Hanging Out or Hooking Up:

Clinical Guidelines on Responding to Adolescent Relationship Abuse

An Integrated Approach to Prevention and Intervention

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PART 1: INTRODUCTION

This resource, ***Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse: An Integrated Approach to Prevention and Intervention,*** focuses on the transformative role of the adolescent health care provider in preventing, identifying and addressing adolescent relationship abuse (ARA). With one in five (20%) U.S. teen girls reporting ever experiencing physical and/or sexual violence from someone they were dating[1] and one in four (25%) teens in a relationship reporting being called names, harassed, or put down by their partner via cell phone/texting,[2] ARA is highly prevalent and has major health consequences. Health care providers can help by providing prevention messages about healthy relationships and helping those exposed to abuse.

These guidelines are all the more critical because, in the summer of 2011, the Institute of Medicine (IOM) issued guidelines that screening for domestic and interpersonal violence be a core component of preventive health services for women and adolescent girls. The recommendations require that new health insurance plans cover domestic violence screening without co-pay and were adopted by the Department of Health and Human Services. Beginning in August 2012, domestic violence screening and counseling will be reimbursed as part of preventive health care services at no additional cost to patients under new health plans. As a result, health care providers need to understand how to routinely assess for and respond to victims of violence.

Background

Futures Without Violence, a leading advocate for addressing intimate partner violence (IPV) in the health care setting, has produced numerous data-informed publications, programs, and resources

to promote routine assessment and effective responses by health care providers. This new resource is adapted from a California publication co-produced by the California Health Adolescent Collaborative and Futures Without Violence, entitled The Healthcare Education, Assessment, and Response Tool for Teen Relationships (HEART) Primer.

In October 2009, California Adolescent Health Collaborative, in partnership with Futures Without Violence and University of California Davis School of Medicine, received funding from the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice to develop a toolkit and accompanying in-person training for California health care providers for addressing adolescent relationship abuse in the clinical setting. Over the course of a year, the HEART Primer and Training Program provided training to over 500 providers throughout the state of California.

At the same time, Futures Without Violence implemented Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women (Project Connect), a national public health initiative funded by the Office of Women's Health to prevent domestic and sexual violence in reproductive, perinatal/MCH, and adolescent health settings. As part of the initiative, state level partners across the country began to train their adolescent health providers on how to respond to ARA. It became clear that a national version of the HEART primer was needed—with a robust focus on prevention of violence through anticipatory guidance about respectful and safe relationships. These guidelines are also informed by a set of reproductive health guidelines created through the Project Connect initiative for adults and adolescents that provide direction on an integrated response to violence and reproductive coercion. (See discussion below)

The Adolescent Relationship Abuse Clinical Guidelines Include:

- Definitions, prevalence, and dimensions of ARA
- An overview of confidentiality and reporting issues and patient-centered reporting
- Clinical strategies to promote universal education about healthy relationships
- Clinical strategies to provide direct assessment and harm reduction strategies for reproductive coercion and ARA
- An overview of preparing your practice to address ARA
- Keys for success, including developing relationships with local domestic violence advocates and community programs
- Policy recommendations

These guidelines are applicable, but not limited to, the following settings serving adolescents:

- Adolescent health clinics and programs
- Pediatric settings
- Family planning clinics
- School-based health centers
- School nurse programs
- OB/GYN and women's health
- Prenatal care and programs
- STI/HIV clinics
- Title X clinics
- HIV prevention programs
- Abortion clinics and services

Adolescent health care providers play an essential role in violence prevention by discussing healthy, consensual, and safe relationships with all patients. The clinical setting may be the sole place an adolescent experiencing abuse may be identified and connected to resources to stay safe.

- Health care providers serving adolescents can offer confidential, safe spaces in which to discuss behaviors that may be abusive and that may be affecting a young person's health.
- Discussions in the clinical context of how abusive behaviors are linked to health risk may facilitate adolescents' recognition of ARA, as well as provide an opportunity to introduce harm reduction behaviors to increase safety and protect their health.
- New research finds that by conducting an assessment and a brief intervention, reproductive health providers can dramatically decrease risk for violence AND unplanned pregnancy.[3]

Unfortunately, the standard-of-care within adolescent health settings does not currently include specified protocols to assess for or intervene to reduce ARA. These guidelines are written with a goal that all adolescents are given universal education on safe, consensual and healthy relationships, and strategies to respond to health issues in a trauma-informed manner. (See box below)

Definitions

One of the challenges in the field of domestic violence research has been a lack of standardized definitions. This is even more so for ARA, also known as dating violence. Although ARA is included in the definition of IPV, experts in the field have noted that while many aspects of ARA are similar to IPV, there are also distinct characteristics relative to the age of the victims and/or perpetrator and different patterns of abusive behaviors.

Adolescent Relationship Abuse

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

What is Trauma-Informed Care?

According to Substance Abuse and Mental Health Services Administration (SAMSHA): Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization. **http://www.samhsa.gov/nctic/trauma.asp**

Dimensions of Abuse	Examples
Emotional/psychological	Name calling via instant messaging or verbally; telling partner what s/he can wear; threatening to spread rumors; threatening to commit suicide if partner tries to leave relationship; smashing things; breaking partner's things; criticizing partners family and friends.
Social	Monitoring partner's cell phone use; preventing partner from going to school or doing things with friends; calling or text messaging multiple times a day to monitor partner's whereabouts; getting angry if partner is talking to someone else.
Financial	Controlling what partner can or can't buy; refusing to help pay for condoms, birth control, or reproductive healthcare; refusing to pay for things that the abuser insisted the partner purchase.
Sexual	Insisting on sexual acts; manipulating contraceptive use; videotaping (including by cell phone) sexual acts then threatening to put them on the internet; preventing partner from using condoms/birth control; forcing partner to get pregnant; forcing partner to use drugs before sexual activity; forced sex/rape.
Physical	Threatening to hit; threatening with a weapon; hurting the partner's pet; hitting slapping, kicking, choking, or shoving.

Adolescent Relationship Abuse (ARA) vs. Teen Dating Violence (TDV)

Teens use a lot of different words for dating and romantic relationships including 'going out,' 'hooking up,' 'talking to,' 'seeing someone,' and many others. These relationships can be a fleeting occurrence or more long term. The term TDV implies a 'dating' relationship, and therefore does not accurately represent the full spectrum of risky or unhealthy relationships. *ARA is a term that encompasses the broadest definition of 'romantic' relationships among teens,* and encourages providers to keep conversations open when framing discussions with patients about relationships. Furthermore, the term 'abuse' calls to mind a wider spectrum of controlling behaviors than the term 'violence.'

The intersections between ARA, reproductive and sexual coercion, and reproductive health have enhanced our understanding of the dynamics and health effects of abusive teen relationships. This has led to expanded terminology to describe forms of abuse and controlling behaviors related to reproductive health.

"Like the first couple of times, the condom seems to break every time. You know what I mean, and it was just kind of funny, like, the first 6 times the condom broke. Six condoms, that's kind of rare, I could understand 1 but 6 times, and then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid."[4]

-17 year old female who started Depo-Provera without partner's knowledge

Reproductive and Sexual Coercion

Reproductive and sexual coercion involves behaviors aimed to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. Most forms of behavior used to maintain power and control in a relationship impacting reproductive health disproportionately affect females. There are, however, some forms of reproductive and sexual coercion that males experience which are included in the definitions below.

Birth Control Sabotage

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

- Hiding, withholding, or destroying a partner's birth control pills
- Breaking or poking holes in a condom on purpose or removing it during sex in an explicit attempt to promote pregnancy
- Not withdrawing when that was the agreed upon method of contraception
- Pulling out vaginal rings
- Tearing off contraceptive patches

Pregnancy Pressure and Coercion

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

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

"He really wanted the baby… he always said, 'If I find out you have an abortion… I'm gonna kill you,' and so I really was forced into having my son. I didn't want to... I just got into [college] on a full scholarship, I just found out, I wanted to go to college and didn't want to have a baby but I was really scared. I was scared of him."[5]

-26 year old female

Sexual Coercion

All experiences of sexual violence including rape impact sexual and reproductive health and there has been a lot of work in the field to address sexual assault in the health care settings. To further support that work, this guide addresses a narrowed focus of interest: sexual coercion.

Sexual coercion expands our understanding beyond traditional definitions of sexual assault and rape. Sexual coercion includes a range of behaviors that a partner may use related to sexual decision-making to pressure or coerce a person to have sex without using physical force. Examples of sexual coercion, which may occur in heterosexual or same sex relationships include:

