IDENTIFYING AND RESPONDING TO HUMAN TRAFFICKING AND INTIMATE PARTNER VIOLENCE IN HEALTHCARE

RESOURCE BOOKLET

Table of Contents

Introduction

Seminar Speakers

Panel Organizations

Call to Action

Local Human Trafficking Resources

Table of Contents

Table of Contents

HT Articles

Strangulation Articles

Additional Information

About this Event

Identifying and Responding to Human Trafficking and Intimate Partner Violence in Healthcare will examine the issues of human trafficking and intimate partner violence from a healthcare and public health perspective, including how to identify, communicate, treat, and provide resources to potential victims. Survivors of human trafficking and intimate partner violence will share their experiences in order to highlight gaps in care and identify areas for intervention.

Evidence-based screening tools and implementation processes will be presented, and representatives from local organizations will discuss resources and services. Attendees will be invited to join a new community of practice to strengthen local data and measure improvements in care in Tarrant County.

H.C.R. No. 35

HOUSE CONCURRENT RESOLUTION

WHEREAS, Human trafficking is a serious and escalating public health issue in the United States, particularly in Texas; and

WHEREAS, It is estimated that there are more than 300,000 victims of human trafficking in the State of Texas, and nearly 80,000 of those are identified as minors; and

WHEREAS, The number of cases reported rose 82 percent from 2015 to 2017, giving Texas the second-highest number of human trafficking reports in the country, with explosive growth occurring across all segments of our society in every ethnicity, gender, and age, regardless of immigration, socioeconomic, or family status; and

WHEREAS, Victims of human trafficking experience a severe and complex trauma that is recognized by the medical community as one of the most challenging to effectively treat; it requires long-term counseling, therapy, and often inpatient treatment, which is complicated by the fact that relatively few facilities in Texas are trained in trauma-informed care; and

WHEREAS, The health problems engendered by human trafficking are a crisis that impacts a substantial number of Texans in communities across the state; sexual exploitation of women and children account for 84 percent of cases and cost the state an estimated $6.6 billion in additional physical and mental health care and social services; this also creates additional strain on our health care and law enforcement systems; and

WHEREAS, Gangs and cartels have combined drug and human trafficking operations to become a primary controlling influence in both, with the traffickers involved proving to be some of the most dangerous and violent criminals to whom thousands more innocent victims fall prey each year; and

WHEREAS, All forms of human trafficking are criminal acts, and it is imperative that this issue be appropriately addressed so that we may bring an end to this atrocious crime and help survivors to move forward with their lives; now, therefore, be it

RESOLVED, That the 86th Legislature of the State of Texas hereby recognize human trafficking as a public health issue.

* * * * *

STATE OF TEXAS
OFFICE OF THE GOVERNOR

The concepts of freedom, justice, and the pursuit of happiness are intricately woven into the fabric of American culture. We may find it hard to fathom that we live in a world where people are deprived of these rights, a world where people are trafficked for labor or bought and sold in the sex trade. The heinous crime of human trafficking is not confined to some remote country; it is happening right here, and even children have become commodities for the pleasure of sexual predators and the profit of traffickers.

The State of Texas will not tolerate the inhumane practices carried out by coercive and manipulative criminals. We provide serious penalties for human traffickers, and we continuously look for ways to better serve the victims. Since the creation of the Child Sex Trafficking Team in my office, innovative and promising practices have been launched around the state. My team knows that a spirit of collaboration is critical in this endeavor, and I commend all those working toward a stronger and more coordinated response.

I thank our state's service providers, law enforcement officers, and prosecutors for their dedication to combating this terrible crime. I also applaud the faith communities, businesses, foundations, and other advocates who are stepping up to make a difference. I especially want to express my gratitude to the incredible survivors who share their voices and their stories to help others; their grit and resilience is a testament to the Texas spirit and a constant inspiration to us all.

At this time, I encourage all Texans to learn more about the risks and indicators of human trafficking and to do their part in helping end this atrocity. The reality of this evil enterprise can be staggering, however Texans will not be overcome in the face of adversity. Together, we can protect the vulnerable, help victims find healing, and bring offenders to justice.

Therefore, I, Greg Abbott, Governor of Texas, do hereby proclaim January 2019, to be

Human Trafficking Prevention Month

in Texas, and urge the appropriate recognition whereof.

In official recognition whereof,
I hereby affix my signature this the
3rd day of January, 2019.

Governor of Texas

Seminar Planning Committee

Tarrant County Public Health

Level I Trauma Center
John Peter Smith Hospital | JPS Health Network

UNBOUND

Harris College of Nursing & Health Sciences

Special thanks to the Sid W. Richardson Foundation for their financial support of this event and thanks to JPS Health Network, UNT Health Science Center, One Safe Place, and Shannon Wolf, PhD, LPC-S for providing CEs for this event.

Objectives

DEFINE

HUMAN TRAFFICKING AND INTIMATE PARTNER VIOLENCE.

EXPLORE

THE MAGNITUDE OF THE PROBLEM AND THE POPULATIONS IMPACTED.

DESCRIBE

THE ROLE OF LAW ENFORCEMENT IN ADDRESSING HUMAN TRAFFICKING AND INTIMATE PARTNER VIOLENCE LOCALLY

UNDERSTAND

TRAUMA BONDS AND HOW THEY IMPACT VICTIMS OF HUMAN TRAFFICKING AND INTIMATE PARTNER VIOLENCE

RECOGNIZE

RED FLAGS AND INDICATORS OF HUMAN TRAFFICKING AND INTIMATE PARTNER VIOLENCE IN HEALTHCARE SETTINGS

UTILIZE

A TRAUMA-INFORMED APPROACH WITH VICTIMS OF HUMAN TRAFFICKING AND INTIMATE PARTNER VIOLENCE.

IDENTIFY

PATHWAYS TO TRANSFORM HEALTHCARE FOR VICTIMS OF HUMAN TRAFFICKING AND INTIMATE PARTNER VIOLENCE.

Identifying and Responding to
HUMAN TRAFFICKING AND INTIMATE PARTNER VIOLENCE in Healthcare

November 14, 2019

Registration Check-in- breakfast and resource tables	**7:30-8:00**
Opening Speaker	**8:00-8:15**
Commissioner Roy Charles Brooks, Tarrant County Precinct 1	
HT/IPV: Public Health and Law Enforcement Perspectives	**8:15-9:00**
Dr. Catherine Colquitt, Tarrant County Public Health	
Officer Hannah Rivard, Fort Worth Police Department	
Sergeant Tyler Stillman, Bedford Police Department	
Trauma Bonds	**9:00-10:00**
Shannon Wolf, PhD, LPC-S	
Morning Break- resource tables	**10:00-10:15**
Healthcare and HT/IPV	**10:15-12:15**
Susan Blume, BSN, RN, CEN, Texas Health Resources HEB, UnBound	
Jessica Peck, DNP, APRN, CPNP-PC, CNE, CNL, FAANP	
Lunch- activity and resource tables	**12:15-1:15**
HT Survivor Story	**1:15-2:00**
Julia Walsh, UnBound	
IPV Survivor Story	**2:00-2:45**
LaTasha Jackson-McDougle, Cheryl's Voice	
Afternoon Break- resource tables	**2:45-3:00**
Evidence-Based Screening Tools	**3:00-3:45**
Mary Ann Contreras, RN, JPS Health Network	
Heather Scroggins, MSN, RN-BC, JPS Health Network	
Local Resources	**3:45-4:15**
Stephanie Byrd, JD, UnBound	
Michelle Morgan, One Safe Place	
Lindsey Speed, Traffick911	
Lindsey Dula, Alliance for Children	
Beckie Wach, The Salvation Army	
Kathryn Jacob, LMSW, SafeHaven of Tarrant County	
Community Action and Next Steps	**4:15-4:25**
Dr. Gary Kesling, Tarrant County Public Health	
Expert Panel	**4:25-5:00**
Event Conclusion- seminar evaluation and certificates of completion	**5:00**

SEMINAR SPEAKERS

Catherine Colquitt, MD

Local Health Authority & Medical Director

Tarrant County Public Health

Main Address:
1101 S. Main Street
Fort Worth, TX 76104

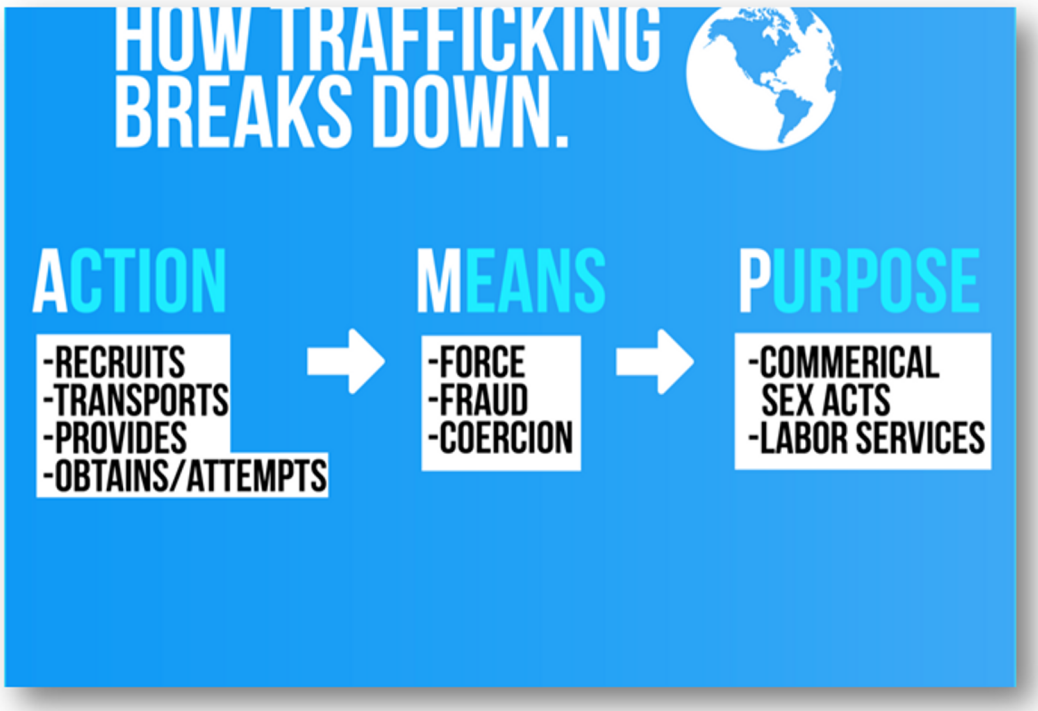
Phone:
817-321-4700

Website:
health.tarrantcounty.com

Officer Hannah Rivard

Fort Worth Police Department
Ofc. H. Rivard #4244
hannah.rivard@fortworthtexas.gov
817-392-4091 (o) / 682-478-9357 (c)

Human Trafficking: An Overview



Top 3 Types of Trafficking Here…

Domestic minor sex trafficking

Adult forced prostitution

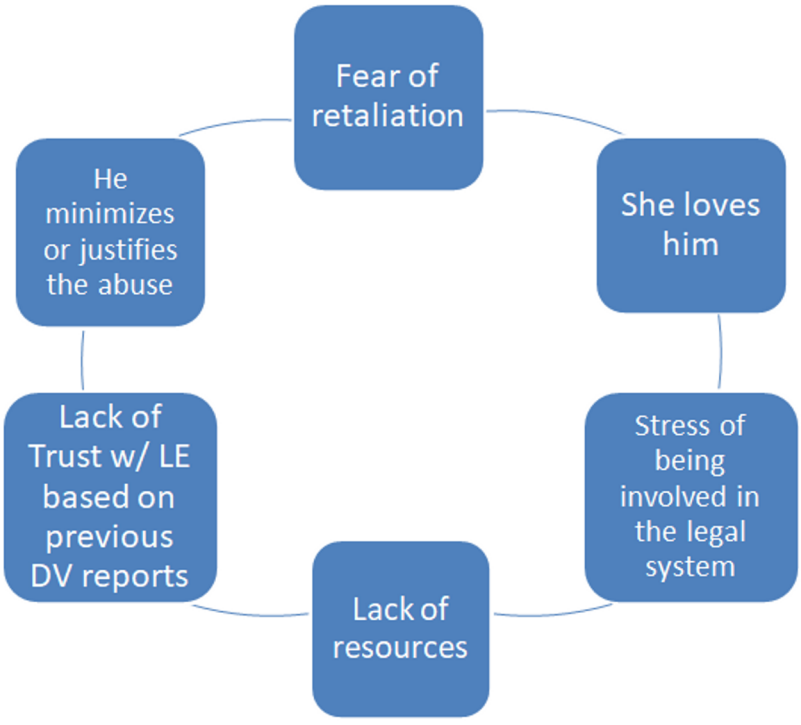
Illegal massage parlors/strip clubs

Sergeant Tyler Stillman

Bedford Police Department
CID Supervisor- IPV/ BIU/ TIU/ SIU
817-952-2434
Tyler.Stillman@Bedfordtx.gov

Intimate Partner Violence

Reasons why victims are uncooperative or later recant



DANGER ASSESSMENT-5

This brief risk assessment identifies women who are at high risk for homicide or severe injury by an intimate partner.[1-2]

Mark **Yes** or **No** for each of the following questions. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

___ 1. Has the physical violence increased in frequency or over the past year?
___ 2. Has he ever used a weapon against you or threatened you with a weapon?
___ 3. Do you believe he is capable of killing you?
___ 4. Does he ever try to choke you?
___ 5. Is he violently and constantly jealous of you?

1 This is a brief adaptation of the Danger Assessment (2003). It is designed for use by a health care provider or other clinician following a positive screen for intimate partner violence. The full Danger Assessment with weighted scoring provides the most accurate assessment of risk.

2 Snider, C., Webster, D., O'Sullivan, C. S. and Campbell, J. (2009), Intimate Partner Violence: Development of a Brief Risk Assessment for the Emergency Department. Academic Emergency Medicine, 16: 1208-1216.

disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care. A covered entity may use professional judgment and its experience with common practice to make reasonable inferences of the individual's best interest in allowing a person to act on behalf of the individual to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

(4) *Use and disclosures for disaster relief purposes.* A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1) (ii) of this section. The requirements in paragraphs (b)(2) and (3) of this section apply to such uses and disclosure to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

[65 FR 82802. Dec. 28. 2000, as amended at 67 FR 53270, Aug. 14. 2002]

§ 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.

A covered entity may use or disclose protected health information without the written authorization of the individual, as described in §164.508, or the opportunity for the individual to agree or object as described in §164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.

(a) *Standard: Uses and disclosures required by law.* (1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(2) A covered entity must meet the requirements described in paragraph (c) , (e), or (f) of this section for uses or disclosures required by law.

(b) *Standard: uses and disclosures for public health activities.* (1) *Permitted disclosures.* A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to:

(i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury. vital events such as birth or death, and the conduct of public health surveillance, public health investigations. and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(iii) A person subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-reg- ulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity. Such purposes include:

(A) To collect or report adverse events (or similar activities with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations;

(B) To track FDA-regulated products;

(C) To enable product recalls, repairs, or replacement, or lookback (including locating and notifying individuals who have received products that have been

recalled, withdrawn, or are the subject of lookback); or

(D) To conduct post marketing surveillance;

(iv) A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition. if the covered entity or public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation; or

(v) An employer, about an individual who is a member of the workforce of the employer, if;

(A) The covered entity is a covered health care provider who is a member of the workforce of such employer or who provides health care to the individual at the request of the employer:

(1) To conduct an evaluation relating to medical surveillance of the workplace; or

(*.2)* To evaluate whether the individual has a work-related illness or injury;

(B) The protected health information that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance;

(C) The employer needs such findings in order to comply with its obligations, under 29 CFR parts 1904 through 1928, 30 CFR parts 50 through 90, or under state law having a similar purpose, to record such illness or injury or to carry out responsibilities for workplace medical surveillance; and

(D) The covered health care provider provides written notice to the individual that protected health information relating to the medical surveillance of the workplace and work-related illnesses and injuries is disclosed to the employer:

(1) By giving a copy of the notice to the individual at the time the health care is provided; or

(2) If the health care is provided on the work site of the employer, by posting the notice in a prominent place at the location where the health care is provided.

(2) *Permitted uses.* If the covered entity also is a public health authority, the covered entity is permitted to use protected health information in all cases in which it is permitted to disclose such information for public health activities under paragraph (b)(1) of this section.

(c) ***Standard: Disclosures about victims of*** *abuse, neglect or* ***domestic violence.*** (1) *Permitted disclosures.* Except for reports of child abuse or neglect permitted by paragraph (b)(1) (ii) of this section**, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of** abuse, neglect, or **domestic violence to a government authority**, including a social service or protective services agency**, authorized by law to receive reports of** such abuse, neglect, or **domestic violence**:

(1) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in **the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual** or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) *Informing the individual.* A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise **of professional judgment, believes informing the individual would place the individual at risk of serious harm;** or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes

the personal representative is responsible for the abuse, neglect, or other injury. and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(d) *Standard: Uses and disclosures for health oversight activities.* (1) *Permitted disclosures.* A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law. including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

(1) The health care system;

(ii) Government benefit programs for which health information is relevant to beneficiary eligibility;

(iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

(iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

(2) *Exception to health oversight activities.* For the purpose of the disclosures permitted by paragraph (d)(1) of this section, a health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

(i) The receipt of health care;

(ii) A claim for public benefits related to health; or

(iii) Qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services.

(3) *Joint activities or investigations.* Nothwithstanding paragraph (d)(2) of this section, if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity for purposes of paragraph (d) of this section.

(4) *Permitted uses.* If a covered entity also is a health oversight agency, the covered entity may use protected health information for health oversight activities as permitted by paragraph (d) of this section.

(e) *Standard: Disclosures for judicial and administrative proceedings.*

(1) Permitted disclosures. A covered entity may disclose protected health information in the course of any judicial or administrative proceeding:

(i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or

(ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:

(A) The covered entity receives satisfactory assurance, as described in paragraph (e)(1) (iii) of this section, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or

(B) The covered entity receives satisfactory assurance, as described in paragraph (e)(1) (iv) of this section, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of paragraph (e)(1) (v) of this section.

(iii) For the purposes of paragraph (e) (1) (ii)(A) of this section, a covered entity receives satisfactory assurances from a party seeking protecting health information if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The party requesting such information has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address);

(B) The notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal; and

Shannon Wolf, PhD, LPC-S

Director of Southcliff Christian Counseling Center
Associate Director of Psychology and Counseling Programs, BH Carroll
swolf@bhcarroll.edu

Trauma Bonds

Risk Factors for Potential Human Trafficking Victims

- Primary risk factor is non-protective family
- Lack of secure bond between parents and child
- Run-aways
- Emotional and physical abuse/abandonment
- Foster Care
- Self-denigration
- Mental Disabilities Substance Abuse
- Childhood sexual assault

Characteristics of Trauma Bonds

- Powerful emotional attachments of a victim to the perpetrator that are mitigated by numerous traumatic events.
- The bonds can be with the trafficker and/or the "family"
- Bonds are adaptive responses to extreme trauma
- These bonds are very difficult to break
- Victims feel emotional ties to the perpetrator and to other girls involved.
- These bonds can be very strong
- The victim may not take opportunities to escape a captor.
- Trauma bonding appears to be an adaptive response to an excessively abusive repeatedly traumatic environment.

Susan Blume, BSN, RN, CEN

Emergency Department Nurse,
Texas Health Resources-HEB
Unbound Fort Worth Volunteer
Susan.blume@unboundnow.org

Healthcare and HT/IPV

Human Trafficking Red Flags in Healthcare

- Intimate Partner Violence
- Sexual Assault
- Psych Complaints in Minors
- Substance Abuse
- Accompanied by Controlling Person
- No ID or Money
- Questionable Employment
- Disorientation
- Contradictory Information
- Pregnancy/STDs in Minors
- Unable to Answer Questions
- Malnutrition
- Involvement in the System
- Industrial Injuries
- Somatic Complaints
- Difficult to Deal With
- Healthcare Provider Gut Instinct
- Various Injuries
- Multiple STDs, Abortions
- Tattoos of Ownership

Jessica Peck, DNP, APRN, CPNP-PC, CNE, CNL, FAANP

Professor of Nursing, Baylor University
President-Elect, National Association of Pediatric Nurse Practitioners
Lead Medical Consultant, UnBound Houston
Facebook and Twitter: @DrPeckPNP

UNBOUND

Healthcare and HT/IPV

Recruitment: How Does a Child Become a Victim?

Traffickers recruit with the "triple T" principle

Target

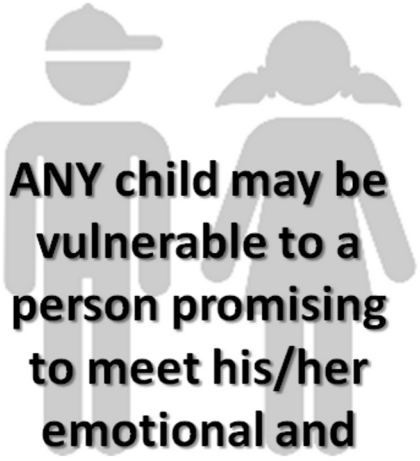
- Traffickers seek out vulnerable children

Trick (or manipulate)

- Traffickers break down a child's natural resistance and suspicion
- Then reveal true intent of relationship

Traumatize

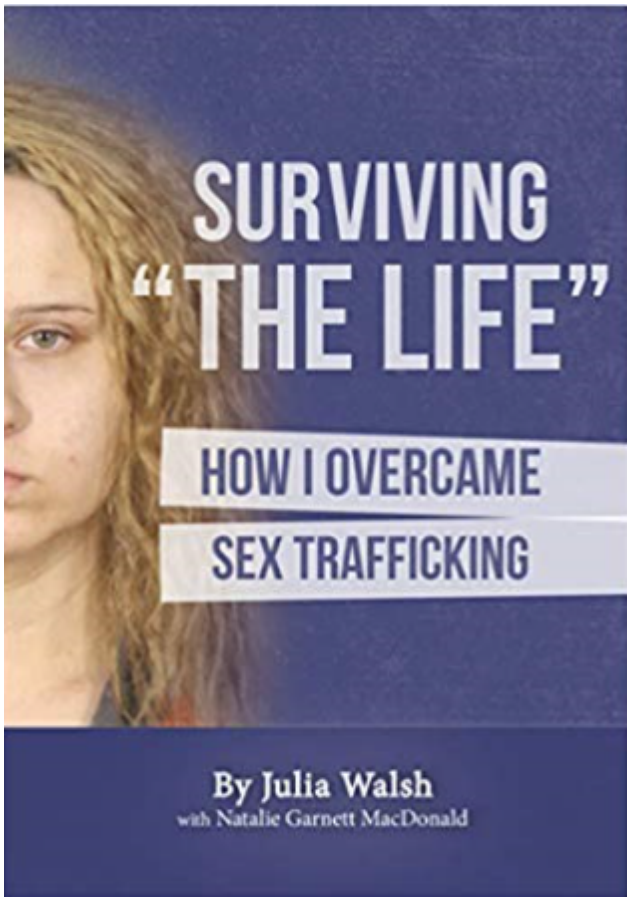
- Child becomes a victim; becomes and feels trapped and powerless
- This "trauma bond" is extremely difficult to break



ANY child may be vulnerable to a person promising to meet his/her emotional and physical needs

Julia Walsh

Survivor Leader
Survivor Advocacy Coordinator
UnBound Fort Worth
Author

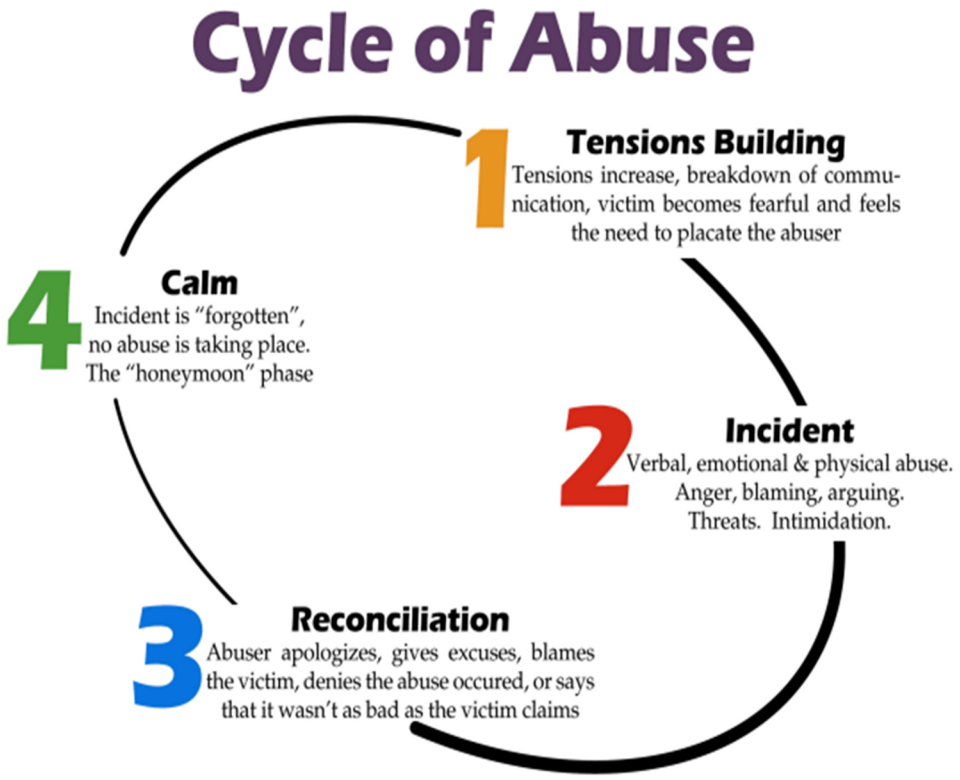


Human Trafficking Survivor Story

LaTasha Jackson-McDougle, BSSW, MSSW, MA

Founder of Cheryl's Voice
Tarrant County Case Manager-Domestic Violence Diversion Program
Adjunct professor-UT Arlington
Author
817-919-5398
www.Cherylsvoice.org

Intimate Partner Violence Survivor Story



Effects of Domestic Violence on Children

Short-Term Effects

Children in homes where one parent is abused may feel fearful and anxious. They may always be on guard, wondering when the next violent event will happen. This can cause them to react in different ways, depending on their age.

Pre-School: Young children who witness intimate partner violence may start doing things they used to do when they were younger, bed-wetting, thumb-sucking, increased crying, and whining. They may also develop difficulty falling or staying asleep; show signs of terror, such as stuttering or hiding; and show signs of severe separation anxiety.

School-Aged Children: Children in this age range may feel guilty about the abuse and blame themselves for it. Domestic violence and abuse hurts children's self-esteem. They may not participate in school activities or get good grades, have fewer friends than others, and get into trouble more often. They also may have a lot of headaches and stomachaches.

Teens: Teens who witness abuse may act out in negative ways:

•fighting with family members

•skipping school.

•engage in risky behaviors

•having unprotected sex and using alcohol or drugs.

•low self-esteem

•trouble making friends.

•start fights or bully others more likely to get in trouble with the law

More common in teen boys. Girls are more likely than boys to be withdrawn and to experience depression.

Long-Term Effects

More than 15 million children in the United States live in homes in which domestic violence has happened at least once.

These children are at greater risk for repeating the cycle as adults by entering abusive relationships or becoming abusers themselves.

Children who witness or are victims of emotional, physical, or sexual abuse are at higher risk for health problems as adults. These can include mental health conditions, such as depression and anxiety. They may also include diabetes, obesity, heart disease, poor self-esteem, infertility struggles, brain issues, and other problems.

Mary Ann Contreras, RN

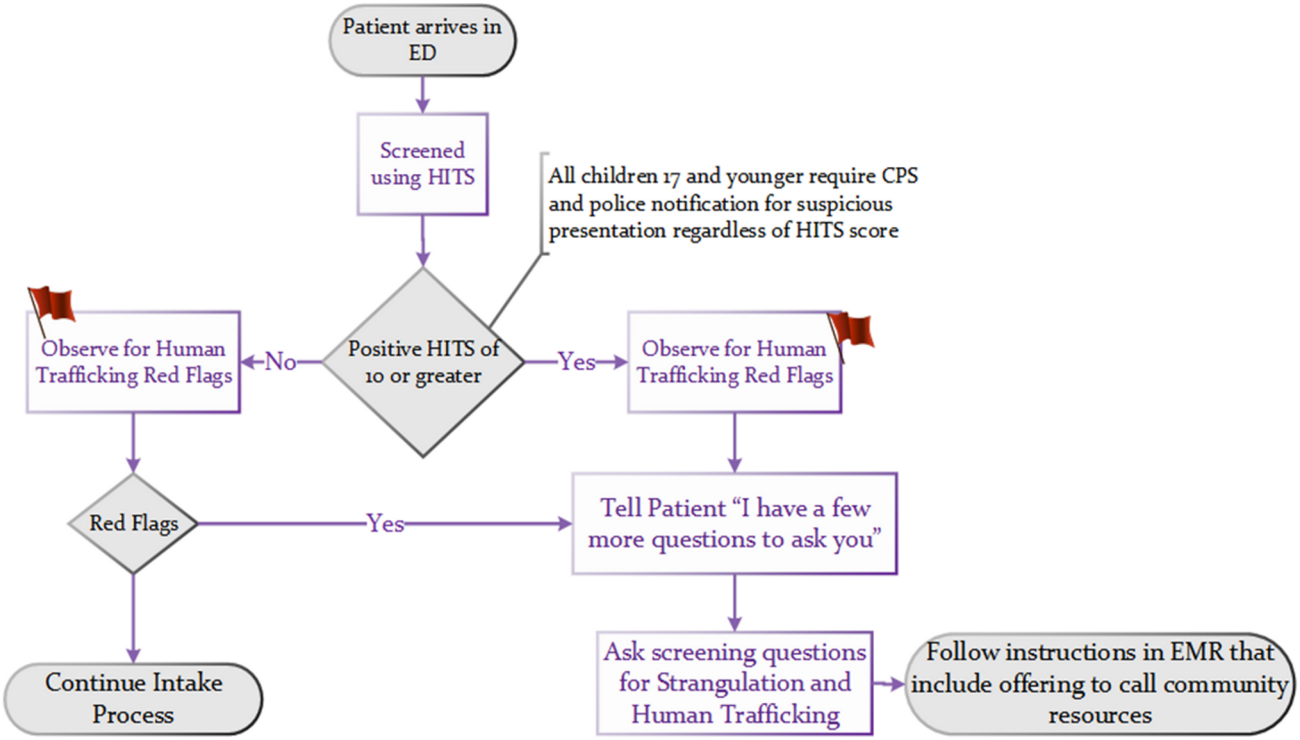
Violence and Injury Prevention Manager,
JPS Trauma Services
Regional and State Trauma Advisory Council member
Texas Injury Prevention Leadership Collaborative member
Tarrant County Adult Fatality Review team member
Tarrant County Domestic Violence High Risk Team member
Challenge of Tarrant County Prevention Providers Coalition member
817-702-8814
MContro1@jpshealth.org

Evidence-Based Screening Tools

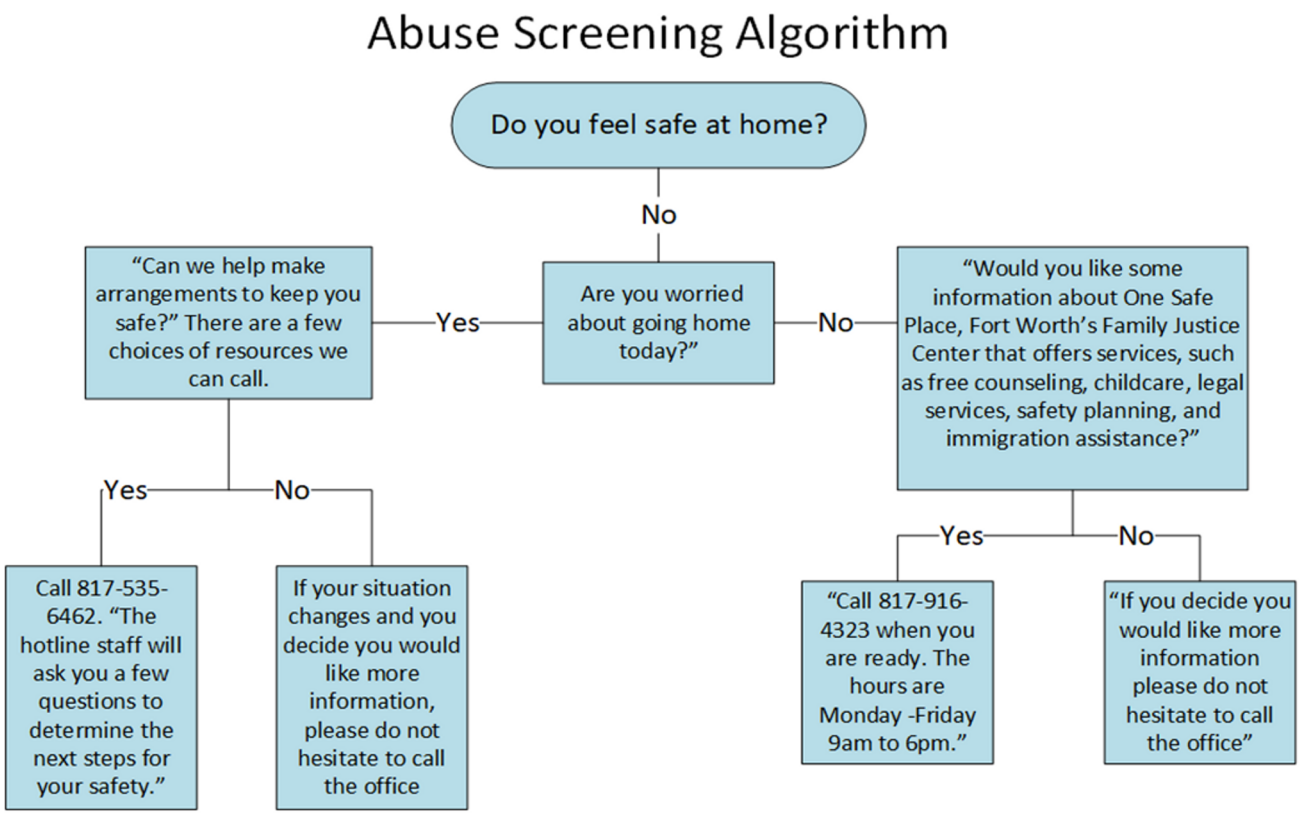
Heather Scroggins, MSN, RN-BC

JPS EMR Clinical Liaison
Dallas/ Fort Worth American Nursing Informatics Association (ANIA) Treasurer
DFW Hospital Council 2019 Community Service Employee of the Year
HScroggi@jpshealth.org

Evidence-Based Screening Tools



How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
1. Physically hurt you					
2. Insult or talk down to you					
3. Threaten you with harm					
4. Scream or curse at you					
	1	2	3	4	5
Total Score:					



Human Trafficking Screening Questions

Can you leave your job situation if you want?
Can you come and go as you please?
Have **you or your family been threatened** if you **try to leave**
Have you **been harmed** in any way?
Do you sleep where you work?
Have you ever been **deprived** of food, water, sleep or medical care?
Do you need to **ask permission** to eat, sleep or go to the bathroom?
Has your ID/Documents been taken from you
Is anyone forcing you to do anything you do not want to do?

PANEL ORGANIZATIONS

1 **STEPHANIE BYRD,JD**

Unbound
Stephanie.Byrd@unboundnow.org

2 **MICHELLE MORGAN**

One Safe Place
mmorgan@onesafeplace.org

3 **LINDSEY SPEED**

Traffick 911
lindsey@traffick911.com

4 **LINDSEY DULA**

Alliance for Children
ldula@allianceforchildren.org

5 **BECKIE WACH**

Salvation Army
beckie.wach@uss.salvationarmy.org

6 **KATHRYN JACOB, LMSW**

SafeHaven of Tarrant County
kjacob@safehaventc.org

HUMAN TRAFFICKING

Minor Sex Trafficking
The recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person under the age of 18 for a commercial sex act

Labor Trafficking
The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of debt bondage, peonage, or slavery

It happens here.

Children and teenagers are especially vulnerable to human trafficking. Common risk factors include:

- History of abuse or trauma
- Mental health issues
- Lack of supervision
- Unsupervised access to phone / internet
- Trouble making friends
- Conflict in home
- Substance use
- Foreign national
- Runaway

PARENTS,

You are the first line of defense in your child's life. Are you prepared to prevent, identify and respond to the threat of human trafficking?

UnBoundnow.org
fortworth@unboundnow.org
@unboundfortworth
24/7: 817-668-6462

Human Trafficking: what parents need to know

PREVENT

Talk to your child about issues regarding relationships and sex. There are many resources on the internet to help facilitate these conversations.

- Healthy Relationships
- Sexual Assault
- Sex Trafficking
- Sexting and Sextortion

Monitor your child's internet and social media usage. Social media is the primary recruitment and grooming tool used by traffickers.

