — hotline | www.elizabethfreemancenter.org |

| BRISTOL COUNTY | | | |
|---|---|---|---|
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Attleboro*<br>Serving: Attleboro District Court, Taunton District Court, and Taunton Probate and Family Court | New Hope | (508) 226-4015 | www.new-hope.org |
| *Fall River*<br>Serving: Bristol County Probate and Family Court (Fall River) and Fall River District Court | The Women's Center at SSTAR Center | (508) 324-3500 | www.sstar.org/womens-center |
| *New Bedford*<br>Serving: Bristol County Probate and Family Court (New Bedford) and New Bedford District Court | New Bedford Women's Center | (508) 672-1222<br>(508) 996-3343 | www.thewomenscentersc.com |
| **FRANKLIN COUNTY** | | | |
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Greenfield*<br>Serving: Franklin County Probate and Family Court, Greenfield District Court, and Orange District Court | (NELCWIT) New England Learning Center for Women in Transition | (413) 772-0871 | www.nelcwit.org |
| **HAMPDEN COUNTY** | | | |
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Holyoke*<br>Serving: Hampden County Probate and Family Court, Chicopee District Court, and Holyoke District Court | Womanshelter/ Compañeras, Inc. | (413) 536-1628 | www.womanshelter.org |
| **HAMPSHIRE COUNTY** | | | |
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Springfield*<br>Serving: Hampshire County Probate and Family Court, Eastern Hampshire District Court (Belchertown), Northampton District Court, and Westfield District Court | YWCA of Western Mass., Inc. | (413) 732-3121 | www.ywworks.org |
| **MIDDLESEX COUNTY** | | | |
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Boston*<br>Serving: Middlesex County Probate and Family Court | Greater Boston Legal Services | (617) 371-1234<br>(800) 323-3205 | www.gbls.org |
| *Leominster*<br>Serving: Ayer District Court | YWCA of Central MA, Inc./BWR | (978) 537-8601 | www.ywcacentralmass.org/ domestic-violence/dvs-bwr |

| PLYMOUTH COUNTY | | | |
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| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Brockton*<br>Serving: Brockton District Court and Brockton County Probate and Family Court (Brockton) | A New Day | (508) 588-2045 | healthimperatives.org/anewday/new-day |
| *North Plymouth*<br>Serving: Plymouth County Probate and Family Court (Plymouth), Hingham District Court, Plymouth District Court, and Wareham District Court | South Shore Women's Resource Center | (508) 746-2664 | www.thesswrc.org |
| **WORCESTER COUNTY** | | | |
| **MUNICIPALITY** | **PROGRAM NAME** | **TELEPHONE** | **WEBSITE** |
| *Leominster*<br>Serving: Clinton District Court, Fitchburg District Court, Gardner District Court, Leominster District Court, and Winchendon District Court | YWCA of Central MA, Inc./BWR | (978) 537-8601 | www.ywcacentralmass.org/domestic-violence/dvs-bwr |
| *Worcester*<br>Serving: Worcester County Probate and Family Court, and Worcester District Court | YWCA of Central MA, Inc./Daybreak | (508) 755-9030 — hotline | www.ywcacentralmass.org/domestic-violence/dvs-daybreak |

| CERTIFIED BATTERER INTERVENTION SERVICES | | | |
|---|---|---|---|
| **BOSTON AREA** | | | |
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Cambridge*<br>Covering Cambridge and Roxbury | Emerge | (617) 547-9879 | www.emergedv.com |
| *Chelsea* | Chelsea ASAP | (617) 884-6829 | www.baycove.org |
| *Jamaica Plain*<br>Covering Cambridge, Dorchester, Jamaica Plain, and Quincy | Common Purpose | (617) 522-6500 | www.commonpurpose.com |
| *Norwood* | Project Safe | (781) 762-0060 | www.baystatecs.org/prevention-ps.html |
| *Somerville* | Massachusetts Alliance for Portuguese Speakers (MAPS) | (617) 864-7600 | www.maps-inc.org |