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

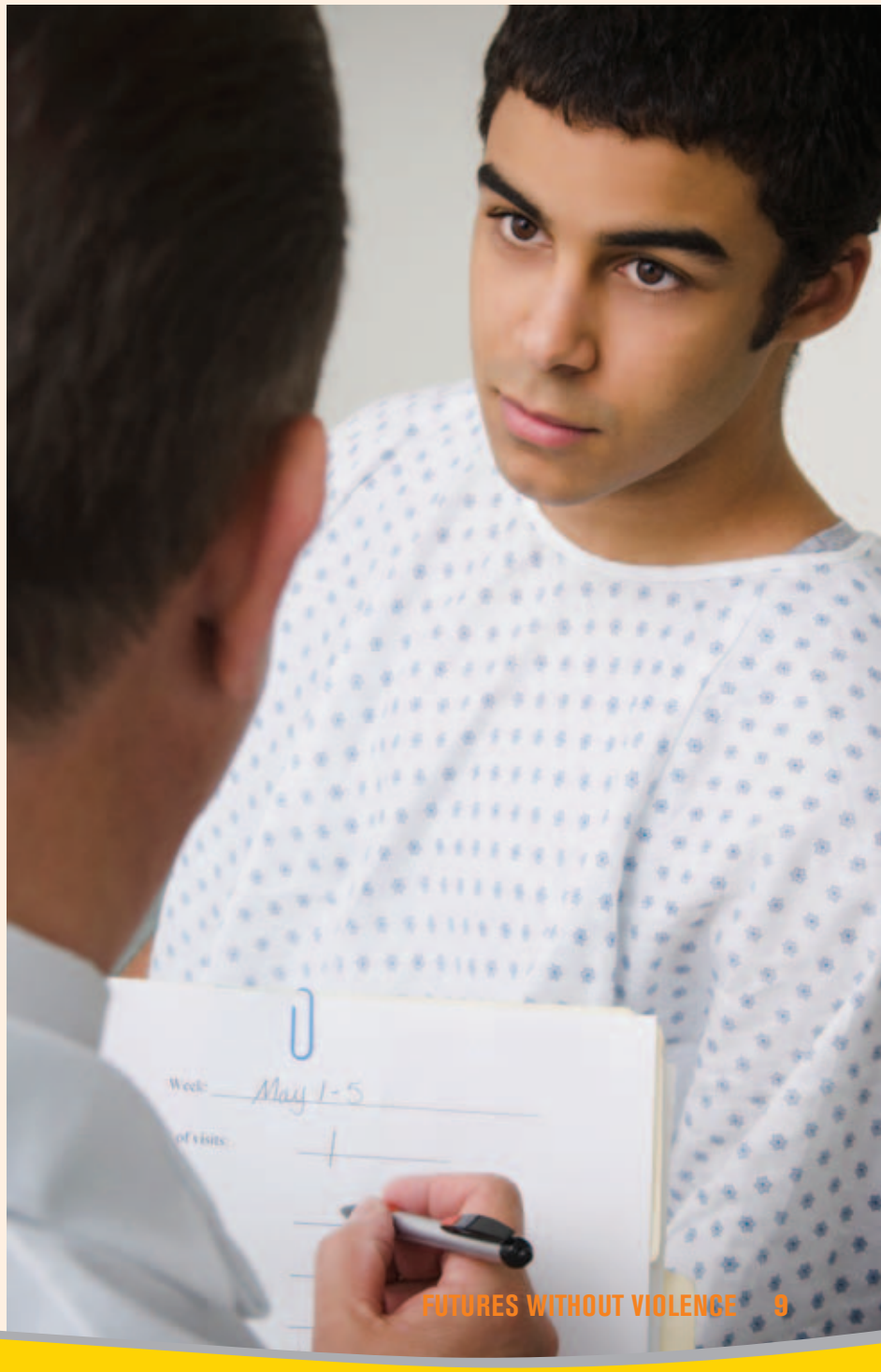
"I'm not gonna say he raped me, he didn't use force, but I would be like, 'No' and then next thing, he pushes me to the bedroom, and I'm like 'I don't want to do anything' and then we ended up doing it, and I was crying like a baby and he still did it. And then after that he got up, took his shower, and I just stayed there like shock."[6]

Males and Reproductive and Sexual Coercion

Adolescent and adult males may also experience reproductive and sexual coercion. A recent national survey on intimate partner and sexual violence in the United States provided the first population based data on males' experiences with reproductive and sexual coercion.[7] Research on the impact of reproductive and sexual coercion on men's reproductive health is urgently needed. This research is essential to inform the development and evaluation of evidence-based interventions for males who experience reproductive and sexual coercion.

What Messages Do We Want to Share with Adolescent and Adult Males?

Male patients need to hear the same messages about the importance of healthy relationships, consensual sex, and consensual contraception to prevent unwanted pregnancies as female patients. Strategies for assessment, harm reduction, and intervention described in these guidelines can be adapted for male patients. As research evidence is being accumulated, clinical experience will help to inform best practices for male patients.



As previously noted, reproductive coercion is limited to heterosexual couples while sexual coercion or rape may occur in heterosexual or same sex couples. Recent research provides some insight into gay and bisexual males' experiences with sexual coercion. In a survey with gay and bisexual men, 18.5% reported unwanted sexual activity.[8] Qualitative data from interviews with gay and bisexual men suggest many of the factors underlying sexual coercion are related more to masculine sexuality versus gay sexuality and that society's response to same sex relationships leads to circumstances such as marginalization that increases vulnerability to sexual violence.[9]

Health care providers have an essential role in prevention by discussing healthy, consensual, and safe relationships with all patients. Some of the screening and intervention strategies described in the guidelines can be adapted for male patients. It is anticipated that future research will provide more information on how to better serve men, same sex couples, and other at-risk populations.

Pediatrics: ARA and Opportunities for Anticipatory Guidance

Many teens seek services at confidential teen clinics because they are or are about to become sexually active—and seek those services because they don't require parent or caregiver consent. All teens are at risk for ARA, including those that receive care from pediatric providers. In some cases, pediatric settings are a primary opportunity to have general conversations before teens begin sexual relationships and seeking out the specialized teen clinics that offer conditional confidential teen health services. The next section of the Guidelines reviews data on the high rates of violence among adolescents seeking services in non-pediatric settings. But this data implies that pediatric providers should also consider conducting conversations with preteens and their parents about the elements of healthy and safe relationships before they seek other services—and what to do and where to go for help if they ever find themselves in an unsafe or unhealthy relationship. The American Academy of Pediatrics has developed guidelines and materials for pediatricians and parents to talk to young people in developmentally appropriate stages about healthy and safe relationships. Please see Connected Kids at **http://www2.aap.org/connectedkids/** for tools and resources.

While Connected Kids spans from early childhood through adolescence, these Clinical Guidelines on Responding to Adolescent Relationship Abuse are focused more narrowly on early to mid adolescence (ages 11-18), offering in-depth strategies for addressing healthy teen relationships specifically during a range of clinical encounters with adolescent patients.

Teen Clinics Essential Sites for ARA Intervention

Adolescent relationship abuse is rarely identified in clinics serving adolescents,[10] but ARA is common among adolescents seeking clinical services.[11,12]

The following adolescent care-seeking patterns underscore the need for teen clinic interventions to identify and intervene in ARA and to provide education regarding ARA for **all** adolescents seeking care:

- Adolescent females utilizing teen clinics, school health centers, and reproductive health clinics report higher rates of physical and sexual violence victimization in their dating relationships than adolescents in the general population.[13,14,15,16,17]
- In adolescent clinic-based samples, the lifetime prevalence of physical and/or sexual violence in dating relationships is about 1.5 to 2 times greater than population-based estimates, ranging from 34% to 53%.[18,19,20]
- Patients with ARA histories do not have a particular risk profile: they seek care for a variety of reasons.[21]
- Only one third of respondents to a clinic-based survey (adolescent females ages 14-20 seeking care in teen clinics) reported having ever been screened for ARA.[22]
- Adolescents report disclosing abusive relationship experiences to friends far more often than to adult caregivers or to health professionals, suggesting that education within clinic settings about 'how to help a friend' may resonate with youth.[23]

As adolescent healthcare utilization patterns differ significantly from those of adults,[24] clinics that serve adolescents in particular, such as confidential teen clinics and school health centers, are strategic sites for adolescent health promotion, prevention, and intervention. Often located in low-income community settings and schools, teen clinics eliminate key barriers to health care by providing comprehensive adolescent health services. Such barriers include concerns about confidentiality, lack of health insurance, and limited knowledge of the healthcare system.[25,26,27] Teen clinics serve large numbers of adolescents who otherwise may not come into contact with health care providers in more traditional settings. Ensuring that practitioners in these clinical settings are equipped with tools to address ARA is a critical component for ARA prevention and intervention.

PART 2: HEALTH EFFECTS OF ADOLESCENT RELATIONSHIP ABUSE

Magnitude of the Problem and Focus

ARA is a pervasive and persistent problem that has major implications for girls and young women and society at large: The 2010 National Intimate Partner and Sexual Violence Survey (NISVSS) by the Centers for Disease Control and Prevention found that more than one in three women (35.6%) and more than one in four men (28.5%) in the US experienced rape, physical violence and/or stalking by an intimate partner in their lifetime. Most female and male victims (69% of female and 53% of male victims) experienced some form of intimate partner violence for the first time before 25 years of age.[28] Each year in the U.S., at least **400,000 adolescents** experience serious physical and/or sexual dating violence.[29] **Two in five (40%)** of female adolescent patients seen at urban adolescent clinics had experienced IPV; 21% reported sexual victimization.[30] In addition to physical injury, ARA is closely linked to many adverse health outcomes including poor mental health, substance use, poor reproductive and sexual health, risky social behavior, and even homicide.