- Place computers and gaming stations in common areas.
- Monitor app and social media accounts (especially those with chat features).
- Require social media accounts to be private, with location services turned off.

Know who your child is spending time with. A child's friends (whether in person or virtual) have an enormous impact on them and can help them stay safe, or put them in danger.

- Spend time with your child.
- Ask questions about who your child is communicating with in person or online.
- Meet his or her friends and their families.

Make sure your child gets the help he or she needs. If your child has experienced physical or sexual abuse, or struggles with mental health, he or she may be at higher risk for human trafficking. Prioritize counseling, mentoring, and other supportive services to keep your child safe.

IDENTIFY

Children and parents often struggle with communication and trust. No matter your relationship with your child, take the time to communicate that he or she can come to you regarding any of these issues. Communicate that you will believe him or her, respond calmly, and be on your child's side.

Signs to look for:

- Sending sexual images via social media or text
- Dramatic change in friend group
- Older or controlling boyfriend
- Unexplained money, clothes, or other material goods
- Anxious, fearful, or submissive behavior
- Abrupt change in behavior, school attendance, or attention to schoolwork
- Shows signs of depression, PTSD, or suicidal ideation
- Running away or sneaking out
- Isolation from friends and family
- Unexplained injuries or bruises
- Development of physical or psychological challenges (ex: stutter, seizures, or learning difficulties)

Social Media & Technology Resources

- My Mobile Watchdog
- Covenant Eyes
- Talk More Tech Less
- Fight the New Drug
- B4UClick
- netsmartz.org
- Net Nanny

RESPOND

- Remain calm. Do not become angry and yell.
- Remember that your child has been victimized and needs support.
- Take your child's phone and computer before any evidence can be deleted.
- Contact local law enforcement if you suspect a crime has been committed by or against your child.

VICTIM RESOURCES

Crisis Response, Emotional Support, & Ongoing Advocacy
UnBound
24/7: 817-668-6462
fortworth@unboundnow.org

Confidential, 24/7, Multilingual
National Human Trafficking Hotline:
1-888-3737-888

TAKE ACTION

UnBound provides free assembly presentations in local schools. Help stop human trafficking before it happens by asking your school to host an UnBound assembly. Contact us at 817-668-6462 or fortworth@unboundnow.org.

ABOUT

UnBound serves all survivors of human trafficking, both minors and adults. We work to educate and empower youth, spread awareness through citywide outreach, and provide human trafficking presentations to local groups and organizations.

Photography by Gittings

"Governor Abbott's Child Sex Trafficking Team is committed to providing trauma-informed advocates for youth who are exploited. We are thrilled that UnBound Fort Worth is our newest partner in meeting this goal. These advocates will provide the trust-based relationships and case management services that help youth heal and thrive."

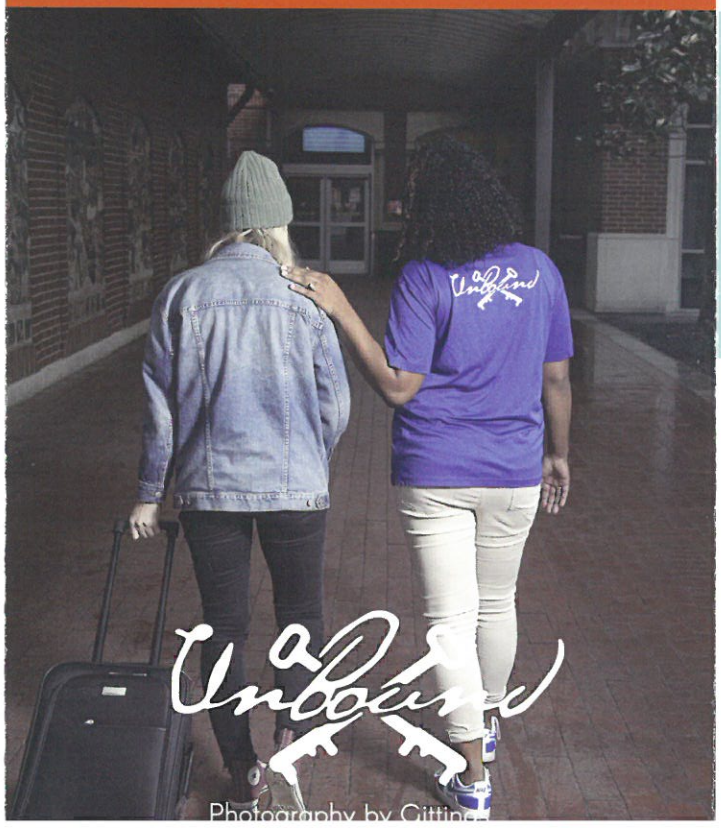
Andrea Sparks
Director, Office of the Texas Governor's
Child Sex Trafficking Team

All services offered at no charge. All survivors eligible for services regardless of race, ethnicity, religion, gender, or sexual orientation.

CONTACT

24/7 Referral Line (Crisis or Non-Crisis)
817-668-6462

UnBound Fort Worth
fortworth@unboundnow.org
5049 Trail Lake Dr., Suite 105
Fort Worth, TX 76133
www.unboundnow.org



Photography by Gittings

UnBound

SURVIVOR ADVOCACY PROGRAM

Tarrant County

24/7 Referral Line (Crisis or Non-Crisis)
817-668-6462

HOW WE SERVE

Prevention & Awareness
Professional Training
Survivor Advocacy
FOR ADULTS AND MINORS

An increasing number of survivors are being rescued from sex trafficking in Tarrant County. These survivors have an array of needs and require a variety of services in their journeys toward restoration.

In the absence of an advocate to walk alongside them and follow them from system to system, survivors can easily fall through the gaps before receiving all the services they need.

Photography by Gittings

OUR ADVOCATES

strengthen victim restoration
by providing child-centered, trauma-informed advocacy for survivors of child sex trafficking

respond to emotional and physical needs
assisting survivors, and as appropriate their families, in stabilizing their lives after victimization and recovery

act as support for victims
during law enforcement stings

communicate with victims
through both English and Spanish speaking advocates

provide relational, trust-based advocacy
encouraging personal growth and pursuit of dreams and goals

In our life, we never get to pick the beginning of our story, but we have the opportunity to determine how our story ends.

– Rundee, Survivor Advocate

Crisis Response

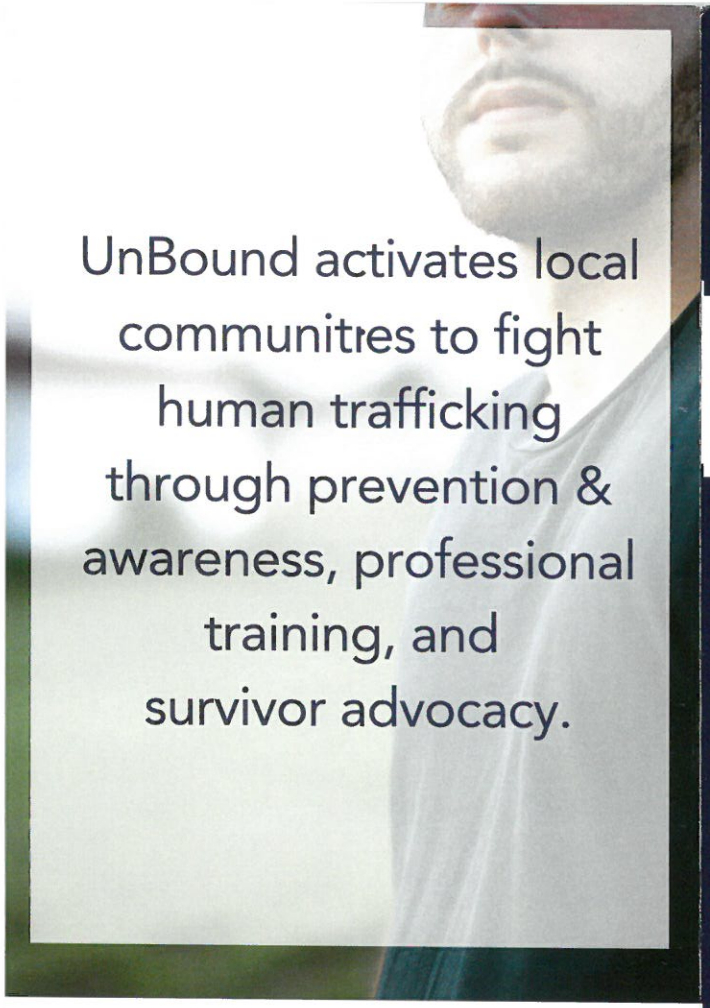
- 24/7 on-call crisis response (for law enforcement and first responders)
- Accompaniment for emergency medical treatment and SANE
- Food, clothing, and arrangement of emergency shelter
- Continued response to urgent needs as they arise

Ongoing Advocacy & Case Management

- Regular face-to-face meetings
- Safety planning
- Assistance completing Crime Victims' Compensation application
- Goal setting
- Court and medical accompaniment
- Transportation to needed services
- Birthday and graduation celebrations
- Wraparound services and support

24/7 Referral Line (Crisis or Non-Crisis)

817-668-6462



UnBound activates local communitres to fight human trafficking through prevention & awareness, professional training, and survivor advocacy.

UnBoundFortWorth.org
Ignite Hope

CONTACT

fortworth@unboundnow.org
817-668-6544
unboundfortworth.org

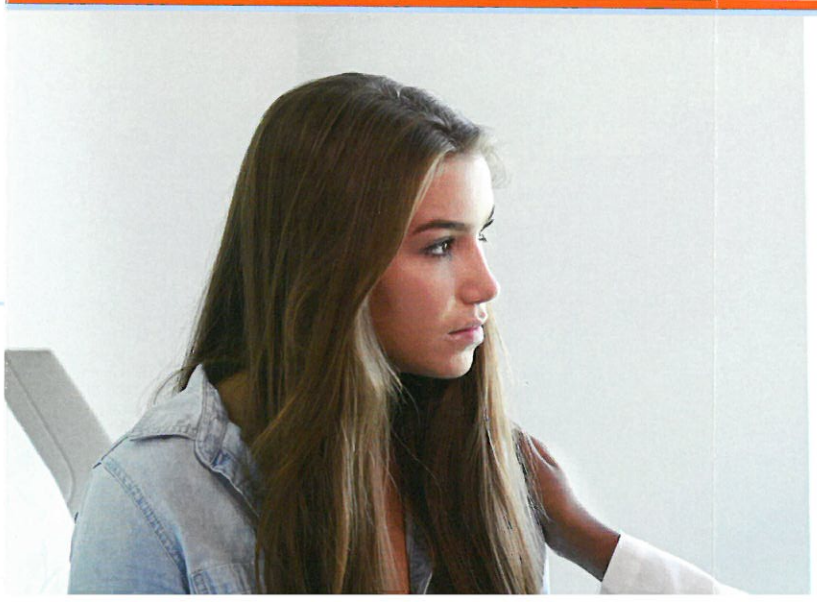
SCHEDULE A TRAINING

All trainings and CNE/CEU offered at no charge

To bring UnBound to your medical facility, email fortworth@unboundnow.org

Raising Awareness: Identifying & Responding to Victims of HUMAN TRAFFICKING in a CLINICAL SETTING

24/7 Referral Line
817-668-6462



HUMAN TRAFFICKING IMPACT IN TEXAS

APPROXIMATELY
79,000
MINORS AND YOUTH ARE VICTIMS OF SEX TRAFFICKING IN TEXAS ★★

APPROXIMATELY
234,000 WORKERS ARE VICTIMS OF LABOR TRAFFICKING

THERE ARE CURRENTLY AN ESTIMATED **313,000** VICTIMS OF HUMAN TRAFFICKING IN TEXAS ★★★★★

TRAFFICKERS EXPLOIT APPROXIMATELY **$600 MILLION** FROM VICTIMS OF LABOR TRAFFICKING IN TEXAS ★★★★★

MINOR AND YOUTH SEX TRAFFICKING COSTS THE STATE OF TEXAS APPROXIMATELY **$6.6 BILLION**

Every day, human trafficking is impacting men, women, youth, and children in our community. UnBound is committed to equipping medical professionals to recognize the signs of human trafficking in patients and respond appropriately.

Picture Source: Busch-Armendariz, N.B., Nale, N.L., Kammer-Kerwick, M., Kellison, B., Torres, M.I.M., Cook-Heffron, L., Nehme, J. (2016). Human Trafficking by the Numbers: Initial Benchmarks of Prevalence & Economic Impact in Texas. Austin, TX: Institute on Domestic Violence & Sexual Assault, The University of Texas at Austin.

Raising Awareness: Identifying & Responding to Victims of Human Trafficking in a Clinical Setting

Learning Objectives

1) Understand different types of human trafficking and their local, statewide and international prevalence
2) Recognize human trafficking indicators and red flags in a clinical setting
3) Discover immediate healthcare needs of identified victims
4) Develop ability for trauma-informed response
5) Learn about available resources for victim service and aftercare

CNE for Nurses
CEU for Social Workers

This continuing nursing education activity was approved by the Texas Nurses Association - Approver, an accredited approver with distinction, by the American Nurses Credentialing Center's Commission on Accreditation.

This program is Approved by the National Association of Social Workers (Approval # 886800783-3277) for 1 continuing education contact hours.

You must attend the entire event and complete a course evaluation to receive a certificate of completion. All persons involved in the planning and development of this course have disclosed no relevant financial relationships or other conflicts of interest related to the course content.

About UnBound's

SURVIVOR ADVOCACY PROGRAM

Survivors of human trafficking have an array of needs and require a variety of services in their journeys toward restoration.

In the absence of an advocate to walk alongside them and follow them from system to system, survivors can easily fall through a gap before receiving all the services they need and deserve.

OUR ADVOCATES

- Respond to emotional and physical needs - 24/7 crisis response
- Provide long-term relational, trust-based case management

STRENGTHEN VICTIM RESTORATION

- Accompaniment for emergency medical treatment and SANE (Sexual Assault Nurse Examiner) and court and law enforcement appointments
- Arrangement of emergency and transitional housing and long-term residential aftercare
- Continued response to urgent needs as they arise
- Safety planning
- Assistance in completing crime victims' compensation application
- Transportation to needed services

All services provided at no cost.

SA JUSTICE
on earth, as it is in heaven

ANTI-HUMAN TRAFFICKING

NATIONAL ANNUAL IMPACT REPORT

2018

The Salvation Army

National Programs

Awareness & Training Impact

TRAINING

- 10,260 individuals trained
- 2,312 staff trained

AWARENESS EVENTS

- 223 community awareness events hosted
- 10,139 people trained in community awarness events

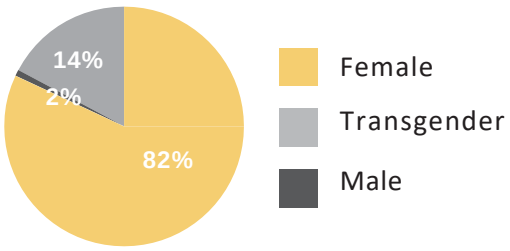
ANNUAL DAY OF PRAYER

- 24,306 people participated in annual day of prayer in September 2018

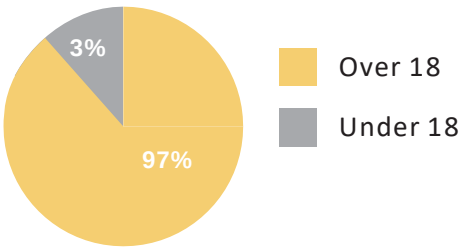
Survivor Services & Recovery Impact

- 3,123 survivors served
- 28,591 nights of housing provided
- 1,754 case management clients
- 2,889 referrals
- 308 program graduates

GENDER OF THOSE SERVED



AGE OF SURVIVORS SERVED



Fort Worth

- **35 Served**
- **8,219 Number or Nights**
- **23 Linked to Housing**
- **23 Graduates**

MABEE SOCIAL SERVICES CENTER

Located southeast of downtown Fort Worth, the Mabee Center serves as the hub of The Salvation Army's Tarrant County operations. This facility is open 24 hours a day, 365 days a year. Whether an individual or family is in need of a hot meal, a place to stay, or any of the variety of residential programs designed to take a family or individual from homelessness to being a stable and productive member of society, help can be found at the Mabee Center.

The following programs and services are offered at this center:

- **Emergency Homeless Shelter**
  Our emergency shelter is open 365 days a year to provide a safe, clean refuge for men, women, families, and women with children. Our guests are provided with sleeping accommodations, hot meals, showers (including towels and toiletries), and clothes. Daily check-in is from 4:30 p.m. to 9 p.m.

- **Daily Meals for the Homeless**
  Hunger and proper nutrition are ongoing issues for people on the streets. To address this need, we serve three hot meals a day in our on-site cafeteria for any and all who show up. The free meals are balanced and nutritious to help meet a person's most basic need.

- **Home Sweet Home**
  This homeless prevention program is for at-risk individuals and families that are on the verge of losing their homes. The goals of this program are to prevent homelessness, support home ownership, and build healthy and self-sufficient families. We value the empowerment, hope, self esteem, independence and dignity of our program participants.

- **Simon Transitional Housing Program**
  This program is for unaccompanied single men and women over age 18 who have a dual diagnosis of mental illness and drug/alcohol addiction. In collaboration with other Tarrant County homeless service agencies, the Simon program provides room and board, as well as life skills, counseling, case management for up to two years.

- **S.T.A.R.T. Program**
  The acronym stands for Stabilizing to Achieve Richer Tomorrows. The program is designed to give people who are shackled by a repetitive cycle of homelessness a new start in life. Case managers function as mentors for each person in their care, and will actually accompany people from place to place helping them to establish relationships and make the arrangements necessary to move to independent living. Participants are required to save up to 75% of all income received. Upon successful completion, participants transition into the Home Sweet Home follow-up program.

- **First Choice Program**
  The First Choice program is a voluntary, long-term residential treatment program uniquely designed for chemically dependent women and their children. Participants receive a wide range of services for up to 12 months, including a private room with bath, transportation, off-site day care, group therapy, 12-step meetings (Narcotics Anonymous and Alcoholics Anonymous), substance abuse counseling, experiential learning activities, life skills, parental training, family counseling, money management, and individual counseling.

- **S.A.V.E.**
  The Salvation Army Veterans Enrichment program provides permanent housing, long-term comprehensive case management, and supportive services for chronically homeless, disabled veterans. Designed to stabilize housing, increase income through job training/placement, and enhance self-determination, S.A.V.E.'s mission is to meet veteran's most urgent needs as rapidly as possible.

1855 E. Lancaster Ave. Fort Worth, TX 76103 | P (817) 344-1800 | F (817) 338-9251

DOING THE MOST GOOD

SAFEHAVEN

817.535.6462 | safehaventc.org | 24-Hour Hotline | 1.877.701.SAFE (7233)

THE MISSION OF SAFEHAVEN IS TO END DOMESTIC VIOLENCE THROUGH:

SAFETY

SafeHaven of Tarrant County provides a 24-hour bilingual hotline that facilitates crisis intervention, safety assessment, information and referrals, access to emergency shelters and connection to SafeHaven services. Additionally, SafeShelters in Arlington and Fort Worth provide emergency shelter with a 164-bed capacity.

SUPPORT

SafeHaven provides counseling, transitional housing and free legal assistance to support survivors in need. Support services are provided at all SafeHaven locations and through the scattered-site housing program.

PREVENTION

In order to cease future domestic violence, SafeHaven provides a robust, multi-session, evidence-based program to students from elementary to high school about respect, anti-bullying and relationships all focused on eliminating future domestic violence.

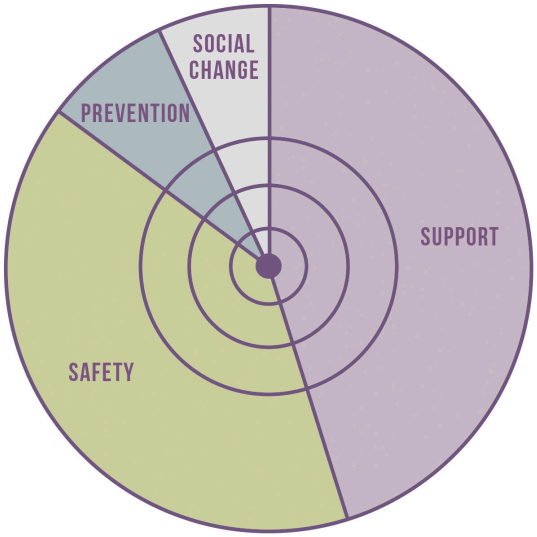
SOCIAL CHANGE

SafeHaven provides its only fee-based service, the Partner Abuse Intervention Program (PAIP), to offenders through a state accredited and evidence-based course. PAIP is a psychoeducational service where offenders are taught the fundamentals of leading a nonviolent lifestyle. The goal of PAIP is to achieve the social change necessary to eliminate domestic violence.

1 IN 3 women in Tarrant County will **experience domestic violence** in her lifetime.

6 women were **killed by their intimate partner** and **1 associated death occurred** in Tarrant County in 2018. Harris County was the only other county in Texas with more deaths due to domestic violence.

164 **total beds** available between two emergency shelters in Arlington and Fort Worth.



OUTER CORE 84%
DIRECT PROGRAM EXPENSES

MIDDLE CORE 10%
ADMINISTRATIVE EXPENSES

INNER CORE 6%
FUNDRAISING EXPENSES

Gary Kesling, PhD, LPC, LMFT, NCC, CCTP

Associate Director of Tarrant County Public Health
Diplomate and Fellow Healthcare Administration
Healthcare Administration Credentialing Commission
Fellow and Diplomate American Academy of Experts in Traumatic Stress
GLKesling@tarrantcounty.com

Tarrant County Public Health

Call To Action

1. Identify challenges in building collaborative partnerships for population health;
2. Identify pathways for caring communities;
3. Connecting at risk populations to community resources;
4. Identify, analyze and distribute information from big, new and real time sources.

LOCAL HUMAN TRAFFICKING RESOURCES

Unbound Fort Worth

24/7 SURVIVOR ADVOCACY
REFERRALS (CRISIS & NON-CRISIS):
817-668-6462
OFFICE NUMBER: 817-668-6544

WEBSITE:
WWW.UNBOUNDFORTWORTH.ORG

Traffick911

PHONE:
817-575-9923

WEBSITE:
WWW.TRAFFICK911.COM

Valiant Hearts

PHONE:
855-524-3747

WEBSITE:
WWW.VALIANTHEARTS.ORG

Salvation Army

MABEE CENTER SOCIAL SERVICES

ADDRESS:
1855 EAST LANCASTER AVENUE,
FORT WORTH, TEXAS 76103

PHONE:
817-344-1811

WEBSITE:
SALVATIONARMYDFW.ORG

5-Stones Taskforce

COMMUNITY NETWORK ENGAGING IN COLLABORATIVE EFFORTS TO END DOMESTIC MINOR SEX TRAFFICKING IN TARRANT COUNTY

WEBSITE:
HTTPS://POLICE.FORTWORTHTEXAS.GOV/SUPPORT/TARRANT-COUNTY-5-STONES-TASKFORCE

TO ATTEND MONTHLY MEETINGS CONTACT:
FELICIA GRANTHAM, HUMAN TRAFFICKING COORDINATOR

FORT WORTH POLICE DEPARTMENT
817-392-4533
FELICIA.GRANTHAM@FORTWORTHTEXAS.GOV

LOCAL HUMAN TRAFFICKING RESOURCES

Rescue Her

OFFICE PHONE:
817-885-9716

24/7 CRISIS HOTLINE
817-891-2093

WEBSITE:
RESCUEHER.ORG

**TO REPORT TIPS, PLEASE CALL THE MAIN OFFICE PHONE

Alliance For Children

CHILD ABUSE RESOURCE

ADDRESS:
908 SOUTHLAND AVENUE
FORT WORTH, TEXAS 76104

PHONE:
817-335-7172

WEBSITE:
WWW.ALLIANCEFORCHILDREN.ORG

The Net FW

ADDRESS:
2640 EAST LANCASTER AVE
FORT WORTH, TX 76103

PHONE:
682-233-4283

WEBSITE:
WWW.THENETFW.COM

LOCAL INTIMATE PARTNER VIOLENCE RESOURCES

One Safe Place

ADDRESS:
1100 HEMPHILL ST, FORT WORTH, TX 76104

MAIN NUMBER:
817-885-7774
FOR HELP WITH DOMESTIC VIOLENCE:
817-916-4323
CRIME STOPPERS:
817-469-8477

WEBSITE:
WWW.ONESAFEPLACE.ORG

SafeHaven

FORT WORTH RESOURCE CENTER:
1100 HEMPHILL ST, FORT WORTH, TX 76104

24-HOUR HOTLINE:
877-701-7233

WEBSITE:
WWW.SAFEHAVENTC.ORG

Cheryl's Voice

ADDRESS:
3000 SOUTH HULEN STREET
SUITE 124
PMB 128
FORT WORTH, TX 76109

PHONE:
817-919-5398

WEBSITE:
WWW.CHERYLSVOICE.ORG

The Women's Center of Tarrant County

ADDRESS:
1723 HEMPHILL
FORT WORTH, TX 76104

MAIN NUMBER:
817-927-4040

RAPE CRISIS OFFICE NUMBER:
817-927-4039

24/7 RAPE CRISIS HOTLINE:
817-927-2737

GENERAL COUNSELING HELPLINE:
817-927-4000

WEBSITE:
WWW.WOMENSCENTERTC.ORG

Resource Services

Local Resource	24/7 services	Serves victims of human trafficking (HT)	Serves victims of intimate partner violence (IPV)	Serves children (<18 years)	Serves only women	Serves men and women	Serves those without permanent resident status	Offers staff training about HT	Offers staff training about IPV
Cheryl's Voice								X	X
One Safe Place			X	X		X	X		X
Rescue Her	X	X			X		X	X	
SafeHaven of Tarrant County	X		X	X		X	X		X
Salvation Army	X	X	X			X	X	X	X
The Net FW		X	X		X		X	X	
The Women's Center of Tarrant County	X	X	X	X		X	X	X	X
Traffick911	X	X		X		X	X	X	
Unbound	X	X		X		X	X	X	
Valiant Hearts		X				X		X	

LAW ENFORCEMENT RESOURCES

IF SOMEONE NEEDS IMMEDIATE ASSISTANCE OR IT IS AN EMERGENCY, CALL 9-1-1

Tarrant County Sheriff's Office Human Trafficking Unit

PHONE:
817-884-2941

EMAIL:
HUMANTRAFFICKING@TARRANTCOUNTY.COM

NOT A 24/7 RESOURCE

Fort Worth Police Department (FWPD) Human Trafficking Unit

PHONE:
817-392-4533

EMAIL:
HUMANTRAFFICKING@FORTWORTHTEXAS.GOV

NOT A 24/7 RESOURCE

NATIONAL RESOURCES

HEAL Trafficking

WEBSITE:
HEALTRAFFICKING.ORG

TO JOIN THE HEAL LISTSERV AND HEAL COMMITTEES:
HTTPS://HEALTRAFFICKING.ORG/JOIN-A-COMMITTEE/

Office On Trafficking in Persons

SOAR TO HEALTH AND WELLNESS TRAINING

WEBSITE:
HTTPS://WWW.ACF.HHS.GOV/OTIP/TRAINING/SOAR-TO-HEALTH-AND-WELLNESS-TRAINING/SOAR-ONLINE

National Human Trafficking Hotline

REPORT TIPS OR RECEIVE ASSISTANCE
MULTILINGUAL STAFF
CALLER CAN REMAIN ANONYMOUS
24/7 RESOURCE

PHONE:
888-3737-888

TEXT:
233733
(BEFREE)

WEBSITE:
HUMANTRAFFICKINGHOTLINE.ORG

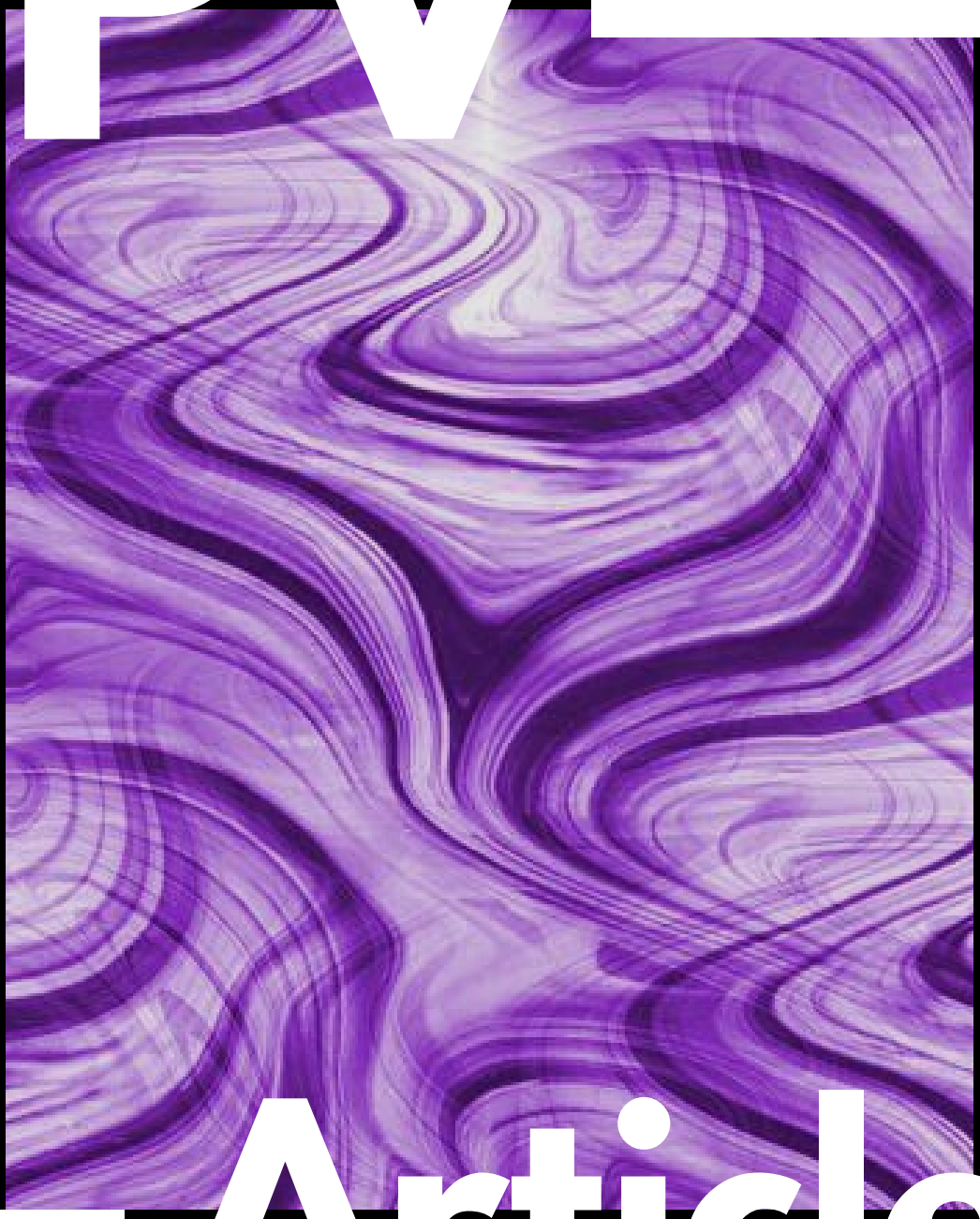
NAPNAP Partners for Vulnerable Youth

HEADQUARTERS ADDRESS:
5 HANOVER SQUARE
SUITE 1401
NEW YORK, NY 10004

PHONE:
917-746-8305

WEBSITE:
NAPNAPPARTNERS.ORG

IPV



Articles

J Community Health (2015) 40:508–514
DOI 10.1007/s10900-014-9964-1

ORIGINAL PAPER

Establishing the Need for Family Medicine Training in Intimate Partner Violence Screening

Patti Pagels · Tiffany B. Kindratt · Guadalupe Reyna · Kenrick Lam · Mandy Silver · Nora E. Gimpel

Published online: 29 October 2014

Abstract In 2012, the USPSTF updated its guidelines and now recommends that all women of childbearing age be screened for IPV and services provided for women who screen positive. Based on these recommendations, objectives of this study were to (1) evaluate IPV knowledge, attitudes, and practices of physicians from different specialties and (2) determine significant differences by medical specialty. We recruited (n = 183) Internal Medicine, Emergency Medicine, Family Medicine (FM) and Obstetrics/Gynecology (OB/GYN) residents and attending physicians to complete a 15-question online survey assessing knowledge, attitudes and current IPV screening practices. We evaluated associations between medical specialty and knowledge, attitudes and practice measures before and after controlling for covariates. Knowledge of how often IPV occurs in society, community resources, and screening tools were significantly different by specialty (all p's < 0.05). A majority of FM physicians (88 %) reported that it is a physician's responsibility to find and treat IPV and 97 % reported that IPV should be included in their training. Compared to OB/GYN physicians in multivariate analyses, FM physicians were less likely to report they were comfortable discussing IPV with their patients in crude (OR = 0.35; 95 % CI = 0.13, 0.94) and adjusted models (OR = 0.20; 95 % CI = 0.06, 0.60). FM physicians were also less likely to report screening female patients for IPV before (OR = 0.25; 95 % CI = 0.08, 0.86) and after adjusting for confounders (OR = 0.11; 95 % CI = 0.03, 0.47). Our results indicate that FM physicians have positive attitudes towards finding and treating IPV yet need enhanced training to improve their comfort level with screening for and discussing IPV with their patients.

Keywords Family Medicine · Intimate partner violence · Domestic violence · Residency · Training

Introduction

Family Medicine (FM) physicians are uniquely trained to provide comprehensive primary care to patients across all phases of the lifespan with a community-based focus. FM physicians provide care to underserved and vulnerable populations, including women experiencing intimate partner violence (IPV). In 2012, the United States Preventive Services Task Force (USPSTF) updated the guidelines for IPV screening to category B [1]. Clinicians are advised to screen all women of childbearing age for IPV and provide services for those who screen positive [1]. The American Academy of Family Physicians (AAFP) upholds this recommendation for FM physicians while the American Congress of Obstetricians and Gynecologists (ACOG) recommends physicians screen all patients for IPV, regardless of age [2, 3]. Several studies evaluating victims of abuse have found that a majority (70–81 %) of women wanted their healthcare providers to screen them for IPV [4–6]. Despite increased emphasis on screening with these recommendations, little is known about an increase in screening for IPV in outpatient settings. Short screening

P. Pagels · G. Reyna · K. Lam · M. Silver · N. E. Gimpel
Department of Family and Community Medicine, University of Texas Southwestern Medical Center, 5920 Forest Park Rd. Suite 650, Dallas, TX 75390-9165, USA

T. B. Kindratt (✉)
Department of Physician Assistant Studies, University of Texas Southwestern Medical Center, 6011 Harry Hines Blvd., Suite V4.114, Dallas, TX 75390-9090, USA
e-mail: tiffany.kindratt@utsouthwestern.edu

tools have been developed and validated to encourage physicians to screen for IPV in a time-efficient manner including the Woman Abuse Screening Tool (WAST) and the Hurt, Insult, Threaten, Scream (HITS) surveys [7, 8]. Previous research has identified lack of knowledge, experiential training, time constraints associated with daily practice and general discomfort as potential barriers for routine screening [9, 10]. This may be particularly true among physician residents.

Residency programs need to find innovative ways to train their residents to meet the unique needs of these populations. The Accreditation Council for Graduate Medical Education (ACGME) requires that residency programs include a Community Medicine curriculum which includes: (1) providing patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health; (2) demonstrating the ability to assess community, environmental, and family influences on the health; and (3) addressing population health, which includes the evaluation of health problems of the community [11]. The curriculum should include the needs of vulnerable populations, such as women experiencing IPV. The AAFP also recommends a training curriculum in IPV for residency programs that includes: (1) epidemiology, risks and red flags for identifying IPV or sexual harassment, and resources available to assist affected women; (2) components of the evaluation and treatment of victims of rape and sexual assault (including psychosocial and legal issues); and (3) the ability to perform or refer women for IPV counseling [12].

Minimal research has evaluated IPV training programs for residents in FM and other physician specialties [13]. Hendricks-Matthews surveyed FM residency program directors about violence education and 59 % of program directors stated that violence education received little or no attention in their curriculum. Rovi and Mouton followed-up this survey several years later and 80 % of directors stated that IPV comprised somewhat or a great deal of the FM curriculum [13]. McColgan and colleagues [14] developed an IPV training curriculum for pediatric residents designed to improve their knowledge, attitudes and screening practices by using screening prompts. Prior to the intervention, less than 1 % of patients were screened for IPV in their continuity clinic. After the intervention, residents showed improvements in the knowledge of IPV screening instruments, resources for referrals and the relationship between IPV and child abuse. 3 and 8 months after the intervention showed an increase in screening to 36 % at 3 months and 33 % at 8 months [14]. Brienza and colleagues [15] used experiential training to expose Internal Medicine residents to IPV. Residents participated in didactics, a video and role-plays. A case group attended meetings where IPV survivors shared their experiences. While all residents showed improvements in skills, attitudes, and knowledge 6–12 months after the training, case residents who attending weekly meetings showed significantly pre-post improvements in knowledge [15]. A quality improvement study was conducted with Emergency Medicine residents to determine whether documentation of screening improved after didactic training. Results indicated no difference in screening documentation after the training [16]. To our knowledge, no Obstetrics/Gynecology (OB/GYN) residency programs have evaluated IPV training curricula.