| CAPE COD AND THE ISLANDS | | | |
|---|---|---|---|
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Hyannis* | Family and Community Resources | (508) 778-0927 | www.fcr-ma.org |
| **SOUTH OF BOSTON** | | | |
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Attleboro*<br>Covering Attleboro, Franklin and Taunton | RESPECT | (508) 226-8286 | www.new-hope.org/respect.html |
| *Brockton*<br>Covering Brockton, Martha's Vineyard, Hyannis, and Nantucket | Family and Community Resources | (508) 584-2207/<br>(508) 778-0927 | www.fcr-ma.org |
| *Fall River* | SSTAR | (508) 324-3597 | www.sstar.org/site/BIP.asp |
| *New Bedford*<br>Covering New Bedford, Wareham, and Plymouth | Stop Taking Others' Power (STOP) | (508) 994-0885, ext. 3155 | www.hptc.org/Brochures/bip.pdf |
| *Plymouth* | South Shore Women's Resource Center | (508) 830-1234 | www.sswrc.org |
| *Quincy* | Project Safe | (617) 471-8400, ext. 129 | www.baystatecs.org/prevention-ps.html |
| **NORTH OF BOSTON** | | | |
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Lynn/Malden* | Impact Batterer Intervention Program | (781) 864-4753 | www.eliotchs.org |
| *Methuen*<br>Covering Gloucester, Haverhill, Lawrence, Lowell, and Newburyport | Family Safety Project | (978) 989-9042 | www.steward.org/holy-family/services-and-clinical-centers/family-safety-project/family-safety-project |
| **WEST OF BOSTON** | | | |
| **MUNICIPALITY** | **ORGANIZATION** | **TELEPHONE** | **WEBSITE** |
| *Fitchburg*<br>Covering Fitchburg, Framingham, Marlborough, Milford, Southbridge, and Worcester | P.A.V.E. | (978) 343-2433, ext. 6108 | www.spectrumhealthsystems.org |
| *Greenfield*<br>Covering Athol, Greenfield, Belchertown, and Northampton | Moving Forward Program | (413) 587-9050 | www.servicenet.org/clinical/moving-forward |
| *Springfield*<br>Covering Springfield and Greenfield | Gandara Mental Health | (413) 846-0418 | www.gandaracenter.org |
| *Ware* | Proteus | (413) 967-9807 | www.carsoncenter.org |
| *Worcester* | RESPECT | (508) 753-3146 | www.new-hope.org/respect.html |

# Supplemental Web Resources

Many violence prevention organizations maintain a robust Internet presence, primarily through websites and social networking. The resources below highlight a few key statewide resources for IPV. This list is not meant to be exhaustive.

## *Massachusetts Resources*

### Asian Task Force Against Domestic Violence
www.atask.org

The Asian Task Force Against Domestic Violence (ATASK) provides a multilingual helpline, an emergency shelter, outreach through trainings for local police and for medical and dental providers, dating violence prevention sessions for youth in area schools, and communication with community members, service providers, and business owners about domestic violence in Asian families and communities. ATASK also offers programs and services including financial literacy, legal referrals, representation through a legal advocacy program, and education through its Youth Empowerment Program and teen dating violence workshops.

### Boston Medical Center Child Witness to Violence Project
www.childwitnesstoviolence.org

The Child Witness to Violence Project is a respected counseling, advocacy, and outreach project based at Boston Medical Center that focuses on children who are bystanders to community and domestic violence.

### Conference of Boston Teaching Hospitals (COBTH), Domestic Violence Council
http://cobth.org/dom_violence.html

The Domestic Violence (DV) Council was created by COBTH member CEOs in 1995 to address the issue of domestic violence. The DV Council works to raise awareness about DV among teaching hospitals, and to enhance collaboration among hospitals. It also explores partnership opportunities with community organizations.

### GLBTQ Domestic Violence Project (GLBTQ-DVP)
www.glbtqdvp.org

The GLBTQ-DVP offers free and confidential support and services for GLBTQ survivors of domestic and sexual violence through community-based services, a legal program, and workshops and trainings.