Mental Health and Substance Abuse Risks

The presence of mental health issues such as depression, thoughts of suicide, substance abuse and disordered eating may be clinical indicators to assess for ARA. **Population-based data indicates that adolescents who experienced forced sexual intercourse were more likely to engage in binge drinking and attempt suicide.**[31] Victims of physical and sexual violence in dating relationships are more likely to:

- Report sadness, hopelessness[32] or suicidal ideation.[33] Over 50% of youth reporting both dating violence and rape also reported attempting suicide.[34]
- Engage in substance use.[35]
- Use vomiting for weight loss.[36]

"It got so bad, I tried to kill myself. I tried jumping off the bridge, and stuff like that; 'cause I just couldn't deal with it anymore. I couldn't deal with it. I stopped talking to all my friends. I had a ton of friends from [my hometown], and I wasn't allowed to talk to any of them."[37]

Teen Pregnancy Risks

Although a myriad of teen pregnancy prevention programs have been developed at state and local levels, few directly address the connection between ARA and pregnancy risk, or recognize the identification of one of these risks as a clinical indicator to screen for the other. A large body of research points to the connection between ARA and teen pregnancy:

- Adolescent girls in physically abusive relationships were 3.5 times more likely to become pregnant than non-abused girls.[38]
- Adolescent mothers who experienced physical abuse within three months after delivery were nearly twice as likely to have a repeat pregnancy within 24 months than non-abused mothers.[39]
- Among teen mothers on public assistance who experienced recent ARA, 66% experienced birth control sabotage by a dating partner.[40]

"He was like, 'I should just get you pregnant and have a baby with you so that I know you will be in my life forever.' It's just like, for what, you want me to not go back to school, not go to college, not want me to do anything just sit in the house with a baby while you are out with friends."[41]

-19 year old female

Condom Use

Numerous studies have linked IPV victimization with inconsistent condom use or a partner refusing to use a condom.[42,43,44,45,46] In a literature review on relationship violence, condom use and HIV risk among adolescent girls, physical partner violence was routinely associated with inconsistent or non-condom use.[47] Adolescent boys who perpetrate dating violence are less likely to use condoms, particularly in steady relationships,[48] while girls **experiencing dating violence are half as likely to use condoms** consistently compared to non-abused girls.[49] The connection between IPV and not using condoms is not limited to physical violence. In a national study of adolescents, girls' current involvement in verbally abusive relationships was associated with not using a condom during the most recent sexual intercourse.[50]

Sexually Transmitted Infections (STIs)/HIV Risks

Many STI/HIV prevention and intervention programs focus on condom education. However, condom negotiation may not be possible for young women in abusive and controlling relationships. Requests for STI testing may be a clinical indicator to screen for ARA.

- Lack of control over contraception and fear of condom negotiation, coupled with coercive or forced unprotected sex increases risk for HIV and other STIs in abused adolescent females.[51]

- Girls who experienced physical dating violence were 2.8 times more likely to fear the perceived consequences of negotiating condom use than non-abused girls.[52]
- Under high levels of fear of abuse, women with high STI knowledge were more likely to use condoms inconsistently than non-fearful women with low STI knowledge.[53]
- **More than one-third (38.8%)** of adolescents girls tested for STI/HIV have experienced dating violence.[54]
- Teen girls who are abused by male partners are three times as likely to become infected with an STI/HIV than non-abused girls.[55,56]

"I told him to put a condom on, he didn't...I went to a clinic, and they were like, 'Oh, he gave you Chlamydia.' [H]e said it was me messin' around with some other guy, and that's not true, 'cause I was like, 'You were the only guy I was with.' And he's like, 'Oh, that's you, you're messin' around... I thought you loved me.'"[57]

Other Risks and Outcomes

In addition to health issues, ARA is linked to other risk behaviors and adverse outcomes.

- Victims and perpetrators are more likely to carry weapons, as well as engage in physical fighting,[58] and other high risk behaviors, such as gambling.[59]
- Physical and sexual violence victimization is associated with an increased risk for school dropout, lower grades, and less connectedness to school.[60]
- A third (32%) of female homicides among adolescents between the ages of 11 and 18 are committed by an intimate partner.[61]

Conclusion

ARA is a serious problem with far-reaching consequences for the health and well-being of young people. The medical community has a unique vantage point and opportunity to address this issue as advocates for adolescent safety and well-being, and to connect with their patients around this sensitive topic in a safe environment. An understanding of the complexities of adolescent health and relationships allows health care providers to play an essential role in assessment and intervention. The tools and resources provided in these guidelines are intended to assist practitioners with ARA prevention and intervention in their own clinical settings.

PART 3: GUIDELINES FOR PROVIDING ANTICIPATORY GUIDANCE & UNIVERSAL EDUCATION ON ADOLESCENT RELATIONSHIP ABUSE

- PREPARE
- TRAIN
- INFORM
- ASK & EDUCATE
- INTERVENE & REFER

The following sections offer suggestions for ways providers can integrate both prevention messages and assessment for adolescent relationship abuse into their clinic visits with adolescent patients. Rather than treating "violence screening" as a separate add-on to the clinical encounter, providers are encouraged to integrate discussions of healthy and unhealthy relationships into their everyday clinical encounters. The suggested scripts included here are not exhaustive, but are intended to illustrate ways to bring discussions about relationships into a range of clinical encounters.

Assessment of a young person's thoughts, feelings, and experiences related to romantic relationships is central to approaching adolescent relationship abuse prevention and intervention. A strength-based, positive approach to relationships and human sexuality can begin with anticipatory guidance long before youth begin exploring romantic relationships more seriously.

Anticipatory guidance on healthy relationships can be used to identify early warning signs of unhealthy relationships, to promote safe healthy relationships, to prevent unintended pregnancies and prevent other poor health outcomes. Because of the high prevalence of adolescent relationship abuse, this

discussion should be introduced starting at the 11-12 year old well child visit, before patients start dating. **We recommend anticipatory guidance as universal education messages for all patients.** If patients are sexually active, we recommend following up with more direct ARA assessment questions, found in Section Four of these guidelines

PREPARE

Create a Safe Environment

There are several important steps you can take to create a safe and supportive environment for discussing ARA. These steps include:

- Having a written policy and training on ARA, including the appropriate steps to inform patients about conditional confidentiality and reporting requirements. *(See Appendix A for a sample protocol).*
- Developing a collaborative model of care, where providers partner with other staff/colleagues, community resources and the patients themselves to provide developmentally appropriate, effective and safe ARA interventions. *(For more information on setting up your practice to develop effective community partnerships and recommendations on best clinic team approach, please see Part 5: Policy Implications & Systems Response of these guidelines.)*
- Having a private place to interview patients, where conversations cannot be overheard or interrupted.
- Displaying educational posters addressing ARA and healthy relationships, as well as reproductive coercion that are multicultural and multilingual, on display in bathrooms, waiting rooms, exam rooms, hallways, and other highly visible areas.
- Having information including hotline numbers, safety cards, and resource cards on display in common areas as well as private areas, such as bathrooms and exam rooms, for victims and perpetrators.

Futures Without Violence **(www.futureswithoutviolence.org/health)** has a culturally diverse selection of posters, educational brochures, and safety cards.

Develop Referral Lists and Partnerships with Local and Regional Services

There is a wide array of resources available for victims of abuse on how to get help. Contact the following entities to learn more about these resources:

- The National Teen Dating Abuse Helpline 1 866 331 9474 or online chat at **www.loveisrespect.org.**
- The domestic violence coalition in your state (for a listing go to: **www.nnedv.org/resources/coalitions.html**).
- The violence prevention program in your state health department.

Meet with local domestic and sexual violence service providers to understand the services they provide for adolescents. Arrangements can often be made so staff can call a domestic violence advocate for advice and discuss a scenario hypothetically, if needed, to understand how to best meet the needs of a patient who is experiencing abuse.

TRAIN

Training on adolescent relationship abuse should discuss prevalence, use case examples and build clinical skills on how to start the conversation, offer anticipatory guidance on healthy relationships, assess for reproductive coercion and ARA and offer harm reduction strategies and referrals when needed. Those who should receive training include:

- Physicians
- Nurse practitioners
- Physician assistants
- Public health professionals
- Medical interpreters
- Nurses and nursing assistants
- Midwives
- Mental health professionals
- Social workers
- Health educators
- All health clinic staff including front desk and security guards

Core Training on ARA should be mandatory for all clinic staff that have contact with patients.

Ongoing Training opportunities should be available for new hires and staff who want to repeat the training or want to make use of training being offered by other organizations or online resources.

Refresher Training or case consultations are important to introduce advances in the field and offer opportunities for staff to discuss progress, challenges, and opportunities.

When possible, training should include staff from domestic violence and sexual assault programs.

Training Resources

Making the Connection: Intimate Partner Violence and Public Health is a free resource developed by Futures that can be used for self-directed training and to provide training to your staff and students (download at **www.futureswithoutviolene.org/health**). The toolkit consists of a PowerPoint presentation, speaker's notes, and an extensive bibliography. The following topics are addressed in the toolkit:

- IPV and Family Planning, Birth Control Sabotage, Pregnancy Pressure, and Unintended Pregnancy
- IPV and Sexually Transmitted Infections/HIV
- Adverse Childhood Experiences (ACE) Study: Leading Determinants of Health

Video Case Studies: Futures Without Violence has developed clinical vignettes that demonstrate:

- Providing anticipatory guidance for healthy, consensual relationships
- Discussing confidentiality and mandatory reporting with teens
- Creating opportunities for private time during visits when teens are accompanied by their parents
- Introducing harm reduction strategies for victims of reproductive and sexual coercion

Go to **www.futureswithoutviolence.org/health** for information on new training opportunities as they become available.

INFORM

Limits of Confidentiality

Navigating the balance between confidentiality and abuse reporting requirements is the fundamental challenge in ARA intervention. Laws requiring mandatory reporting of child abuse perpetrated by a parent or caregiver are often clear. However, laws vary widely from state to state for adolescents when it comes to sexual or physical abuse by a partner. As a provider, it is critical to understand the state's minor consent and confidentiality, physical and sexual abuse laws (and in some state, statutory rape laws), and that you are able to clearly articulate them to your patients.

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

Contact the following entities for information and resources specific to your state/region:

- Children protection/child welfare services in your state for information about reporting requirements for minors experiencing and/or exposed to violence
- The domestic violence and sexual assault coalitions in your state may have legal advocates or other experts that provide information and training on reporting requirements for IPV. For a complete list go to **www.nnedv.org/resources/coalitions.html.**

Make sure that you have accurate, up-to-date information about reporting laws for your state, and disclose limits of confidentiality prior to screening.

Provider Tips for Discussing Conditional Confidentiality

- Be direct: Discuss confidentiality and the conditions under which it might be breached at the beginning of the visit.
- Keep it simple: Tailor your discussion to the youth's age and context.
- Communicate caring and concern: Frame your need to breach confidentiality in the context of "getting them the help that they might need," rather than using the law, policy, or phrase "I am a mandated child abuse reporter," as a reason to breach confidentiality.
- Assure two-way communication: Let your patient know if you are going to share information that they told you in confidence.
- Know the law.
- Check for understanding: Ask the patient to explain what they understand about conditional confidentiality.
- Document your communications, understanding and actions in the medical record.