In order to determine curriculum needs in our FM residency program, two objectives of this study were: (1) to evaluate IPV knowledge, attitudes, and practices of physicians from different specialties; and (2) determine whether there were significant differences by program before and after controlling for potential confounders. Results will be used to develop a curriculum to increase screening practices and expose FM residents attending physicians to the unique needs to this vulnerable population.

Methods

Setting and Subjects

Parkland Health and Hospital System (PHHS) serves as the teaching hospital for University of Texas Southwestern Medical Center (UTSW) residency programs. Training for PHHS residents is provided by UTSW attending physicians. PHHS contains a 744-bed, county hospital that serves a primarily uninsured or underinsured population in Dallas, Texas. Physicians from Internal Medicine, Emergency Medicine, FM and OB/GYN were recruited for this cross-sectional study because they are at the forefront of exposure to IPV. Subspecialties such as cardiology, urology, and infectious diseases were excluded from the survey. Pediatricians were also excluded as this study focused on screening adult women. Only UTSW faculty and PHHS residents were surveyed. The study was approved by the UTSW Institutional Review Board. This study was developed as part of the Community Action Research Experience (CARE) program. CARE a longitudinal community-based participatory research training program available to selected residents at the UTSW FM Residency Program [17].

Data Collection

Data was collected from October 2010 to February 2011. A link (SurveyMonkey®) to complete a 15-question survey evaluating knowledge, attitudes and current IPV screening practices was emailed to residents and attending physicians. The survey took 3–5 min to complete. Two reminder emails were sent during the data collection period.

Participants were able to enter a drawing at the end of the survey to be awarded a $100, $50 or $25 gift card. The three winners were chosen by number randomization at the close of the survey.

Demographic information collected included: program specialty (Emergency Medicine, FM, Internal Medicine, or OB/GYN), position (resident or attending), sex (male or female), and number of years practicing medicine (<5 or 5 years or more). *Knowledge* was measured by asking participants how frequently they thought IPV occurs in society (never/rarely or occasionally/frequently) and whether they knew about internal (Parkland Victim Intervention Program/Race Crisis Center) and external community referral agencies (yes or no) for IPV victims. *Attitudes* were measured by asking participants whether they thought that finding and treating IPV should be the responsibility of physicians (yes or no), whether IPV should be included in their training (yes or no) and whether they believed that their medical training (medical school or residency) adequately prepared them to treat victims (yes or no). *Practice* was measured by asking participants how often they encountered IPV in their patient population (never/rarely or occasionally/frequently), how comfortable they were discussing IPV with their female patients (not/somewhat or fairly/very), and how often they screened for IPV (never/rarely or occasionally/frequently). Participants were also asked whether they had heard of validated screening tools such as the WAST and the HITS (yes or no) and if so, had they ever used them (yes or no) as a measure of both knowledge and practice.

Statistical Analysis

Chi-square was used to determine statistically significant differences by physician specialty for demographic characteristics, knowledge, attitudes and practice. We used logistic regression models to evaluate the association between specialty (independent variable) and all knowledge, attitudes and practice measures (dependent variable) before and after controlling for sex (Model 1) and experience (years in position and rank) covariates. SAS 9.3 was used to conduct the analysis.

Results

Selected Characteristics

Out of 553 potential participants, we received 183 (33 %) responses. Response rates from FM were much higher than the rest of the specialties (75 vs. ~27 % for the other specialties). However, Internal Medicine comprised the largest portion of our sample (51 %). FM physicians were mostly female (73 %). Over half (58 %) were residents and had less than 5 years of experience (61 %). *Knowledge* of how often IPV occurs in society, community referral agencies available (internally and community-based), and screening tools such as the WAST and HITS were significantly different by specialty (all p's < 0.05). FM physicians reported the most positive *attitudes* towards IPV recognition and the need for adequate training. A majority (88 %) reported that it is a physician's responsibility to find and treat IPV and 97 % reported that IPV should be included in their professional medical training. Significant differences in *practice* were also found when comparing how often physicians' screen for IPV, IPV patient encounters, comfort discussing IPV with patients and the use of validated screening tools (all p's < 0.05) (see Table 1).

Multivariate Results

In crude analyses (Table 2, Model 1), FM physicians were 65 % less likely (OR = 0.35; 95 % CI = 0.13, 0.94) to report that they were comfortable discussing IPV with their patients compared to OB/GYN physicians. After adjusting for sex (OR = 0.35; 95 % CI = 0.13, 0.96) and experience (Table 2, Model 3), results remained significantly different. FM physicians were 80 % less likely (OR = 0.20; 95 % CI = 0.06, 0.60) to report they were comfortable discussing IPV with their patients when compared to OB/GYN physicians. Similar results were found when evaluating screening practices for IPV. In unadjusted models, FM physicians were 75 % less likely (OR = 0.25; 95 % CI = 0.08, 0.86) to report screening female patients for IPV. After adjusting for sex (OR = 0.26; 95 % CI = 0.08, 0.86) and experience (Table 2, Model 3), FM physicians were 89 % less likely to report that they screen their female patients for IPV (OR = 0.11; 95 % CI = 0.03, 0.47) compared to OB/GYN physicians. There were no significant differences between FM and OB/GYN physicians when evaluating knowledge of how often IPV occurs in society, external and internal referral programs before or after adjusting for covariates. Furthermore, there were no significant differences when evaluating a physician's responsibility to find and treat IPV, effectiveness of prior training, current IPV encounters and the need for IPV training in professional medical education.

Discussion

The objectives of this study were to evaluate IPV knowledge, attitudes, and practices of physicians from different specialties and determine significant differences by program before and after controlling for potential confounders.

Table 1 Selected characteristics of physicians by specialty (N = 183)

	Emergency Medicine N (%) (N = 19)	Family Medicine N (%) (N = 33)	Internal Medicine N (%) (N = 94)	Obstetrics/Gynecology N (%) (N = 37)	*p* value
Sex					
Male	16 (84.2)	9 (27.3)	56 (59.6)	5 (13.5)	<.0001
Female	3 (15.8)	24 (72.7)	38 (40.4)	32 (86.5)	
Position					
Attending	8 (42.1)	14 (42.4)	38 (40.4)	1 (2.7)	0.0002
Resident	11 (57.9)	19 (57.6)	56 (59.6)	36 (97.3)	
Years of experience					
Less than 5 years	12 (63.2)	20 (60.6)	64 (68.1)	36 (97.3)	0.0015
5 years or more	7 (36.8)	13 (39.4)	30 (31.9)	1 (2.7)	
Knowledge					
How often IPV occurs in society					
Never/rarely	12 (63.2)	12 (36.4)	41 (43.6)	8 (21.6)	0.0173
Occasionally/frequently	7 (36.8)	21 (63.6)	53 (56.4)	29 (78.4)	
Community referral agencies					
No	11 (57.9)	23 (71.9)	86 (95.6)	25 (73.5)	<.0001
Yes	8 (42.1)	9 (28.1)	4 (4.4)	9 (26.5)	
Parkland Victim Intervention Program					
No	7 (36.8)	8 (25.0)	68 (75.6)	4 (11.8)	<.0001
Yes	12 (63.2)	24 (75.0)	22 (24.4)	30 (88.2)	
Not heard of screening tools (i.e. HITS)					
No	2 (10.5)	17 (53.1)	14 (15.6)	9 (26.5)	0.0001
Yes	17 (89.5)	15 (46.9)	76 (84.4)	25 (73.5)	
Attitudes					
Doc responsible to find/treat DV					
No	5 (26.3)	4 (12.1)	32 (34.0)	7 (18.9)	0.0607
Yes	14 (73.7)	29 (87.9)	62 (66.0)	30 (81.1)	
DV training should be included in professional medical training					
No	2 (10.5)	1 (3.0)	18 (19.2)	4 (10.8)	0.1128
Yes	17 (89.5)	32 (97.0)	76 (80.9)	33 (89.2)	
Prior medical training was provided and very helpful					
No	9 (47.4)	21 (63.6)	69 (73.4)	22 (59.5)	0.1100
Yes	10 (52.6)	12 (36.4)	25 (26.6)	15 (40.5)	
Practice					
Encounter IPV in own patient population					
Never/rarely	6 (31.6)	7 (21.1)	57 (60.6)	4 (10.8)	<.0001
Often/occasionally	13 (68.4)	26 (78.8)	37 (39.4)	33 (89.2)	
Comfortable discussing DV with patients					
Not or somewhat	8 (42.1)	17 (51.5)	65 (69.1)	10 (27.0)	<.0001
Fairly or very	11 (57.9)	16 (48.9)	29 (30.9)	27 (73.0)	
Screen female patients for DV					
Never/rarely	9 (47.4)	13 (40.6)	70 (77.8)	5 (14.7)	<.0001
Often/occasionally	10 (52.6)	19 (59.4)	20 (22.2)	29 (85.3)	
Have heard of screening tools and not used them					
No	17 (89.5)	19 (59.4)	78 (86.7)	25 (73.5)	0.0054
Yes	2 (10.5)	13 (40.6)	12 (13.3)	9 (26.5)	

Table 2 Knowledge, attitudes and practice by specialty (N = 183)

Specialty	Model 1 crude	Model 2[a] demographic	Model 3[b] experience
Obstetrics/Gynecology	1.00	1.00	1.00
Knowledge			
How often DV occurs in society			
Family Medicine	0.48 (0.17, 1.39)	0.50 (0.17, 1.44)	0.36 (0.12, 1.10)
Internal Medicine	0.36 (0.15, 0.86)	0.40 (0.16, 1.02)	0.28 (0.10, 0.77)
Emergency Medicine	0.16 (0.05, 0.54)	0.19 (0.05, 0.70)	0.15 (0.04, 0.59)
Community referral agencies			
Family Medicine	1.09 (0.37, 3.21)	1.11 (0.37, 3.29)	0.64 (0.18, 2.26)
Internal Medicine	0.13 (0.04, 0.46)	0.14 (0.04, 0.53)	0.08 (0.02, 0.34)
Emergency Medicine	2.02 (0.62, 6.62)	2.30 (0.57, 9.32)	1.96 (0.36, 10.81)
Parkland Victim Intervention Program (Internal Referral Program)			
Family Medicine	0.40 (0.11, 1.49)	0.42 (0.11, 1.59)	0.52 (0.13, 2.08)
Internal Medicine	0.04 (0.01, 0.14)	0.05 (0.02, 0.17)	0.06 (0.02, 0.22)
Emergency Medicine	0.23 (0.06, 0.93)	0.33 (0.07, 1.48)	0.43 (0.09, 2.05)
Have not heard of screening tools			
Family Medicine	0.32 (0.11, 0.89)	0.32 (0.11, 0.89)	0.47 (0.15, 1.43)
Internal Medicine	1.95 (0.76, 5.06)	1.88 (0.68, 5.20)	3.34 (1.04, 10.74)
Emergency Medicine	3.06 (0.59, 15.95)	2.87 (0.50, 16.52)	4.68 (0.70, 31.37)
Attitudes			
Doc responsible to find/treat DV			
Family Medicine	1.69 (0.45, 6.40)	1.84 (0.48, 7.05)	1.72 (0.43, 6.92)
Internal Medicine	0.45 (0.18, 1.14)	0.58 (0.21, 1.56)	0.53 (0.19, 1.52)
Emergency Medicine	0.65 (0.18, 2.43)	0.95 (0.23, 3.93)	0.94 (0.22, 4.11)
Prior medical training was provided and very helpful			
Family Medicine	0.84 (0.32, 2.20)	0.79 (0.30, 2.09)	0.74 (0.26, 2.07)
Internal Medicine	0.53 (0.24, 1.18)	0.43 (0.17, 1.03)	0.42 (0.16, 2.07)
Emergency Medicine	1.62 (0.54, 4.97)	1.19 (0.35, 4.05)	1.26 (0.34, 4.61)
DV training should be included in professional medical training			
Family Medicine	3.87 (0.41, 36.60)	4.14 (0.44, 39.41)	3.42 (0.35, 33.67)
Internal Medicine	0.51 (0.16, 1.63)	0.62 (0.18, 2.17)	0.53 (0.14, 2.05)
Emergency Medicine	1.03 (0.17, 6.20)	1.38 (0.20, 9.43)	1.32 (0.17, 10.08)
Practice			
Encounter IPV in own patient population			
Family Medicine	0.45 (0.12, 1.71)	0.48 (0.13, 1.84)	0.35 (0.09, 1.41)
Internal Medicine	0.08 (0.03, 0.24)	0.10 (0.03, 0.31)	0.07 (0.02, 0.23)
Emergency Medicine	0.26 (0.06, 1.09)	0.36 (0.08, 1.64)	0.31 (0.06, 1.51)
Comfortable discussing DV with patients			
Family Medicine	0.35 (0.13, 0.94)	0.35 (0.13, 0.96)	0.20 (0.06, 0.60)
Internal Medicine	0.17 (0.07, 0.39)	0.17 (0.07, 0.42)	0.90 (0.03, 0.26)
Emergency Medicine	0.51 (0.16, 1.63)	0.54 (0.15, 1.89)	0.34 (0.09, 1.36)
Screen female patients for DV			
Family Medicine	0.25 (0.08, 0.82)	0.26 (0.08, 0.86)	0.11 (0.03, 0.47)
Internal Medicine	0.05 (0.02, 0.14)	0.06 (0.02, 0.18)	0.02 (0.01, 0.09)
Emergency Medicine	0.19 (0.05, 0.71)	0.27 (0.07, 1.09)	0.14 (0.03, 0.71)
Have heard of screening tools and not used them			
Family Medicine	1.90 (0.67, 5.37)	1.91 (0.68, 5.43)	1.29 (0.41, 4.06)
Internal Medicine	0.43 (0.16, 1.13)	0.44 (0.15, 1.25)	0.26 (0.08, 0.86)
Emergency Medicine	0.33 (0.06, 1.70)	0.34 (0.06, 1.98)	0.23 (0.04, 1.53)

[a] Adjusts for sex (male as referent)

[b] Adjusts for variables in model 2 plus rank (faculty as referent) and years of experience (less than 5 as referent)

Results will be used to determine training needs for FM physicians. Our three main findings were that FM physicians: (1) have positive attitudes towards finding and treating IPV and the need for improved IPV training in their professional medical training; (2) were less likely to report they were comfortable discussing IPV with their patients and; (3) were less likely to screen for IPV among their patients when compared to OB/GYN providers.

FM physicians had the highest percentage of providers who reported that it is their responsibility identify and treat IPV, that IPV should be included in their training, and that their prior training was not helpful compared to other specialties. Previous studies have evaluated practicing physicians and residents' knowledge, attitudes and/or practice towards IPV before and after targeted interventions [18, 19]. However, to our knowledge, this is the first study to compare multiple medical specialties which are at the forefront of IPV patient care. Few training programs have been targeted towards improving knowledge, attitudes and practice among FM residents and attending physicians. Papadakaki and colleagues evaluated changes in knowledge, preparedness and detection among residents and general practitioners in Greece. Results showed that after a two-day didactic and interactive training program, perceived knowledge and preparedness increased [20]. Our results also indicated that FM physicians were 80 % less likely to report they were comfortable discussing IPV with their patients and 89 % less likely to report that they screen their female patients for IPV when compared to OB/GYN physicians. Our results were similar to Ramsay and colleagues [18], who found that less than 10 % of general practitioners (GPs) and nurses in the United Kingdom were prepared to ask appropriate questions about IPV or knew questions to ask to identify IPV among their patients.

Strengths and Limitations

Among the strengths of this study is its ability to survey residents and faculty physicians from multiple specialties. Several limitations may have affected our results. All results were self-reported and therefore may not accurately reflect true estimates. Yet, previous research evaluating self-reported perceived knowledge and actual knowledge has found consistent results between both measurements [20]. Furthermore, this study was performed at a single academic setting and is not representative of physicians in the community at large. In the county hospital setting, there may be increased rates of IPV in the patient population. Our response rate was only 33 %, which is lower than a 40–50 % recommended response rate for email surveys [21, 22]. Although our overall response rate was low, the response rate in our target specialty of FM was 75 %. Our study also suffered from uneven sample sizes between specialties and physician experience. In particular, only one OB/GYN attending physician responded to the survey.

Future Directions

Results of this study will be used to implement a curriculum to increase awareness among FM attending physicians and train residents to screen for IPV in their continuity clinic. Residents will provide care at a local IPV shelter under faculty supervision. Residents will participate in several didactic and experiential learning activities which will allow them to gain awareness and compassion for the unique needs of this population. Knowledge, attitudes and practice will be evaluated after implementation on the intervention. Our findings showed that FM physicians have the knowledge and attitudes required to provide patient care to IPV victims yet need improved training to implement them in practice.

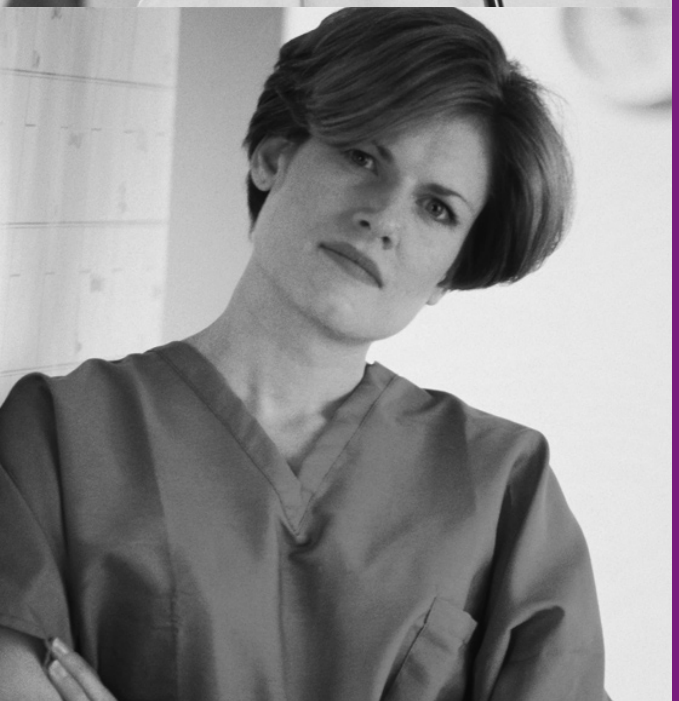
Acknowledgments We would also like to acknowledge Emeka Jay Ohagi, MPH, Barbara Foster, PhD and Amer Shakil, MD for their support and contribution to this project.

Conflict of interest None.

References

1. Moyer, V. A. (2013). Screening for intimate partner violence and abuse of elderly and vulnerable adults: A U.S. preventive services task force recommendation statement. *Annals of Internal Medicine, 158*(6), 478–486.
2. Screening Tools—Domestic Violence. (n.d.). In The American Congress of Obstetricians and Gynecologists. (2014). Retrieved from www.acog.org/About-ACOG/ACOG-Departments/Violence-Against-Women/Screening-Tools–Domestic-Violence
3. ACOG Committee Opinion No. 518: Intimate partner violence. (2012). *Obstetrics and Gynecology*, 119(2, Part 1), 412–417.
4. Parsons, L., Goodwin, M. M., & Petersen, R. (2000). Violence against women and reproductive health: Toward defining a role for reproductive health care services. *Maternal and Child Health Journal, 4*(2), 135–140.
5. Parker, B., McFarlane, J., & Soeken, K. (1994). Abuse during pregnancy: Effects on maternal complications and birth weight in adult and teenage women. *Obstetrics and Gynecology, 84*(3), 323–328.
6. McFarlane, J., Parker, B., & Soeken, K. (1996). Physical abuse, smoking, and substance use during pregnancy: Prevalence, interrelationships, and effects on birth weight. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 25*(4), 312–320.
7. Brown, J. B., Lent, B., Brett, P. J., Sas, G., & Pederson, L. L. (1996). Development of the woman abuse screening tool for use in family practice. *Family Medicine, 28*(6), 422–428.
8. Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: A short domestic violence screening tool for use in a family practice setting. *Family Medicine, 30*(7), 508–512.
9. Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. (2007). Factors influencing identification of and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health, 7*, 12.

10. Sprague, S., Madden, K., Simunovic, N., et al. (2012). Barriers to screening for intimate partner violence. *Women and Health, 52*(6), 587–605.
11. ACGME Program Requirements for Graduate Medical Education in Family Medicine. (2013). Accreditation Council for Graduate Medical Education.
12. Women's Health: Recommended Curriculum Guidelines for Family Medicine Residents. (2012). American Academy of Family Physicians.
13. Hamberger, L. K. (2007). Preparing the next generation of physicians: Medical school and residency-based intimate partner violence curriculum and evaluation. *Trauma, Violence, & Abuse, 8*(2), 214–225.
14. McColgan, M. D., Cruz, M., McKee, J., et al. (2010). Results of a multifaceted Intimate Partner Violence training program for pediatric residents. *Child Abuse and Neglect, 34*(4), 275–283.
15. Brienza, R. S., Whitman, L., Ladouceur, L., & Green, M. L. (2005). Evaluation of a women's safe shelter experience to teach internal medicine residents about intimate partner violence. A randomized controlled trial. *Journal of General Internal Medicine, 20*(6), 536–540.
16. Sims, C., Sabra, D., Bergey, M. R., et al. (2011). Detecting intimate partner violence: More than trauma team education is needed. *Journal of the American College of Surgeons, 212*(5), 867–872.
17. Shakil, A., Gimpel, N., Ohagi, J., & Dobbie, A. (2009). A community action research experience (CARE) program for family medicine residents. *Family Medicine, 41*(3), 158–159.
18. Ramsay, J., Rutterford, C., Gregory, A., et al. (2012). Domestic violence: Knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. *British Journal of General Practice, 62*(602), 647–655.
19. Papadakaki, M., Prokopiadou, D., Petridou, E., Kogevinas, M., & Lionis, C. (2012). Defining physicians' readiness to screen and manage intimate partner violence in Greek primary care settings. *Evaluation and the Health Professions, 35*(2), 199–220.
20. Papadakaki, M., Petridou, E., Kogevinas, M., & Lionis, C. (2013). Measuring the effectiveness of an intensive IPV training program offered to Greek general practitioners and residents of general practice. *BMC Medical Education, 13*, 46.
21. Nulty, D. D. (2008). The adequacy of response rates to online and paper surveys: What can be done? *Assessment & Evaluation in Higher Education, 33*(3), 301–314.
22. Fincham, J. E. (2008). Response rates and responsiveness for surveys, standards, and the Journal. *American Journal of Pharmaceutical Education, 72*(2), 43.



Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings

Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1 is a publication of the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Centers for Disease Control and Prevention
Julie L. Gerberding, MD, MPH, Director

Coordinating Center for Environmental Health and Injury Prevention
Henry Falk, MD, MPH, Director

National Center for Injury Prevention and Control
Ileana Arias, PhD, Director

Division of Violence Prevention
W. Rodney Hammond, PhD, Director

Editing services were provided by the Office of Communication Resources, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Suggested Citation: Basile KC, Hertz MF, Back SE. Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings

Version 1.0

Compiled and Edited by:

Kathleen C. Basile, Ph.D.
Marci F. Hertz, M.S.
Sudie E. Back, Ph.D.

ACKNOWLEDGMENTS

We acknowledge the contributions of several CDC colleagues who reviewed the document and provided expert advice: Linda E. Saltzman, PhD; Tom Simon, PhD; Jim Mercy, PhD, and Joanne Klevens, MD. In addition, we would like to thank the numerous external experts in the fields of intimate partner violence and sexual violence who provided feedback on the scales identified for this compendium.

DEDICATION

We dedicate this document to the memory of Linda E. Saltzman, PhD, our colleague, mentor, and friend, whose influential work in the fields of intimate partner violence and sexual violence has improved the lives of many women and children.

CONTENTS

Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings

Purpose of this document

This document is a compilation of existing tools for assessing intimate partner violence (IPV) and sexual violence (SV) victimization (defined below) in clinical/healthcare settings.

The purpose of this compilation of assessment instruments is: 1) to provide practitioners and clinicians with the most current inventory of assessment tools for determining IPV and/or SV victimization and 2) to supply information on the psychometric properties of these instruments, when available, to inform decisions about which instruments are most appropriate for use with a given population. This document should serve as a guide to aid in the selection of assessment instruments for use in health care settings to identify victims requiring additional services. The identification can help practitioners make appropriate referrals for both victims and perpetrators.

Contents of this document

The document is divided into two sections. Section A includes intimate partner violence victimization tools. Section B includes sexual violence victimization tools. A table is included at the beginning of each section that lists each of the instruments included in the section. The actual instruments follow the table. Some instruments found in Section A are repeated in Section B if they include at least one item pertaining to sexual violence victimization.

When available, the following information is provided for each instrument:

- Instrument characteristics, such as how many items are included and what is specifically being measured;
- Administration method, such as whether information is collected through self-report or through clinician administration;
- Scoring procedures, such as what score constitutes victimization;
- Follow-up procedures, such as referral to services;
- Populations studied, such as whether the instrument was used with males or females, and with specific racial groups;
- Psychometric properties, including:
    - Reliability - the extent to which a scale's items are consistently measuring the same characteristic and are responded to similarly over time by the same individual
    - Validity - the extent to which a scale measures what it is supposed to measure
    - Specificity - the proportion of all "true" negative cases in a target population that are correctly identified by a particular scale
    - Sensitivity - the proportion of all "true" positive cases in a target population that are correctly identified by a particular scale;
- The author(s) who developed the instrument, including the relevant citation;
- Any recent articles published at the time of this writing that discuss the instrument.

Intimate Partner Violence and Sexual Violence Definitions

In the context of this document, intimate partner violence (IPV) is defined as actual or threatened physical, sexual, psychological, emotional, or stalking abuse by an intimate partner. An intimate partner can be a current or former spouse or non-marital partner, such as a boyfriend, girlfriend, or dating partner (Saltzman, et al., 1999). Intimate partners can be of the same or opposite sex (National Center for Injury Prevention and Control, 2002).

For the purposes of this document, sexual violence (SV) includes nonconsensual completed or attempted penetration of the vagina or anus, nonconsensual completed or attempted oral sex, nonconsensual intentional touching of a sexual nature, or nonconsensual non-contact acts of a sexual nature such as voyeurism and verbal or behavioral sexual harassment. SV can be perpetrated by anyone, such as a friend/acquaintance, a current or former spouse/partner, a family member, or a stranger (Basile and Saltzman, 2002).

Methods used to collect assessment instruments

To identify potential scales, we conducted an intensive literature search that involved a review of the articles published and indexed in PsycInfo and Medline and on Yahoo or Google internet sites. Search terms used included: *IPV, intimate partner violence, DV, domestic violence, abuse screening, assault screening, spouse abuse, partner abuse, dating violence, date rape, rape, wife rape, marital rape, sexual abuse, sexual assault, sexual victimization, youth violence, sexual violence, woman abuse, teen violence, acquaintance rape, psychological abuse, risk assessment, danger assessment, sexual offense, spousal assault risk, violent offense, sexual perpetrators, sexual predator, DV perpetrators, IPV perpetrators, perpetrator, propensity, interpersonal violence perpetrator, stalking perpetrator, and stalking.*

Articles identified through the search were used to gather information about the characteristics of the scale, the population(s) for which it was developed, and the psychometric properties.

Inclusion Criteria

Only assessment instruments for clinical purposes (as opposed to solely for research purposes) were considered for this document. Such assessment tools were limited to those that contained 20 items or fewer, as longer tools would be infeasible in many health care settings due to time constraints. In addition, while we prefer published assessment tools with reliability and validity information available, unpublished measures (particularly for topic areas in which few published assessment tools are available) that met the other inclusion criteria were also included.

Expert review

Once an initial list of scales was compiled, it was e-mailed to 14 expert clinicians and researchers in sexual and/or intimate partner violence prevention. The draft was also distributed to rape prevention and education program coordinators at state and territory departments of health, using the Rape Prevention and Education listserv. This listserv represents all 50 states, the District of Columbia, Puerto Rico, and seven U.S. territories. The reviewers were asked to comment on the selected scales, indicate if any scales were missing, and indicate whether the included scales could reasonably be used in a clinical setting. The comments were used to identify new scales and to improve the summary information provided.

Definitions of terms used

The following technical terms are used in this document:

Construct: An unobserved characteristic on which people vary and which scales are intended to measure.

Construct validity: The extent to which a scale's items measure the hypothesized underlying construct. One type is convergent validity.

> Convergent validity: The extent to which responses on a scale are correlated to responses on another scale that assesses a similar underlying construct.

Internal consistency reliability: Internal consistency reliability is typically measured using the Cronbach's alpha coefficient, which assesses the degree to which responses to items within a scale are correlated. Scores can range from 0 to 1.0, with higher scores reflecting greater homogeneity among the items. A general guideline for evaluating the adequacy of alpha coefficients is that scores greater than or equal to .80 reflect "exemplary" internal consistency reliability, scores ranging from .70 to .79 indicate "extensive" internal consistency reliability, scores ranging from .60 to .69 indicate "moderate" internal consistency reliability, and scores less than .60 reflect minimal reliability (Robinson, Shaver, & Wrightsman, 1991).

Test-retest reliability: The extent to which an individual's responses on a scale provided at one point in time correlate with his or her responses on the same scale at another point in time.

The sources for these definitions include Ghiselli, Campbell, and Zedeck (1981), Rathus and Feindler (2004), Robinson, Shaver, and Wrightsman (1991), and Teutsch and Churchill (2000).

Uses and limitations

The scales presented in this compilation represent all of the instruments known to the authors that met the inclusion criteria. This document is not intended to provide an exhaustive list of instruments. It should also be noted that the CDC is not endorsing any particular assessment instrument presented, but only provides information to help practitioners and clinicians make informed decisions about choosing instruments that assess exposure to IPV and SV victimization. These assessment instruments should only be used if there are resources available to distribute to clients for primary prevention purposes (preventing violence before it starts); and if there are mechanisms in place to refer clients exposed to IPV or SV for a comprehensive assessment and appropriate victim services. Further, at this time the U.S. Preventive Service Task Force has concluded that there is insufficient evidence to recommend routine IPV screening in healthcare settings (U.S. Preventive Task Force, 2004). More research is needed to further our understanding of the benefits and consequences of assessing exposure to IPV and SV in the healthcare setting (Chamberlain, 2005). We also hope that this document will aid in the field's efforts to increase the knowledge base around the pros and cons of assessing exposure to IPV and SV in the healthcare setting.

This document focuses on assessment tools for SV and IPV victimization, but there are several other types of interpersonal violence for which assessment in a clinical setting would be worthwhile. For example, although an attempt was made to include scales for SV and IPV perpetration, none met the selected criteria. Furthermore, this document does not include scales pertaining to the abuse of the elderly, children, or the disabled. While including these areas went beyond the scope of this project, future projects should address these and other special populations.

REFERENCES

Basile KC, Saltzman LE. (2002), *Sexual violence surveillance: Uniform definitions and recommended data elements. Version 1.0.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Chamberlain L. (2005). The USPSTF recommendation on intimate partner violence: What we can learn from it and what can we do about it. *Family Violence Prevention and Health Practice, 1, 1-24.*

Ghiselli EE, Campbell JP, Zedeck S. (1981). *Measurement theory for the behavioral sciences.* New York: W.H. Freeman and Company.

National Center for Injury Prevention and Control (2002). *CDC Injury Research Agenda*. Atlanta (GA): Centers for Disease Control and Prevention.

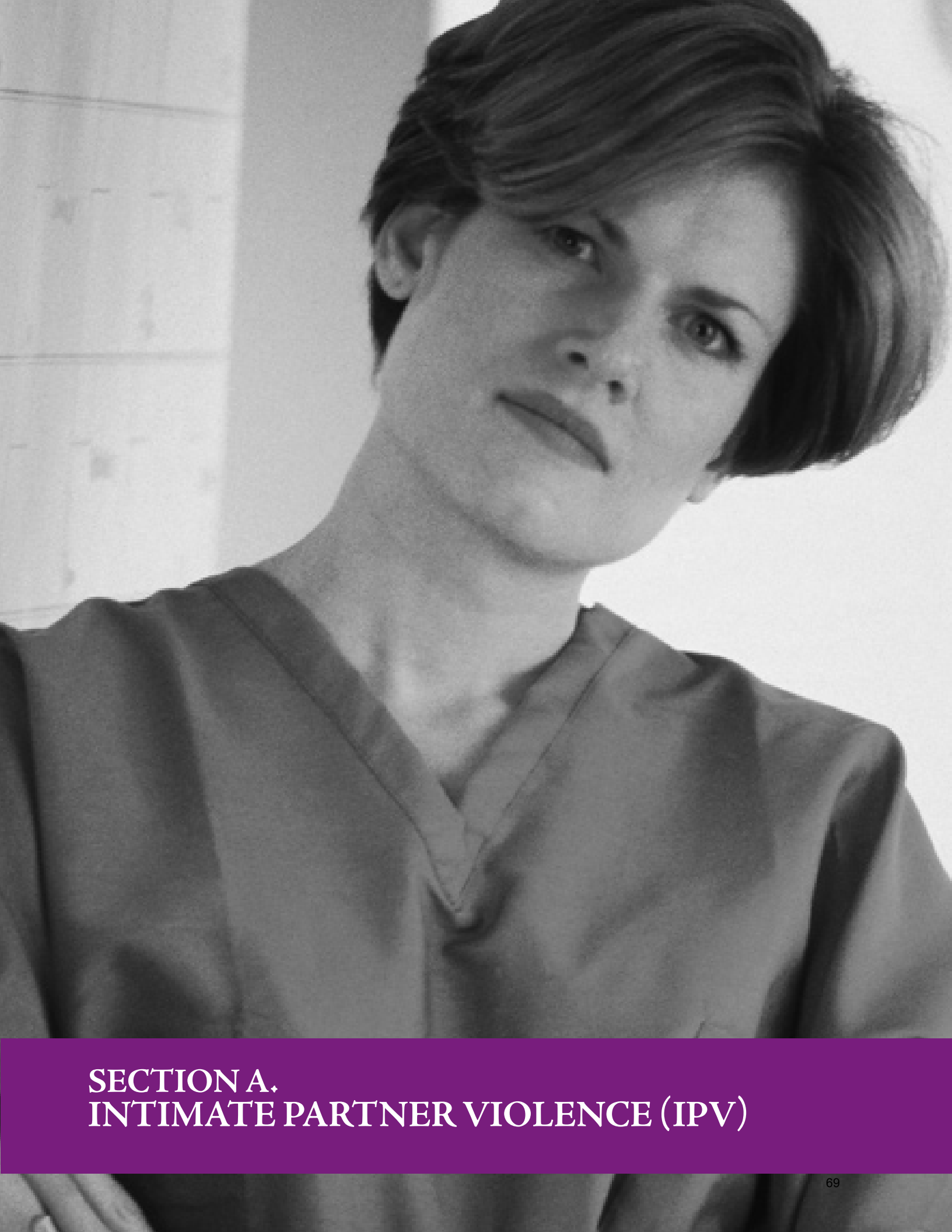
Rathus JH, Feindler EL. (2004). *Assessment of partner violence: A handbook for researchers and practitioners.* Washington DC: American Psychological Association.

Robinson JP, Shaver PR, Wrightsman LS. (1991). *Measures of personality and social psychological attitudes*. San Diego, CA: Academic Press, Inc.

Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. (1999). *Intimate partner violence surveillance: Uniform definitions and recommended data elements. Version 1.0* Atlanta, GA: CDC, National Center for Injury Prevention and Control.

Teutsch SM, Churchill RE. (Eds.). (2000). *Principles and practice of public health surveillance (2nd ed.)*. New York, NY: Oxford University Press, Inc.