### Jane Doe, Inc.
www.janedoe.org

Jane Doe Inc. (JDI) is a statewide membership advocacy organization of 60 community-based sexual assault and domestic violence programs across the Commonwealth. JDI works closely with its member programs to understand the impact that domestic and sexual violence has on survivors, their children, and local communities and improve options for their dignity, liberty, and safety. JDI works closely with

its membership, state agencies, the executive and legislative branches of state government, other state and national advocacy organizations, federal agencies, and elected officials to integrate local, state, and national practices to end domestic and sexual violence.

### Mass Legal Help

www.masslegalhelp.org/domestic-violence/where-do-we-go-from-here

Funded by the Massachusetts Legal Assistance Corporation, this site provides a range of information and resources, including an online self-help guide for survivors and domestic violence advocates.

### Massachusetts Department of Public Health, Division of Violence and Injury Prevention

www.mass.gov/eohhs/gov/departments/dph/programs/community-health/dvip and www.mass.gov/eohhs/gov/departments/dph/programs/hcq/healthcare-quality/health-care-facilities/hospitals/dv-sv/supporting-resources.html

The Division of Violence and Injury Prevention funds programs that provide direct services, technical assistance, support, outreach, education, training, and data collection to individuals, communities, and organizations across the state. Four program units comprise the Division: the Child and Youth Violence Prevention Unit, the Injury Prevention and Control Program, the Sexual and Domestic Violence Prevention Unit, and the Suicide Prevention Program.

### Massachusetts General Laws

https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter260

In August 2014 Governor Deval Patrick signed a comprehensive domestic violence bill into law. Chapter 260 of the Acts of 2014 provides new legal protections for victims, brings new criminal offenses, and imposes training for a wide variety of professionals including physicians, nurses, and other health care providers.

### Massachusetts Medical Society Campaign Against Violence

www.massmed.org/violence

The Massachusetts Medical Society (MMS) advocates for the shared interests of patients and the medical profession. Since 1992, the MMS Campaign Against Violence has provided leadership, policy support, and educational materials for health professionals and patients in the areas of intimate partner violence, child abuse and neglect, youth violence, sexual assault, human trafficking, and elder abuse.

### The Network/La Red

www.tnlr.org

Founded in 1989, The Network/La Red is a national resource and model for battered women's programs; batterer intervention programs; and gay, lesbian, bisexual, and transgender organizations. The Network/La Red is a founding member of the Boston area GLBT Domestic Violence Coalition and a member of many national, state, and local coalitions, commissions, and boards.

## *National Resources*

### Academy on Violence and Abuse
www.avahealth.org

The Academy on Violence and Abuse is an academic and health professional membership-based organization dedicated to advancing health education and research on the prevention, recognition, and treatment of the health effects of violence and abuse.

### Centers for Disease Control and Prevention: National Center for Injury Prevention and Control, Division of Violence Prevention
www.cdc.gov/ncipc/dvp/dvp.htm

The CDC National Center for Injury Prevention and Control provides up-to-date research and statistics related to child maltreatment, intimate partner violence, sexual violence, suicide, and youth violence.

### FaithTrust Institute
www.faithtrustinstitute.org

The FaithTrust Institute provides multi-faith and religion-specific intervention and prevention training, consulting, and educational materials for national, state, and community faith-based and secular organizations about domestic and sexual violence, healthy teen relationships, child abuse, child and youth exposure to violence, trafficking of persons, and healthy boundaries for clergy and spiritual leaders.

### Futures Without Violence
www.futureswithoutviolence.org

Formerly known as the Family Violence Prevention Fund, Futures Without Violence (Futures) serves as the national health resource center for family violence. Futures provides a broad range of programs, policies, and campaigns that empower individuals and organizations working to end violence against women and children.

### Health Professional Education, Advocacy and Linkage (HEAL) Trafficking
www.healtrafficking.org

HEAL Trafficking is a national collaborative network of health professionals and advocates passionate about ending human trafficking and supporting its victims. The HEAL Trafficking website offers a compendium of medical literature and educational resources on human trafficking prevention, identification, care, and referral.