Adapted from *Second edition: Duplessis V, Goldstein S and Newlan S, (2010) Understanding Confidentiality and Minor Consent in California: A Module of Adolescent Provider Toolkit. Adolescent Health Working Group, California Adolescent Health Collaborative.*

Sample Script to Inform Patient About Limits of Confidentiality:

"Before we get started I want you to know that everything here is confidential, meaning I won't talk to anyone else about what is happening unless you tell me that you are (add state specifics here: being hurt physically or sexually by someone, planning on hurting yourself [suicidal], or are planning on hurting someone else). Those things I would have to report, ok?"

Even after clearly outlining the limits of confidentiality with your patients, situations will arise when a report of abuse must be made. Principles of patient-centered reporting will be covered in the **Intervene & Refer** section of these guidelines below.

ASK & EDUCATE

Goals for Universal Education about Healthy Relationships:

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

How Often Should You Educate?

At least annually and with each new partner

When Should You Provide Universal Education?

During any health appointment—including sports physicals

Where Should You Provide Education?

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

Who Should Receive Education About Healthy Relationships?

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

SAFETY TIP

One key recommendation for clinics or providers in private practice is to develop a sign for your waiting room that says: In this clinic, we respect a patient's right to privacy and always see patients alone for some portion of their visit. Having a clearly stated policy like this helps the staff normalize the experience of seeing the patient alone without a friend or family member there—especially if there is an established pattern allowing partners or family members in during the entire visits. Displaying the policy on a sign in the waiting room takes the burden off the patient needing to ask to be seen alone, while allowing the staff member to point to the sign if there is any opposition from the patient's partner.

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

Introductory Statements

Now that you're getting older, you may find that you are attracted to boys or girls or both. One of the things that I talk to all my patients/teens/kids about is how you deserve to be treated by the people you go out with.

Anticipatory Guidance & Educational Messages

I'm talking to you about relationships because I want you to know how important I think it is for your relationships to be healthy, respectful, and to make you feel good.

PROVIDER TIP

It is essential to find out, prior to educating about ARA and reproductive and sexual coercion, whether a patient has sex with males, females, or both so you can tailor your conversation appropriately. For example, for a young woman engaging only in same sex relationships, questions would focus on ARA and sexual coercion while it would not be necessary to ask questions about birth control sabotage. The patient's responses to these questions will help to inform the provider about the best way to proceed relative to the assessment questions and treatment plan.

Hanging Out or Hooking Up Safety Card

As the basis of this anticipatory guidance, Futures Without Violence recommends using the *Hanging Out or Hooking Up* safety cards, which provides information that helps teens make the connection between unhealthy relationships and poor health outcomes. Research shows that brochure-based interventions can be effective at promoting health and safety, and that providers find the tool helpful for starting the conversation.

The safety card includes information about:

- Healthy and respectful relationships
- Adolescent relationship abuse and reproductive and sexual coercion
- How to help a friend experiencing these things
- Textual harassment and digital dating abuse
- Basic safety planning strategies for ARA
- National teen hotline numbers

It is important to discuss the card during the visit, rather than simply handing patients the card. Remember, it may not be safe for some patients who are currently experiencing abuse to leave the clinic with the safety card, so providers should always ask if the patient feels it is safe to take the card with him/her.

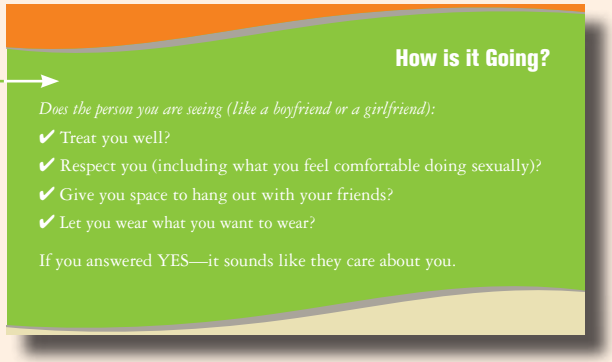
The *Hanging Out or Hooking Up* adolescent safety card, provided as a tear-out resource at the end of this chapter, has been tested in focus groups with a wide range of adolescents—male, female, homeless and LGBTIQ youth. Available in English and Spanish, the safety card is available for free for a limited period of time by going to **www.futureswithoutviolence.org/health**

Remember to discuss limits of confidentiality BEFORE you introduce the card.

Before you introduce the card—normalize

Sample Script:

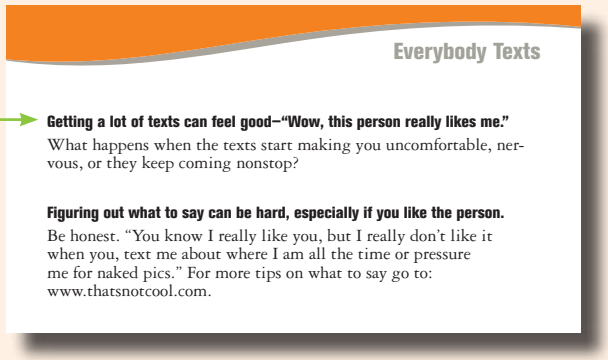
"We've started talking to all the teens in our clinic about what they deserve in relationships. This card is like a magazine quiz (open the card) and it talks about the difference between healthy and unhealthy relationships and tells you how to help a friend if they have anything like this happening to them."



It is not necessary to review all eight panels. Depending on the visit type or questions raised during the visit, the provider can select which panel to focus on. For example,

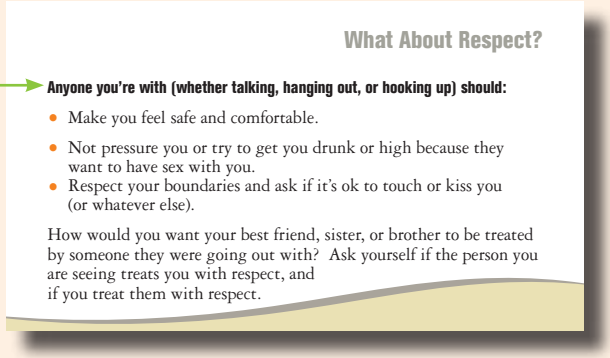
Sample Script:

"I am talking to all the teens in my practice about texting and sending naked pictures online because we know there is a lot a pressure to do this. It can be hard to figure out what to say or do if you are uncomfortable. This section of the card gives you options, things to say and great website to go to for more information to help you figure out what to do if it is an issue for you."



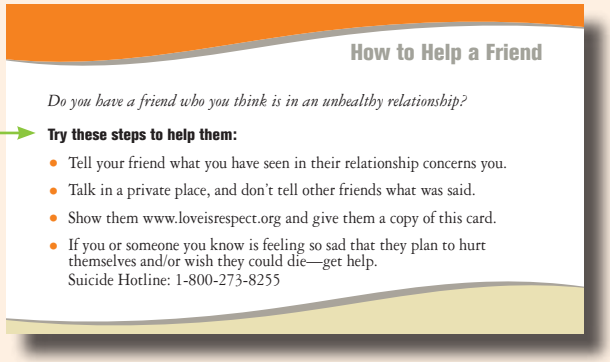
Sample Script:

"It's important that you are treated with respect, and that you treat the person you are seeing with respect, too. Here are some examples of the rights you have in any relationship."



Sample Script:

"I really want to make sure that we spend time talking about relationships, because a healthy relationship is something every young person deserves. If you ever need to help a friend you think is in an unhealthy relationship there are some tips here, and some teen-specific websites and numbers to call. You can take extra cards, if you'd like."



Integrating Assessments: Trauma Informed Responses to Substance Abuse, Depression/Suicide and Disordered Eating

Depending on the purpose and scope of the visit, the *Hanging Out or Hooking Up* safety card can also be used as a tool to talk about other issues, such as substance abuse, disordered eating, depression and suicidal ideation in a trauma-informed manner. As previously noted, ARA is closely linked to many adverse health outcomes and risk behaviors.

Substance Abuse

Remember the facts: Victims of physical and sexual violence in dating relationships are more likely to engage in substance use.[62] Population-based data indicates that adolescents who experienced forced sexual intercourse were more likely to engage in binge drinking and attempt suicide.[63]

What About Respect Panel to provide guidance if your adolescent patient reveals that s/he is smoking, drinking and/or using substances regularly:

Sample Script:

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

Depression and Suicide

Remember the facts: Depressed adolescents are more likely to report having ever been physically or sexually hurt by someone they were dating or going out with.[64]

How to Help a Friend Panel to provide guidance for adolescents that reveal they are sad, irritable, not sleeping well, and/or not motivated:

Sample Script:

"On this panel of the card 'How to Help a Friend' it talks about ways to support someone who might be in an unhealthy relationship. It also talks about if you know someone who is feeling so sad they wish they could die, get help. This is really important because a lot of teens feel depressed or hopeless. Has anyone you were going out with made you feel so bad about yourself that you thought about hurting yourself?"

Disordered Eating

Remember the facts: Adolescents who have experienced ARA are more likely to use vomiting for weight loss.[65]

Sample Script for a patient with an eating disorder:

"This safety card talks a lot about control—ways someone you are seeing can control you. Sometimes, a response to feeling out of control in a relationship, is controlling what you eat and how you eat. Do you ever throw up or use laxatives to make you feel better about yourself, your relationship or to feel more in control?"