US Preventive Services Task Force. (2004). See website: http://www.ahrq.gov/clinic/uspstf/uspsfamv.htm



SECTION A.
INTIMATE PARTNER VIOLENCE (IPV)

DESCRIPTION OF IPV MEASURES

Scale/Assessment	Characteristics	Administration Method	Populations Studied*
			*This list is not exhaustive.
Abuse Assessment Screen (AAS)	5 items assess frequency and perpetrator of physical, sexual, and emotional abuse by anyone. Body map to document area of injury.	Clinician administered	Abused pregnant and nonpregnant African-American, Hispanic, and white women in health and prenatal clinics and emergency departments.
AAS - Spanish Version	5 items assess frequency and perpetrator of physical, sexual, and emotional abuse by anyone. Body map to document area of injury.	Clinician administered	Abused pregnant and nonpregnant African-American, Hispanic, and white women in health and prenatal clinics and emergency departments.
American Medical Association Screening Questions	10 sample items inquire about physical, sexual, and emotional IPV to be asked in physician's own words.	Physician or clinician administered	Women patients in health care settings.
Assessment of Immediate Safety Screening Questions	11 items assess physical safety of patients who disclose current IPV.	Clinician administered or self report	Women and men patients in health care settings.
Bartlett Regional Hospital Domestic Violence Assessment	18 items assess IPV, patient safety, and referral options. Body map to document site of injury.	Clinician administered	Female patients over 16 in a hospital setting.
Computer Based IPV Questionnaire	14 items assess physical and emotional IPV, suicidal ideation, perpetration, sexual violence victimization, and access to handguns.	Self report via a computer in emergency department	African-American and white men and women in emergency departments.
Danger Assessment	15 items assess a woman's potential danger of homicide by an intimate male partner. Available in English Characteristics and Spanish.	Self report	Abused women in the community, battered women shelters, prenatal clinics, and primary care clinics. African-American, white, and Hispanic women.
Domestic Violence Initiative Screening Questions	6 items assess physical, and emotional IPV, and desire for professional assistance.	Clinician administered	Obstetric patients during their initial visit to a hospital based maternity clinic.
Domestic Violence Screening for Pediatric Settings	6 items (3 from American Medical Association and 3 new items) screen for IPV and availability of handguns in the home.	Clinician administered checklist	African-American and white women in a hospital-based pediatric clinic.
Domestic Violence Screening/ Documentation Form	20 items assess physical IPV, patient safety, handguns in the home, substance use, and referral/reporting options.	Designed to be administered by home care nurses	Women and men patients in home care settings.

	Reliability/Validity	Sensitivity/Specificity	Developer	Articles
	Test/retest reliability across the same trimester for pregnant women was 83%.	Sensitivity: 93%; Specificity: 55% (Using the Index of Spouse Abuse [ISA] as the gold standard)	McFarlane, Parker, Soeken, & Bullock, 1992	Norton, Peipert, Zierler, Lima, & Hume, 1995; Soeken, McFarlane, Parker, & Lominack,1998; Weiss, Ernst, Cham, & Nick, 2003
	Unavailable	Unavailable		
	Unavailable	Unavailable	American Medical Association, 1992	Unavailable
	Unavailable	Unavailable	Family Violence Prevention Fund, 2002	Unavailable
	Unavailable	Unavailable	Bartlett Regional Hospital	Bartlett Regional Hospital Domestic Violence Protocol
	Unavailable	Unavailable	Rhodes, Lauderdale, He, Howes, & Levinson, 2002	Heron & Kellermann, 2002
	Internal consistency: 0.66 -0.86. Test/retest reliability: 0.89 -0.94. Construct validity convergent with the Conflict Tactics Scale (CTS), r = 0.49 - 0.55 and ISA, r = 0.44 - 0.75.	Unavailable	Campbell, 1986	Campbell, 1989, 1995; Goodman, Dutton, & Bennett, 2000; McFarlane, Greenberg, Weltge, & Waston, 1995
	Unavailable	Unavailable	Queensland Government, 1998	Webster, Stratigos, & Grimes, 2001; Webster & Holt, 2004
	Unavailable	Unavailable	Siegel, Hill, Henderson, Ernst, & Boat, 1999	Unavailable
	Unavailable	Unavailable	Family Violence Prevention Fund,1996	Cassidy, 1999; Family Violence Prevention Fund, 2002

DESCRIPTION OF IPV MEASURES

Scale/Assessment	Characteristics	Administration Method	Populations Studied*
			*This list is not exhaustive.
Emergency Department Domestic Violence Screening Questions	5 items assess violence in the home.	Self report	Canadian women in emergency departments.
Falmouth Pediatric Associates Violence Handout	5 items adapted from the American Medical Association and Siegel et al. 1999 assess IPV, handguns in the home, and previous discussions with health care providers about IPV.	Self report	Mothers of young children in a pediatric group practice.
HITS	4 items assess the frequency of IPV.	Self report or clinician administered	Female patients in family practice settings; male patients in health care settings.
Minnesota Tool	13 items and color-coded stickers assess physical, emotional, and sexual IPV.	Self report	Women and men in a community hospital setting.
New South Wales Department of Health Survey	3 items assess IPV in the last year and current safety.	Clinician administered	Australian women, predominantly white, in emergency departments.
Ongoing Abuse Screen (OAS)	5 items adapted from the AAS assess ongoing physical, sexual, emotional IPV, and fear.	Self report	Women and men in emergency departments. Tested on African Americans, Hispanics, and whites.
Ongoing Violence Assessment Tool (OVAT)	4 items assess ongoing physical and emotional IPV.	Self report	Women and men in emergency departments. Tested on African Americans, Hispanics, and whites.
Partner Violence Screen (PVS)	3 items assess physical IPV in the last year and current safety.	Clinician administered	Women and men in emergency room settings in the United States and Canada.
Patient Satisfaction and Safety Survey (PSSS)	4 items adapted from AAS assess physical, sexual, and emotional IPV.	Self report or clinician-administered	Women in emergency room settings.

	Reliability/Validity	Sensitivity/Specificity	Developer	Articles
	Unavailable	Unavailable	Morrison, Allan, & Grunfeld, 2000	Unavailable
	Unavailable	Unavailable	Parkinson, Adams, & Emerling, 2001	Unavailable
	For women: internal consistency 0.80; concurrent validity: correlation with the CTS of 0.85. Internal consistency 0.76 for English version and 0.61 for Spanish; correlation of 0.76 with ISA-P and 0.75 with Woman Abuse Screening Tool (WAST). For men: concurrent validity: correlation with CTS of 0.86.	For women: English version, Sensitivity: 86%-96%; Specificity: 91%-99% (using cut off score of 10.5, using CTS or ISA as gold standard); Spanish version, Sensitivity: 100%; Specificity: 86% (using cut off score of 5.5, using WAST as gold standard). For men: English version, Sensitivity: 88%; Specificity: 97% (using cut-off score of 11, using CTS as gold standard).	Sherin, Sinacore, Li, Zitter, & Shakil, 1998	Punukollu, 2003; Shakil, Donald, Sinacore, & Krepcho, 2005; Chen, Rovi, Vega, Jacobs, & Johnson, 2005
	Unavailable	Unavailable	md4peace@earthlink.net	Family Violence Prevention Fund, 2003
	Unavailable	Unavailable	Ramsden & Bonner, 2002	Unavailable
	Inter-item correlation: 0.23; Cronbach's alpha: 0.59.	Sensitivity: 30%-60%; Specificity: 90%-100% (Using the ISA as the gold standard).	Weiss et al., 2003	Ernst, Weiss, Cham, & Marquez, 2002
	Inter-item correlation: 0.38-0.44; Cronbach's alpha: 0.60-0.72.	Sensitivity: 86%-93%; Specificity: 83%-86% (Using the ISA as the gold standard).	Weiss et al., 2003	Ernst, Weiss, Cham, Hall, & Nick, 2004
	Unavailable	Sensitivity: 64.5%-71.4% Specificity: 80.3%-84.4% (Using ISA and CTS, respectively, as gold standards).	Feldhaus, Koziol-McLain, Amsbury, Norton, Lowenstein, & Abbott, 1997	Davis, Parks, Kaups, Bennink, Biello, 2003; Morrison, Allan, & Brunfeld, 2000
	Unavailable	Unavailable	Glass, Dearwater, & Campbell, 2001	Unavailable

DESCRIPTION OF IPV MEASURES

Scale/Assessment	Characteristics	Administration Method	Populations Studied*
			*This list is not exhaustive.
RADAR	5 areas to help physicians recognize and discuss physical IPV and safety.	Physician administered	Female and male patients in health care settings.
RADAR for Men	5 areas to help physicians recognize and discuss physical IPV victimization and perpetration.	Physician administered	Male patients in health care settings.
Relationship Chart, The	4-item word and picture tool assesses frequency of physical and psychological IPV in the past 4 weeks.	Self report	Women in obstetrics and gynecology clinics and domestic violence support groups.
Screening Tools - Domestic Violence	3 items; 2 assess physical and sexual violence by anyone; 1 assesses physical IPV.	Clinician administered	Female patients in health care settings.
STaT	3 items; 2 assess physical IPV; 1 assesses threats.	Clinician administered	Female patients in non-acute section of hospital emergency department.
Suggested Screening Questions	3 framing items and 8 direct items to assess physical, sexual, and emotional IPV.	Clinician administered	Female and male patients in health care settings.
Two-Question Screening Tool	2 items; 1 assesses physical IPV; 1 assesses sexual violence (SV).	Clinician administered	African-American, Hispanic, and white women in public and private emergency departments.
Universal Violence Prevention Screening Protocol	7 items assess physical violence and SV by anyone and fear of harm by an intimate partner in the last year and last month.	Nurse administered	Women and men in emergency departments.
Universal Violence Prevention Screening Protocol - Adapted	6 items; 1 screener and 5 items assessing physical, sexual, and emotional IPV in the last year.	Clinician administered or self report	Low income African-American women in emergency departments.
Victimization Assessment Tool	5 items assess physical IPV, SV, suicidal ideation, and risk of hurting others.	Clinician administered	Women and men in primary care settings.
Women Abuse Screening Tool (WAST)	7 items assess physical, and emotional IPV.	Self report	Abused and non-abused English-speaking women in clinical health care settings and women's shelters.

	Reliability/Validity	Sensitivity/Specificity	Developer	Articles
	Unavailable	Unavailable	Alpert, 2004	Alpert, 1995
	Unavailable	Unavailable	Jaeger, 2004	Unavailable
	Test/retest reliability is 0.60; Evidence of face and criterion validity.	Unavailable	Wasson, Jette, Anderson, Johnson, Nelson, & Kilo, 2000	Unavailable
	Unavailable	Unavailable	American College of Obstetricians and Gynecologists, 2003	Unavailable
	Unavailable	Sensitivity: 96% for STaT score of 1, 89% for score of 2, 64% for score of 3; Specificity: 75% for score of 1, 100% for 2 or 3 (Using lifetime IPV from semi-structured interview as reference standard).	Paranjape & Liebschutz, 2003	Unavailable
	Unavailable	Unavailable	Family Violence Prevention Fund, 2002	Unavailable
	Unavailable	Unavailable	McFarlane, Greenberg, Weltge, & Watson, 1995	Unavailable
	Unavailable	Unavailable	Dutton, Mitchell, & Haywood, 1996	Unavailable
	Unavailable	Sensitivity: 31%-95% (Using the ISA physical and nonphysical scale as the gold standard).	Heron, Thompson, Jackson, & Kaslow, 2003	Unavailable
	Inter-rater agreement: 61.7%-86.7% for female patients.	Unavailable	Hoff & Rosenbaum, 1994	Unavailable
	Cronbach's alpha: 0.75; construct validity: correlation with Abuse Risk Inventory (ARI) of 0.69; Discriminant validity: significant differences between abused and non-abused women for each item.	Unavailable	Brown, Lent, Schmidt, & Sas, 2000	Punukollu, 2003; Valente, 2002; Brown, Lent, Brett, Sas, & Pederson, 1996

DESCRIPTION OF IPV MEASURES

Scale/Assessment	Characteristics	Administration Method	Populations Studied*
			*This list is not exhaustive.
WAST - Short	2 items assess tension in relationship and how respondent and partner work out arguments.	Self report	Abused and non-abused English-speaking women in clinical health care settings and women's shelters.
WAST - Spanish Version	8 items assess physical, sexual, and emotional IPV.	Self report	Abused and non-abused Spanish-speaking women in clinical health care settings and women's shelters.
Women's Experience with Battering Scale (WEB)	10 items assess emotional IPV or battering.	Self report	African-American and white women in family practice settings.
Work/School Abuse Scale	12 items assess physical and nonphysical tactics used by intimate partners to prevent partner from or interfere with going to work or school.	Self report	African-American and white women in domestic violence shelters.

	Reliability/Validity	Sensitivity/Specificity	Developer	Articles
	Construct validity: correlation with 7-item WAST of 0.86 and with ARI of 0.90.	Sensitivity: 91.7%; Specificity: 100% (Using a criterion cut-off score of 1).	Brown, Lent, Brett, Sas, & Pederson, 1996	Punukollu, 2003; Valente, 2002; Brown, Lent, Schmidt, & Sas, 2000
	Cronbach's alpha: 0.91.	Sensitivity: 89%; Specificity: 94% (Using only items 5 and 7 and comparing to 8-item WAST as the gold standard).	Fogarty & Brown, 2002	Unavailable
	Cronbach's alpha: 0.95.	Sensitivity: 86.0%; Specificity: 91.0% (Using ISA as the gold standard).	Smith, Tessaro, & Earp, 1995	Smith, Thorton, DeVellis, Earp, & Coker, 2002; Coker, Bethea, Smith, Fadden, & Brandt, 2002; Punukollu, 2003
	Full scale, Cronbach's alpha: 0.82; restraint subscale: 0.73; interference subscale: 0.77; Convergent validity: full scale correlation with CTS physical assault subscale: 0.43; correlation with Psychological Abuse Index: 0.39.	Unavailable	Riger, Ahrens, & Blickenstaff, 2001	Unavailable

Abuse Assessment Screen

Instructions: Circle Yes or No for each question

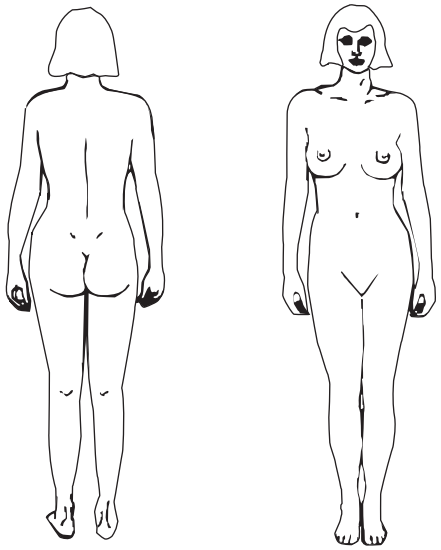
1. Have you ever been emotionally or physically abused by your partner or someone important to you? YES NO

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? YES NO
   If YES, who? (Circle all that apply)
   Husband Ex-Husband Boyfriend Stranger Other Multiple
   Total no. of times _____

3. Since you've been pregnant, have you been slapped, kicked or otherwise physically hurt by someone? YES NO
   If YES, who? (Circle all that apply)
   Husband Ex-Husband Boyfriend Stranger Other Multiple
   Total no. of times_____

Mark the area of injury on the body map. Score each incident according to the following scale:

	SCORE
1 = Threats of abuse including use of weapon	_____
2 = Slapping, pushing; no injuries and/or lasting pain	_____
3 = Punching, kicking, bruises, cuts, and/or continuing pain	_____
4 = Beating up, severe contusions, burns, broken bones	_____
5 = Head injury, internal injury, permanent injury	_____
6 = Use of weapon; wound from weapon	_____



4. Within the last year, has anyone forced you to have sexual activities? YES NO
   If YES, who? (Circle all that apply)
   Husband Ex-Husband Boyfriend Stranger Other Multiple
   Total no. of times _____

5. Are you afraid of your partner or anyone you listed above? YES NO

Journal of the American Medical Association, 1992, 267, 3176-78.

Developer: Judith McFarlane, Barbara Parker, Karen Soeken, and Linda Bullock

Publication Year: 1992

Administration method: Provide a private and confidential setting. Inform each woman that all women attending this clinic are being assessed for abuse. Read the Abuse Assessment Screen (AAS) question to the woman.

Scoring procedures: If any questions on the screen are answered affirmatively, the AAS is considered positive for abuse (Weiss, Ernst, Cham, & Nick, 2003).

Follow-up procedures: Document the abuse and respect the woman's response to the questions. If a woman reports physical abuse, give her a pencil and have her mark the areas of abuse on the body map (Soeken, McFarlane, Parker, & Lominack, 1998). At a minimum, all agencies should offer patients referral sources and legal options (Soeken et al. 1998).

Index Reference:

McFarlane J, Parker B, Soeken K, Bullock L. (1992). Assessing for abuse during pregnancy: Severity and frequency of injuries and associated entry into prenatal care. *Journal of the American Medical Association*, 267, 3176-78.

Additional References:

Norton LB, Peipert JF, Zierler S, Lima B, Hume L. (1995). Battering in pregnancy: An assessment of two screening methods. *Obstetrics & Gynecology*, 85, 321-25.

Soeken KL, McFarlane J, Parker B, Lominack MC. (1998). The Abuse Assessment Screen: A clinical instrument to measure frequency, severity, and perpetrator of abuse against women. In JC Campbell (Ed.), *Empowering survivors of abuse: Health care for battered women and their children* (pp. 195-203). Thousand Oaks, CA: Sage Publications.

Weiss SJ, Ernst AA, Cham E, Nick TG. (2003). Development of a screen for ongoing intimate partner violence. *Violence and Victims*, 18, 131-41.

Encuesta Sobre El Maltrato

(Abuse Assessment Screen, Spanish Version)

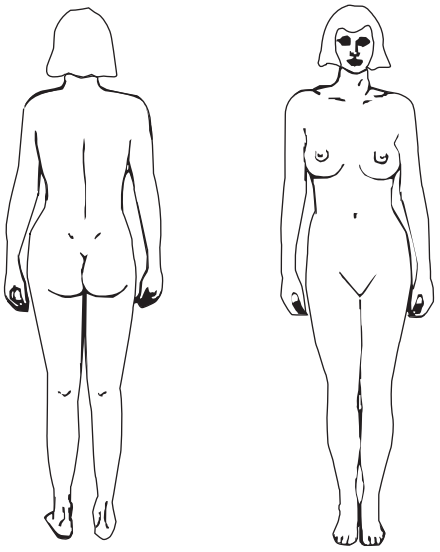
1. Durante el ultimo ano, fue golpeada, bofeteada, pateada, o lasatimada fisicamente de alguna otra manera por alguien? SI NO
   Si la respuesta es "si" por quien(es) _____

2. Desde que salio embarazado, ha sido golpeada, bofeteada, pateada, o lastimada fisicamente de alguna otra manera por alguien? SI NO
   Si la respuesta es "si" por quien(es) _____

En el diagrama anatomico marque las partes de su cuerpo que han sido lastimadas. Valore cada incidente usando las siguinete escala:

GRADO

1 = Amenazas de maltrato que incluyen el use de un arma _____
2 = Bofeteadas, empujones sin lesiones fisicas o dolor permanente _____
3 = Moquestas, patadas, moretones, heridas, y/o dolor continuo _____
4 = Molida a palos, contusiones several, quemaduras fracturas de huesos _____
5 = Heridas en las cabeza, lesiones internal, lesiones permanentes _____
6 = Uso de armas; herida por arma _____



Si cualquiera de las situaciones valora un numero alto en la escala.

3. Durante el ultimo ano, fue forzada a tener relaciones sexuales? SI NO
   Si la respuesta es "si" por quien(es) _____
   Cuantas veces? _____

American Medical Association Screening Questions

1. Are you in a relationship in which you have been physically hurt or threatened by your partner?
2. Are you in a relationship in which you felt you were treated badly? In what ways?
3. Has your partner ever destroyed things that you cared about?
4. Has your partner ever threatened or abused your children?
5. Has your partner ever forced you to have sex when you didn't want to? Does he force you to engage in sex that makes you feel uncomfortable?
6. We all fight at home. What happens when you and your partner fight or disagree?
7. Do you ever feel afraid of your partner?
8. Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
9. You mentioned that your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?
10. Do you have guns in your home? Has your partner ever threatened to use them when he was angry?

Developer: American Medical Association

Publication year: 1992

Administration method: Interview the patient alone. Begin with an opening statement such as, "Because abuse and violence are so common in women's lives, I've begun to ask about it routinely." These items are sample questions that should be asked in the physician's own words.

Scoring procedures: This information is not available.

Follow-up procedures: Document the abuse. Assess the patient's safety before she leaves the medical setting. Provide her with written information about legal options, crisis intervention services, local counseling, shelters, and the National Domestic Violence Hotline (1-800-799-SAFE or www.ndvh.org). See the website (www.ama-assn.org/ama/pub/category/3548.html) for more detailed information.

Index Reference:

American Medical Association. *Diagnosis and treatment guidelines on domestic violence*. (1992) Chicago, IL: American Medical Association.

Assessment of Immediate Safety Screening Questions

1. Are you in immediate danger?
2. Is your partner at the health facility now?
3. Do you want to (or have to) go home with your partner?
4. Do you have somewhere safe to go?
5. Have there been threats of direct abuse of the children (if s/he has children)?
6. Are you afraid your life may be in danger?
7. Has the violence gotten worse or is it getting scarier? Is it happening more often?
8. Has your partner used weapons, alcohol, or drugs?
9. Has your partner ever held you or your children against your will?
10 Does your partner ever watch you closely, follow you or stalk you?
11. Has your partner ever threatened to kill you, him/herself or your children?

Reprinted with permission from Family Violence Prevention Fund.

Produced by
The Family Violence Prevention Fund
383 Rhode Island Street, Suite 304
San Francisco, CA 94103-5133
(415) 252-8900
TTY (800) 595-4889
First Printing: September, 2002
Updated: February, 2004

Developer: Family Violence Prevention Fund

Publication year: 2002

Administration method: Clinician administered.

Scoring procedures: This information is not available.

Follow-up Procedures: Clinicians should assess the impact of the abuse on the patient's health and the pattern and history of the abuse. Clinicians also need to provide validation, information about domestic violence, referrals to local resources, and information about safety planning. See the National Consensus Guidelines (2002) for more detailed information.

Index Reference:

Family Violence Prevention Fund. *National consensus guidelines on identifying and responding to domestic violence victimization in health care settings*. San Francisco, CA: Author. www. endabuse.org/programs/healthcare/files/Consensus.pdf

Bartlett Regional Hospital Domestic Violence Assessment

DOMESTIC VIOLENCE ASSESSMENT

Date _____ Patient ID # _____

Patient Name _____

Patient pregnant _____ yes _____ no

R= Routinely Screen
"Because violence is so common in peoples' lives, I've begun to ask about it routinely."

A=Ask Direct Questions

_____ yes _____ no Are you afraid at home?
_____ yes _____ no Are you in a relationship in which you have been hurt or threatened?
_____ yes _____ no Have you ever been hit, kicked, or punched by someone close to you? _____ # of times in the past year.
_____ yes _____ no I notice you have a number of bruises; did someone do this to you?

D=Document Your Findings
Patient report: Patient's description of assault (use patient's own words)

_____
_____
_____
_____
_____
_____
_____
_____

_____ yes _____ no Domestic Violence confirmed by patient.
If yes, name and relationship of perpetrator:
_____
_____

_____ yes _____ no Domestic Violence suspected. State reasons:
_____
_____
_____
_____

A=Assess Patient Safety

_____ yes _____ no Is client afraid to go home?
_____ yes _____ no Increase in severity/frequency of abuse?
_____ yes _____ no Threats of homicide or suicide?
_____ yes _____ no Weapon present?
_____ yes _____ no Do you want police intervention?

R=Review Options and Referrals

_____ yes _____ no Need immediate shelter?
_____ yes _____ no Hotline number/community resources given?
_____ yes _____ no Referred to AWARE staff?
_____ yes _____ no Referred to outside source?
_____ yes _____ no Follow-up appointment made? Date _____
_____ yes _____ no Can patient be called at home? If no, is there a safe number where patient can be reached?
_____

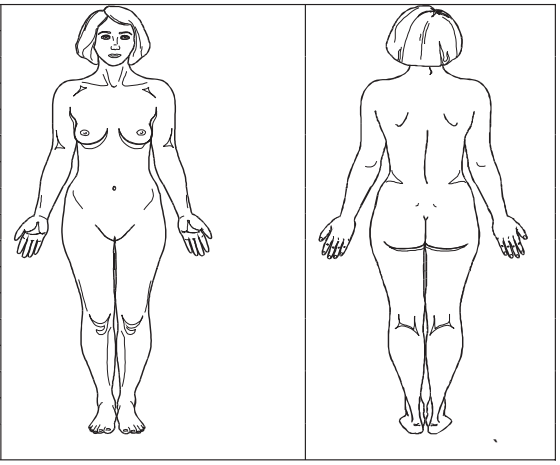
Provider Evaluation
_____
_____

Provider Signature _____

Check Physical Findings

	Contusion	Abrasion	Laceration	Bleeding	Tenderness
Head					
Ears					
Nose					
Cheeks					
Mouth					
Neck					
Shoulder					
Arms					
Hands					
Chest					
Back					
Abdomen					
Genitals					
Buttocks					
Legs					
Feet					

Indicate Where Injury Was Observed



_____ yes _____ no Photographs taken?

Addressograph

Developer: Bartlett Regional Hospital

Publication year: This information is not available

Administration method: Clinician administered. Begin with saying "Because domestic violence is so common among many peoples' lives, I've begun to ask all my patients about it routinely."

Scoring procedures: This information is not available

Follow-up procedures: Assess immediate safety, notify the medical doctor, notify security if necessary, and document the patient's report. Discuss a safety plan and offer referrals for shelters and legal assistance. See the website listed below for more detailed information.

Index Reference:

Bartlett Regional Hospital Domestic Violence Assessment
www.hospitalsoup.com/public/dvassess.pdf

Additional Reference:

Bartlett Regional Hospital Domestic Violence Protocol, from
www.hospitalsoup.com/public/brhdvprotocol.pdf

Computer-Based IPV Questionnaire

Intimate Partner Violence Questions

Possible emotional abuse

- Do you have a partner or spouse who gets very jealous or tries to control your life? YES NO
- Does your partner or spouse try to keep you away from your family or friends? YES NO
- Does someone close to you sometimes say insulting things or threaten you? YES NO

(Yes to at least one of the above emotional abuse questions?) YES NO

Perception of safety

- Is there someone you are afraid to disagree with because they might hurt you or other family members? YES NO

Physical abuse in a current relationship

- Are you in a relationship with someone who has pushed, hit, kicked, or otherwise physically hurt you? YES NO

(Possible current intimate partner abuse?) YES NO

(Yes to any of the above domestic violence questions?) YES NO

Other violence-related questions

- Have you ever physically hurt someone close to you? YES NO
- Are you worried that you might physically hurt someone close to you? YES NO
- In the past 12 months, have you ever felt so low that you thought about harming yourself or committing suicide? YES NO
- Have you ever been made to have sex when you didn't want to? YES NO
- Is there a handgun in your home or car? YES NO
- Have you ever witnessed or taken part in any argument or fight where someone had a gun or knife? YES NO

Developer: Karin Rhodes, Diane Lauderdale, Theresa He, David Howes, and Wendy Levinson

Publication year: 2002

Administration method: Self-report via computer located in the emergency department (ED). Note that phrases in parentheses are intended for the individual reviewing the print out (e.g., nurse) and not the patient.

Scoring procedures: Patients answer each question "yes" or "no." If a patient responds affirmatively to questions about either emotional or physical abuse by a current partner, this is considered positive for IPV (Rhodes et al. 2002).

Follow-up procedures: After completing the computer-based questionnaire, patients are offered a printout to take with them, which lists their individualized health recommendations. The results of the patient survey are shared with the treating physician in the ED and the summary includes a physician prompt to assess for domestic violence if the patient has answered one or more of the IPV questions affirmatively. Community service, hotline numbers, and hospital-based social service resources are also provided to the patient (Rhodes et al. 2002).

Index Reference:

Rhodes KV, Lauderdale DS, He T, Howes DS, Levinson W (2002). "Between me and the computer": Increased detection of intimate partner violence using a computer questionnaire. *Annals of Emergency Medicine*, 40, 476-84.

Additional Reference:

Heron SL, Kellermann AL (2002). Screening for intimate partner violence in the emergency department: Where do we go from here? *Annals of Emergency Medicine*, 40, 493-95.

Danger Assessment

Several risk factors have been associated with homicides (murders) of both batterers and battered women in research conducted after the murders have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation.

On the calendar, please mark the approximate dates during the past year when you were beaten by your husband or partner. Write on that date how long each incident lasted in approximate hours and rate the incident according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number.)

Answer these questions Yes or No. The "he" in the questions refers to your husband, partner, ex-husband, or whoever is currently physically hurting you.

___1. Has the physical violence increased in frequency over the past year?
___2. Has the physical violence increased in severity over the past year and/or has a weapon or threat from a weapon ever been used?
___3. Does he ever try to choke you?
___4. Is there a gun in the house?
___5. Has he ever forced you to have sex when you did not wish to do so?
___6. Does he use drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
___7. Does he threaten to kill you and/or do you believe he is capable of killing you?
___8. Is he drunk every day or almost every day? (In terms of quantity of alcohol.)
___9. Does he control most or all of the your daily activities? For instance: does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him, check here: _____)
___10. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: _____
___11. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
___12. Have you ever threatened or tried to commit suicide?
___13. Has he ever threatened or tried to commit suicide?
___14. Is he violent toward your children?
___15. Is he violent outside of the home?
___ Total "Yes" Answers

Reprinted with permission from
Jacquelyn Campbell, PhD
Johns Hopkins Bloomberg School of Public Health
Johns Hopkins University
525 N. Wolfe St. Rm 436
Baltimore, MD 21205

Developer: Jacquelyn Campbell

Publication year: 1986

Administration method: Self report.

Scoring procedures: Sum the number of total positive (i.e., "yes") responses.

Follow-up procedures: This measure is to be used as the basis for discussion with battered women, to help women assess their danger of homicide, and to help them make decisions about what to do in their situation.

Index Reference:

Campbell JC (1986). Nursing assessment for risk of homicide with battered women. *Advances in Nursing Science, 8,* 36-51.

Additional References:

Campbell JC (1989). Women's responses to sexual abuse in intimate relationships. *Health Care for Women International, 10,* 335-46.

Campbell JC (1995). Prediction of homicide of and by battered women. In JC Campbell (Ed.), *Assessing dangerousness: Violence by sexual offenders, batterers, and child abusers* (pp. 96 - 113). Thousand Oaks: Sage Publications.

Goodman LA, Dutton MA, Bennett L (2000). Predicting repeat abuse among arrested batterers. *Journal of Interpersonal Violence*, 15, 63-74.

McFarlane J, Greenberg L, Weltge A, Watson M (1995). Identification of abuse in emergency departments: Effectiveness of a two-question screening tool. *Journal of Emergency Nursing*, 21, 391-94.

Domestic Violence Initiative Screening Questions

Health worker to explain the following in own words:

- In this health service, we are concerned about your health and safety, so we ask all women the same questions about violence at home;
- This is because violence is very common and we want to improve our response to families experiencing violence.

Health worker to ask the following questions of ALL female patients on their own:

1.	Are you ever afraid of your partner?	YES	NO
2.	In the last year, has your partner hit, kicked, punched or otherwise hurt you?	YES	NO
3.	In the last year, has your partner put you down, humiliated you or tried to control what you can do?	YES	NO
4.	In the last year, has your partner threatened to hurt you?	YES	NO

If domestic violence has been identified in any of the above questions, continue to questions 5 and 6.

5.	Would you like help with any of this now?	YES	NO
6.	Would you like us to send a copy of this form to your doctor?	YES	NO

Name of Doctor:
Address: _____
_____
_____
_____

_____
Signature of Client

_____
Date

DV Risk Status:

Domestic Violence not identified ☐
Domestic Violence identified, refused help ☐
Domestic Violence identified, help provided ☐

Provided With:

Contact phone numbers for DV ` ☐
Written information for DV ☐
Referral to hospital-based service ☐
Referral to community DV service ☐
Referral to GP ☐
Other: _____

Screening Not Completed Due to:

Presence of partner ☐
Presence of family member/friend ☐
Absence of interpreter ☐
Woman refused to answer the questions ☐
Additional Comments:

Signature of Health Professional:

_____
Date:

IF THIS FORM WAS NOT COMPLETED PLEASE SCREEN ON NEXT VISIT

Reprinted with permission from
Joan Webster, RN
Nursing Director, Research
Centre for Clinical Nursing
Royal Brisbane and Women's Hospital
Herston 4029
Australia

Developer: Joan Webster, RN , Susan M. Stratigos, MA, and Kerry M. Grimes, BA

Publication year: 1998

Administration method: Clinician administered.

Scoring procedures: There are no scoring procedures for this tool. These questions are used as a guide for nurses when questioning women about their experience of violence.

Follow-up procedures: Educational materials on domestic violence are provided to women who are positive for partner abuse, and they are offered referral to a support agency.

Index Reference:

Queensland Government (1998). Domestic violence initiative screening tool, from http://www.health.qld.gov.au/violence/domestic/dvi/publications.asp)

Additional Reference:

Webster J, Stratigos SM, Grimes KM (2001). Women's responses to screening for domestic violence in a health-care setting. *Midwifery, 17,* 289-294.

Webster J, Holt, V. (2004). Screening for partner violence: direct questioning or self-report? *Obstetrics & Gynecology,* 103, 299-303.

Domestic Violence Screen for Pediatric Settings

1 Are you in a relationship now or have you ever been in a relationship in which you have been harmed or felt afraid of your partner?
2. Has your partner ever hurt any of your children?
3. Are you afraid of your current partner?
4. Do you have any pets in the house?
5. Has your partner or child ever threatened or hurt any of the pets?
6. Are there any guns in your house?

Reprinted with permission from Robert M. Siegel, MD.

Developer: Robert M. Siegel, Teresa Hill, Vicki Henderson, Heather Ernst, and Barbara Boat

Publication year: 1999

Administration method: Clinician administered.

Scoring procedures: This information is not available.

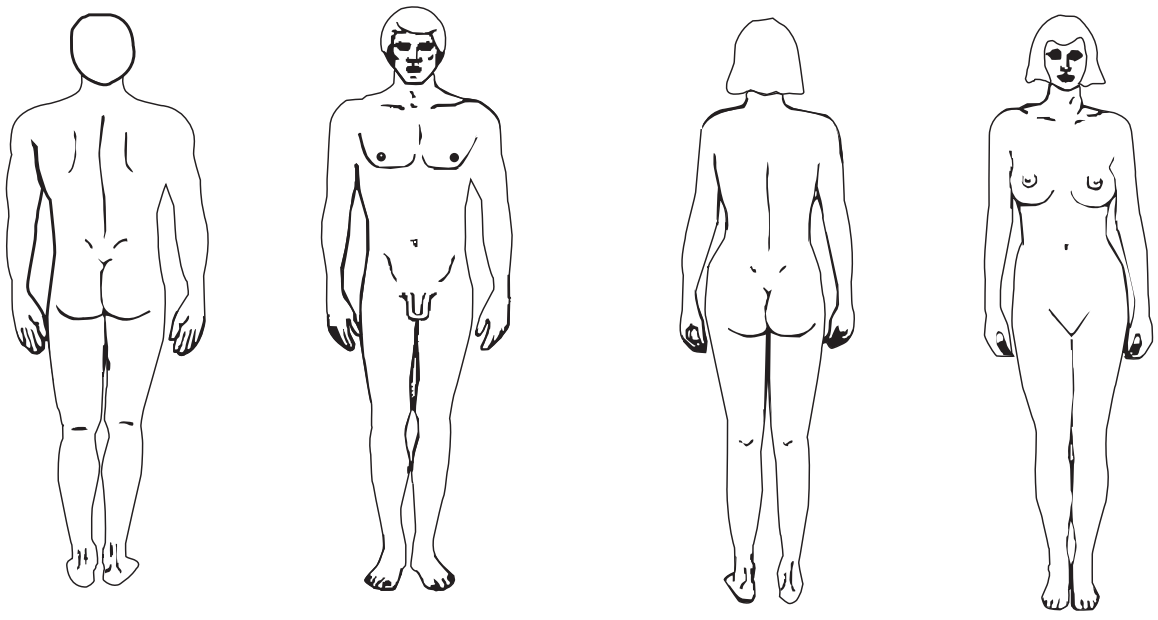
Follow-up procedures: If a woman responds affirmatively to any of the first three questions, she is referred to an in-house social worker. The patient is then referred to a domestic violence program, local women's center, legal services, and/or family counseling (Siegel et al. 1999).

Index Reference:

Siegel RM, Hill TD, Henderson VA, Ernst HM, Boat BW (1999). Screening for domestic violence in the community pediatric setting. *Pediatrics 104*, 874-77.

Domestic Violence Screening/Documentation Form

Date _____ Patient ID# _____
Patient Name_____
Provider Name _____
Patient Pregnant? YES NO



ASSESS PATIENT SAFETY

☐YES ☐NO Is abuser here now?
☐YES ☐NO Is patient afraid of their partner?
☐YES ☐NO Is patient afraid to go home?
☐YES ☐NO Has physical violence increased in severity?
☐YES ☐NO Has partner physically abused children?
☐YES ☐NO Threats of homicide?
By whom: _____
☐YES ☐NO Threats of suicide?
By whom: _____
☐YES ☐NO Is there a gun in the home?
☐YES ☐NO Alcohol or substance abuse?
☐YES ☐NO Was safety plan discussed?

