FUTURES WITHOUT VIOLENCE™

Formerly Family Violence Prevention Fund

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.**

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.

[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.