INTERVENE & REFER

If your patient says, "No, this is NOT happening in my life:"

Affirm:

- *"I am so glad nothing like that is going on for you"*
- *"It sounds like you are in a healthy relationship, that's great."*

Encourage the patient to take the safety card:

- *"If anything changes or if you have a friend who needs help, this clinic is a safe place to come and talk about it."*
- *"I give this card out to everyone, just in case they have a friend or family member who needs help."*

If a patient discloses abuse: What next?

After ARA has been identified, your goal is to support the patient and gather information without overwhelming the patient. Acknowledge the information shared and validate the strength of the patient for sharing their experience. Once they disclose, the patient may become frightened or overwhelmed, or may not want to discuss the subject any further.

Utilize validating messages

- *"I'm so sorry that happened—it happens way too often."*
- *"You don't deserve to be hurt, and it is not your fault."*
- *"I'm worried about your safety."*

Assure the patient that this is a safe environment

- *"I'm glad you told me, and you can always talk to me about this."*
- *"Is there anything else I can do to help?"*

Remember to address the patient's health issues

It is important to attend to the presenting problem that initiated the patient's visit. Be sure to proceed with your treatment plan in a trauma-informed manner.

Supported Referral Using the Futures Safety Card

The safety card can also be used to discuss safety planning and available resources for patients who are experiencing ARA and/or reproductive and sexual coercion. A sample script for how to use the safety card as an intervention tool is provided below

Sample Script:

"I want you to know that on the back of this safety card there are national hotline numbers with folks who are available 24/7 if you want to talk. They can connect you to local shelter services if you need more urgent help. Also, I know (insert name of local advocate) who I can put you on the phone with right now if you would like to talk to her."

Harm Reduction Strategy

Abusive partners often monitor phones and text messages, so it is important to offer use of a private phone in the clinic to a patient so she can make the call to a shelter or advocacy program without the number being traced by her partner.

If the abusive behavior is not physically dangerous:

> *"I'd like to talk about some strategies for what to say to the person you are seeing when <insert problem here: the constant texting, being disrespected, or being pushed to have sex when you don't want to, etc.> comes up again. Would you feel safe talking to the person you are seeing about this? Are you afraid at all of what they might do if you bring this up?"*

If written information is given to the patient, it should be able to fit in their pocket and done so only if the patient feels safe accepting it.

Work with the patient to identify other adults they may be able to talk to for additional support (parents, older relatives, teachers, clergy, etc.)

> *"Is there any adult you would consider talking to about this, or who could help you if you were hurt?"*

KEY CONSIDERATION

Many clinic staff have never called a local domestic violence service provider or hotline number. We recommend all staff call to find out about the services provided. Clinic staff who engaged in this activity reported greater confidence in giving the referral. Additionally, patients are more likely to use the referral.

For more information on setting up your practice to develop effective community partnerships with local domestic and sexual violence programs, please see Part 5: Policy Implications & Systems Response of these guidelines.

Make a Follow-up Plan

> *"I'd like to check in with you again in a few weeks, let's make an appointment for you."*

Adolescents are often hard to get in touch with. Recording a safe phone number and best ways to follow-up with them will assist in maintaining a connection. This may include getting the young person's permission to contact them through another provider, such as the school nurse, who may have an ongoing relationship with them as well.

If a Positive Disclosure Requires a Report, Practice Patient-centered Reporting

While the language in many mandated reporting laws state that the person who becomes aware of the abuse should report 'immediately' to the relevant authorities, the focus should **always** be on the care and safety of the young person first.

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

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

Always acknowledge their feelings:

Many times, a teen will not want a report to be filed, and will feel helpless, betrayed or angry.

> *"I really hear that you don't want me to do the report, and I am sorry but I have to do this even if I don't want to…"*

Offer ways they can shape the reporting process:

"I do have to make the report, but you are welcome to listen as I call in the report so you know what is being said and there are no surprises. I can also put in the report any concerns you have about what will happen when your parent's are told about what happened or the best ways to inform them (place, time, one parent over the other etc)."

- Explain what will happen after the report is made —invite the patient to share their concerns about a report being made, who would find out and how they might react; it often helps a young person to know that they are not at fault and that the provider does not have a choice about making such a report.
- Call an advocate to help her create a safety plan in case of retaliation—for example, offering for a meeting with the child welfare investigator to occur at the clinic site may be an option.
- Maximize the role of the patient—asking the patient how to make the report in a way that is as safe as possible is key; whenever possible, the report should be made with the young person in the room so they can provide accurate information and know what is being disclosed.

Sample Futures Safety Card for Adolescent Relationship Abuse

Tear out this sample card and fold it to wallet size. To order additional free cards for your practice go to: www.FuturesWithoutViolence.org/health

What About Respect?

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

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

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

FOLD >

How to Help a Friend

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

Try these steps to help them:

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

FOLD >

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FUTURES WITHOUT VIOLENCE™

Formerly Family Violence Prevention Fund

FuturesWithoutViolence.org

The American College of Obstetricians and Gynecologists

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

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

Suicide Prevention Hotline
1-800-273-8255

Teen Runaway Hotline
1-800-621-4000

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

FOLD >

Hanging out or Hooking up?

How is it Going?

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

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

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

And on a Bad Day?

How often does the person you are seeing:

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

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

Everybody Texts

Getting a lot of texts can feel good–"Wow, this person really likes me."
What happens when the texts start making you uncomfortable, nervous, or they keep coming nonstop?

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

What About Sex?

Can you talk to the person you are seeing about:

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

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

PART 4: DIRECT ASSESSMENT FOR REPRODUCTIVE COERCION OF SEXUALLY ACTIVE ADOLESCENT GIRLS

While the preceding section of these guidelines focused on anticipatory guidance and universal education on healthy relationships, this section focuses on reproductive and sexual coercion as a health issue for adolescent girls, with a particular focus on how both teen and adult males can interfere with and limit their female partners' ability to make choices about their reproductive health.

Which safety card should I use?

These guidelines offer two cards. One (reviewed in Part 3) which focuses on healthy and unhealthy relationships and is intended to be gender neutral and inclusive of diverse sexual orientations. The second card is specific to assessment for reproductive coercion (reviewed below). We recommend utilizing this card specifically when an adolescent female is presenting for:

- Emergency contraception
- Pregnancy testing
- STI testing
- Contraceptive counseling

If the provider's assessment suggests that reproductive coercion may be occurring in the relationship, offering this card to the patient may be more relevant. In other instances, where the provider's assessment suggests that a broader focus on healthy relationships is more relevant, the *Hanging Out Hooking Up* card may be more relevant.

The safety card for reproductive health, developed by Futures Without Violence and co-branded by the American College on Obstetricians and Gynecologists (the College), is a wallet-size card that includes self-administered questions for ARA and reproductive and sexual coercion, harm reduction and safety planning strategies, and information about how to get help and resources. Providers can use the safety card to facilitate screening and educate patients about the impact of ARA and reproductive and sexual coercion on reproductive health.

In a randomized controlled trial, women seen at four family planning clinics were asked questions about IPV and reproductive and sexual coercion and reviewed the safety card with their providers. The time required to review the safety card with a patient varied from less than a minute to longer discussions when IPV and/or reproductive and sexual coercion were disclosed.

Among women who reported IPV in the past three months at the time of initial assessment and received the safety card intervention, there was a 71% reduction in the odds of pregnancy pressure and coercion at the followup, 12 to 24 weeks later.[66]

Women who received the safety card were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe regardless of whether they had disclosed a history of IPV. This intervention is based on more than two decades of research, including other randomized controlled trials, which has shown that assessment combined with a small safety card can reduce violence and improve safety behaviors among female patients disclosing IPV.[67,68,69,70]

How can using the safety card help with screening given many women choose not to disclose what is happening to them?

Some patients may not feel safe or comfortable disclosing ARA or reproductive and sexual coercion when asked. Research also shows that cultural stereotypes about rape and sexual assault influence a woman's perceptions of sexually coercive experiences. Coerced sex by an intimate partner may not be perceived as a real sexual assault or rape. Sexual coercion by a dating partner, especially when alcohol is involved, may be minimized due to cultural stereotypes.[71]

Regardless of whether a patient discloses abuse, assessment is an opportunity to educate patients about how abusive and controlling behaviors in a relationship can affect her reproductive health. The safety card provides information that helps adolescents to make the connection between unhealthy relationships and reproductive health concerns such as unintended pregnancies. *Asking about IPV and reproductive and sexual coercion lets patients know that they are not alone and that you are a safe person to talk to.* The safety card includes information about safety strategies and referrals a patient can refer to after her visit. The safety card was designed as a small, easy to conceal card based on strategies used by domestic violence advocates who are experts on safety concerns and safety planning with IPV victims. It is important to remember that it may not be safe for some patients who are currently experiencing abuse to leave the clinic with the safety card.

Remember before you ask — always discuss limits of confidentiality.

How Often Should You Ask?

At least annually and with each new partner (If a patient has multiple repeat visits for pregnancy testing, STI testing etc consider these as clinical indicators to assess more frequently).

When Should You Ask?

During any reproductive health appointments—(Pregnancy tests, STI/HIV tests, initial and annual visits, abortions, birth control options counseling).

Where Should You Ask?

In a private setting such as the exam room and only when the patient is by herself without parents, partners, or friends present.

PROVIDER TIP

Asking questions about reproductive and sexual coercion will help you develop a patient's treatment plan, identify potential complications and compliance considerations, and assess other health risks and safety concerns. This approach will save time and improve outcomes.

Making the link between violence and reproductive health uncovers risk factors that are compromising a patient's reproductive health and allows providers to offer interventions that are the most likely to succeed.

For example, research has shown that women under high levels of fear of abuse with high STI knowledge used condoms less consistently than non-fearful women with low STI knowledge.[72] More HIV education without addressing the role of abuse is unlikely to lead to safer sex practices in this scenario.