PHOTOGRAPHS

☐YES ☐NO Consent to be photographed?
☐YES ☐ NO Photographs taken?
Attach photographs and consent form

REFERRALS

☐Hotline number given
☐Legal referral made
☐Shelter number given
☐In house referral made
Describe: _____
☐Other referral made
Describe: _____

REPORTING

☐Law enforcement report made
☐Child Protective Services report made
☐Adult Protective Services report made

Developed by the Family Violence Prevention Fund and Educational Programs Associates, Inc.

Developer: Family Violence Prevention Fund and Educational Programs Associates, Inc.

Publication year: 1996

Administration method: Home care nurse administered.

Scoring procedures: This information is not available.

Follow-up procedures: Provide information about local resources, shelters, and legal assistance. Help the person plan for future safety (Cassidy 1999). See the Family Violence Prevention Fund guidelines for more detailed information.

Index Reference:

Family Violence Prevention Fund (1996). Health alert: *Strengthening the health care system's response to domestic violence*. San Francisco, CA: Author.

Additional References:

Cassidy K (1999). How to assess and intervene in domestic violence situations. *Home Healthcare Nurse,* 17, 664-72.

Family Violence Prevention Fund (2002). *National consensus guidelines on identifying and responding to domestic violence victimization in health care settings*. San Francisco, CA: Author.

Emergency Department Domestic Violence Screening Questions

1. Does anyone in your family have a violent temper?
2. During an argument at home have you ever worried about your safety or the safety of your children?
3. Many women who present to the Emergency Department with similar injuries or complaints are victims of violence at home. Could this be what happened to you?
4. Would you like to speak to someone about this?
5. Were any of the previous visits to the Emergency Department prompted by an injury or symptom suffered as a victim of violence at home?

Reprinted from *The Journal of Emergency Medicine*, 19, Morrison LJ, Allan R, Grunfeld A, Improving the emergency department detection rate of domestic violence using direct questioning, 117-24, Copyright 2000, with permission from Elsevier.

Developer: Laurie Morrison, Rebecca Allan, and Anton Grunfeld

Publication year: 2000

Administration method: Self report.

Scoring procedures: Based on the patient's response, individuals are grouped into the following categories:

Acute domestic violence = Yes to question 3, or yes to question 1 or 2 and 4
Probable acute domestic violence = Yes to question 1 or Yes to question 2, or both
Past domestic violence = Yes to question 5

Follow-up procedures: Morrison , Allan, and Grunfeld (2000) report the following:

> If the patient responded positively to question 4, the patient was offered all of the following options: 1) to notify the Emergency Physician, 2) immediate assistance with respect to shelters, victim advocacy, police involvement or protective admission to hospital, 3) a follow-up appointment the next day with the ED social worker, and 4) printed matter on shelters, legal aid, social services, and community support groups, etc. (p. 119).

Index Reference:

Morrison LJ, Allan R, Grunfeld A (2000). Improving the emergency department detection rate of domestic violence using direct questioning. *The Journal of Emergency Medicine, 19*, 117-24.

Falmouth Pediatric Associates Violence Handout

Today's Date _____

Child's Name (optional) _____ Child's Date of Birth ___/___/___
Mother's Name (optional) _____ Mother's Date of Birth ___/___/___

Please confirm that the person filling out this form is the child's mother

Y N

In your current relationship, have you ever been harmed or felt afraid of your partner?

Y N No current relationship

In a previous relationship, have you ever been harmed or felt afraid of your partner?

Y N

Has your current or past partner harmed any of your children?

Y N

Are there any guns in your home?

Y N

Has any health professional ever asked you about domestic violence before?

Y N

Note: The original handout also includes several questions about demographic characteristics (e.g., type of medical insurance, number of children). See Parkinson, Adams, & Emerling, 2001 for further details.

Developer: Gregory Parkinson, Richard Adams, and Frank Emerling

Publication year: 2001

Administration method: Self report.

Scoring procedures: This information is not available.

Follow-up procedures: All participants are given the Falmouth Pediatric Associates Violence Handout, a personalized safety plan:
FALMOUTH PEDIATRIC ASSOCIATES VIOLENCE HANDOUT

Here is a PERSONALIZED SAFETY PLAN that you may find useful:

Suggestions for increasing safety in the relationship

- I will have important phone numbers available to my children and myself.
  - Police: 911
  - National Domestic Violence Hotline: (800) 797-SAFE
  - INSERT OTHER LOCAL RESOURCES
  - SafeLink: (877) 785-2020 (toll free)
    (877) 561-2601 (hearing impaired)
  - Parents Anonymous: (800) 882-1250 (for parents with trouble coping)

I can tell _____ and _____ about the violence and ask them to call the police if they hear suspicious noises coming from my home.

- If I leave my home, I can go (list places):
  1._____
  2._____
  3._____

  - I can leave extra money, car keys, clothes, and documents with _____.
  - If I leave, I will bring:
    - ✓ Identification
    - ✓ Birth certificates for me and my children
    - ✓ Social Security cards
    - ✓ School and medical records
    - ✓ Money, bankbooks, credit cards
    - ✓ Keys-house/car/office
    - ✓ Driver's license and registration
    - ✓ Medications
    - ✓ Change of clothes
    - ✓ Welfare identification
    - ✓ Passports
    - ✓ Divorce papers
    - ✓ Lease/rental agreement, house deed
    - ✓ Mortgage payment book, current unpaid bills
    - ✓ Insurance papers
    - ✓ Address book
    - ✓ Pictures, jewelry, items of sentimental value
    - ✓ Children's favorite toys and/or blankets

- To ensure safety and independence, I can: keep change for phone calls with me at all times; open my own savings account; practice my escape route with a support person; and review safety plan on _____ (date).

Suggestions for increasing safety when relationship is over:

- I can: change the locks; install steel/metal doors, a security system, smoke detectors and an outside lighting system.
- I will inform _____ and _____ that my partner no longer lives with me and ask them to call the police if s/he is observed near my home or my children.
- I will tell people who take care of my children the names of those who have permission to pick them up. The people who have permission are:
    1. _____
    2. _____
    3. _____
- I can tell _____ at work about my situation and ask _____ to screen my calls.
- I can avoid stores, banks, and _____ that I used when living with my battering partner.
- I can obtain a protective order form the local court house. I can keep it on or near me at all times as well as leave a copy with _____.
- If I feel down and ready to return to a potentially abusive situation, I can call _____ for support or attend workshops and support groups to gain support and strengthen my relationships with other people.

Index Reference:

Parkinson GW, Adams RC, Emerling FG (2001). Maternal domestic violence screening in an office-based pediatric practice. *Pediatrics*, 108, 1-9.

HITS

Hurt, Insult, Threaten, and Scream

How often does your partner physically **H**urt you?
How often does your partner **I**nsult or talk down to you?
How often does your partner **T**hreaten you with physical harm?
How often does you partner **S**cream or curse at you?

Reproduced with permission from
Kevin Sherin MD, MPH
Orange County Health Department
6101 Lake Ellenor Drive
Orlando, FL 32809
Kevin_Sherin@doh.state.fl.us

Developer: Kevin Sherin, James Sinacore, Xiao-Qiang Li, Robert Zitter, and Amer Shakil

Publication year: 1998

Administration method: Self report or clinician administered.

Scoring procedures: Each question is answered on a 5-point scale:

1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, 5 = frequently

The scores range from 4 to a maximum of 20. For female patients, A HITS cut off score 10 or greater was used to classify participants as victimized; for male patients, A HITS cut off score of 11 or greater was used to classify participants as victimized (Sherin et al 1998; Shakil et al. 2005).

Follow-up procedures: This information is not available.

Index Reference:

Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. (1998). HITS: A short domestic violence screening tool for use in a family practice setting. *Family Medicine, 30,* 508-12.

Additional References:

Punukollu M (2003). Domestic violence: Screening made practical. *The Journal of Family Practice, 52,* 537-43.

Shakil A, Donald S, Sinacore JM, Krepcho M. (2005). Validation of the HITS domestic violence screening tool with males. *Family Medicine*, 37, 193-98.

Chen PH, Rovi S, Vega M, Jacobs A, Johnson MS. (2005). Screening for domestic violence in predominantly Hispanic clinical settings, *Family Practice*, 22, 617-23.

Minnesota Tool

To our patients:

The staff at *Anyplace* Health Center know that many things happen in our lives that affect our physical and mental health. We have started a new program to find and help people who are now, or have been, in difficult or harmful relationships. Your response to this survey will help us make that program better. It's easy.

1. Please **read** the statements below.
2. **Decide** which group of statements fits your life best.
3. Then, **peel** off the sticker next to that group and put it on the **same** colored circle at the bottom of this page.

Your answers will be kept confidential.

If you do not wish to answer this survey, please return it without moving any of the stickers. If you have any comments, please let us know.

If any of the following statements applies to you, please attach the blue sticker to the bottom of the page. You do not need to identify your responses in any other way.

- I do not feel safe with my current partner.
- My partner often puts me down, yells at me, calls me names, or tells me I'm worthless.
- My partner is jealous, accuses me of being unfaithful, is suspicious of my activity.
- My partner does not allow me to see my friends, make phone calls, or have money without his/her approval.
- My partner has hit me, slapped me, kicked me, pushed me, punched me, pulled my hair or in some other way hurt me.
- I am here today because of injuries caused by my partner.
- My partner has hurt or threatened to hurt my pet(s).
- I have had sex with my partner when I didn't want to, or performed sex acts that I didn't want to do.

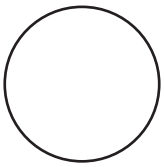
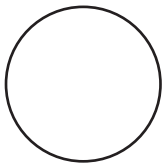
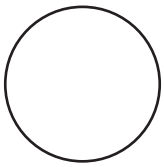
If the next group of statements apply to you, please attach the green sticker to the bottom of the page:

- I am in a healthy relationship.
- I trust my partner to respect me and not to hurt me on purpose.
- I feel safe with my current partner.

Attach the yellow sticker if the following is true:

- None of the statements above applies to me
- I am not now in any close relationship with another person

Please place this survey in the envelope and give to the nurse or doctor when they come back. If you attached the blue sticker, one of our staff will give you a chance to talk privately about your answer.

Whether or not you are in a troubled relationship, we would like you to know about resources for people who are. If you know of a friend or relative who needs help, or feel you might need information in the future, please take the card attached to the back of this survey for future use.

Reproduced with permission from David McCollum, MD.

Developer: David McCollum

Publication year: 2001

Administration method: The form is Z-folded and inserted into a brown envelope (to help ensure privacy). The patient completes the form which is collected by the nurse or physician. If the "blue" sticker has been placed on the circle at the bottom of the page, the patient is moved to a private room and a face-to-face interview is conducted using a scripted form (see below). This is generally done by the physician, but could be done by nursing, social service or an advocate.

Scoring procedures: If the patient places the "blue" sticker on the circle at the bottom of the page, this is considered positive for IPV.

Follow-up procedures: If a patient screens positive for IPV, the following survey is generally completed by a physician, but could be completed by nursing, social service or an in-house advocate if the physician is delayed.

Secondary Survey

Face-to-face

This is to be filled out if the patient screens positive for IPV. It should be completed by the nurse or physician caring for the patient, but may at times, be completed by social services or Family Violence Services Response team.

Introductory statements should be made, e.g.:
"I want to review with you your response to the survey that you just completed. I understand that you may be in a relationship that is difficult in one way or another. I am concerned that we provide care for all of your needs. So, I'd like to ask you a few more questions. Can you tell me which of the statements are true for you?"

Filled out by:
MD ☐
RN ☐
SW ☐
FVSA ☐

- ☐ I do not feel safe with my current partner
- ☐ Does your partner frequently put you down, yell at you, call you names, or tell you you're worthless?
- ☐ Is your partner jealous, accuse you of being unfaithful, is suspicious of your activity?
- ☐ Does your partner ever prevent you from seeing your friends, making phone calls, or having access to money without his/her approval?
- ☐ Has your partner ever hit you, kicked you, pushed you, punched you, pulled your hair or in some other way hurt you?
- ☐ Are you here today because of injuries caused by your partner?
- ☐ Has your partner hurt or threatened to hurt your pet(s)?
- ☐ Have you had sex with your partner when you didn't want to, or performed sex acts that you didn't want to do?
- ☐ How long have you been in this relationship? _____
- ☐ Have you ever tried to leave this relationship? _____
  If so, what happened? _____

"I'm sorry those things have happened to you. Nobody deserves to be hurt or treated in that manner. Now I'd like to ask you some other questions that will help us know how best to help you."

Determine current level of safety for the patient:

Questions should include determining whether there is escalation of the abuse and severity of abuse. One suggested severity ranking scale is as follows:

Filled out by:
MD ☐
RN ☐
SW ☐
FVSA ☐

- ☐ Throwing things, punching the wall
- ☐ Pushing, shoving, grabbing, throwing things at the victim
- ☐ Kicking, biting
- ☐ Hitting with a closed fist
- ☐ Attempted strangulation
- ☐ Beating up/pinned to wall or floor
- ☐ Threatening with a weapon
- ☐ Assault with a weapon

Many women who are physically assaulted also feel sexually assaulted. Escalating levels of sexual assault or sexual coercion are risk factors for serious injury and death. Asking questions about this may help determine safety risk.

Survey for past issues of abuse: "**Many patients who are experiencing relationships like yours, have also had other unpleasant or harmful events happen to them earlier in their lives, as teenagers or even as children. Can you tell me if any of the following has happened to you?"**

- ☐ Have you been in relationships in the past that have been harmful or hurtful, either verbally, physically or sexually? _____
- ☐ Were you hurt physically when you were growing up?
- ☐ Were you hurt sexually or made to do things you didn't want to sexually when you were growing up?
- ☐ Did you ever feel that you were raped? If so, did you report it?_____
- ☐ Did you ever feel that you were being followed, watched, or stalked?_____
- ☐ Did you grow up with one parent ☐ , or both ☐?
- ☐ Were your parents in an abusive relationship/Did your parents fight a lot?_____
- ☐ Was either of your parents alcoholic? _____

Filled out by:
MD ☐
RN ☐
SW ☐
FVSA ☐

If the patient has been acutely injured or has physical evidence of injury, photographic documentation is desirable. Recommended procedure includes:

1. Obtain patient consent - acknowledge that it may be uncomfortable for them to have pictures taken and that if they want to stop at any time, they may ask to do so.
2. One photo should show the whole body including face.
3. Subsequent photos are closer in.
4. Take two pictures of each area.
5. Number the pictures for reference (1,2,3, etc.)
6. Offer the patient one set of pictures.

Filled out by:
MD ☐
RN ☐
SW ☐
FVSA ☐

Referral options:

- ☐ Information given (package)
- ☐ Called social services
- ☐ Called shelter (Southern Valley, e.g.)
- ☐ Called police
- ☐ Called Sexual Violence Center
- ☐ Called crisis worker
- ☐ 1-800-799-SAFE given
- ☐ Supportive statements only
- ☐ Other _____

Filled out by:
MD ☐
RN ☐
SW ☐
FVSA ☐

Index Reference:

Contact Dr. David McCollum at md4peace@earthlink.net

Additional Reference:

Family Violence Prevention Fund (2003). Interpersonal Violence New Tool for Identification in Health Care Settings, *Health Alert, 9,* 8-9.

New South Wales Department of Health Survey

In this Health Survey we have begun a new project to routinely ask all women the same questions about violence. This is because violence in the home is very common and can be serious and we want to improve our responses to women experiencing domestic violence. You don't have to answer these questions if you don't want to. This information will remain confidential to the Health Service except where you give us information that indicates that you or your children are at immediate risk of serious harm.

1. Within the last 12 months, have you been hit, slapped or hurt in other ways by your partner or ex-partner?

2. Are you frightened of your partner or ex-partner?

3. Are you safe to go home when you leave here?

Reprinted from *Accident and Emergency Nursing*, 10, Ramsden C, Bonner M, A realistic view of domestic violence screening in an emergency department, 31-9, Copyright 2002, with permission from Elsevier.

Developer: Clair Ramsden and Michelle Bonner

Publication year: 2002

Administration method: Clinician administered.

Scoring procedures: This information is not available.

Follow-up procedures: If IPV was identified in any of the first three questions, a fourth question is asked: "Would you like some assistance with this?" Any further action taken is documented on the form. All women, regardless of whether domestic violence was disclosed, were still given an information resource card and told "here is some information that we are giving to all women about domestic violence" (Ramsden & Bonner 2002 p. 33).

Index Reference:

Ramsden C, Bonner M. (2002). A realistic view of domestic violence screening in an emergency department. *Accident and Emergency Nursing, 10*, 31-9.

Ongoing Abuse Screen (OAS)

1. Are you presently emotionally or physically abused by your partner or someone important to you? (Yes/No)
2. Are you presently being hit, slapped, kicked, or otherwise physically hurt by your partner or someone important to you? (Yes/No)
3. Are you presently forced to have sexual activities? (Yes/No)
4. Are you afraid of your partner or anyone of the following (circle if appropriate): husband/wife, ex-husband/ex-wife, boyfriend/girlfriend, stranger
5. (If pregnant) Have you ever been hit, slapped, kicked, or otherwise physically hurt by your partner or someone important to you during pregnancy? (Yes/No)

Reprinted with permission from Medical Science Monitor.

Developer: Steve Weiss, Amy Ernst, Elaine Cham, and Todd Nick

Publication year: 2003

Administration method: Self report.

Scoring procedures: If any questions on the screen are answered affirmatively, the OAS is considered positive for ongoing abuse.

Follow-up procedures: Referrals to social services are offered.

Index Reference:

Weiss SJ, Ernst AA, Cham E, Nick TG. (2003). Development of a screen for ongoing intimate partner violence. *Violence and Victims, 18*, 131 -41.

Additional Reference:

Ernst AA, Weiss SJ, Cham E, Marquez M. (2002). Comparison of three instruments for assessing ongoing intimate partner violence. *Medical Science Monitor, 8*, 197-201.

Ongoing Violence Assessment Tool (OVAT)

1. At the present time does your partner threaten you with a weapon? (Yes/No)
2. At the present time does your partner beat you up so badly that you must seek medical help? (Yes/No)
3. At the present time does your partner act like he/she would like to kill you? (Yes/No)
4. My partner has no respect for my feelings. (Never, Rarely, Occasionally, Often, Always)

Reprinted with permission from *Medical Science Monitor.*

Developer: Steve Weiss, Amy Ernst, Elaine Cham, and Todd Nick

Publication year: 2003

Administration method: Self report.

Scoring procedures: This information is not available.

Follow-up procedures: Referrals to social services are offered.

Index Reference:

Weiss SJ, Ernst AA, Cham E, Nick TG. (2003). Development of a screen for ongoing intimate partner violence. *Violence and Victims, 18*, 131-41.

Additional Reference:

Ernst AA, Weiss SJ, Cham E, Hall L, Nick TG. (2004). Detecting ongoing intimate partner violence in the emergency department using a simple 4-question screen: the OVAT. *Violence and Victims, 19*, 375-84.

Partner Violence Screen (PVS)

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?

2. Do you feel safe in your current relationship?

3. Is there a partner from a previous relationship who is making you feel unsafe now?

Reprinted with permission from Davis JW, Parks SN, Kaups KL, Bennink LD, Bilello JF. (2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. *Journal of Trauma*, 54, 352-55.

Developer: Kim Feldhaus, Jane Koziol-McLain, Holly Amsbury, Ilena Norton, Steven Lowenstein, and Jean Abbott

Publication year: 1997

Administration method: Clinician administered.

Scoring procedures: Feldhaus et al. (1997) report the following:

> A "yes" response to the physical violence question was considered positive for partner violence if the perpetrator was a current or former spouse or other intimate partner. For the safety questions, women who reported feeling unsafe because of a current or past partner and those who were unsure about their safety were considered positive for partner violence...A positive response to any 1 of the 3 questions constitutes a positive screen for partner violence.

Follow-up procedures: All positive screens should be documented in the medical record, and the patient should be offered support, counseling, and referrals to safe shelters. A plan to ensure their future safety should be created (Feldhaus et al. 1997).

Index Reference:

Feldhaus KM, Koziol-McLain J, Amsbury HL, Norton IM, Lowenstein SR., Abbot JT. (1997). Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. *Journal of the American Medical Association*, 277, 1357-61.

Additional References:

Davis JW, Parks SN, Kaups KL, Bennink LD, Bilello JF. (2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. *Journal of Trauma*, 54, 352-55.

Morrison LJ, Allan R, Grunfeld A. (2000). Improving the emergency department detection rate of domestic violence using direct questioning. *The Journal of Emergency Medicine, 19,* 117-24.

Patient Satisfaction and Safety Survey (PSSS)

1. Did you come to the emergency department today because you were hurt by your current or former husband, boyfriend, or partner?
2. Within the past year, have you been pushed, shoved, hit, slapped, kicked, or otherwise hurt by a current or former husband, boyfriend, or partner?
3. Within the past year, has your current or former husband, boyfriend, or partner forced you to have sexual activities?
4. Have you ever been emotionally or physically abused by your current or former husband, boyfriend, or partner?

Note. The original PSSS also contained 14 other items about demographics, whether patients were screened for IPV, mandatory reporting, and their perception of the medical care received from the ED staff.

Developer: Nancy Glass, Stephen Dearwater, and Jacquelyn Campbell

Publication year: 2001

Administration method: Self report.

Scoring procedures: This information is not available.

Follow-up procedures: Best practice interventions are recommended. These include legal interventions, assessment of physical and psychological consequences of abuse, and referral to appropriate community resources (Glass, Dearwater & Campbell 2001).

Index Reference:

Glass N, Dearwater S, Campbell J. (2001). Intimate partner violence screening and intervention: Data from eleven Pennsylvania and California community hospital emergency departments. *Journal of Emergency Nursing, 27,* 141-9.

RADAR

The acronym "RADAR" summarizes action steps physicians should take in recognizing and treating victims of partner violence.

Remember to ask routinely about partner violence in your own practice.

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

Document information about "suspected domestic violence" or "partner violence" in the patient's office.

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

Review options with your patient. Know about the types of referral options (e.g., shelters, support groups, legal advocates).

Note. There is another version of the RADAR screening tool (called RADAR/SA) that also assesses for sexual assault with the following question: "Have you ever been sexually assaulted or involved in sexual acts against your will?"

Reprinted from *Annals of Internal Medicine,* 123, Alpert EJ. Violence in intimate relationships and the practicing internist: New "disease" or new agenda? 774-81 Copyright 1995, with permission from American College of Physicians.

Developer: RADAR was developed by the Massachusetts Medical Society. The sexual assault question was developed by Dr. Wanda Filer.

Publication year: 1992, 1996, 1999, 2004

Administration method: Physician administered.

Scoring procedures: This information is not available.

Follow-up procedures: This information is included in the screening tool.

Index Reference:

Alpert EJ. (Ed.) (2004). Partner violence: How to recognize and treat victims of abuse, Fourth Edition. Waltham, MA: Massachusetts Medical Society.

Additional Reference:

Alpert EJ. (1995). Violence in intimate relationships and the practicing internist: New "disease" or new agenda? *Annals of Internal Medicine*, 123, 774-81.

RADAR for Men: A Domestic Violence Intervention

R=Routine inquiry
A=Always ask
D=Document findings
A=Assess safety and lethality
R=Respond

Domestic violence (DV) remains a common problem encountered by clinicians in the practice of medicine. Traditionally, screening for DV has focused on female victims. This approach ignores the reality that men are commonly involved in DV, both as perpetrators and victims.

DV is a risk to your patient's health. A lack of provider interest in a patient's health risks communicates to the patient that the status quo is acceptable. Screening for DV must provoke a helpful, positive response which does not humiliate or punish, but which focuses on improving the health, well-being and safety of **all** our patients. Asking men about DV is a way to protect women, children and men from the consequences of DV.

R= Routine inquiry of all male patients 14 and older
Some patients will not volunteer information concerning the presence of DV, but will talk freely about it when asked. Asking your male patients about domestic violence should be a routine part of medical care, whether the patient appears to be involved in DV or not. We expect health care providers to ask their male patients at a first visit and on a yearly basis.

In addition to routine inquiry, providers should ask about DV whenever patients present with risk factors such as substance abuse; PTSD; financial stressors such as job loss or foreclosure; unexplained bruises or injuries; or depression. Abuse may increase during pregnancy; partners of pregnant women should be asked about DV.

A=Always ask
Below are several questions you might ask your patient to assess his involvement in a violent relationship. You may also want to notify the patient of exceptions to confidentiality. Specifically, if children are being harmed, you will have to involve the appropriate authority in your municipality; and if your questions discover an imminent risk to your patient or someone else, you will have to involve the police.

Providers have their own personal style, and this will affect how you ask your patients. The exact wording is not that important; what is important is that you ask. Patients report being more comfortable with health care providers who ask in a non-judgmental fashion and who appear to be genuinely interested in their well-being.

"Are you in a relationship in which you are being hurt or threatened?"

"Have you ever used any kind of physical force against your partner?"

"Has your partner ever pushed, grabbed, slapped, choked, or hit you?"
"Have you ever done that to her/him?"

"Has your partner ever forced you to have sex or perform sexual acts which you did not want to do?"
"Have you done that to her/him?"

Some providers and patients are more comfortable with questions that assess the nature of the relationship first.

"How would you characterize your relationship with your partner?"

"All people argue. How do you and your partner handle disagreements or fights?"
"Do your fights ever become physical?"

If a patient admits to DV, it may be difficult to determine whether the patient is primarily the victim or the perpetrator. Your response and advice are based to a great extent on the balance of power and control in the relationship. The following questions may help to further define the patient's role in the relationship.

"Does your partner put you down or make you feel bad about yourself?"
"Do you do that to her/him?"

"Are you afraid of your partner?" "Is he/she afraid of you?"

"Has your partner stopped you from going places or seeing people?"
"Have you done that to her/him?"

"Who controls financial decisions in your relationship?"
"Do you share decisions over financial matters?"

"Has your partner threatened to call immigration and have you deported?"
"Have you done that to her/him?"

If the patient answers "Yes" to either being a perpetrator or victim of DV, see what to do under the **"Respond"** section below, and then continue with the following steps.

D=Document findings
Document in the chart that you asked about DV, and what the patient said. If the patient denies DV, it is important to document that you asked, as this is widely becoming a standard of care. If the patient admits to being involved in DV, document his story. Use quotation marks to document exact words. Note what injuries, if any, you observed. State your assessment of the potential for future violence including threats made. Describe safety and follow-up plans including your next scheduled appointment. Document that you asked about safety of children in the home.

A=Assess for safety and lethality
We can never totally predict who will do harm to their partner, but there are some questions you can ask to help asses the current situation.

If your patient acknowledges being a victim of domestic violence:
Is it safe for him to go home today?
Is he being stalked?
Has there been an increase in the frequency or severity of violence?
Are there weapons easily accessible to the perpetrator?
Have there been threats of homicide or suicide to him, the children, and/or pets?

If your patient admits to being a perpetrator:
Has there been an increase in the frequency or severity of violence?
Is your patient tracking his partner's behavior without his/her knowledge?
Are there weapons easily accessible to him?
Has there been prior contact with the police? Is there a Protection From Abuse Order?
Are issues such as substance abuse, depression, or mental illness exacerbating his behavior?
Should you consider contacting the victim?

It is important to identify whether there are children in the home and whether or not the children are being harmed. If you have evidence that the children are being harmed, you have a moral and legal obligation to involve the appropriate agency in your municipality.

If your patient discloses intent to imminently harm a named victim, you may have a duty to warn that person. Case law in California established that the provider who has reason to believe that someone may be at risk for injury from his/her client has a duty to initiate contact with that person to warn the victim. It is important for sites to develop and implement policies that reflect existing statutes, protect victims of DV, and protect patient confidentiality.

R=Respond
A general statement should first be made: "Being in a violent relationship affects the health and well-being, of you, your partner, your children and your community. This kind of stress can worsen illness, and depression, and increase substance abuse and absence from work. This is hard, complicated and will take time to work out."

If your patient is a victim of DV, you can respond as follows:
Encourage him to talk about it:
"Would you like to talk about what has happened to you? Would you like some help?"

Validate his experience and emphasize the risk of violence to his and his families' health and well-being.

"Many people feel that only women are victims of domestic violence, but we know that it can happen to anyone, including men. No one deserves to be treated this way."
"If you're being hurt, your kids are being hurt, too."

If the patient does not need immediate assistance, offer information about resources in the community.

"I can put you in touch with someone who can help you."

Acknowledge that change is a process, and follow the situation over time:

"I am glad you told me about this, and I want to help you to stay healthy and safe. Let's make sure we bring this up at the next visit."

If your patient acknowledges being a perpetrator of DV, you can respond as follows:
Positively reinforce the patient's telling you about this, and reframe the issue as a health issue.

"I am glad you told me about this. I'd like to spend some time talking about this because I am concerned about your health and safety. Do you feel that this behavior is affecting your health in any way?"

Make it clear that you do not condone this behavior.
"I strongly believe that violence is not an acceptable way to resolve disputes. The behavior you describe is dangerous and illegal."

Remind the patient of the consequences of his abusive behavior.
"This situation puts at risk everything you care about - your health, the health of your partner and children, your freedom, your job. You must stop the violence and stay away from your family if you have an urge to use force. You could be arrested and convicted for hurting your partner. Also, your kids are learning from your behavior."

Offer hope that the patient can change his behavior and offer appropriate referrals.
"You can do something about this. Are you interested in help to change your behavior? Do you have friends or family you can turn to for help with this? Can your faith help you? I know some community programs for men that can help."

Recognize that change is a process, and follow the pattern of behavior over time.
"Again, I am glad you told me about this. I want to help you to stay healthy and safe. Let's make sure we bring this up at the next visit."

Make referrals and schedule a follow-up appointment.

Developer: RADAR for Men was developed by Jeffrey R. Jaeger, MD and The Family Violence Clinical Network.

Publication year: 2004

Administration method: Physician administered.

Scoring procedures: This information is not available.

Follow-up procedures: This information is included in the screening tool.

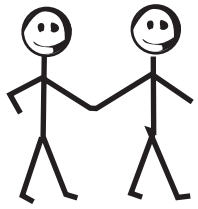
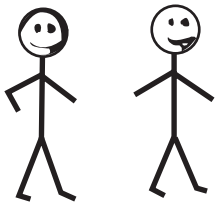
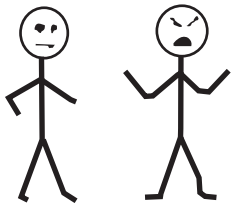
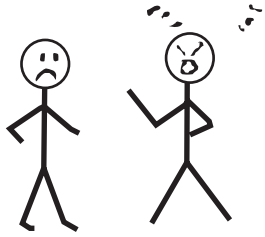
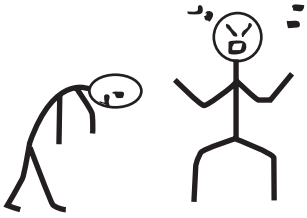
Index Reference:

Jaeger JR. (2004). *RADAR for Men* [teaching protocol]. Philadelphia, PA: Institute for Safe Families.

The Relationship Chart

DURING THE PAST 4 WEEKS, HOW OFTEN HAVE PROBLEMS IN YOUR HOUSHOLD LED TO:

- INSULTING OR SWEARING?
- YELLING?
- THREATENING?
- HITTING OR PUSHING?

None of the Time	
A Little of the Time	
Some of the Time	
Most of the Time	
All of the Time	

Reprinted with permission from
John Wasson, MD
Research Director
Dartmouth Medical School
Hanover, NH 03755

Developer: John Wasson, Anne Jette, Jessica Anderson, Deborah Johnson, Eugene Nelson, and Charles Kilo

Publication year: 2000

Administration method: Self report.

Scoring procedures: Items are scored on a 5-point scale:

1 = None of the time
2 = A little of the time
3 = Some of the time
4 = Most of the time
5 = All of the time

Follow-up procedures: If a woman indicates that she has experienced an abusive relationship at least some of the time in the past 4 weeks, more direct inquiry about the nature of the abuse is indicated (Wasson et al. 2000).

Index Reference:

Wasson JH, Jette AM, Anderson J, Johnson DJ, Nelson EC, Kilo CM. (2000). Routine, single-item screening to identify abusive relationships in women. *The Journal of Family Practice, 49,* 1017-22.

Screening Tools-Domestic Violence

American College of Obstetricians and Gynecologists

Because violence is so common in many women's lives and because there is help available for women being abused, I now ask every patient about domestic violence:

1. Within the past year - or since you have become pregnant - have you been hit, slapped, kicked, or otherwise physically hurt by someone?

2. Are you in a relationship with a person who threatens or physically hurts you?

3. Has anyone forced you to have sexual activities that made you feel uncomfortable?

Reprinted with permission from American College of Obstetricians and Gynecologists.

Developer: American College of Obstetricians and Gynecologists

Publication year: 2003

Administration method: Clinician administered.

Scoring procedures: This information is not available.

Follow-up procedures: Please see the ACOG website for more information.
www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=585

Index Reference:

American College of Obstetricians and Gynecologists (2003). Screening tools-domestic violence. Available at: http://www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=585 Retrieved August 8, 2006.

STaT
(Slapped, Things, and Threaten)

NOTE: This scale is available for purchase from Mary Ann Liebert, Inc.

Developer: Anuradha Paranjape and Jane Liebschutz

Publication year: 2003

Administration method: Clinician administered.

Scoring procedures: A positive response to each item scores 1 point.

Follow-up procedures: This information is not available.

Index Reference:

Paranjape A. Liebschutz J. (2003). STaT: A three-question screen for intimate partner violence. *Journal of Women's Health*, 12, 233-9.

Suggested Screening Questions

Framing Questions

1. Because violence is so common in many people's lives, I've begun to ask all my patients about it.
2. I am concerned that your symptoms may have been caused by someone hurting you.
3. I don't know if this is (or ever has been) a problem for you, but many of the patients I see are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely.

Direct Verbal Questions

1. Are you in a relationship with a person who physically hurts you or threatens you?
2. Did someone cause these injuries? Was it your partner/husband?
3. Has your partner or ex-partner ever hit you or physically hurt you? Has he ever threatened to hurt you or someone close to you?
4. Do you feel controlled or isolated by your partner?
5. Do you ever feel afraid of your partner? Do you feel you are in danger?
6. Is it safe for you to go home?
7. Has your partner ever forced you to have sex when you didn't want to? Has your partner ever refused to practice safe sex?
8. Has any of this happened to you in a previous relationship?

Produced by
The Family Violence Prevention Fund
383 Rhode Island Street, Suite 304
San Francisco, CA 94103-5133
(415) 252-8900
TTY (800) 595-4889
First Printing: September, 2002
Updated: February, 2004

Developer: Family Violence Prevention Fund

Publication year: 2002

Administration method: Clinician administered.

Scoring procedures: This information is not available.

Follow-up procedures: Clinicians should assess 1) the impact of the abuse on the patient's health, and 2) the pattern and history of the abuse. Clinicians also need to provide 1) validation, 2) information about domestic violence, 3) referrals to local resources, and 4) information about safety planning. See the National Consensus Guidelines (2002) for more detailed information.

Index Reference:

Family Violence Prevention Fund (2002, September). *National consensus guidelines on identifying and responding to domestic violence victimization in health care settings.* San Francisco, CA: Author. www.endabuse.org/programs/healthcare/files/Consensus.pdf

Two-Question Screening Tool

1. Have you ever been hit, slapped, kicked, or otherwise physically hurt by your male partner? (If yes, ask date of last episode)

2. Have you ever been forced to have sexual activities? (If yes, ask date of last episode)

Developer: Judith McFarlane, Lyn Greenberg, Arlo Weltge, and Mary Watson

Publication year: 1995

Administration method: Nurse administered.

Scoring procedures: A woman is considered abused if she gives a positive response to either question.

Follow-up procedures: All women who participated were offered an informational brochure on abuse. Women who are identified as abused need to be further assessed for level of personal danger. A safety plan should be discussed with them, and they should receive information regarding abuse and community resources (McFarlane et al. 1995).

Index Reference:

McFarlane J, Greenberg L, Weltge A, Watson M. (1995). Identification of abuse in emergency departments: Effectiveness of a two-question screening tool. *Journal of Emergency Nursing, 21,* 391-4.

Universal Violence Prevention Screening Protocol

Introduction:

1. These days many people are exposed to violence in some form.
2. Violence is a health risk and can result in physical and emotional problems.
3. It is our routine procedure to ask adult patients about their exposure to violence.
4. If you are a violence victim, we can better help you if we know it.

	Last 12 months		If "yes" to 12 Months, Last 1 Month?	
1. In the past 12 months...has anyone **threatened** you with or **actually used** a knife or gun to **scare or hurt you**?	Yes	No	Yes	No
2. ...**choked, kicked, bit, or punched** you?	Yes	No	Yes	No
3. ...**slapped, pushed, grabbed, or shoved** you?	Yes	No	Yes	No
4. ...forced or coerced you to have sex?	Yes	No	Yes	No
5. ...have you been **afraid** that a current or former intimate partner would hurt you physically?	Yes	No	Yes	No

6. What is your relationship with the person who has hurt you?

___ Current or former intimate partner
___ Other family member
___ Acquaintance or friend
___ Coworker
___ Stranger
___ Other (specify)

7. Have the **police** been notified within the **last month** about any of these experiences?

YES NO

Developer: Mary Ann Dutton, Barbara Mitchell, and Yolanda Haywood

Publication year: 1996

Administration method: Nurse administered.