### Minnesota Center Against Violence and Abuse
www.mincava.umn.edu

The Minnesota Center Against Violence and Abuse is a respected online clearinghouse providing access to research, education, and other violence-related publications and resources.

### National Center on Elder Abuse
www.ncea.aoa.gov

The National Center on Elder Abuse (NCEA) is a national resource for law enforcement and legal professionals, public policy leaders, researchers, and the public. The center's mission is to promote understanding, knowledge sharing, and action on elder abuse, neglect, and exploitation.

### National Criminal Justice Reference Service
www.ncjrs.org

The National Criminal Justice Reference Service is a federally-funded resource that supports a range of research, policy, and program development initiatives.

### National Domestic Violence Hotline
www.ndvh.gov

The National Domestic Violence Hotline operates a 24-hour, toll-free, confidential hotline that provides support and information for survivors of abuse and for concerned friends and family. The hotline number is 1-800-799-SAFE (7233); TTY 1–800–787–3224.

### National Coalition Against Domestic Violence
www.ncadv.org

The NCADV is an advocacy organization dedicated to education, technical assistance, community awareness and outreach, and survivor support.

### National Health Collaborative on Violence and Abuse
www.nhcva.org

The National Health Collaborative on Violence and Abuse is comprised of more than 30 national professional health associations (including the Massachusetts Medical Society), dedicated to reducing and addressing the health consequences of intimate partner violence (IPV) and other forms of abuse.

### National Institute of Justice: Bureau of Justice Statistics
www.bjs.gov

Provides up-to-date information on research and statistics related to crime victimization including intimate partner violence.

### National Network to End Domestic Violence
www.nnedv.org

Established in 1990, the National Network to End Domestic Violence, Inc., provides training and technical assistance to state coalitions against domestic violence, furthers public awareness of domestic violence issues, and advocates for federal legislation and funding to better serve those affected by domestic violence.

### National Resource Center on Domestic Violence
www.nrcdv.org

The National Resource Center on Domestic Violence (NRCDV) is a comprehensive source of information for those wanting to educate themselves and help others on issues related to domestic violence. Through its many key initiatives such as VAWnet, the Domestic Violence Awareness Project, the Domestic Violence Evidence Project, and Building Comprehensive Solutions to Domestic Violence, NRCDV works to improve community response to domestic violence and, ultimately, prevent its occurrence. It offers technical assistance, training and resource development to broadly serve those dedicated to ending violence in relationships and communities.

### Nursing Network on Violence Against Women International
www.nnvawi.org

The Nursing Network on Violence Against Women International (NNVAWI) encourages the development of nursing practice to address the health and social effects of violence in women's lives.

### Partnership Against Domestic Violence
www.padv.org

This website houses a virtual library of information about violence, representing data from seven different federal agencies.

### Rape, Abuse and Incest National Network
www.rainn.org

The Rape, Abuse and Incest National Network (RAINN) is the nation's largest anti-sexual assault organization. RAINN operates the National Sexual Assault Hotline (1-800-656-HOPE) and carries out programs to prevent sexual assault, help victims, and ensure rapists are brought to justice.

### U.S. Department of Justice, Office of Violence Against Women
www.justice.gov/ovw

The OVW website provides federal leadership to reduce violence against women and to administer justice and strengthen services to victims of domestic violence, dating violence, sexual assault, and stalking.