Using the safety card integrates assessment with patient education. This integrated approach informs patients about the increased risk of contracting STIs/HIV in abusive relationships and teaches condom negotiation skills within the context of abusive relationships. The safety card also offers less detectable female controlled protective strategies that can improve reproductive health outcomes and enhance quality of care.

Examples of scripts that demonstrate how to counsel a patient about harm reduction strategies when IPV and/or reproductive and sexual coercion is disclosed, including sample scripts for different types of visits and clinical scenarios, are shown below.

Strategic Safety Card Use: Assessment and Intervention for ARA, Reproductive and Sexual Coercion

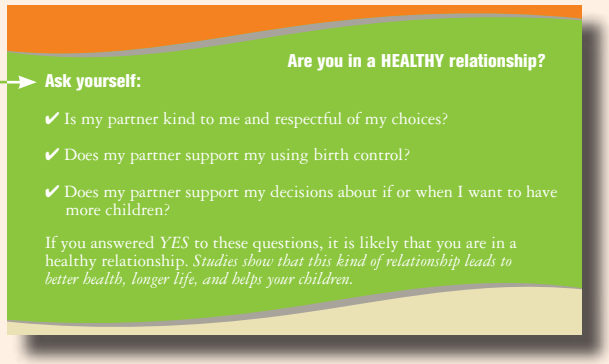
Select relevant panels of the card based on the type of visit for assessment and offer visit-specific harm reduction strategies when problems are identified.

Part of patient education is talking about healthy, safe, and consensual relationships. Health care providers can also play an important role in preventing abuse by offering education and anticipatory guidance about what a healthy relationship looks like, particularly for adolescent girls—but this is true for adult women too.

The following sample script provides more messaging about healthy, safe, and consensual relationships that can be shared with every patient.

Sample Script:

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



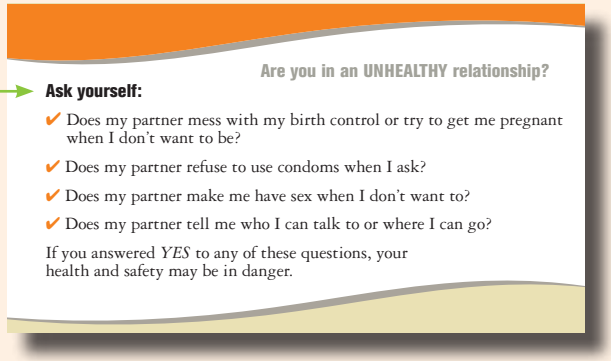
Birth Control Options Counseling

PROVIDER TIP

Before spending valuable time counseling a patient about various contraceptive methods, assess if she is at risk for reproductive coercion. By changing the pronouns in the self-quiz found in the safety card,

Sample Script:

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



Harm Reduction Strategy:

If her answer is yes, talk with her about contraceptive options that are less vulnerable to being tampered with, such as IUDs, Depo-Provera and Implanon.

Sample Script:

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

Taking Control:

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

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

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

Although discrepancies may still exist between clinical protocols regarding appropriate timing for use of intrauterine devices (IUDs) in nulliparous women and adolescent girls, recent recommendations clearly state that IUDs offer a safe and appropriate option for nulliparous women and teens. In 2011, The American College of Obstetricians and Gynecologists (ACOG) issued a Practice Bulletin on long-acting, reversible contraception.[73] There are no studies that have demonstrated an increased risk of pelvic inflammatory disease (PID) in nulliparous IUD users and there is no evidence that IUD use is associated with subsequent infertility. As described in the bulletin, the U.S. Medical Eligibility Criteria for Contraceptive Use assigns a Category 1 for contraceptive implant use among nulliparous women and adolescents.

SAFETY FIRST!

It is important to be aware that some controlling partners may monitor bleeding patterns and menstrual cycles. For these women, the safest option may be the Copper T IUD as it does not change their cycle.

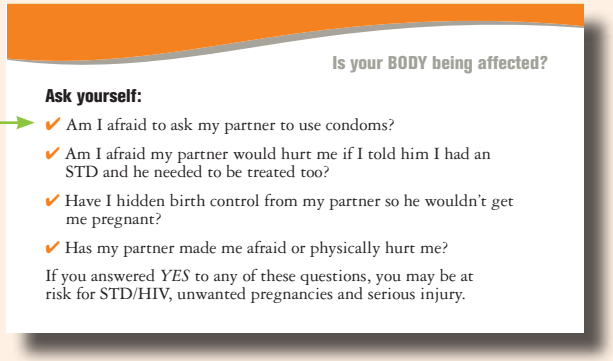
For IUD users, it is also recommended to discuss cutting the strings short in the cervical canal so the device cannot be felt or detected by her partner.

When Condoms Are the Preferred Contraceptive Method

Ask the patient if she is comfortable asking her partner to use condoms and if her partner is supportive of her choice.

Sample Script:

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



Is your BODY being affected?

Ask yourself:

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

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

What to do if you get a "yes" to difficulty negotiating condoms:

Sample Script:

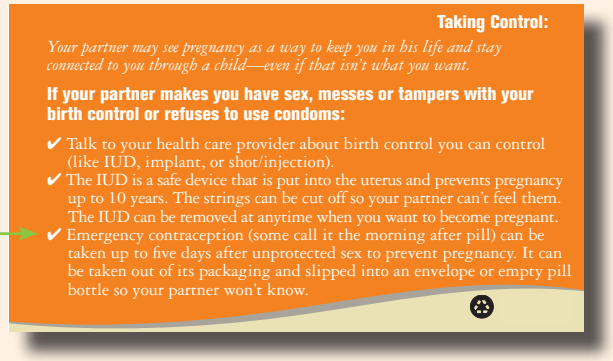
"I have had a lot a patients tell me they are (fill in blank) uncomfortable asking, worried about breakage or not sure what to do when he gets mad. There is another method you might consider that doesn't have hormones that doesn't depend upon him using condoms."

Emergency Contraceptive Visit

Whenever someone comes in for Emergency Contraception (EC) or the morning after pill there are key questions to ask and patient education to provide to help determine whether the sex was consensual or if any contraceptive tampering may be occurring. Due to some patients not feeling comfortable disclosing what is happening to them, it is helpful to review the harm reduction portion of the card so that all EC patients know about this strategy whether they disclose or not.

Sample Script:

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



PROVIDER TIP

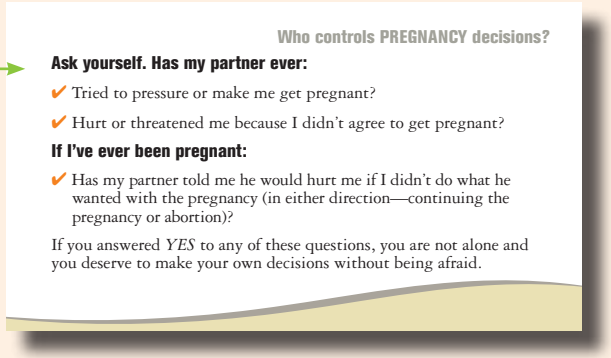
EC Harm Reduction Strategy: Emergency contraception is often packaged in a large box with bold labeling and could easily be discovered in a purse or a backpack by an abusive partner. Consider offering harm reduction strategies such as giving a patient an envelope so that she can remove the EC from the packaging and then conceal it in the envelope so it is less likely to be detected by her partner.

Pregnancy Test Visits

The panel, "Who controls PREGNANCY Decisions?" of the safety card should be reviewed with patients for all positive or negative pregnancy test results. Pregnancy options counseling should also include these key assessment questions.

Sample Script:

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



Harm Reduction Strategy

If a patient discloses that she is afraid of her partner, follow up by offering referrals to local domestic violence programs and reminding her about the National Domestic Violence Hotline shown on the back of the safety card.

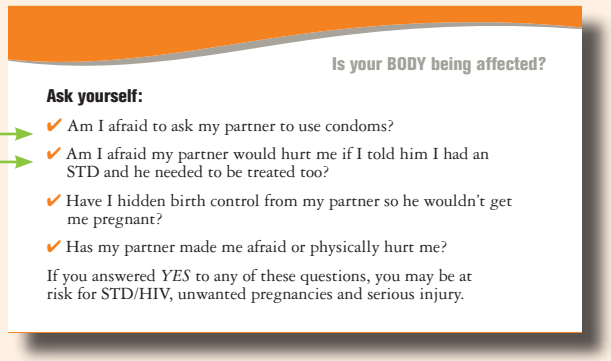
Testing for Sexually Transmitted Infections (STIs)

Because STI/HIV is highly correlated with abusive relationships it is important to make sure she is safe and able to make decisions about condoms.

Sample Script:

"Anytime patients come in for STI/HIV testing, we always ask if they feel comfortable talking to their partners about using condoms."

"Are you afraid to ask your partner to use condoms or does he ever get mad at you for asking?"

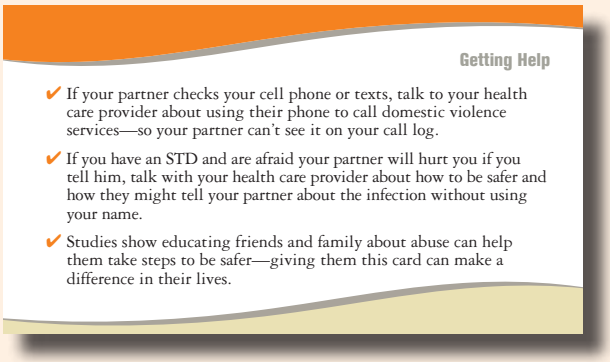


Positive STI Test Result—Seeking Treatment for STI Exposure

Patient-initiated partner notification for treatment of STIs/HIV can compromise a patient's safety if she is in an abusive relationship. Women experiencing physical or sexual IPV are more likely to be afraid to notify their partners of a STI. In a study with a culturally diverse sample of patients seeking care at family planning clinics, female patients exposed to IPV were more likely to have partners who responded to partner notification by saying that the STI was not from them or accusing her of cheating. Some of the women reported threats of harm or actual harm in response to notifying their partner of an STI.