Scoring procedures: This information is not available.

Follow-up procedures: A positive score for any of the items signals the need for further risk assessment.

Index Reference:

Dutton MA, Mitchell B, Haywood Y. (1996). The emergency department as a violence prevention center. *Journal of American Medical Women's Association, 51,* 92-6.

Universal Violence Prevention Screening Protocol - Adapted

Have you been in a relationship with a partner in the past year? (Yes/No)

If yes, within the past year has a partner:

(a) Slapped, kicked, pushed, choked, or punched you? (Yes/No)

(b) Forced or coerced you to have sex? (Yes/No)

(c) Threatened you with a knife or gun to scare or hurt you? (Yes/No)

(d) Made you afraid that you could be physically hurt? (Yes/No)

(e) Repeatedly used words, yelled, or screamed in a way that frightened you, threatened you, put you down, or made you feel rejected? (Yes/No)

Developer: Sheryl Heron, Martie P. Thompson, Emily Jackson, and Nadine Kaslow

Publication year: 2003

Administration method: Clinician administered or self report.

Scoring procedures: This information is not available.

Follow-up procedures: This information is not available.

Index Reference:

Heron SL, Thompson MP, Jackson E, Kaslow NJ. (2003). Do responses to an intimate partner violence screen predict scores on a comprehensive measure of intimate partner violence in low-income black women? *Annals of Emergency Medicine, 42*, 483-91.

Victimization Assessment Tool

1. Have you been troubled or injured by any kind of abuse or violence (e.g., hit by partner, forced sex)?

   Yes _____ No _____ Not sure _____ Refused _____
   If yes, check one:
   By someone in your family _____
   By an acquaintance or stranger _____
   Describe:

2. If yes, has something like this ever happened before?

   Yes _____ No _____ If yes, when? _____
   Describe:

3. Do you have anyone you can turn to or rely on now to protect you from possible further injury?
   Yes _____ No _____ If yes, who? _____

4. Do you feel so badly now that you have thought of hurting yourself/suicide?
   Yes _____ No _____

   If yes, what have you thought about doing?
   _____

5. Are you so angry about what's happened that you have considered hurting someone else?
   Yes _____ No _____

   If yes, describe briefly: _____

Developer: Lee Ann Hoff and Linda Rosenbaum

Publication year: 1994

Administration method: Clinician administered.

Scoring procedures: According to Hoff and Rosenbaum (1994), individuals are classified into one of the following risk groups based on the degree of victimization:

1 = No experience of physical violence or abuse.

2 = Experience of abuse/violence with minor physical and/or emotional trauma (e.g., verbal arguments that occasionally escalate to pushing and shoving or mild slapping. History may include past victimization that is no longer problematic.)

3 = Experience of abuse/violence with moderate physical and/or emotional trauma (e.g., abused several times a month in recent years resulting in moderate trauma or emotional distress. No threat to life, no weapons available. History may include past victimization that is still somewhat problematic.)

4 = Experience of abuse/violence with severe physical and/or emotional trauma (e.g., violently attacked or physically abused in recent years, resulting in physical injury requiring medical treatment. Threats to kill, no guns available. History may include serious victimization requiring medical and/or physical treatment.)

5 = Life-threatening or prolonged abuse/violence with very severe physical and/or emotional trauma (e.g., recent or current life-threatening physical abuse, potentially lethal assault or threats with available deadly weapons. History may include severe abuse requiring medical treatment, frequent or ongoing sexual abuse, recent rape, other physical attack requiring extensive medical treatment.)

Follow-up procedures: If rating is Level 2 or above on the assessment scale, clinician should discuss with client and recommend referral to victim care specialist for full assessment and follow-up care.

Index Reference:

Hoff LA, Rosenbaum L. (1994). A victimization assessment tool: Instrument development and clinical implications. *Journal of Advanced Nursing,* 20, 627-34.

Woman Abuse Screening Tool (WAST)

1. In general, how would you describe your relationship?
   - ☐ A lot of tension
   - ☐ Some tension
   - ☐ No tension
2. Do you and your partner work out arguments with:
   - ☐ Great difficulty?
   - ☐ Some difficulty?
   - ☐ No difficulty?
3. Do arguments ever result in you feeling down or bad about yourse1f?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never
4. Do arguments ever result in hitting, kicking or pushing?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never
5. Do you ever feel frightened by what your partner says or does?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never
6. Has your partner ever abused you physically?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never
7. Has your partner ever abused you emotionally?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never
8. Has your partner ever abused you sexually?
   - ☐ Often
   - ☐ Sometimes
   - ☐ Never

Reprinted from *Family Medicine*, 28, Brown JB, Lent B, Brett PJ, Sas G, Pederson LL, Development of the Woman Abuse Screening Tool for use in family practice, 422-28, Copyright (1996) with permission from the Society of Teachers of Family Medicine, www.stfm.org.

Developer: Judith Belle Brown, Barbara Lent, Gail Schmidt, and George Sas

Publication year: 2000

Administration method: Self report.

Scoring procedures: Recode responses to reflect a higher score for higher reported frequency of experiences and sum the WAST scores for individuals who answered all 8 items.

Follow-up procedures: This information is not available.

Index Reference:

Brown JB, Lent B, Schmidt G, Sas G. (2000). Application of the woman abuse screening tool (WAST) and WAST-short in the family practice setting. *The Journal of Family Practice, 49,* 896-903.

Additional References:

Brown JB, Lent B, Brett PJ, Sas G, Pederson LL. (1996). Development of the Woman Abuse Screening Tool for use in family practice. *Family Medicine, 28,* 422-28.

Punukollu M. (2003). Domestic violence: Screening made practical. *The Journal of Family Practice, 52,* 537-43.

Valente SM. (2002). Evaluating intimate partner violence. *Journal of the American Academy of Nurse Practitioners, 14,* 505-13.

Woman Abuse Screening Tool (WAST) - Short

1. In general, how would you describe your relationship?
   - ☐ A lot of tension
   - ☐ Some tension
   - ☐ No tension
2. Do you and your partner work out arguments with:
   - ☐ Great difficulty?
   - ☐ Some difficulty?
   - ☐ No difficulty?

Developer: Judith Belle Brown, Barbara Lent, Pamela J. Brett, George Sas, and Linda L. Pederson

Publication year: 1996

Administration method: Self report.

Scoring procedures: Assign a score of 1 to the most extreme positive response ("a lot of tension") and a score of 0 to other response options. Scores range from 0 to 2 and criterion cut-off score is 1.

Follow-up procedures: According to the authors, if a woman answers affirmatively to these two questions, the physician can then use the remaining WAST questions or other appropriate questions to elicit more information about the patient's experience of abuse. This can ultimately lead to an assessment of additional factors such as history of prior abuse, extent and severity of abuse, sources of support, need for legal assistance, and information about available community resources (Brown, et al., 1996).

Index Reference:

Brown JB, Lent B, Brett PJ, Sas G, Pederson LL. (1996). Development of the Woman Abuse Screening Tool for use in family practice. *Family Medicine, 28*, 422 -28.

Additional References:

Brown JB, Lent B, Schmidt G, Sas G. (2000). Application of the woman abuse screening tool (WAST) and WAST-short in the family practice setting. *The Journal of Family Practice, 49*, 896-903.

Punukollu M. (2003). Domestic violence: Screening made practical. *The Journal of Family Practice, 52*, 537-43.

Valente SM. (2002). Evaluating intimate partner violence. *Journal of the American Academy of Nurse Practitioners, 14*, 505-13.

Pruebas De La Violencia Contra La Mujer

(Women Abuse Screening Tool (WAST), Spanish Version)

1. En general, como describiría usted su relación con su pareja?
   - ☐ Mucha tension
   - ☐ Alguna tension
   - ☐ Sin tension
2. Usted y su pareja resuelven sus discusiones (argumentos) con...
   - ☐ Mucha dificultad
   - ☐ Alguna dificultad
   - ☐ Sin dificultad
3. Al terminar las discusiones usted se siente decalda o mal con usted misma?
   - ☐ Muchas veces
   - ☐ A veces
   - ☐ Nunca
4. Las discusiones terminan en golpes, patadas, o empujones?
   - ☐ Muchas veces
   - ☐ A veces
   - ☐ Nunca
5. Siente miedo de lo que su pareja diga o haga?
   - ☐ Muchas veces
   - ☐ A veces
   - ☐ Nunca
6. Su pareja ha abusado de usted fisicamente?
   - ☐ Muchas veces
   - ☐ A veces
   - ☐ Nunca
7. Su pareja ha abusado de usted emocionalmente?
   - ☐ Muchas veces
   - ☐ A veces
   - ☐ Nunca
8. Su pareja ha abusado de usted sexualmente?
   - ☐ Muchas veces
   - ☐ A veces
   - ☐ Nunca

Reprinted with permission from American Board of Family Medicine.

Developer: Colleen T. Fogerty and Judith Belle Brown

Publication year: 2002

Administration method: Self report.

Scoring procedures: This information is not available.

Follow-up procedures: This information is not available.

Index Reference:

Fogarty CT, Brown JB. (2002). Screening for abuse in Spanish-speaking women. *Journal of the American Board of Family Practitioners, 15,* 101-11.

Women's Experience with Battering Scale (WEB)

Following are a number of statements that women have used to describe their relationships with their "male partners." Please read each statement and then circle the answer that best describes how much you agree or disagree in general with each one as a description of your relationship with your "partner." If you do not now have a partner, think about your last one. There are no right or wrong answers; just circle the number that seems to best describe how much you agree or disagree with it.

Description of how your partner makes you feel:	Agree strongly	Agree somewhat	Agree a little	Disagree a little	Disagree somewhat	Disagree strongly
1. He makes me feel unsafe even in my own home	6	5	4	3	2	1
2. I feel ashamed of the things he does to me	6	5	4	3	2	1
3. I try not to rock the boat because I am afraid of what he might do	6	5	4	3	2	1
4. I feel like I am programmed to react in a certain way to him	6	5	4	3	2	1
5. I feel like he keeps me prisoner	6	5	4	3	2	1
6. He makes me feel like I have no control over my life, no power, no protection	6	5	4	3	2	1
7. I hide the truth from others because I am afraid not to	6	5	4	3	2	1
8. I feel owned and controlled by him	6	5	4	3	2	1
9. He can scare me without laying a hand on me	6	5	4	3	2	1
10. He has a look that goes straight through me and terrifies me	6	5	4	3	2	1

Developer: Paige Hall Smith, Irene Tessaro, and Jo Anne Earp

Publication year: 1995

Administration method: Self report.

Scoring procedures: Reverse score and then add the responses for all items. Range of scores is 10 to 60. A score of 20 or higher is a positive screening test for battering (Coker et al. 2002; Punukollu 2003).

Follow-up procedures: This information is not available.

Index Reference:

Smith PH, Tessaro I, Earp JA. (1995). Women's experiences with battering: A conceptualization from qualitative research. *Women's Health Issues*, 5, 173-82.

Additional References:

Smith PH, Thornton GE, DeVellis R, Earp JA, Coker AI. (2002). A population-based study of the prevalence and distinctiveness of battering, physical assault, and sexual assault in intimate partner relationships. *Violence Against Women*, 8, 1208-32.

Coker AL, Bethea L, Smith PH, Fadden MK, Brandt HM. (2002). Missed opportunities: Intimate partner violence in family practice settings. *Preventive Medicine*, 34, 445-54.

Punukollu, M. (2003). Domestic violence: Screening made practical. *The Journal of Family Practice, 52*, 537-43.

Work/School Abuse Scale

The following questions are about things that _____ (ABUSER'S NAME) may have done to bother you at work or to keep you from going to work. During your relationship with _____ did he ever....

1. Come to your work to harass you?	YES	NO	N/A
2. Bother your coworkers?	YES	NO	N/A
3. Lie to your coworkers about you?	YES	NO	N/A
4. Sabotage the car so you couldn't go to work?	YES	NO	N/A
5. Not show up for childcare so you couldn't go to work?	YES	NO	N/A
6. Steal your keys or money so you couldn't go to work?	YES	NO	N/A
7. Refuse to give you a ride to work?	YES	NO	N/A
8. Physically restrain you from going to work?	YES	NO	N/A
9. Threaten you to prevent your going to work?	YES	NO	N/A
10. Physically force you to leave work?	YES	NO	N/A
11. Lie about your children's health or safety to make you leave work?	YES	NO	N/A
12. Threaten you to make you leave work?	YES	NO	N/A

The following questions are about things that _____ (ABUSER'S NAME) may have done to bother you at school or to keep you from going to school. During your relationship with _____ did he ever....

1. Come to school to harass you?	YES	NO	N/A
2. Bother your school friends or teachers?	YES	NO	N/A
3. Lie to your friends/teachers about you?	YES	NO	N/A
4. Sabotage the car so you couldn't go to school?	YES	NO	N/A
5. Not show up for childcare so you couldn't go to school?	YES	NO	N/A
6. Steal your keys or money so you couldn't go to school?	YES	NO	N/A
7. Refuse to give you a ride to school?	YES	NO	N/A
8. Physically restrain you from going to school?	YES	NO	N/A
9. Threaten you to prevent your going to school?	YES	NO	N/A
10. Physically force you to leave school?	YES	NO	N/A
11. Lie about your children's health or safety to make you leave school?	YES	NO	N/A
12. Threaten you to make you leave school?	YES	NO	N/A

Developer: Stephanie Riger, Courtney Ahrens, and Amy Blickenstaff

Publication year: 2001

Administration method: Self-report.

Scoring procedures: There are two subscales. The Restraint Tactics Subscale contains 6 items that assess the use of tactics that prevent the respondent from going to work or school and includes items 4-9. The Interference Tactics Subscale contains 6 items that assess the use of tactics aimed at making the respondent leave work or school and includes items 1-3 and 10-12. Items are scored as yes = 1, no = 0.

Follow-up procedures: This information is not available.

Index Reference:

Riger S, Ahrens C, Blickenstaff A. (2001). Measuring interference with employment and education reported by women with abusive partners: Preliminary data. In D. O'Leary and R. Maiuro (Eds.), *Psychological abuse in violent domestic relations* (pp. 119 -33). New York, NY: Springer Publishing Co.

Clinical Research and Methods

HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting

Kevin M. Sherin, MD, MPH; James M. Sinacore, PhD; Xiao-Qiang Li, MD; Robert E. Zitter, PhD; Amer Shakil, MD

Background and Objectives: *Domestic violence is an important problem that is often not recognized by physicians. We designed a short instrument for domestic violence screening that could be easily remembered and administered by family physicians.* Methods: *In phase one of the study, 160 adult female family practice office patients living with a partner for at least 12 months completed two questionnaires. One questionnaire was the verbal and physical aggression items of the Conflict Tactics Scale (CTS). The other was a new four-item questionnaire that asked respondents how often their partner physically Hurt, Insulted, Threatened with harm, and Screamed at them. These four items make the acronym HITS. In phase two, 99 women, who were self-identified victims of domestic violence, completed the HITS.* Results: *For phase one, Cronbach's alpha was .80 for the HITS scale. The correlation of HITS and CTS scores was .85. For phase two, the mean HITS scores for office patients and abuse victims were 6.13 and 15.15, respectively. Optimal data analysis revealed that a cut score of 10.5 on the HITS reliably differentiated respondents in the two groups. Using this cut score, 91% of patients and 96% of abuse victims were accurately classified.* Conclusions: *The HITS scale showed good internal consistency and concurrent validity with the CTS verbal and physical aggression items. The HITS scale also showed good construct validity in its ability to differentiate family practice patients from abuse victims. The HITS scale is promising as a domestic violence screening mnemonic for family practice physicians and residents.*

(Fam Med 1998;30(7):508-12.)

In the United States, 8–12 million women are victims of domestic violence from current or former partners.[1] Domestic violence is related to serious morbidity and is a major public health problem in our society.[1] Recent research has found, however, that only a small percentage of victims of domestic violence are identified in medical practice.[2,3]

Screening for domestic violence by physicians is done infrequently for a variety of reasons.[2-4] We believe that one of the main reasons is that existing instruments are time-consuming to administer and complete. For example, the Wife Abuse Inventory[5] has 40 items, and the Conflict Tactics Scale (CTS)[6] has multiple scoring protocols and requires the purchase of a scoring manual. Hence, physicians may be deterred from using these instruments in busy clinical settings. In the present study, we developed and tested a short domestic violence screening tool that could be suitable for use in office practice.

From the Department of Family Medicine, University of Illinois at Chicago.

Methods

Overview

Instrument development began by assembling a focus group of family physicians[7] to discuss the type and wording of items that would comprise a useful screening instrument. The group decided that the items should be few in number and focused on verbal abuse and physical violence. The group ultimately decided on four items that would ask a patient to indicate how often her partner physically Hurts, Insults, Threatens, and Screams at her. Collectively, these items can be remembered by the acronym "HITS."

The research was conducted in two phases. In phase one, the reliability (ie, internal consistency) and the concurrent validity of the HITS instrument were as-

sessed with a group of female patients who were visiting their family physician. The CTS was chosen to establish concurrent validity because it is the instrument most widely used to measure marital violence.[8] In addition, the CTS assesses both the severity and chronicity of that violence. Moreover, the CTS has been used in three nationally normed studies[9-11] and has a high level of internal consistency, concurrent validity,[12-14] and content and construct validity.[8] The CTS also has been found to correlate well with spouse reports of domestic violence.[13]

In phase two, the construct validity of the HITS was tested by comparing the responses of the participants in phase one (general patients visiting their physician) with the responses of self-identified victims of domestic violence. If the HITS is a useful screening tool, victims of violence should score higher than the general population of patients. Moreover, it should be possible to find a cut score that reliably differentiates victims of violence from patients in general.

Instruments

The CTS. The CTS contains 15 items that measure perception of verbal and physical violence; all 15 of these items were used in this study. The CTS's four remaining "reasoning" items were not included because they are not directly related to domestic violence.

Using the response format of the original instrument, patients were asked to estimate how often within the previous year their partner committed acts toward them such as: sulked and/or refused to talk, stomped out of the house or room; threatened to hit or throw something; slapped; kicked, bit, or hit with a fist; and threatened with a knife or gun. Respondents made their estimates using a 7-point frequency scale of never, once, twice, 3–5 times, 6–10 times, 11–20 times, and more than 20 times. Score values could range from a minimum of 15 to a maximum of 105. To ensure that the verbal and physical violence items from the CTS continued to be a meaningful scale without the reasoning items, we conducted an internal consistency analysis; the data was collected from the patients in the study. Cronbach's alpha was .87 for the 15 items.

The HITS Scale. The HITS scale is a paper-and-pencil instrument that was comprised of the following four items: "How often does your partner: physically hurt you, insult you or talk down to you, threaten you with harm, and scream or curse at you?" Patients responded to each of these items with a 5-point frequency format: never, rarely, sometimes, fairly often, and frequently. Score values could range from a minimum of 4 to a maximum of 20.

Participants

For phase one of the study (reliability and concurrent validity testing), 160 female patients visiting a family practice clinic during April, May, and June 1996 participated in this study. For inclusion, participants had to be over age 21 and had to have lived with the same partner for at least 12 months. All participants were patients in the Family Practice Center of Christ Hospital Medical Center (Advocate), which serves a population of urban/suburban patients in the southwest Chicago area of Oak Lawn.

For phase two of the study (measuring construct validity), 99 women, who were self-identified as victims of domestic violence, participated. Some participants were residents of domestic violence crisis shelters (n=54), and others presented to an emergency room (n=45).

Instrument Administration

In phase one, the CTS and HITS were each printed on a separate page and stapled together. To control for presentation effects, the sequencing of the scales was counterbalanced so that half of the participants completed the CTS followed by the HITS, and the other half completed the instruments in the reverse order.

Following approval from our institution's Medical Investigations Committee, female patients in the family practice population were asked by nursing staff to participate in the present study during a normal office visit. Volunteers completed forms privately in exam rooms, and forms were collected before leaving the office. To maintain confidentiality, no identifying information was recorded.

In phase two, copies of the HITS were sent to each of the crisis shelters and the agency that attended women who presented in the emergency room. Staff coordinators at each site were asked to solicit participation by clients and to distribute and collect the forms at a time that did not disrupt counseling sessions or other important therapeutic events.

Data Analysis

Phase One: Reliability and Concurrent Validity. For this part of the study, frequency distributions were constructed for total scores on the CTS and HITS. Descriptive statistics for the HITS also were computed. The internal consistency (ie, reliability) of the HITS was determined with Cronbach's coefficient alpha. A scatter plot of the total scores for the CTS and HITS was constructed, and the scores were then correlated to establish the concurrent validity of the HITS. In addition, subscores for items that assessed verbal abuse and physical abuse were computed separately and correlated across instruments.

Tests for presentation effects were conducted by comparing the total score for participants who completed an instrument first in the set with those who completed it second. The Mann-Whitney U test was used for this comparison because the distribution of scores for both instruments was clearly not normal.

None of the participants had any missing data on the HITS. However, 10 participants (6% of 160) did not provide complete data on the CTS. Nine participants had one missing item, and one participant had two missing items. To use all subjects in the analysis, missing values were imputed with the mean value of the existing CTS items.

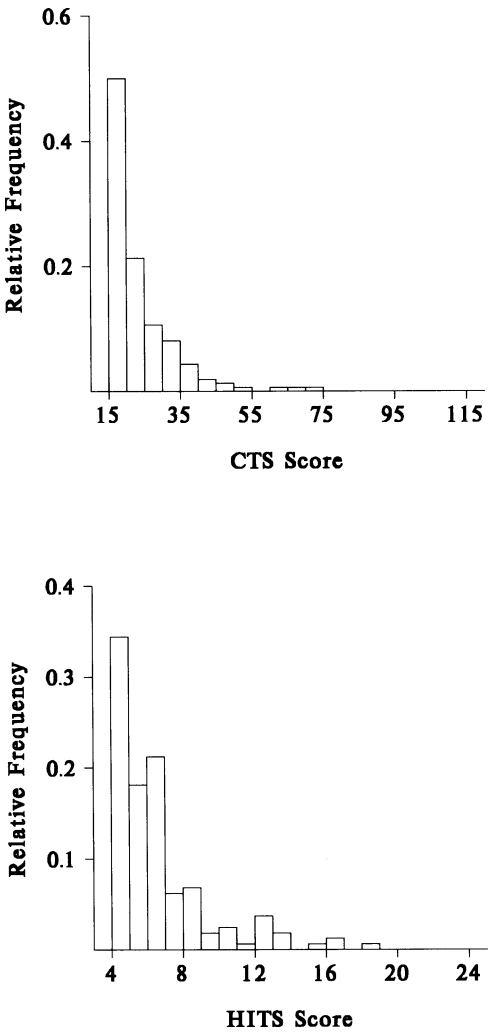
Phase Two: Construct Validity. To measure the construct validity of the HITS, scores for the respondents at the shelters and emergency room were compared with scores of the 160 female patients in phase one. If the screening tool is efficacious, HITS scores of self-identified victims of domestic violence should be significantly higher than those of general patients who are visiting their physician. HITS scores were therefore compared using Student's *t* test for independent samples.

In addition, the Optimal Data Analysis® program (ODA 1.0, Optimal Data Analysis for DOS, Chicago, Optimal Data Analysis, Inc) was used to find a cut score that reliably differentiated the two groups of participants. The intent of this was to find a score above which domestic violence probably has occurred.

In evaluating the cut score to distinguish victimized and non-victimized respondents, a leave-one-out validation method was used. To do this, one score was held out while the other 258 (ie, 160 subjects in phase one plus 99 subjects in phase two, minus one) were used to find the cut score. This cut score was then used to classify the holdout score in terms of it belonging to the office or victimized group. After this was done for all 259 scores, the results were merged to examine the overall percentage accuracy classification. The leave-one-out methodology allows one to classify HITS scores that are not used to derive the cut score, thus rendering an unbiased account of classification accuracy.

Figure 1

Frequency Distributions of CTS and HITS Scores



CTS—Conflict Tactics Scale
HITS—acronym for Hurts, Insults, Threatens, and Screams

Results

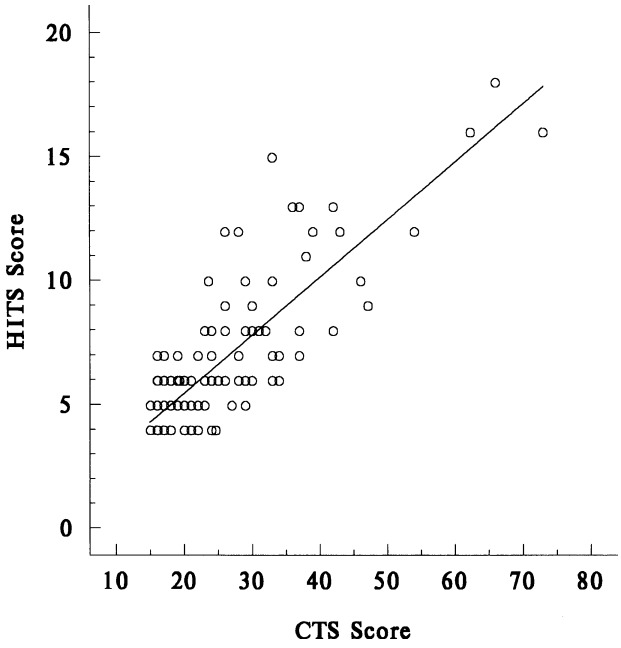
Phase One: Reliability and Concurrent Validity

The frequency distributions for the CTS and HITS scores from phase one are shown in Figure 1. As can be seen, both distributions are L-shaped, indicating that the majority of respondents scored in the low (non-victim) range of the scale. The lowest and highest HITS scores were 4 and 18, respectively. The mean was 6.13, the median was 5, and the standard deviation was 2.75. Cronbach's alpha was .80 for the four-item scale. The analysis further showed that deleting the item about being physically hurt would leave alpha unchanged. However, alpha would notably decrease if any of the other items were dropped from the scale.

Figure 2 shows the scatterplot of HITS and CTS scores. The lower left portion shows a higher density of points due to the L-shaped nature of the score distributions. However, the relationship is positive and linear. A correlation of .85 was found between HITS and CTS total scores. Subscores on both instruments that measured respondents' experience of physical violence showed a correlation of $r = .82$. The same was true for items that measured verbal violence, $r = .81$.

Figure 2

Scatter Plot of HITS and CTS Scores



CTS—Conflict Tactics Scale
HITS—acronym for Hurts, Insults, Threatens, and Screams

Presentation Effects. Presentation effects were not found. The median total HITS score was 5 for those who completed the instrument first, as well as for those who completed it second, z=.23, P=.815. The median CTS scores were 19.64 and 20 for those completing the instrument first and second, respectively, z=.26, P=.794.

Phase Two: Construct Validity

The mean HITS scores for the victimized and office groups were 15.12 and 6.13, respectively. This difference was statistically significant, t=24.12, P< .0005. Computations showed that 69% of the variance in HITS scores was attributable to group membership.

ODA® analysis revealed that the score of 10.5 reliably discriminated the two study groups (P<.05).Table 1 shows the cut score classification performance summary. In terms of actual group membership, 96% (95/99) of the victimized participants and 91% (146/160) of the office participants were classified correctly using this cut score. This is analogous to sensitivity and specificity, respectively. In terms of making predictions, 87% (95/109) of those predicted to be victimized by domestic violence and 97% (146/150) of those predicted to be office patients were accurate. This is analogous to the positive and negative predictive values, respectively.

Discussion

The HITS scale is not the first short domestic violence screening tool to be developed for outpatient clinical settings. Other short instruments, such as the Abuse Assessment Screen,[15] have been developed for the same purpose, but the HITS instrument is shorter than others.[15-17] HITS has only four items, two each that address verbal and physical aggression. The brevity of the HITS is rivaled only by the three-item Partner Violence Screen developed by Feldhaus et al.[18] However, the latter was designed for use in an emergency room, and the items do not form an easily remembered acronym.

The results from phase one indicate that the HITS has good internal consistency and concurrent validity with the CTS. Although the four reasoning items were not used in the CTS, there is no reason to believe that this affected the ability of the scale to measure perception of physical and verbal violence. An internal consistency analysis of the 15-item CTS with our office sample revealed an alpha of .87.

The results from phase two of the study provide two important findings to demonstrate the construct validity of the HITS. First, the group of self-identified victims of abuse scored significantly higher than family practice patients. Second, ODA® revealed that the score of 10.5 reliably differentiated the two groups of respondents. These findings are consistent with an effective screening tool.

Table 1

Cut Score Classification Performance Summary

		Predicted Group Membership			
		Victimized	Office	Total	Accuracy
Actual Group Membership	Victimized	95	4	99	96%
	Office	14	146	160	91%
	Total	109	150		
	Accuracy	87%	97%		

Note: A HITS score of >10.5 classified someone as a victimized respondent.

HITS—acronym for Hurts, Insults, Threatens, and Screams

In practice, the cut score of 10.5 is not directly usable because the HITS scoring procedure does not allow for fractions of points. We, therefore, suggest that clinicians suspect domestic violence when their patients have a HITS score greater than 10.

Despite the statistical findings of the HITS cutoff, physicians should investigate domestic violence whenever they believe such a problem might exist. The HITS is not used, nor should it be used, in lieu of good clinical judgment. One must keep in mind that our sample of office patients was compared with a group of women for whom the experience of domestic violence led them to seek professional help. We suspect that there are many more women who cope with a violent home life, yet, for whatever reason, do not want to bring up the issue with a health care professional. As always, clinical acumen should outweigh test scores if there appears to be a discrepancy between the two.

Hopefully, a verbal form of the HITS with a yes-no response format would have similar accuracy as the written instrument used in this study. If so, physicians could screen for domestic violence during a conversation with a patient, thus obviating the need for a paper-and-pencil instrument (albeit a short one).

Given the positive results from this study, additional work should be done to explore the characteristics of the HITS. For example, concurrent validity with other normed instruments, such as the Index of Spouse Abuse,[19] should be examined. HITS scores also could be correlated with the incidence of violence that is reported in medical records.[20] In addition, the utility of the HITS should be studied with other women who are known to be at high risk of violence.

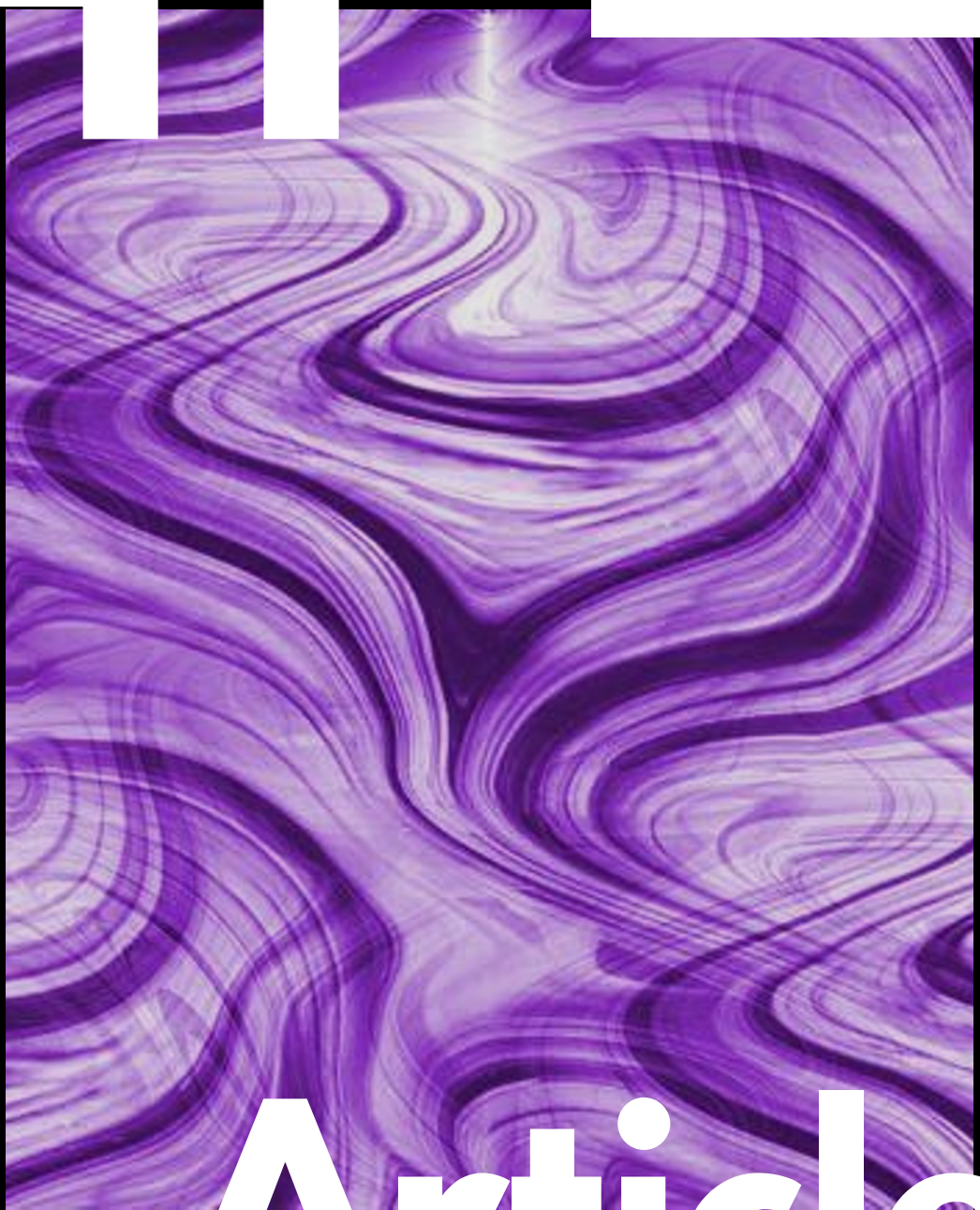
Acknowledgments: This research was supported by a grant from the Med Fund of Christ Hospital Medical Center (Advocate). The Med Fund has sole rights for the reprint or use of the HITS questionnaire herein described. The authors extend their appreciation to the following individuals and organizations that participated in this study: Sr. Cathleen Moore and Pat Meneghini from Good Shepherd, Jenny Miller from Crisis Center Advocates, Sharon Harold from South Suburban Family Shelter, and Theresa DuBoise from Family Rescue. A portion of this work was presented at the 1997 Society of Teachers of Family Medicine (STFM) Annual Spring Conference in Boston and the 1998 STFM Annual Spring Conference in Chicago. The work also was presented at the 1997 American Academy of Family Physicians Scientific Assembly in Chicago.

Corresponding Author: Address correspondence to Dr Sherin, University of Illinois at Chicago, Christ Family Medicine Residency Program, 4400 W 95 Street, Suite 207, Oak Lawn, IL 60453. 708-346-5324. Fax: 708-346-2003. E-mail: ksherin@uic.edu.

References

1. American Medical Association. Diagnostic and treatment guidelines on domestic violence. Chicago: American Medical Association, 1994.
2. Hamberger LK, Saunders DG, Hovey M. Prevalence of domestic violence in community practice and rate of physician inquiry. Fam Med 1992;24(4):283-7.
3. Tilden VP, Schmidt TA, Limandri BJ, Chiodo GT, Garland MJ, Loveless PA. Factors that influence clinicians' assessment and management of family violence. Am J Public Health 1994;84(4):628-33.
4. Parsons LH, Zaccaro D, Wells B, Stovall TG. Methods of and attitudes toward screening obstetrics and gynecology patients for domestic violence. Am J Obstet Gynecol 1995;173(2):381-6.
5. Lewis BY. The wife abuse inventory: a screening device for the identification of abused women. Soc Work 1985;Jan-Feb:32-5.
6. Straus MA. Physical violence in American families. New Brunswick, NJ: Transaction Publishers, 1990.
7. Brown JR, Sas C. Focus groups in family practice research: an example study of family physicians' approach to wife abuse. Fam Pract Res J 1994;14(1):19-28.
8. Straus MA. Measuring intrafamily conflict and violence: the conflict tactics scales. Journal of Marriage and the Family 1979;4:75-88.
9. Aldorondo E, Straus MA. Screening for physical violence in couple therapy: methodological, practical, and ethical considerations. Fam Process 1994;33(4):425-39.
10. Straus MA, Gelles R. Societal change and change in family violence from 1975 to 1985 as revealed by national survey. Journal of Marriage and the Family 1986;48:465-79.
11. O'Leary KD, Barling J, Arias I, Rosenbaum A, Malone J, Tyree A. Prevalence and stability of physical aggression between spouses: a longitudinal analysis. J Consult Clin Psych 1989;57:263-8.
12. Cronbach LJ. Essentials of psychological testing, third edition. New York: Harper and Row, 1970.
13. Bullcroft RA, Straus MA. Validity of husband, wife, and child reports of intrafamily violence and power. Durham, NH: Family Research Lab, University of New Hampshire, 1975:16.
14. Kramer JJ, Conoley JC. The 11th mental measurement yearbook. Lincoln, Neb: University of Nebraska Press, 1992.
15. Norton L, Peipert J, Zierler S, Lima B, Hume L. Battering in pregnancy: an assessment of two screening methods. Obstet Gynecol 1995;85(3):321-25.
16. Gendron C. The development of a questionnaire for identification of women who are victims of violence in the conjugal milieu. Can J Nurs Res 1991;23(3):21-32.
17. Attala JM. Risk identification of abused women participating in a women, infants, and children program. Health Care Women Int 1994;15(6):587-97.
18. Feldhaus KM, Koziol-McLain JK, Amsbury HL, Norton IM, Lowenstein SR, Abbott JT. Accuracy of three brief screening questions for detecting partner violence in the emergency department. JAMA 1997;277(17):1357-61.
19. McFarlane J, Parker B, Soeken K, Bullock L. Assessing for abuse during pregnancy: severity and frequency of injuries and associated entry into prenatal care. JAMA 1992;267(23):3176-8.
20. Sanders DG, Hamberger LK, Hovey M. Indicators of woman abuse based on a chart review at a family practice center. Arch Fam Med 1993;2:537-43.