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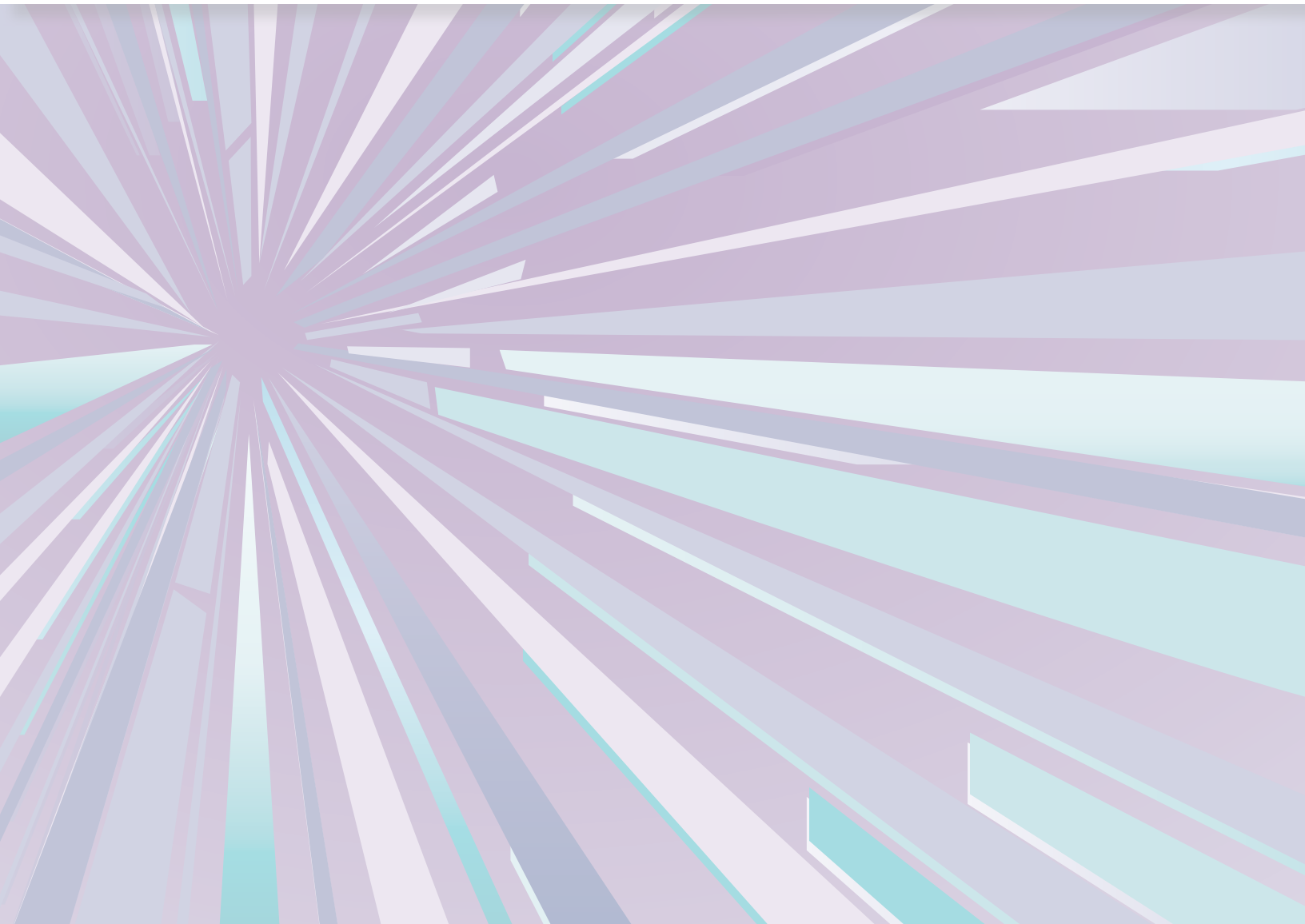

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## 24-HOUR HOTLINES

National Domestic Violence Hotline (Nationwide)
(800) 799-SAFE

SafeLink, the Massachusetts Statewide
Domestic Violence Hotline
(877) 785-2020

## INFORMATION AND REFERRAL IN MASSACHUSETTS

Jane Doe Inc., the Massachusetts Coalition
Against Sexual Assault and Domestic Violence
(617) 248-0922
(Monday through Friday, 9 a.m. to 5 p.m.)

## FOR PHONE NUMBERS OF LOCAL SERVICES AND SHELTERS FOR BATTERED WOMEN AND MEN IN MASSACHUSETTS, CALL:

Directory Assistance
411

For Emergency Assistance
911

For additional resource information, see pages 61 to 76.

CAMPAIGN AGAINST
VIOLENCE

**Massachusetts Medical Society**
**Massachusetts Medical Society Alliance**
**860 Winter Street**
**Waltham, Massachusetts 02451-1411**