Harm Reduction Strategy

"I want to go over the "Getting Help" panel of the safety card with you… I know this isn't a perfect answer, but often controlling partners have multiple sex partners and it is possible that the STI notification call could be about someone other than you— this may reduce the likelihood that you would be hurt by your partner when he finds out he has an STI. We can have someone call your partner anonymously from the health department saying that someone he has slept with in the past year has (name of STI) and he needs to come and be treated."



If the patient says she is afraid of how her partner may react if she notifies him about the STI, consider calling the partner yourself, especially if asking your health department to make the call is not an option.

ALWAYS FOLLOW UP POSITIVE DISCLOSURES OF REPRODUCTIVE COERCION WITH ADDITIONAL ARA QUESTIONS

Any positive disclosure of reproductive or sexual coercion should be followed up by questions about other abuse in her relationship.

Supported Referral

Sample Script:

"What you are telling me about your relationship makes me wonder if there are other things that make you uncomfortable. Has there ever been a situation where he has hurt you or made you have sex when you didn't want too?"

Another integral part of reproductive health care is called supported referral. This is a strategy for addressing reproductive and sexual coercion and ARA. By offering support to facilitate the referral process, providers can increase the likelihood a patient follows through with a referral. Two key strategies for supported referral are acknowledging a patient's safety concerns and offering options. Additionally, offering a patient use of a phone at the clinic to call a domestic violence hotline or an advocate can be a safer strategy that increases access to services.

A key step in developing supported referral is to connect health providers with existing support services for ARA in the community. Making this connection is mutually beneficial.

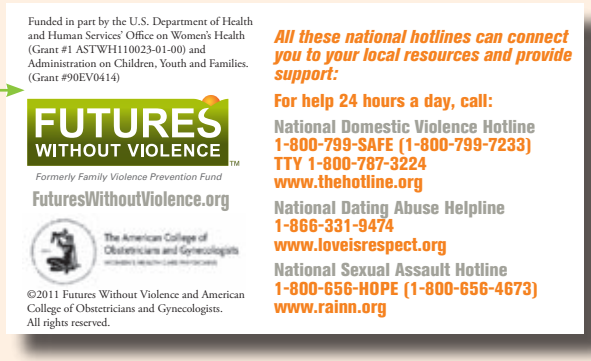
- Domestic violence and sexual assault advocates from shelters/advocacy programs are an excellent resource for training and advocacy.
- Domestic violence and sexual assault advocates will become more aware of what reproductive health services are available for young women and girls experiencing ARA.
- Health care providers will become more familiar with what services for ARA are available locally and have a specific name/person to contact when referring patients.

Respect Her Answer

If she says yes to relationship problems but doesn't disclose more than something vague:

Sample Script:

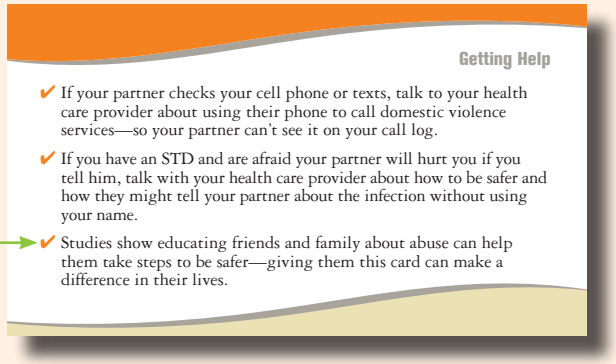
"You mentioned things are sometimes complicated in your relationship. I just want you to know that sometimes things can get worse. I hope this is never the case, but if you are ever in trouble you can come here for help. I am also going to give you a card with a hotline number on it. You can call the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



What to say when she says: "No, this isn't happening to me."

Sample Script:

"I'm really glad to hear nothing like this is going on for you. We are giving this card to all of our patients so that they will know how to help a friend or a family member having difficulties in their relationship."



Documentation and Follow Up

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

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

When a patient discloses victimization or abuse is suspected, a follow-up to ensure continuity of care should be discussed and documented. In addition to offering appropriate referrals and assistance contacting local resources, such as a domestic violence or sexual assault advocate, ask the patient if a follow-up appointment can be scheduled at the present time. It is also helpful to ask the patient for contact information, such as a phone number where it is safe to contact her at, so that any future contact will be done in a way that minimizes risk to the patient.

What about boys and men?

The opportunities for screening, education, and prevention with male patients are similar to those described for female patients. Share pro-active messages with all male patients that emphasize the importance of healthy, safe, and consensual relationships. Counseling about safe sex and STI prevention should include messaging on how condom use can prevent unintended pregnancies and STIs. Male patients need to understand how victimization such as sexual coercion may impact their reproductive and sexual health and risk-taking behaviors.

Find out what resources are available for male patients by contacting local domestic violence and sexual assault programs/shelters or National Hotline.

PART 5: POLICY IMPLICATIONS & SYSTEMS RESPONSE

There are a number of important steps to take to prepare your practice to identify and respond to victims of adolescent relationship abuse (ARA). It is essential that the clinical setting be designed to support the staff to respond effectively and efficiently. In preparing your practice to begin routine inquiry for and response to ARA, it is advisable to obtain support from the leadership and administration at your setting as well as staff input. Finally, as the Joint Commission on the Accreditation of Health Care Organization requires, and the Institute of Medicine recommends, staff should receive initial and on-going training.

Develop Protocols

System wide changes in practices will only be implemented and sustained when there are tangible changes in policies and the infrastructure to support these changes. A formalized protocol is an essential step to institutionalizing a trauma-informed coordinated response addressing ARA. The protocol should include the following elements:

1. Definitions and guiding principles
2. Training requirements for staff
    a. Content of training
    b. Staff proficiencies for knowledge and skills
3. Confidentiality procedures
4. Assessment strategies including setting, frequency, and cultural and language considerations
5. Harm reduction counseling for patients disclosing ARA and/or reproductive coercion
6. Follow-up and referral strategies
7. Documentation
8. Roles and responsibilities of staff

All staff should receive an orientation on the protocol. This protocol should be updated regularly and informed by new knowledge, laws and policies regarding ARA. This protocol should be accessible to all staff.

Provider Resources Should Include:

- "Hanging Out or Hooking Up" and "Did You Know Your Relationship Affects Your Health" safety cards (Available at www.futureswithoutviolence.org/health)
- Posters and practitioner pocket cards (Available at www.futureswithoutviolence.org/health)
- Consultation with on-site or off-site ARA advocates, legal and forensic experts, counselors with expertise in trauma treatment, and community experts from diverse (LGBTIQ, disability, teen, ethnic specific and immigrant) communities
- Documentation (Refer to the *National Consensus Guidelines on Identifying and Responding to Domestic Violence in Health Care Settings* for sample forms, available at www.futureswithoutviolence.org/health)
- Chart prompts in the medical record

Develop a Collaborative Model of Care

Prior to assessment for abuse and violence, practitioners should ensure protocols are in place for a safe and effective response. This means having specified roles and responsibilities within the clinic setting, knowledge of existing resources within the local community (in schools, local domestic violence and rape crisis agencies, mental health agencies, child protective services), and an established system for activating these resources depending on the situation.

- **A Team Approach is Beneficial** – Providers should not feel that they must have "all the answers." In these moments, having a team in place to call upon is necessary so the provider is not left carrying the weight of the situation alone. It is ideal to have an in-person introduction to an advocate or social worker to connect the young person with ongoing support.
- **Emphasize Care as a Team Rather Than Passing Off Care** – The provider's response when a young person shares experiences of control and abuse is crucial for continuing support. Adolescents need to feel they are heard and that the provider, as a trustworthy adult, can handle what they have been through and just disclosed. A provider who seems uncomfortable or who simply tells the adolescent to speak with a social worker about this may be interpreted as uncaring or dismissive.
- **Involve the Young Person in the Team and Decision-making** – While adolescents may initially appear not to want the help of adults, they do desire to be protected and cared for. In the moments following a disclosure, the provider's job is to validate what they have shared, affirm the courage it takes to talk openly of their experiences, in addition to offering a range of options to support healing and intervention. It is natural to want to promise "everything will be okay," but rather than making empty statements, it is important to offer clear and realistic next steps while maintaining boundaries. "We're all going to work together to help you stay safe."
- **Know the Limits of Confidentiality and Mandated Reporting Requirements** – Knowledge of mandated reporting requirements and how to support a minor in the safest way possible requires consultation. Developing connections with colleagues to call to talk through

options and best approaches is essential. Reporting a case to an outside agency without thoughtfully considering safety could put the young person at significantly greater risk for harm and even death.

The resources available to a provider may be within the health system in which s/he works. A social worker or mental health worker within a clinic is often a good first connection. Some health systems have hospital-based domestic violence programs to support providers and offer services to victims. Having a referral list in your network (within both the health system and local resources) will assist you in knowing your allies and creating a collaborative network of resources.

Part of implementing a protocol for assessment and intervention with adolescent relationship abuse should include having first-hand knowledge of these local resources, and integrating these resources directly into the clinical protocol.

Supporting Staff Who May Be Exposed to Violence

Strategies that will help to institutionalize a trauma-informed, coordinated response to ARA include:

- Implement and routinely update workplace policies to:
  - Include language on ensuring a violence-free workplace
  - Offer support for staff exposed to violence including services through employee assistance programs
  - Describe plans for addressing stalking and workplace harassment by an abusive partner
  - For more information please see the Futures Without Violence website on workplace response to abuse at www.workplacesrespond.org
- Promote awareness that life experiences of staff may influence their comfort level and effectiveness with addressing ARA.
- Create a network of clinicians within your organization who have expertise on this issue and will champion the cause.