HT



Articles

JOGNN

AWHONN POSITION STATEMENT

Human Trafficking

An official position statement of the Association of Women's Health, Obstetric and Neonatal Nurses

Approved by the AWHONN Board of Directors, March 2016.

AWHONN 1800 M Street, NW, Suite 740 South, Washington, DC 20036, (800) 673-8499

Position

Nurses are ideally positioned to screen, identify, care for, provide referral services for, and support victims of human trafficking. Therefore, the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) supports improved education and awareness for nurses regarding human trafficking. Patients should be screened for human trafficking in private, safe, health care settings. If there is a language barrier, professional interpreter services are imperative.

To protect the safety of women who have been trafficked, AWHONN opposes laws and other policies that require nurses to report the results of screening to law enforcement or other regulatory agencies without the consent of the woman who experiences the human trafficking. However, nurses and other health care professionals should be familiar with laws for mandatory reporting in their states, especially for minors, and comply as applicable.

Background

Human trafficking, a modern form of slavery, is generally divided into several categories: forced sexual exploitation, forced labor, and domestic servitude. Victims of forced sexual exploitation may have to work in a variety of settings, including but not limited to prostitution, exotic dancing, pornography, and/or as mail order brides (Richards, 2014). Victims of forced labor work for little or no money, often for long hours, and without appropriate safety measures or compensation. Female victims of forced labor are also often sexually exploited (U.S. Department of State, 2005).

Human trafficking is a global problem present in all countries, including the United States. Within the United States, sex trafficking of U. S. citizens is more common than labor trafficking; labor trafficking is more prevalent among foreign nationals (Sabella, 2011). Trafficking victims in the United States come from all over the world, but not all of these victims originate from other countries; many are U.S. citizens.

While there is no single profile for those who have been trafficked, certain individuals may be more vulnerable to being victimized: runaways; homeless and orphaned adolescents; foreign nationals; individuals with histories of trauma or violence; females; and lesbian, gay, bisexual, and transgender individuals (Greenbaum, 2014; Institute of Medicine, 2013; National Human Trafficking Resource Center, n.d.).

While the exact number of trafficking victims is unknown, it is estimated that 80% of the victims are women and girls (U.S. Department of State, 2005). As such, they are at increased risk for gynecologic and obstetric problems, including persistent or untreated sexually transmitted infections, unintended pregnancies, repetitive abortions or miscarriages, trauma to the rectum or vagina, and infertility. Further, basic primary health care services are rarely provided to this population. As a result, they often have untreated medical problems, including but not limited to physical injuries associated with abuse and torture (e.g., burns, lacerations, missing or broken teeth), malnutrition, dehydration, substance use disorders, depression, anxiety, and posttraumatic stress disorder (Deshpande & Nour, 2013; Grace, Ahn, & Macias Konstantopoulos, 2014; Richards, 2014).

The Role of the Nurse

One of the most challenging issues associated with human trafficking for nurses and other clinicians is the identification of victims (American College of Obstetricians and Gynecologists, 2011). In a survey of trafficking survivors, 28% came into contact with health care workers during the trafficking situation but were not recognized as victims (Family Violence Prevention Fund, 2005). Victims may not have the language or maturity to disclose their trafficking status and/or may fear what will happen if they do disclose.

Nurses are some of the few professionals who may interact with trafficked women and girls while they are still in captivity (Dovydaitis, 2011); thus, they should be aware of the warning signs

(physical and emotional) associated with trafficking in women and girls. The National Human Trafficking Resources Center (2012) identified a number of these warning signs:

- Presence of cotton or debris in vagina and/or rectum,
- Problems with jaw or neck,
- Inability to keep appointments,
- No identification,
- Tattoos or branding,
- Accompanied by a person who does not allow her to speak or does not want to leave her alone during interview and/or care,
- Inconsistent stories (conflicting stories or misinformation),
- May not speak English, and
- Lack of documentation of age appropriate immunizations and health care encounters.

Interviewing a woman who has been trafficked poses safety concerns for the woman, others close to her, and the interviewer. For this reason, the interview technique must be specific to the situation in order to avoid the potential for causing harm (World Health Organization, 2003). Nurses should be specifically trained about the safety needs of this vulnerable population, including how to phrase conversations, the availability of appropriate resources for immediate and follow-up care, and the various cultural aspects and norms of care. Education should also extend to the implications for anonymity, confidentiality, and informed consent as appropriate, such as in the case of specific traumas.

As part of the educational process, nurses should examine their own perceptions of human trafficking so they do not inadvertently impose those perceptions and leave the individual feeling more victimized and/or criticized. Respect and nonjudgment are key components of the interview and care encounter (International Organization for Migration, 2007). Nurses must also be aware of the range of risks involved for the victim, including immigration violations, labor laws, and other legal implications. Victims may also experience physical harm or death for revealing the situation, and their families may punish or banish them as well (World Health Organization, 2003).

Nurses also support and participate in safety planning for victims and are encouraged to be aware of follow-up resources. Delays or inappropriate referrals can result in harm and/or increased risk for the victim. These resources may include local organizations specializing in working with trafficked women; free health services (general practice, reproductive health, hospital, and mental health); sources of advice on housing and other social services; legal aid/immigration advice services; local churches/community support organizations; language training centers; and nongovernmental organizations in the women's home country (World Health Organization, 2003).

Nurses should be aware of the need to establish boundaries as appropriate to maintain their personal safety. It is not unusual for care providers of victims of abuse (in this case human trafficking) to experience emotional distress themselves; therefore, nurses should be aware of professional resources for debriefing and counseling (International Organization for Migration, 2007). Nurses are uniquely situated as trusted professionals that provide support and empathetic care. The perception of the victim that the nurse can be trusted can facilitate honest communication and a willingness to share the situation.

Recommendations

AWHONN supports research and policy initiatives to improve care and support for victims of human trafficking. Such initiatives may include the following:

- Development of a validated, brief, screening tool to better identify victims of human trafficking in clinical settings.
- Mechanisms to support continuity of care, especially when warning signs of human trafficking are present.
- Advancement of research focused on the long-term health implications for victims of human trafficking.
- Development of educational opportunities in relation to interdisciplinary and multidisciplinary interviews and ongoing care.
- Development of validated lists for legal, health care, mental health, safe housing, and culturally appropriate resources. One such resource is the National Human Trafficking Resource Center, which maintains a crisis hotline.
- Enhancement of multi-sector collaboration and coordination in order to support information sharing.

- Public health campaigns to raise awareness of human trafficking particularly targeted to at-risk populations.
- Support for legislative efforts that seek to penalize traffickers and fund support services for victims.

Nurses should take leadership roles in these initiatives. Improvements in screening, identification, and treatment will ultimately lead to safer, healthier women.

REFERENCES

American College of Obstetricians and Gynecologists. (2011). Human trafficking; Committee opinion no. 507. *Obstetrics & Gynecology, 118*(3), 767–770. http://dx.doi.org/10.1097/AOG.0b013e3182310d06

Deshpande, N. A., & Nour, N. M. (2013). Sex trafficking of women and girls. *Reviews in Obstetrics & Gynecology, 6*(1), e22–e27. http://dx.doi.org/10.3909/riog0214/

Dovydaitis, T. (2011). Human trafficking: The role of the health care provider. *Journal of Midwifery & Women's Health, 55*(5), 462–467. http://dx.doi.org/10.1016/j.jmwh.2009.12.017

Family Violence Prevention Fund. (2005). *Turning pain into power: Trafficking survivors' perspectives on early intervention strategies.* Retrieved from https://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/Turning%20Pain%20intoPower.pdf

Grace, A. M., Ahn, R., & Macias Konstantopoulos, W. (2014). Integrating curricula on human trafficking into medical education and residency training. *JAMA Pediatrics, 168*(9), 793–794. http://dx.doi.org/10.1001/jamapediatrics.2014.999

Greenbaum, V. J. (2014). Commercial sexual exploitation and sex trafficking of children in the United States. *Current Problems in Pediatric and Adolescent Health Care, 44*, 245–269. http://dx.doi.org/10.1016/j.cppeds.2014.07.001

International Organization for Migration. (2007). *The IOM handbook on direct assistance for victims of human trafficking.* Retrieved from https://healtrafficking.files.wordpress.com/2015/03/iom_handbook_assistance.pdf

Institute of Medicine. (2013). *Confronting commercial sexual exploitation and sex trafficking of minors in the United States: A guide for the health care sector.* Retrieved from http://iom.nationalacademies.org/~/media/Files/Resources/SexTrafficking/guideforhealthcaresector.pdf

National Human Trafficking Resource Center. (2012). *Modern day slavery in America: Recognizing and responding to human trafficking in a healthcare context.* Retrieved from https://traffickingresourcecenter.org/resources/recognizing-and-responding-human-trafficking-healthcare-context

National Human Trafficking Resource Center. (n.d.). *The victims.* Retrieved from https://traffickingresourcecenter.org/what-human-trafficking/human-trafficking/victims

Richards, T. A. (2014). Health implications of human trafficking. *Nursing for Women's Health, 18*(2), 155–162. http://dx.doi.org/10.1111/1751-486X.12112

Sabella, D. (2011). The role of the nurse in combating human trafficking. *American Journal of Nursing, 111*(2), 28–37.

U.S. Department of State. (2005). *Trafficking in persons report.* Retrieved from http://www.state.gov/j/tip/rls/tiprpt/2005/46606.htm

World Health Organization. (2003). *WHO ethical and safety recommendations for interviewing trafficked women.* Retrieved from http://www.who.int/mip/2003/other_documents/en/Ethical_Safety-GWH.pdf

Child Abuse & Neglect 44 (2015) 98–105

Contents lists available at ScienceDirect

Child Abuse & Neglect

Research article

Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States☆

Selina Varma[a], Scott Gillespie[b], Courtney McCracken[b], V. Jordan Greenbaum[c,*]

[a] Emory University School of Medicine, Emory Woodruff Memorial Research Building, 1648 Pierce Dr. NE, Atlanta, GA 30322, USA
[b] Emory University School of Medicine, Health Sciences Research Building, 1760 Haygood Dr., Atlanta, GA 30322, USA
[c] Stephanie V. Blank Center for Safe and Healthy Children, Children's Healthcare of Atlanta, 975 Johnson Ferry Rd, NE, Suite 350, Atlanta, GA 30342, USA

ARTICLE INFO

Article history:
Received 3 February 2015
Received in revised form 28 March 2015
Accepted 6 April 2015
Available online 18 April 2015

Keywords:
Child sex trafficking
Commercial sexual exploitation of children
Human trafficking
Child prostitution

ABSTRACT

The objective of the study is to describe distinguishing characteristics of commercial sexual exploitation of children/child sex trafficking victims (CSEC) who present for health care in the pediatric setting.

This is a retrospective study of patients aged 12–18 years who presented to any of three pediatric emergency departments or one child protection clinic, and who were identified as suspected victims of CSEC. The sample was compared with gender and age-matched patients with allegations of child sexual abuse/sexual assault (CSA) without evidence of CSEC on variables related to demographics, medical and reproductive history, high-risk behavior, injury history and exam findings.

There were 84 study participants, 27 in the CSEC group and 57 in the CSA group. Average age was 15.7 years for CSEC patients and 15.2 years for CSA patients; 100% of the CSEC and 94.6% of the CSA patients were female. The two groups significantly differed in 11 evaluated areas with the CSEC patients more likely to have had experiences with violence, substance use, running away from home, and involvement with child protective services and/or law enforcement. CSEC patients also had a longer history of sexual activity.

Adolescent CSEC victims differ from sexual abuse victims without evidence of CSEC in their reproductive history, high risk behavior, involvement with authorities, and history of violence.

Introduction

While the true prevalence of human trafficking is unknown, the International Labour Organization estimates that 20.9 million people are victims of forced labor around the world. This estimate includes victims of labor and sex trafficking. Of this enormous group, approximately 4.5 million people are victims of forced sexual exploitation, including approximately 945,000 children (International Labor Organization, 2012). The Institute of Medicine defines the commercial sexual

Abbreviations: CSA, child sexual abuse/sexual assault; ASA, acute sexual assault; AUC, area under curve; AUROC, area under the receiver operating curve; CSEC, commercial sexual exploitation of children; ED, emergency department; NP, nurse practitioner; STI, sexually transmitted infection.

☆ This study was funded by the Arthur Blank Family Foundation.

* Corresponding author.

http://dx.doi.org/10.1016/j.chiabu.2015.04.004
0145-2134/

exploitation of minors and sex trafficking of minors as "a range of crimes of a sexual nature committed against children and adolescents, including (1) recruiting, enticing, harboring, transporting, providing, obtaining, and/or maintaining (acts that constitute trafficking) a minor for the purpose of sexual exploitation; (2) exploiting a minor through prostitution; (3) exploiting a minor through survival sex (exchanging sex/sexual acts for money or something of value, such as shelter, food or drugs); (4) using a minor in pornography; (5) exploiting a minor through sex tourism, mail order bride trade and early marriage; and (6) exploiting a minor by having her/him perform in sexual venues (e.g., peep shows or strip clubs) (Institute of Medicine and National Research Council, 2013). For the purposes of this report, this definition will be labeled "commercial sexual exploitation of children", or CSEC.

Given the difficulty in identifying victims and those at risk, accurate statistics for incidence and prevalence are not available (Stansky & Finkelhor, 2008). Estes and colleagues suggest that as many as 326,000 U.S. children are *at risk* for CSEC each year (Estes & Weiner, 2002).

There is a lack of quantitative peer-reviewed research regarding risk factors and health consequences of CSEC (Barrows & Finger, 2008; Gozdziak & Bump, 2008; Macy & Graham, 2012). Oram, Stockl, Busza, Howard, and Zimmerman, (2012) conducted a systematic review of published research on the prevalence and risk of violence and health problems among human trafficking victims and found only 19 eligible studies, and these typically combined both women and girls in their samples of sexually exploited victims. Combining study participants of varying age precludes identifying factors specific to children and adolescents. Much of the available data on CSEC is qualitative (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Raphael, Reichert, & Powers, 2010; Raymond & Hughes, 2001), involving interviews of survivors or professionals who work with them. Many studies include victims of different forms of trafficking (Baldwin et al., 2011) (labor and sexual) or victims with very diverse geographic backgrounds (Decker, McCauley, Phuengsamran, Janyam, & Silverman, 2011; Sarka et al., 2008; Silverman et al., 2007). A number of risk factors have been associated with CSEC, although studies documenting these have important limitations. Williamson interviewed 13 female victims and found high rates of abuse prior to exploitation (91%), high rates of parental substance abuse (64%) and frequent runaway behavior (described as 'common' although no percentage given). However, this study had a very small sample size and no comparison group (Williamson & Prior, 2009). There are several studies on homeless and runaway youth in the United States and Canada documenting a high prevalence of survival sex (Walls & Bell, 2011) (Bigelsen & Vuotto, 2013; Chettiar, Shannon, Wood, Zhang, & Kerr, 2010; Greene, Ennett, & Ringwalt, 1999), with surveys reporting a range of 10–50% of youth engaging in exchanging sexual acts for food, lodging, drugs, or money. Walls found a 9.4% prevalence of survival sex among 1,755 homeless youth and young adults. Increased risk was associated with (1) identifying as African-American or 'Other'; (2) identifying as gay, lesbian or bisexual; (3) prior use of inhalants or methamphetamines, (4) history of a suicide attempt and (5) history of parental substance abuse (Walls & Bell, 2011). However, this study and others (Chettiar et al., 2010; Greene et al., 1999) combined adolescents with young adults and included only homeless persons. Studies of CSEC risk factors and other characteristics identified at the time of presentation for health care are lacking.

Risk factors may or may not play a causal role in CSEC, and if they are causal, their role may be direct or indirect. Cochran, Stewart, Ginzler, and Cauce (2002) found that 14% of homeless young people identifying themselves as gay/lesbian/bisexual/transgender (GLBT) left home due to family conflict over their sexual orientation. Homeless and runaway youth have few options for accessing money for food, shelter and other necessities. Homelessness increases the risk of youth engaging in survival sex, especially for those living on the street rather than in shelters (Greene et al., 1999). Sexual abuse has been associated with subsequent CSEC and possible mediating factors include increased risk-taking behavior in victims of childhood sexual abuse, or altered emotional development in abused children that later renders them more vulnerable to CSEC (Stoltz et al., 2007). Substance abuse may increase the risk of CSEC because addicted youth need a constant supply of drugs which may outstrip their ability to secure money. Additionally, drugs and alcohol may decrease inhibitions and impair judgment, which may then lead to risk-taking behavior, or a failure to recognize dangerous situations. Young age renders a youth at risk because of limited life experience and immature brain development that favors risk-taking behavior and impulsivity. The adolescent brain has limited capacity to think critically, weigh the pro's and con's of a situation, and analyze risks. As is clear, only some risk factors are modifiable, but recognition of risk factors is important for prevention and early intervention.

Available information suggests that victims of human trafficking experience significant adverse behavioral and physical health consequences. In a study of health consequences of sex trafficking, Lederer conducted a mixed-methods approach, using qualitative data from focus groups and interviews of 107 female sex trafficking survivors in the United States, and quantitative data from a health survey (Lederer & Wetzel, 2014). They obtained detailed information documenting extensive physical and emotional adverse effects of trafficking, including significant weight loss in 43%, injuries sustained by 70%, signs/symptoms of depression in 89% and of post-traumatic stress disorder in 55%. Eighty-four percent reported substance abuse and 67% reported having an STI during their period of exploitation. However, this study combined adolescent and adult females and the number of participants under age 18 years is not listed. In addition, the study included no comparison group.

Results of the Lederer study indicated that frequently victims of sex trafficking seek medical care. In that study, 88% of victims had visited a medical provider during their period of exploitation (Lederer & Wetzel, 2014). Victims may present with signs/symptoms of a sexually transmitted infection, injuries related to physical or sexual assault, exacerbation of an untreated chronic disease, suicide attempt, drug ingestion, assistance with contraception, abortion or complications of pregnancy (Institute of Medicine and National Research Council, 2013; Lederer & Wetzel, 2014). Over 75% of a sample of

adolescent CSEC victims in New York City reported seeking medical care within the past 6 months (Curtis, Terry, Dank, Dombrowski, & Khan, 2008). The most common reasons for visiting a health care provider included a general check-up (42.6%) testing for sexually transmitted infections (34.1%); and testing for HIV (20.9%).

Due to the frequency of adverse health consequences and the likelihood that victims will seek medical care, health care providers are in a unique position to identify and assist victims of CSEC. The health care professional must learn to recognize high-risk patients, even as fear, shame, distrust of authorities, lack of perception of victim status, and language barriers prevent many patients from disclosing their victimization (Baldwin et al., 2011; Estes & Weiner, 2002; Institute of Medicine and National Research Council, 2013). A number of organizations have published recommendations for screening and victim identification, including the Polaris Project and the US Department of Health and Human Services (Polaris Project, 2012; United States Department of Health and Human Services, 2008). Many of these strategies lack clinical validation and aim to include adults and children, victims of all types of trafficking, and domestic as well as international trafficking (Barrows & Finger, 2008). The VERA Institute developed and validated a tool for use by victim service providers, although most participants in the validation study were adults and foreign-born. The shortened form of the tool still contained 16 questions which imply a relatively lengthy interview. While this may reveal extremely helpful information, its implementation in a busy health care setting may be difficult (Vera Institute of Justice, 2014). The Covenant House of New York developed and validated a screening tool for use in a homeless shelter; their study population included older adolescents and young adults (18–23 years old) (Bigelsen & Vuotto, 2013). The generalizability to younger adolescents presenting to a medical facility is not clear. Currently there is a lack of evidence-based screening tools for specifically identifying sexually exploited domestic minors in a health care setting (Macy & Graham, 2012).

To develop an effective screening tool that identifies youth at high risk for CSEC when they present for medical care, quantitative studies comparing known or suspected victims with a control group of youth are needed in order to identify key differentiating characteristics. The aim of our study was to identify characteristics of CSEC patients that distinguished them from victims of child sexual abuse and sexual assault (CSA) not related to CSEC when seeking medical care at a large metropolitan pediatric facility.

Materials and methods

Study design

This study was approved by the study site's Institutional Review Board. A medical record review was conducted by a senior medical student (SV), who received instruction on chart review methodology and database management, as well as information on the specific study variables, and methods of relevant data retrieval from the electronic medical records. The medical student received oversight by the senior author (JG) and when there were questions or concerns, these were discussed with the senior author and a conservative decision was made regarding data inclusion. The review was conducted of patients identified as "suspected CSEC" who presented to any of three emergency departments or one child protection clinic at a major metropolitan children's hospital in the southern United States. The child protection team keeps a log of patients for whom information obtained from authorities, family, child, medical record or other sources indicates a high likelihood that the patient is a victim of CSEC according to the IOM definition (Institute of Medicine and National Research Council, 2013). For example, law enforcement may bring a child to the emergency department after discovering her during a raid of a known site of prostitution, or a child may disclose to the medical provider during an evaluation of acute sexual assault that the assault occurred in the context of child trafficking. To be included in the 'suspected CSEC' group definite legal confirmation of victimization is not required as this is not always available at the time of the medical visit. The majority of patients in this group were brought to the emergency departments or clinic by law enforcement specifically due to concerns of CSEC. The hospital child protection team is called to the emergency departments to consult on patients in whom CSEC is suspected. Additional patients are seen in the child protection clinic. These patients are entered into the log kept by the child protection team. Patients who come to the hospital but are not seen by the team may be identified during a monthly community multidisciplinary meeting in which CSEC cases are reviewed and discussed. Eligible patients for this study were between 12 and 18 years of age and presented between January 1, 2011 and December 31, 2013.

A control group ("child sexual abuse/sexual assault" (CSA) group) was formed by a search of the hospital database for patients aged 12–18 years with a diagnosis of child sexual abuse (ICD-9 code 995.53) who presented to any of the three emergency departments or one child protection clinic between 2010 and 2013. Patients received this ICD-9 code when they presented with a history of alleged sexual abuse or acute sexual assault, or suspected abuse/assault was discovered during the course of the visit (for example, a child may present with a vaginal discharge and disclose recent assault when answering questions for the medical history). Legal or child protective service confirmation of abuse/assault was not required. Youth who come to the child protection clinic do so for evaluation of suspected abuse and are referred by medical providers, law enforcement or child protective services. Suspected victims who present to the emergency department may be self-referred or brought in by authorities. The vast majority of patients in the control group presented with abuse/assault as their chief complaint. Patients were excluded from this group if there was evidence suggesting commercial sexual exploitation (for example, the child was sexually assaulted by a customer during a commercial sexual transaction).

The CSEC patients were matched with controls based on age at first CSEC exam (±6 months), date of CSEC exam (±1 year), race/ethnicity, and gender. At least two controls were sought for each case. One case only had one matched control, due to the fact that a second control could not be identified within the inclusion criteria. All available controls patients were used from the database.

Data was collected from electronic medical records, including current and prior visits to the institution. Information included demographics, such as age, gender and race/ethnicity. The general demeanor of the child during the medical visit related to CSA or CSEC (index visit) was recorded (cooperative or not), since the child's behavior may reflect the likelihood that they will agree to provide information to the examiner which could help in identifying risk. Variables associated with possible risk factors for CSEC were evaluated, including prior history of mental health disorders as reported by the patient or other source (including but not limited to, depression, bipolar disorder, attention deficit hyperactivity disorder, schizophrenia), history of acute sexual assault prior to the index visit, history of CSEC activity as defined by IOM, history of violence at the hands of caregivers (physical abuse), any history of use of alcohol or drugs, either during events leading to the index visit, or before this time. Information regarding recent and remote episodes of running away from home was documented, as was known involvement of the child's family by child protective services (excluding public benefits) or prior history of child involvement with law enforcement and the judicial system. As complications of CSEC activity may alert health care providers to the possibility of victimization, variables associated with adverse effects of CSEC were evaluated. Information was obtained related to current anogenital complaints at the time of the index visit as these may reflect a sexually transmitted infection (STI). Information was extracted related to any prior history of STIs or pregnancy, and current or prior history of menstrual problems, such as excessive pain, or excessive/prolonged bleeding. Data was extracted related to prior history of sexual violence (for example, forcible restraint, penetration with foreign object), or prior history of major physical trauma (bony fractures, wounds requiring sutures, traumatic loss of consciousness). The sexual violence and physical trauma may reflect prior abuse (risk factor for CSEC) or violence occurring during the victimization period. To identify high-risk behaviors that may lend themselves to anticipatory guidance by health care providers, information was sought regarding frequency of condom use during prior sexual encounters and prior or current use of contraception. To determine if youth had sought medical care during victimization or in the recent past (when they were likely at very high risk of CSEC), information was sought related to recent contact with health care providers (within the past 2 months of index visit).

Existing data did not allow determination of whether some events included in these variables occurred prior to any CSEC activity, or during the period of exploitation. For example, when a patient is asked how often she uses condoms, her reply of, 'rarely' may apply to the sexual encounters she had prior to exploitation, to those she had while being victimized, or to both.

Data analysis

Statistical significance was evaluated at the 0.05 level, and data analyses were performed using SAS 9.3 (Cary, NC). Descriptive characteristics were evaluated overall and by sexual exploitation status (CSEC vs. CSA) using means and standard deviations for continuous variables and frequencies and percents in discrete cases. In circumstances of non-normality, means and standard deviations were replaced with medians and interquartile ranges (IQR). CSEC and CSA patients were age and gender-matched in a 1:2 ratio to reduce potentially confounding effects and selection bias, with CSA patients identified from the aforementioned hospital database. Differences between sexual exploitation groups were assessed using t-tests for continuous variables and Chi-square tests of independence in discrete cases. In situations of non-normality, the *t*-test was replaced by a non-parametric equivalent (Mann–Whitney *U* or Kolmogorov–Smirnov test); likewise, an exact form of the Pearson's Chi-square test was implemented when expected frequency counts were low (<5).

Results

The sample was comprised of 84 patients of whom 27 were CSEC victims and 57 were CSA victims. The average age of CSEC patients was 15.7 years compared to 15.2 years for CSA patients. Among the CSEC victims, over half (56%) were African American and 30% were white. A majority (89%) identified as non-Hispanic. The CSA group was similar in that over half (53%) were African American, 32% were white, and 84% identified as non-Hispanic. Only three males were included in the sample, all of whom were part of the CSA group. There were no significant demographic differences between the two groups. Demographic characteristics are summarized in Table 1.

Complete information was not available for every patient. The variable was coded as missing (N/A) if its presence or absence was not specifically documented. Considering only the variables for which at least 50 patients had data, the following were significantly more common in the CSEC group than in the CSA group: how long the patient had been sexually active prior to the index visit ($p = 0.001$), frequency of condom use ($p = 0.010$), prior history of STI ($p < 0.001$), use of contraception other than condoms ($p < 0.001$), history of violence by parents/caregivers ($p = 0.001$), history of violence with sexual activity ($p = 0.012$), drug/alcohol use ($p < 0.001$), multiple drug use ($p < 0.001$), history of running away from home ($p < 0.001$), history of child protective services involvement ($p = 0.003$), and history of law enforcement involvement ($p < 0.001$). There were no statistical differences in history of pregnancy, menstrual problems, history of mental health disorders, prior sexual abuse, or commercial sexual exploitation.

Table 1
Characteristics of CSEC[1] and CSA[2] groups: demographics, medical history, current anogenital symptoms, sexual history and other history.

Characteristic	Level	CSEC/CST(total $N=27$)[3]	CSA/SA(total $N=57$)[3]	p-Value
Demographics, *N* (%)				
Gender ($N=83$)	Female	27(100%)	53(94.6%)	0.548
	Male	0(0%)	3(5.4%)	
Race ($N=84$)	White	8(29.6%)	18(31.6%)	0.969
	African American	15(55.6%)	30(52.6%)	
	Other	4(14.8%)	9(15.8%)	
Ethnicity ($N=84$)	Hispanic	3(11.1%)	9(15.8%)	0.743
	Non-Hispanic	24(88.9%)	48(84.2%)	
Age (years), mean (SD)	–	15.7 (1.5)	15.2 (1.4)	0.128
Demeanor of child, *N* (%)				
Cooperative ($N=78$)	Yes	24(96%)	53(100%)	0.321
Medical history, *N* (%)				
Mental health disorder ($N=81$)	Yes	10(38.5%)	25(45.5%)	0.553
Health visit with last 2 months ($N=27$)	Yes	6(42.9%)	6(46.2%)	0.863
History of CSEC or ASA[4] ($N=79$)	Yes	10(40.0%)	19(35.2%)	0.680
Current anogenital symptoms, *N* (%)				
Vaginal discharge ($N=84$)	Yes	8(29.6%)	11(19.3%)	0.291
Genital pain ($N=84$)	Yes	1(3.7%)	7(12.3%)	0.427
Itching ($N=84$)	Yes	2(7.4%)	5(8.8%)	1.000
Abnormal bleeding ($N=84$)	Yes	1(3.7%)	4(7.0%)	1.000
Pelvic pain ($N=84$)	Yes	1(3.7%)	0(0%)	0.321
Rectal pain ($N=84$)	Yes	1(3.7%)	0(0%)	0.321
Sexual history, *N* (%)				
How long sexually active ($N=28$)	Never	3(33.3%)	18(94.7%)	0.001
	<1 Year	3(33.3%)	1(5.3%)	
	≥1 Year	3(33.3%)	0(0%)	
Frequency of condom use ($N=19$)	Never	5(50.0%)	0(0%)	0.010
	Rarely	2(20.0%)	5(55.6%)	
	Sometimes	0(0%)	3(33.3%)	
	Often/always	3(30.0%)	1(11.1%)	
History of STI[5] ($N=59$)	Yes	10(52.6%)	3(7.5%)	<0.001
Pregnancy ($N=61$)	Yes	2(10.5%)	1(2.4)	0.227
Birth control use ($N=57$)	Yes	5(35.7%)	0(0%)	<0.001
Menstrual problems ($N=69$)	Yes	3(15.0%)	1(2.0%)	0.070
Other history, *N* (%)				
History of violence with caregivers ($N=66$)	Yes	7(43.8%)	3(6.0%)	0.001
History of fractures, LOC[6], wounds ($N=17$)	Yes	2(40.0%)	7(58.3%)	0.620
History of violence with sex ($N=66$)	Yes	4(30.8%)	2(3.8%)	0.012
History drug use ($N=75$)	Yes	16(69.6%)	10(19.2%)	<0.001
History of multiple drug use ($N=72$)	Yes	10(50.0%)	3(5.8%)	<0.001
History of running away ($N=83$)	Yes	21(80.8%)	7(12.3%)	<0.001
CPS[7] history ($N=74$)	Yes	9(47.4%)	7(12.7%)	0.003
History with police ($N=50$)	Yes	12(75.0%)	4(11.8%)	<0.001

[1] CSEC, commercial sexual exploitation of children/child sex trafficking.
[2] CSA, child sexual abuse/sexual assault.
[3] Data not available for all patients for all questions.
[4] ASA: acute sexual assault.
[5] STI, sexually transmitted infection.
[6] LOC: loss of consciousness.
[7] CPS: child protective services.

Discussion

Children are inherently more vulnerable than adults to exploitation and are susceptible to deception and manipulation given their limited life experience, and their tendency toward risk-taking behavior and impulsivity. Studies focusing specifically on child commercial sexual exploitation and sex trafficking in the United States are very limited (Gozdziak & Bump, 2008; Institute of Medicine and National Research Council, 2013). Many combine adolescents and young adults in their study sample, lack a comparison group, and/or focus on a restricted population, such as homeless drug-using youth (Bigelsen & Vuotto, 2013; Chettiar et al., 2010; Cochran et al., 2002). Studies focusing specifically on CSEC youth who present for medical care are lacking. Studies that compare CSEC youth with other high-risk youth are lacking. This dearth of information makes development of an effective CSEC screening tool for health care settings very difficult. The current study attempted to address these issues. Specifically, it targeted victimized youth who presented to one of three emergency departments

or one child protection clinic at a large pediatric facility in the southern United States. It relied on information that was available to medical providers. This is important, as the environment of the emergency department typically precludes very prolonged contact with youth and does not involve repeated contact over time, during which a relationship of trust may be built. Similarly, children and youth referred to a child protection clinic typically attend for one or two visits only. Thus one cannot assume that information available to other professionals operating in different settings may be available to a health care provider. Nonetheless, the study revealed that important historical information related to reproductive history, high-risk behavior, prior violence and contact with medical providers was available and that CSEC youth reported high rates on many variables.

The current study varied from others in that it used a comparison group of age-matched sexually abused/assaulted adolescents to compare with suspected CSEC youth, and it excluded adult patients. In this well-defined group of domestic child sex trafficking/sexual exploitation victims, there were high rates of prior STIs (53%); physical abuse (44%); history of violence with sex (31%), drug/alcohol use (70%), multiple drug use (50%), history of running away from home (81%), prior involvement with child protective services (47%) and with law enforcement (75%). All of these variables were significantly more common among CSEC patients than among the group of sexually abused/assaulted adolescents. While the degree to which the above events and conditions occurred prior to, versus during, CSEC victimization is unknown, the fact that the patients differed significantly on variables that were identifiable at the time of the medical visit is potentially very helpful to the health care provider and suggests that these same variables may be useful in identifying high risk patients. If a clinician asks specific questions about high-risk behavior, past violence and abuse, and sexual history they may uncover CSEC, and if not, they may still receive valuable information to guide them in making appropriate referrals, and providing critical anticipatory guidance and patient education.

There was no statistically significant difference between the groups in prior history of mental health disorders, although it should be noted that the CSEC group had a relatively high rate of 39%. Small sample size and use of a relatively high risk group as a comparison may help explain the lack of significant differences between the groups on this variable. A child suffering from untreated bipolar disorder, schizophrenia, oppositional defiant or other mental health disorder may be at risk for manipulation by traffickers, sexual abusers and other exploiters due to impaired judgment, altered mental status or impulsivity.

Notably, 46% of CSEC victims in the current study had been to a medical provider within the past 2 months. This is consistent with prior studies documenting that 88% of adult and adolescent trafficking survivors sought medical care during their period of exploitation (Lederer & Wetzel, 2014) and more than 75% of CSEC youth had contact with health care providers within the past 6 months (Curtis et al., 2008). While the data in the current study does not allow determination of whether the visits occurred during the period of exploitation, it is likely that the youth were at least at very high risk for exploitation at the time of their visits. If the medical providers treating them were aware of the increased incidence of the several characteristics identified in this study they may have asked related questions of the adolescents that led to consideration of possible commercial sexual exploitation. Whether or not the child was actively being victimized at the time of that visit, anticipatory guidance on topics such as condom use, STIs, other forms of contraception, and/or safety tips when living on the streets may have benefited the youth. Anticipatory guidance on CSEC prevention may have altered the youth's outcome.

This study provides quantitative data to suggest reproductive, behavioral, and historical features that distinguish CSEC victims from youth experiencing child sexual abuse/sexual assault. While both of these populations have experienced significant trauma, these results suggest significant differences between the two groups. Further research is needed to explore these differences. For example, there may be variations between the populations in conditions under which drugs/alcohol are used (self-medication, social events, response to peer pressure), how frequently they are used, and how they are obtained. While results did not show a significant difference in the incidence of recent health visits between the groups, there may be difference in the reasons for seeking health care, or the places where health care was sought.

Additional research is need to differentiate significant events/conditions that occurred prior to exploitation from those that occurred during the period of exploitation, as this will help determine risk factors to aid in prevention efforts. Identification of risk factors may prompt health care providers to engage in specific anticipatory guidance or CSEC prevention discussions that could lead to important changes in a youth's life.