Continuous Quality Improvement (CQI) Program

Develop program quality improvement goals through a consensus process with staff, and monitor your organization's progress. A quality assurance/quality improvement (QA/QI) tool has been developed for implementing and evaluating a trauma-informed, coordinated response to ARA in the adolescent health care setting. The QA/QI tool (See Appendix B), which uses a checklist format, can help clinics and programs to identify their goals and monitor their progress. Topics addressed in the QA/QI tool are:

- Assessment methods
- Intervention strategies
- Networking and training
- Self care and support
- Data and evaluation
- Education and prevention
- Environment and resources

For a sample protocol, please see Appendix A.

APPENDIX A

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

Protocol for Adolescent Relationship Abuse Prevention and Intervention

SECTION I: INTRODUCTION

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

Guiding Principles

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

Training Requirements

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

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

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

Confidentiality

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

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

SECTION II: UNIVERSAL EDUCATION–ANTICIPATORY GUIDANCE ON HEALTHY RELATIONSHIPS

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

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

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

The clinician should follow up with the patient during the health visit. **Remember to discuss the limits of confidentiality before reviewing the card.** Please see pages 23-25 of *Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse* for sample scripts that correspond to each panel of the safety card. It is not necessary to review all eight panels. Depending on the type of visit or questions raised during the visit, the clinician can select which panel(s) to focus on. **It is important to discuss the card during the visit rather than simply handing them the card.**

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

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

SECTION III: DIRECT ASSESSMENT WITH SEXUALLY ACTIVE YOUNG WOMEN

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

Who Shall Conduct Assessment:
Assessments will be conducted by a health care professional who has been:

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

How to Assess:

- When assessing for RC and ARA utilize a private, safe environment. Separate any accompanying persons from the patient. If this cannot be done, postpone assessing for a follow-up visit.
- Explain the limits of confidentiality prior to assessment; patients should be informed of any reporting requirements or other limits to provider/patient confidentiality.
- When unable to converse fluently in the patient's primary language, use a professional interpreter or another health care provider fluent in the patient's language. The patient's family, friends or children should not be used as interpreters when asking about RC and ARA.
- Introduce the assessment using your own words in a non-threatening, non-judgmental way. *"I talk to all my female patients about how they deserve to be treated in a relationship, especially when it comes to decisions about sex."*
    - Use the *Did You Know Your Relationship Affects Your Health?* safety card to ask questions that are integrated into the reason for the visit. See the *Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse* (pp. 32-37) for visit-specific sample scripts, follow up questions and harm reduction strategies.
        - Contraception/birth control options counseling visit: Use "Are you in an UNHEALTHY relationship?" panel
        - Pregnancy testing visit: Use "Who controls PREGANCY decisions?" panel
        - STI testing visit: Use "Is your BODY being affected?" panel
        - Emergency contraception visit: Use "Taking control" panel
- Always follow up disclosures of RC with additional questions about ARA. Please see Section IV: Documentation and Follow Up for information on steps to take if a patient discloses ARA.

SECTION IV: DOCUMENTATION OF ASSESSMENT AND FOLLOW-UP

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

- Confirmation that the assessment occurred, or the reason why it did not, and what follow-up actions were taken to ensure that assessment will occur at a future visit

- The patient's response
- Documentation of resources provided, such as safety cards
- Referrals provided

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

Positive Assessment

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

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

Suspected But Unconfirmed ARA

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

Patient-centered Mandatory Reporting

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

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

While the language in the mandated reporting laws state that the person who becomes aware of the abuse should report 'immediately' to the relevant authorities, the focus should **always** be on the care and safety of the young person first. **After** the reason the young person was seeking care has been addressed (such as treatment for a possible STI), the provider should remind the young person of the limits of confidentiality discussed at the start of the visit, then inform the patient of the requirement to report. See patient-centered mandatory reporting scripts, see pages 26-27 of *Hanging Out or Hooking Up: Clinical Guidelines on Responding to Adolescent Relationship Abuse.*

Law Enforcement Intervention

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

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

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

APPENDIX B

Adolescent Health Programs
Adolescent Relationship Abuse And Sexual Assault
Quality Assessment/Quality Improvement Tool

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

We hope that this tool will help provide guidance on how to enhance your program to respond to adolescent relationship abuse and sexual assault.

Program:_____

Date: __ __ / __ __ / __ __

Completed by (title only) _____

Assessment Methods				
Does your clinic/program have a written protocol for assessment and response to:	**Yes**	**No**	**N/A**	**Don't Know**
Adolescent relationship abuse				
Sexual assault				
Reproductive and sexual coercion (birth control sabotage, pregnancy pressure, STI/HIV risk, partner notification risk)				
Does your site provide universal education and anticipatory guidance on healthy relationships during all clinical encounters?				
Does your site provide direct assessment for reproductive coercion during:	**Yes**	**No**	**N/A**	**Don't Know**
Birth control counseling				
STI/HIV visits				
Emergency contraception visits				
Pregnancy tests				
Are there any written materials available to patients when they check-in for their clinic visit informing them about confidentiality and limits of confidentiality?				

Assessment Methods (Cont.)	Yes	No	N/A	Don't Know
Are there any scripts or instructions on your assessment form that providers can use to inform patients about confidentiality and mandated reporting requirements?				
Are there any scripts or sample questions that providers can use on your assessment forms to ask patients about relationship abuse and sexual assault?				
Are there specific prompts on the intake form (or in the electronic record) to encourage providers to assess for relationship abuse and sexual assault?				
Are there any scripts or sample questions that providers can use on your assessment forms to ask patients about reproductive coercion?				
Is there a private place in your clinic to screen and talk with patients?				
Does your clinic have a policy to ensure that providers ask about relationship abuse, sexual assault, and reproductive coercion when the patient is alone (i.e. no friends, parents, etc. present)?				
Intervention Strategies				
Does your staff have:	**Yes**	**No**	**N/A**	**Don't Know**
Scripted tools/instructions about what to say and do when a patient discloses relationship abuse?				
Scripted tools/instructions on how to do safety planning with patients who disclose current abuse?				
Safety cards/information to give to patients even when abuse is not disclosed or suspected? *(Recommendation: give card to all patients. If they don't need it themselves, tell them you are giving it to them so they know how to help a friend or family member)*				
An on-call advocate or counselor who can provide on-site follow-up with patients who disclose abuse?				
A safe place where a patient can use a phone to talk to a violence advocate/shelter/support services at your facility?				
A clear protocol for what types of behaviors require mandated reporting?				

Assessment Methods (Cont.)				
Does your program have resource lists that:	Yes	No	N/A	Don't Know
Identify referrals/resources (shelters, legal advocacy, housing, etc.) for patients who disclose relationship violence?				
Identify referrals/resources for patients who disclose sexual assault?				
Includes a contact person for each referral agency?				
Has a staff person who is responsible for updating the list?				
Are these lists updated at least once a year?				
Networking and Training				
Has your staff had contact with representatives from any of the following types of agencies in the past year?	Yes	No	N/A	Don't Know
Domestic violence advocates/shelter staff				
Child protective services				
Rape crisis				
Legal advocacy/legal services				
Law enforcement				
Is there anyone on your staff who is especially skilled/comfortable dealing with relationship violence and/or reproductive coercion issues?				
Does your protocol advise staff on what to do if they do not feel comfortable or adequately skilled to help a patient when abuse is disclosed/suspected? (Example: Can staff 'opt out' if they are survivors of or currently dealing with personal trauma?)				
Does anyone on your staff participate in a local domestic violence task force or related subcommittee?				
Is there a buddy system or internal referral for staff to turn to for assistance when they are overwhelmed or uncomfortable addressing violence with a patient?				
Do new hires receive training on assessment and intervention for relationship abuse and sexual assault during orientation?				

Does your staff receive booster training on assessment and intervention for relationship abuse and sexual assault at least once a year?				
Self-Care and Support				
	Yes	No	N/A	Don't Know
Does your program have a protocol for what to do when a staff person is experiencing intimate partner violence?				
Have you talked with your employee assistance program (EAP) about what resources/help they can provide for staff who disclose current or past victimization?				
Does your program have a protocol for what to do if a perpetrator is on-site and displaying threatening behavior or trying to get information?				
Does staff have the opportunity to meet and discuss challenges and successes with cases involving relationship abuse or sexual assault?				
Data and Evaluation				
	Yes	No	N/A	Don't Know
Does your program record the rate of documented screening for relationship abuse and sexual assault?				
Does your program record the rate of documented disclosures of relationship abuse or sexual assault by patients?				
Does your program conduct an annual review and update of all protocols addressing violence?				
Does your program do any type of consumer satisfaction surveys or patient focus groups that ask patients' opinions about assessment and intervention strategies for violence?				
Does your program provide regular (at least annual) feedback to providers about their performance regarding relationship abuse and sexual assault assessment?				
Education and Prevention				
	Yes	No	N/A	Don't Know
Does your program provide information to patients on how violence can impact their health?				
Does any of the information that you provide to patients address healthy relationships?				
Does your program sponsor any patient or community education to talk about healthy relationships and indicators of abuse?				

Environment and Resources				
	Yes	No	N/A	Don't Know
Are there posters and other written information about what "confidentiality" means and the limits of confidentiality?				
Are there any brochures/cards or other information about relationship abuse and sexual assault designed for teens?				
Are there any posters about healthy and unhealthy relationships displayed at your facility?				
Are materials available specific to LGBTIQ relationship abuse?				
Have these brochures/cards/posters been placed in an easily visible location?				
Have these brochures/cards/posters been reviewed by underserved communities for inclusivity, linguistic and cultural relevance?				
Are there any brochures/cards or other information about reproductive and sexual coercion that are designed for teens?				
Additional Comments and Observations:				

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About the National Health Resource Center on Domestic Violence

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

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