Future research is needed to use variables identified in this study to develop and validate a screening tool that will identify CSEC victims and those at high risk of CSEC in the medical setting. Such a tool may take the form of a brief set of written questions that a patient completes prior to the exam. The provider may review the answers and follow up positive responses with additional questions. Or, the screening questions may be incorporated into the routine questions used for obtaining a medical history. Key to the success of a tool is choosing variables that are easily identified in children and youth presenting in a variety of medical settings beyond the emergency department and child protection clinic. Future research may also use alternative comparison groups (for example, non-CSEC youth presenting to an urban teen clinic), which may provide information useful to medical professionals working with very specific populations. Ultimately, it will be desirable to compare CSEC victims with adolescents in the general population, as the screening tool validated under these conditions will be the most widely applicable. The results of the current study provide important initial information to guide future study design.

Limitations

This study has a number of limitations. The sample size is small. Victims of CSEC are very difficult to identify due to the numerous factors inhibiting disclosure of exploitation. In addition, local law enforcement has only recently received general training on CSEC so that victim identification by officers is only slowly increasing and they are an important source of patients. This reliance on law enforcement referrals highlights another limitation. There may well be a large population of CSEC victims who do not come to the attention of law enforcement for runaway behavior, minor offences or other reasons. If they do not self-identify and are not referred to the study's medical facility by others, they would not be included in the CSEC group. Their characteristics may or may not be similar to those identified in the current study population. Thus, findings cannot be generalized to the total CSEC population.

Although the study involved patients presenting to three emergency departments and one child protection clinic, the sites are all part of a single institution, a pediatric facility within a large city in the southern United States. Generalizations cannot be made to other medical settings, to rural communities or to other urban centers in the United States or elsewhere. There were no boys or international victims in the CSEC group. Boys are often underrepresented in studies related to sexual exploitation, and are often viewed as offenders instead of victims (Dennis, 2008; ECPAT USA, 2013). Thus the lack of male patients in the CSEC group in the current study is not surprising. The lack of international CSEC victims in the study may be due to a number of factors. It is possible that providers in the emergency department failed to identify international victims due to difficulties with language barriers, time constraints, or simply a lack of awareness. It is also possible that international victims are not seeking care at pediatric health care facilities.

Legal confirmation of sexual abuse/assault or commercial sexual exploitation was not required for this study. It is possible that some patients in the control group were not actually abused/assaulted or that they had been involved in CSEC activity but did not disclose. In the latter situation this would tend to minimize the differences between the two groups, and thus our results may be viewed as conservative. It is also possible that youth in the CSEC group had not been commercially sexually exploited. However, to be included in the group there had to be evidence in the medical record that made exploitation highly likely. When there was doubt about victim status, the patient was excluded from the group.

Given that this was a retrospective cross-sectional study, no assumptions can be made as to causal factors. In some of the cases there was limited data available in the medical record, although in general the social worker notes were invaluable sources of historical data. Finally, the control group does not consist of the general adolescent population and further research is necessary to determine the differences between CSEC victims and that much larger group.

Conclusions

This study demonstrates that female youth aged 12–18 years who are suspected victims of CSEC significantly vary from victims of alleged sexual abuse/sexual assault on a number of reproductive, behavioral, and historical factors. This comparative study provides quantitative support for the existence of multiple identifiable characteristics that may be useful in design of a screening tool for victims of commercial sexual exploitation.

References

Baldwin, S., Eisenman, D., Sayles, J., Ryan, G., & Chuang, K. (2011). Identification of human trafficking victims in health care settings. *Health Human Rights*,. Accessed at ⟨http://www.hhrjournal.org/2013/08/20/identification-of-human-trafficking-victims-in-health-care-setting/⟩ (on Sept 21, 2013).

Barrows, J., & Finger, R. (2008). Human trafficking and the healthcare professional. *Southern Medical Journal*, *101*(5), 521–524. http://dx.doi.org/10.1097/SMJ.0b013e31816c017d

Bigelsen, J., & Vuotto, S. (2013). *Homelessness, survival sex and human trafficking: As experienced by the youth of Covenant House New York. 2013*. Available at ⟨http://www.covenanthouse.org/sites/default/files/attachments/Covenant-House-trafficking-study.pdf⟩ (accessed on Nov 30, 2014).

Chettiar, J., Shannon, K., Wood, E., Zhang, R., & Kerr, T. (2010). Survival sex work involvement amnog street-involved youth who use drugs in a Canadian setting. *Journal of Public Health*, *32*, 322–327.

Cochran, B. N., Stewart, A. J., Ginzler, J. A., & Cauce, A. M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health*, *92*(5), 773–777.

Curtis, R., Terry, K., Dank, M., Dombrowski, K., & Khan, B. (2008). *The commercial sexual exploitation of children in New York City: Volume 1: The CSEC population in New York City: Size, characteristics and needs*. New York: US Department of Justice, National Institute of Justice.

Decker, M., McCauley, H., Phuengsamran, D., Janyam, S., & Silverman, J. (2011). Sex trafficking, sexual risk, sexually transmitted infection and reproductive health among female sex workers in Thailand. *Journal of Epidemiology & Community Health*, *65*(4), 334–339.

Dennis, J. (2008). Women are victims, men make choices: The invisiblity of men and boys in the global sex trade. *Gender Issues*, *25*, 11–25.

ECPAT USA. (2013). *ECPAT USA. And Boys Too: An ECPAT-USA discussion paper about the lack of recognition of the commercial sexual exploitation of boys in the United States*. ECPAT USA. Available at ⟨http://ecpatusa.org/wp/wp-content/uploads/2013/08/AndBoysToo_FINAL_single-pages.pdf⟩ (accessed on Nov 10, 2013).

Estes, R. J., & Weiner, N. A. (2002). *The commercial sexual exploitation of children in the U.S., Canada and Mexico. 2002*. Center for the Study of Youth Policy, University of Pennsylvania. Available at ⟨http://www.sp2.upenn.edu/restes/CSEC_Files/Complete_CSEC_020220.pdf⟩ (accessed on 7/7/12).

Gozdziak, E., & Bump, M. (2008). *Data and research on human trafficking: Bibliography of research-based literature*. Washington, DC: Institute for the Study of International Migration, Walsh School of Foreign Service, Georgetown University.

Greene, J. M., Ennett, S. T., & Ringwalt, C. L. (1999). Prevalence and correlates of survival sex among runaway and homeless youth. *American Journal of Public Health*, *89*(9), 1406–1409.

Institute of Medicine and National Research Council. (2013). *Confronting commercial sexual exploitation and sex trafficking of minors in the United States*. Washington, DC: The National Academies Press.

International Labor Organization. (2012). *Global estimate of forced labour: Executive summary*. Available at: ⟨http://www.ilo.org/wcmsp5/groups/public/—ed_norm/—declaration/documents/publication/wcms_181953.pdf⟩ (accessed Dec 23, 2014).

Lederer, L., & Wetzel, C. (2014). The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *Annals of Health Law*, *23*, 61–91.
Macy, R. J., & Graham, L. M. (2012). Identifying domestic and international sex-trafficking victims during human service provision. *Trauma, Violence, & Abuse*, *13*(2), 59–76. http://dx.doi.org/10.1177/1524838012440340
Oram, S., Stockl, H., Busza, J., Howard, L. M., & Zimmerman, C. (2012). Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human trafficking: A systematic review. *PLoS Medicine*, *9*(5), e1001224.
Polaris Project. (2012). *Polaris Project Recognizing the signs*. Accessed from ⟨http://www.polarisproject.org/human-trafficking/recognizing-the-signs⟩ on July 7, 2012.
Raphael, J., Reichert, J., & Powers, M. (2010). Pimp control and violence: Domestic sex trafficking of Chicago women and girls. *Women & Criminal Justice*, *20*, 89–104.
Raymond, J., & Hughes, D. (2001). *Sex trafficking of women in the United States: International and domestic trends*. Coalition Against Trafficking in Women. Available at ⟨http://www.uri.edu/artsci/wms/hughes/sex_traff_us.pdf⟩ (accessed on Aug 4, 2012).
Sarka, K., Bal, B., Mukherjee, R., Chakraborty, S., Saha, S., Ghosh, A., & Parsons, S. (2008). Sex-trafficking, violence, negotiating skill and HIV infection in brothel-based sex workers of Eastern India, adjoining Nepal, Bhutan and Bangladesh. *Journal of Health, Population and Nutrition*, *26*(2), 223–231.
Silverman, J., Decker, M., Gupta, J., Maheshwari, A., Willis, B., & Raj, A. (2007). HIV prevalence and predictors of infection in sex-trafficked Nepalese girls and women. *The Journal of the American Medical Association*, *298*(5), 536–542.
Stansky, M., & Finkelhor, D. (2008). *How many juveniles are involved in prostitution in the U.S.?* Accessed at ⟨http://www.unh.edu/ccrc/prostitution/Juvenile_Prostitution_factsheet.pdf⟩ (on 7/7/13).
Stoltz, J. M., Shannon, K., Kerr, T., Zhang, R., Montaner, J. J. S., & Wood, E. (2007). Associations between childhood maltreatment and sex work in a cohort of drug-using youth. *Social Science & Medicine*, *65*(6), 1214–1221.
United States Department of Health and Human Services. (2008). *Resources: Screening tools for victims of human trafficking*. Washington, D.C.: United States Department of Health and Human Services. Accessed from ⟨http://www.acf.hhs.gov/trafficking/campaign_kits/tool_kit_social/screen_questions.html⟩ on June 12, 2012.
Vera Institute of Justice. (2014). *Screening for Human Trafficking: Guidelines for administering the trafficking victim identification tool*. New York, NY: Vera Institute of Justice. ⟨www.vera.org⟩.
Walls, N., & Bell, S. (2011). Correlates of engaging in survival sex among homeless youth and young adults. *Journal of Sex Research*, *48*, 423–436.
Williamson, C., & Prior, M. (2009). Domestic minor sex trafficking: A network of underground players in the midwest. *Journal of Child & Adolescent Trauma*, *2*, 1–16.

New Joint Commission advisory on identifying human trafficking victims in health care

Safety actions for health care professionals to consider to keep victims safe

June 19, 2018

By: **Katie Looze Bronk**, Corporate Communications

(OAKBROOK TERRACE, Illinois – June 19, 2018) – Human trafficking is the fastest growing criminal industry in the world and the second-largest source of income for organized crime.[1] Knowing how to identify victims, when to involve law enforcement, and what community resources are available is important information for all health care professionals to know—and is the focus of a new *Quick Safety* advisory from The Joint Commission.

Human trafficking is modern-day slavery and a public health issue that impacts individuals, families and communities. The alert provides health care professionals with tips to recognize the signs of human trafficking, including a patient's poor mental and physical health, abnormal behavior, and inability to speak for himself/herself due to a third party insisting on being present and/or interpreting.

The alert encourages medical providers to provide trafficking victims with information and options, while supporting them through the process of connecting with service providers, if they are ready to report their situation. It also provides the following actions to help support and keep victims safe:

- In situations of immediate, life-threatening danger, follow institutional policies for reporting to law enforcement.
- Provide the patient with the National Human Trafficking Resource Center (NHTRC) hotline number. If the patient feels it is dangerous to have the number, help him/her memorize it.
- Provide the patient with options for services, reporting and resources. Ensure that safety planning is included in the discharge planning process.
- If a patient is a minor, follow mandatory state reporting laws and institutional policies for child abuse or serving unaccompanied youth.
- Accurately document the patient's injuries and treatment in the patient's records.
- Gain permission and consent from adult patients who have been trafficked before disclosing any personal information about the patient to others, including service providers.
- Utilize social workers as they can be instrumental in getting the support and resources patients need.

Resources from the National Human Trafficking Hotline, NHTRC, United Nations Office on Drugs & Crime, U.S. Department of Health & Human Services and others are highlighted in the advisory.

The *Quick Safety* is available on The Joint Commission website. It may be reproduced if credited to The Joint Commission.

[1]Isaac R, et al. Health care providers' training needs related to human trafficking: Maximizing the opportunity to effectively screen and intervene. *Journal of Applied Research on Children: Informing Policy for Children at Risk*, Human Trafficking, 2011; Vol. 2: Issue 1, Article 8.

###

The Joint Commission
Founded in 1951, The Joint Commission seeks to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. The Joint Commission accredits and certifies more than 21,000 health care organizations and programs in the United States. An independent, nonprofit organization, The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care. Learn more about The Joint Commission at www.jointcommission.org.

American Academy of Nursing on Policy, Council for the Advancement of Nursing Sciences

Policy brief on the nursing response to human trafficking

Patricia M. Speck, DNSc, APN, APRN, FNP-BC, DF-IAFN, FAAFS, FAFN, FAAN[a,*], *Stacey A. Mitchell, DNP, MBA, RN, SANE-A, SANE-P, FAFN, FAAN*[b], *Rachell A. Ekroos, PhD, APRN-BC, AFN-BC, DF-IAFN, FAAN*[c], *Rosario V. Sanchez, MSN, CCRN, SANE-A*[d], *DeAnne K. Hilfinger Messias, PhD, RN, FAAN*[e]

[a] *Department of Family, Community, & Health Systems, The University of Alabama at Birmingham School of Nursing, 1720 Second Avenue South, Birmingham, AL 35294-1210*

[b] *College of Nursing, Texas A&M University, Mail Stop 1359, 8447 Riverside Parkway, Bryan, TX 77807-3260*

[c] *School of Nursing, Affiliate Faculty, Center for Biobehavioral Interdisciplinary Science, University of Nevada, Las Vegas, 4505 S Maryland Pkwy, Las Vegas, NV 89154*

[d] *School of Nursing, Rutgers University, 195 University Ave, Newark, NJ 07102*

[e] *College of Nursing and Women's and Gender Studies, University of South Carolina, 1601 Greene Street, Columbia, SC 29208*

Executive Summary

Human trafficking is a public health emergency affecting an estimated 12 to 30 million people globally. Given that 85% of trafficked victims have contact with health care providers in any year, nurses are critical to: the identification of trafficked persons; effective promotion of their physical, mental, and cognitive health; development and implementation of practice guidelines; implementation of research to inform bestpractices globally; and championing public policy initiatives at local, state, and national levels.

Background

Human trafficking is a public health emergency (Krug etal., 2002; United Nations Office on Drugs and Crime, 2015) affecting an estimated 12 to 30 million people globally and is part of a $32 billion illicit business enterprise (Meinert, 2012; U.S. Department of State, 2014). The United Nations defines human trafficking as "the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception…" (United Nations, 2000) (Article 3) with the primary purpose of exploitation for labor or sex.

The expanded definition adopted by the National Institute of Justice (NIJ), consists of the following four elements:

(1) adult or child participates in commercialized sex, labor, organ procurement, or war, where induction for the adult (not necessary for child) is by force, fraud, or coercion;
(2) recruitment processes involve obtaining persons through lure, ploy, harboring, capture, smuggling, and/or kidnap for recruitment;
(3) procurement of services through force, coercion and/or fraud, involuntary servitude, peonage, debt bondage, identity theft, slavery; and
(4) transport locally, regionally, nationally, and/or transnationally (National Human Trafficking Resource Center 2014; National Institute of Justice, 2014).

However, human trafficking is often defined very broadly, with documented reports of 25 different types of human trafficking (Anthony et al., 2017). There are no positive health outcomes from human trafficking (Anda et al., 2006; Anda et al., 2009; Gillies et al., 2016; Kiss et al., 2015; U.S. Department of State, 2016; Zimmerman, Hossain, & Watts, 2011), particularly for the children trafficked. The individual outcomes are costly to society-at-large, mainly within the health care and justice systems, with trafficking experiences resulting in poor immediate, intermediate, and long-term

* Corresponding author: Patricia M. Speck, Department of Family, Community, & Health Systems, The University of Alabama at Birmingham School of Nursing, 1720 Second Avenue South, Birmingham, AL 35294-1210.
E-mail address: pmspeck@uab.edu (P.M. Speck).

https://doi.org/10.1016/j.outlook.2018.06.004

health outcomes (Anda et al., 2009; Argentieri et al., 2017; McEwen, 1998; Oram et al., 2012).

Despite difficulties in measuring the prevalence and incidence of human trafficking, it is clear that human trafficking is recognized as a public health emergency (Clawson & Dutch, 2008; Dovydaitis, 2010; Edmonson et al., 2017; U.S. Department of Health and Human Services, 2017). All states have legislation protecting children from trafficking (National Conference of State Legislatures, 2016), however not all states provide protection for sex-trafficked adolescents arrested for prostitution (Adelson, 2008). Coupled with the lack of recognition of the trafficked person, health care systems for adolescents seeking sexual health care have no mandate to report child sexual abuse because traffickers are not a parent, guardian, or caretaker (New York Civil Liberties Union, 2017).

Given the inconsistencies between and across federal and state legislation and regulations, health care professionals often are unaware of, or question, which protections apply in their practice areas: state legislation (i.e., child abuse reporting), federal regulations regarding Title X reproductive rights (i.e., confidentiality, emancipation, HIPAA) *or* federal human trafficking statutes (i.e., sex slavery) (Adelson, 2008; Price, 2017). The inconsistency in health care policy, procedure, practice, and state and federal regulation results in 87% of trafficked persons having contact with health care providers without recognition or rescue while being trafficked (Lederer & Wetzel, 2014).

National and Global Policy Responses and Options

National Legislative Action

Examples of national legislative initiatives include the Trafficking Victims Protection Reauthorization Act[s] (2013) (Polaris, 2017), which involved passage of an amendment in 2013 to the *Violence Against Women Act* (1994) regarding susceptible people at risk for human trafficking in disasters and emergencies, and prevention of child marriage. This legislation also created structure in *the National Defense Authorization Act* (2013) to prevent the use of business contracts when engaging in human trafficking practices (Polaris, 2017).

The *Fight Online Sex Trafficking Act* (H.R. 1865, 115 Cong. (2017-18)) was signed into law April 11, 2018, allowing investigation and prosecution of websites facilitating sex-trafficking;providing civil remedies for the children sex-traffickedon websites; and removing legislative protections for internet sites (Fonrouge, 2018).

Other recent legislative initiatives include H.R.767 (115th Congress, 2017-2018) that introduced *Stop, Observe, Ask, and Respond (SOAR)* and *Health and Wellness Act of 2017,* establishing programs, training, and best practice processes. As of April 2018, the current bill is under consideration by the Senate Committee on Health, Education, Labor, and Pensions (Cohen, 2017).

Global Organizations and Regulations

Nations around the globe report the impact of human trafficking (U.S. Department of State, 2016) and are engaged in activities to combat this complex issue that respects no borders. The United Nations General Assembly resolution on Transnational Organized Crime resulted in one toolkit and one protocol (King, 2008); a toolkit designed to assist those fighting transnational organized crime of firearms and human trafficking (United Nations, 2000); and a protocol to penalize traffickers while preventing and suppressing trafficking of women and children, and granting temporary or permanent residence to victims in destination countries (Polaris, 2017).

The number and types of transnational organizations that recognize, identify, rescue or facilitate elopement, and provide wrap-around services for traffickedpersons are increasing (U.S. Department of Justice Office for Victims of Crime, 2014; United Nations Office on Drugs and Crime, 2016). Some examples include: *Polaris, Heal Trafficking, Prajwila, Stop the Traffik, Children's Organization of Southeast Asia, Urban Light, Empower Foundation, Catholic Relief Services, Red Carpet Project, Not For Sale, GoodWeave, and A21.*

Responses from Professional Organizations

- In 2008, 2010, and again in 2016, the *American Nurses Association* highlighted human trafficking as a public health and human rights crisis (American Nurses Association, 2008; American Nurses Association, 2010; ANA Center for Ethics and Human Rights, 2016), aiming to ensure nurses have skill sets properly identifying and referring victims of human trafficking, and to advocate and support protection and prosecution legislation.
- In 2014, *Vera Institute of Justice* completed research and published *Trafficking Victim Identification Tool* (Simich et al., 2014) and *Toolkit to Combat Trafficking in Persons: Global Programme against Trafficking in Human Beings* (United Nations Office on Drugs and Crime, 2006; United Nations Office on Drugs and Crime, 2018). Although these toolkits address the complexity of a comprehensive and coordinated community response to combating human trafficking, still lacking are examples of the implementation of well-developed health care responses (Barrows & Finger, 2008; Dovydaitis, 2010; Isaac, Solak, & Giardino, 2011).
- In 2015, the *American Public Health Association* published *Expanding and Coordinating Human Trafficking-Related Public Health Research, Evaluation, Education, and Prevention* (American Public Health Association, 2015). This policy statement advocates for the promotion of quality curricula, provision of guidance supporting survivor-centered and trauma informed care, and

recommends specific actions to disseminate knowledge through societies, funding, and certification bodies.
- In 2016, the *Association of Women's Health, Obstetric, and Neonatal Nursing* adopted policy (Association of Women's Health Obstetric and Neontal Nurses, 2016), and published *Human Trafficking* to promote and enhance nurses' engagement in screening, familiarity with mandatory reporting, and efforts supporting human trafficking victims (Association of Women's Health Obstetric and Neontal Nurses, 2016).
- In 2017, the *National Association of Pediatric Nurse Practitioners* provided support with a human trafficking web page (National Association of Pediatric Nurse Practitioners, 2017) and annual meeting promotion of awareness.
- In 2017, the *Nurse Practitioners in Women's Health* adopted policy recommending safety planning with community partnerships and developing evidence-based interventions (Nurse Practitioners in Women's Health, 2017).
- In 2017, the Emergency Nurses Association (ENA) published a resource web page (Emergency Nurses Association, 2017), including *ENA Connection* and *Human Trafficking: What Emergency Nurses Need to Know*.

The Academy's Position

The American Academy of Nursing (Academy) supports the promotion of health and safety in persons affected by human trafficking through closure of gaps in macro and micro systems of nursing education, reflective ethics, practice improvement, systems leadership, and ongoing research related to improvement of cognitive, physical, mental, social and spiritual health outcomes.

The Academy advocates for the inclusion of Forensic Nurse experts with advanced nursing practice preparation for leadership appointments in federal and state government workgroups and national, state, and local organizations; for service on interprofessional teams; as leaders and team members in coordinated community responses to human trafficking victims; as advisors to government officials of practice area gaps; as subject matter experts serving on interprofessional community organization boards; as champions for raising awareness for screening in all nurse practice settings; as advancd nurse expert clinicians designing and implementing best practices; and as contributors to planning interventions with community partners that encompass immediate and long-term needs and health of the person trafficked.

The Academy supports routine screenings for violence against persons in all nurse practice settings, particularly for child maltreatment, including persons victimized through human trafficking by intimates and family members (Amar et al., 2013). The Academy also supports interventions that promote healthy growth and development, particularly of children exposed to the toxic stress (Gross etal., 2016) of human trafficking.

The Academy advocates for the integration of forensic nursing content into all nursing practice guidelines by educational and practice organizations and institutions, such as emergency and primary health care settings (specifically to provide skilled forensic nursing care in response to the particular needs of human trafficking victims), and where advanced forensic nursing experts influence policy for populations at primary, secondary, and tertiary care levels, in institutions and organizations globally, and where nursing care of patients intersects with legal systems (American Nurses Association, 2009; Edmonson et al., 2017; Speck & Peters, 1999).

Recommendations

- Promote:
  - The inclusion of advanced forensic nurses with expertise in human trafficking as members of private business boards; commercial bank boards; not-for-profit service organizations; and, government and other organization task forces, advisory boards, and technical working groups, specifically to influence health care policy, advocacy activities, and legislation related to human trafficking and to promote justice for victims of human trafficking.
  - Faculty-led scholarship indexed in the Sigma Theta Tau International Virginia Henderson Repository to chronicle the intersection of nursing with human trafficking victims through qualitative, quantitative, and mixed methods research.
  - Awareness and education of human trafficking through collaboration with specialty nursing organizations, whose members are likely to encounter victims of human trafficking, on promoting awareness and education, particularly the organizations serving nurse practitioners and RNs intersecting with human trafficking patients.
  - Existing legislation, awareness, and continued appropriations, including passage of SOAR Training on Human Trafficking 2017, among nursing educators and education organizations to integrate ahuman trafficking curriculum to promote strengths-based workforce to advance the health of persons affected by human trafficking through recognition, identification, and management.
  - Advocate to place forensic nurses, acute care nurses, and community nurses on each state's and territory's Human Trafficking Task Force, joining attorneys, law enforcement, community programs responding to human trafficking, and organizations supporting the work of the interprofessional team committed to elimination of human trafficking.
- Advocate:
  - Promote nurse workforce development of human trafficking expertise with policy for foundation and commercial enterprises (National Institute of Nursing Research [NINR], Robert Wood Johnson Foundation, Johnson & Johnson, Dove and others) to fund development of expertise through scholarship and leadership voices condemning human trafficking.

- For closure of legislative and regulation gaps, wherever found, including the gap in Title X practice guidelines, to formally *include* sex-trafficking of adolescents as child sex abuse, reportable under all state and territory statutes.
- To federal and state legislators to enact funded legislation that protects and facilitates rescue or elopement of children and other persons ensnared in human trafficking and to support federal and state agencies mandated in the response.
- For legislation, in collaboration with the Academy of Forensic Nursing, American Association of Nurse Practitioners, Nurse Practitioners in Women's Health, American Academy of Emergency Nurse Practitioners, Emergency Nursing Association, and others to require every emergency department to have a competent registered nurse 24/7/365 who has advanced nursing education in general forensic nursing principles, concepts, content, and practice to facilitate identification and rescue of persons affected by human trafficking across all developmental stages and in all presentations.

- Encourage nurses to participate in review panels and technical working groups at the Health and Human Services/National Institutes of Health, NINR, Substance Abuse and Mental Health Services Administration, Department of Justice/NIJ/Office of Justice Programs to include programs that build strengths-based nursing workforce as collaborative members of response teams in the recognition, identification, and intervention strategies necessary to mitigate the biopsychosocial and spiritual impact on health following trafficking trauma.
- Identify advanced forensic nurse educators for, and consultants to, local, state, tribal, and military law enforcement and criminal justice communities.
- Urge Congress to support recommended appropriations with adequate funding and distribution in legislative initiatives for the Violence Against Women Act, Victims of Trafficking and Violence Prevention Act, and The Child Abuse Prevention and Treatment Act among others.

Acknowledgments

The authors express appreciation for guidance and assistance provided by Inge Corless, PhD, RN, FAAN and Catherine Catrambone, PhD, RN, FAAN, Co-Chairs; Azita Emami, PhD, MSN, RNT, RN, FAAN, Co-Chair; Paula Milone-Nuzzo, PhD, RN, FHHC, FAAN, Board Liaison to the Global Health Expert Panel and Matthew J. Williams, JD, MA, Policy Manager and Academy Staff Liaison to the Global Health Expert Panel; and Previous Chairs: DeAnne Messias (2016–2017), Kathleen Capitulo (2015–2016), Lynn Callister (2009), Marianne Hattar (2009), Marlene M. Rosenkoetter (2003), Joan Uhl Pierce (1999–2001) and for the review and support by the members of the expert panels: Global Nursing and Health; Violence; Women's Health; Psychiatric, Mental Health & Substance Abuse; Cultural Competence & Health Equity; and Expert Panel members interested in promoting liberty and health in vulnerable populations.

REFERENCES

Adelson, W.J. (2008). Child prostitute or victim of trafficking? *University of St. Thomas Law Journal*, *6*(1), 33.

Amar, A.. (2013). Screening and counseling for violence against women in primary care settings. *Nursing Outlook*, *61*(3), 187–191.

American Nurses Association. (2008). RN delegates to ANA's biennial meeting take action to work toward greater nurse retention, address public health issues. In: *News release*. American Nurses Association.

American Nurses Association. (2009). In: *Forensic nursing: Scope and standards of practice* (2nd ed., pp. 97). Washington, DC: American Nurses Association.

American Nurses Association. (2010). *The nurse's role in ethics and human rights: Protecting and promoting individual worth, dignity, and human rights in practice settings* (pp. 17). Nursing World.

American Public Health Association. Expanding and coordinating human trafficking-related public health research, evaluation, education, and prevention. (2015), Policy Statements and Advocacy]. Available from: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/26/14/28/expanding-and-coordinating-human-trafficking-related-public-health-activities

ANA Center for Ethics and Human Rights. (2016). The nurse's role in ethics and human rights: Protecting and promoting individual worth, dignity, and human rights in practice settings. In *ANA Board of Directors* (Ed.). MD: American Nurses Association: Silver Springs.

Anda, R.F.. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives in Psychiatry Clinical Neuroscience*, *256*(3), 174–186.

Anda, R.F., et al. (2009). The relationship of adverse childhood experiences to a history of premature death of family members. *BMC Public Health*, *9*(106), doi:10.1186/1471-2458-9-106.

Anthony, B.. (2017). *The typology of modern slavery: Defining sex and labo trafficking in the United States*. Polaris Project.

Argentieri, M.A.. (2017). Epigenetic pathways in human disease: The impact of DNA methylation on stress-related pathogenesis and current challenges in biomarker development. *EBioMedicine*, *18*, 327–350.

Association of Women's Health Obstetric and Neontal Nurses. (2016). Human trafficking. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *45*, 458–460.

Association of Women's Health Obstetric and Neontal Nurses, AWHONN position statement: Human trafficking. (2016).

Barrows, J., & Finger, R. (2008). Human trafficking and the healthcare professional. *Southern Medical Journal*, *101*(5), 521–524.

Clawson, H.J., & Dutch, N. (2008). *Identifying victims of human trafficking: Inherent challenges and promising strategies from the field* (pp. 7). Washington, DC: U.S. Department of Health and Human Services.

Cohen, S. (2017) Stop, Observe, Ask, and Respond (SOAR) to Health and Wellness Act of 2018, U.S. House of Representative, (Ed.)., Congress.gov.

Dovydaitis, T. (2010). Human trafficking: The role of the health care provider. *Journal of Midwifery & Women's Health*, *55*(5), 462–467.

Edmonson, C.. (2017). Emerging global health issues: A nurse's role. *Online Journal of Issues in Nursing*, *22*(1), pp. 1–1.
Emergency Nurses Association. Human trafficking. (2017); Available from: https://www.ena.org/practice-resources/human-trafficking.
Fight Online Sex Trafficking Act (FOSTA), H.R. 1865, 115th Cong. (2017-18).
Fonrouge, G. (2018). Trump signs law against online sex trafficking. In: *New York Post*. New York, NY: Murdoch's News Corporation.
Gillies, D.. (2016). Psychological therapies for children and adolescents exposed to trauma. *Cochrane Database System Review*, *10*, Cd012371.
Gross, D.. (2016). Toxic stress: Urgent action needed to reduce exposure to toxic stress in pregnant women and young children. *Nursing Outlook*, *64*(5), 513–515.
Isaac, R., Solak, J., & Giardino, A.P. (2011). Health care providers' training needs related to human trafficking: Maximizing the opportunity to effectively screen and intervene. *Journal of Applied Research on Children*, *2*(1), 32.
King, L. (2008). *International law and human trafficking* (88–103). Available from:, https://www.du.edu/korbel/hrhw/researchdigest/trafficking/InternationalLaw.pdf.
Kiss, L.. (2015). Exploitation, violence, and suicide risk among child and adolescent survivors of human trafficking in the greater Mekong subregion. *JAMA Pediatrics*, *169*(9), e152278.
Krug, E.G. (2002). The world report on violence and health. *Lancet*, *360*, 3–19.
Lederer, L.J., & Wetzel, C.A. (2014). The health consequences of sex trafficking and their implications for identifying victims in health care facilities. *Annals of Health Law*, *23*(1), 61–91.
McEwen, Bruce (1998). Stress, adaptation, and disease: Allostasis and allostatic load. *Annals of the New York Academy of Sciences*, *840*, 33–44.
Meinert, D. (2012). Modern-day slavery. In: *HRMagazine*. p. 22–27.
National Association of Pediatric Nurse Practitioners. Human trafficking prevention. (2017); Available from: https://www.napnap.org/human-trafficking-prevention.
National Conference of State Legislatures. Human trafficking state laws. (2016), Available from: http://www.ncsl.org/research/civil-and-criminal-justice/human-trafficking-laws.aspx.
National Human Trafficking Resource Center. Comprehensive human trafficking assessment. (2014), Available from: http://mspny.org/wp-content/uploads/2013/06/Trafficking-Assessment.pdf.
National Institute of Justice. (2014). *Expert working group on trafficking in persons research meeting*. Washington, DC, p. 1–34.
New York Civil Liberties Union. Child abuse reporting and teen sexual activity: Clarifying some common misunderstandings (FAQ). (2017). Available from: https://www.nyclu.org/en/publications/child-abuse-reporting-and-teen-sexual-activity-clarifying-some-common-misunderstandings.
Nurse Practitioners in Women's Health. Human sex trafficking. (2017) Available from: https://www.npwh.org/lms/filebrowser/file?fileName=NPWH%20Position%20Statement%20on%20Human%20Sex%20Trafficking%20for %20public%20comment.pdf.
Oram, S.. (2012). Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human trafficking: Systematic review. *PLOS Medicine*, *9*(5), e1001224.
Polaris. (2017). *The typology of modern slavery defining sex and labor trafficking in the United States*.
Polaris. Current federal laws. (2017). Available from: https://polarisproject.org/current-federal-laws
Price, B. (2017). Does child protective services respond to human trafficking in your state? In: *Forensic Nurses Open Community*, International Association of Forensic Nurses: IAFN Member Community.
Simich, L., etal. (2014). Improving human trafficking victim identification—validation and dissemination of a screening tool. p. 455. Available from: https://www.ncjrs.gov/pdffiles1/nij/grants/246712.pdf.
Speck, P.M., & Peters, S. (1999). Forensic nursing: Where law and nursing intersect. In: *Advance for nurse practitioners*. p. 10.
U.S. Department of Health and Human Services. (2017). The role of healthcare providers in combatting human trafficking during disasters. Public Health Emergency. Available from: https://www.phe.gov/Preparedness/planning/abc/Pages/human-trafficking.aspx.
U.S. Department of Justice Office for Victims of Crime. (2014). *Coordination, collaboration, capacity: Federal strategic action plan on services for victims of human trafficking in the United States 2013-2017* (pp. 84).
U.S. Department of State, *Trafficking in persons report*, Office of the Under Secretary for Civilian Security and Human Rights, (2014), Washington, DC. p. 422.
U.S. Department of State, *Trafficking in persons report*, 2016 (2016).
United Nations Office on Drugs and Crime. (2006). *Toolkit to combat trafficking in persons* (pp. 562). New York, NY: United Nations.
United Nations Office on Drugs and Crime. Human trafficking. (2015), Available from: http://www.unodc.org/unodc/en/human-trafficking/what-is-human-trafficking.html.
United Nations Office on Drugs and Crime, *Global report on trafficking in persons 2016*. (2016), United Nations.
United Nations Office on Drugs and Crime. (2018). Online edition—Toolkit to combat trafficking in persons (2006). Available from https://www.unodc.org/unodc/en/human-trafficking/2008/electronic-toolkit/electronic-toolkit-to-combat-trafficking-in-persons—index.htmlAims.
United Nations. (2000). *Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the United Nations convention against transnational organized crime* (1–12).
Zimmerman, C., Hossain, M., & Watts, C.H. (2011). Human trafficking and health: A conceptual model to inform policy, intervention and research. *Social Science and Medicine*, *73*(2), 327–335.

Human Trafficking Victim Identification, Assessment, And Intervention Strategies In South Texas Emergency Departments

Authors: Jean Dowling Dols, PhD, RN, NEA-BC, FACHE, Diana Beckmann-Mendez, PhD, RN, FNP-BC, Jessica McDow, BSN, RN, Katherine Walker, MSN, RN, and Michael D. Moon, PhD, MSN, RN, CNS-CC, CEN, FAEN, San Antonio, TX

Contribution to Emergency Nursing Practice

- The current state of scientific knowledge on human trafficking indicates that victims seek care in emergency departments. However, there is a lack of knowledge regarding effective methods to identify and intervene for these victims in the emergency department.
- The main finding of this research is the majority of emergency departments surveyed in south Texas do not specifically screen for human trafficking.
- Key implications for emergency nursing practice from this research are that consistent use of validated screening instruments and standardization of processes for human trafficking is needed.

Abstract

Introduction: Human-trafficking victims seek assistance for health issues in emergency departments. This point of contact provides an opportunity for screening and identification of the victim's situation, enabling intervention.

Methods: This descriptive research study was designed to identify whether a standard protocol is currently used to identify, assess, and intervene for human-trafficking victims in 47 south Texas counties. ED leaders were surveyed using a sequential set of strategies including online, e-mail, and/or phone surveys to identify the methods used in emergency departments screening for adult/child human-trafficking victims.

Results: Researchers surveyed 99 emergency departments in south Texas, which includes 21 counties bordering Mexico. Twenty-seven ED leaders responded (27.3%). Despite being located in an area with high rates of human trafficking, these leaders stated that few trafficking victims were identified in 2017. Eleven (40.7%) of the responding emergency departments specifically screened adults for human trafficking, and 10 (37.0%) specifically screened children for human trafficking. A variety of methods were used by each of these emergency departments to identify human-trafficking victims.

Discussion: The failure to recognize human-trafficking victims prevents assessment of the victim's status and further delays referral to appropriate resources. Barriers to screening for human trafficking included lack of awareness of the human-trafficking experience, need for clinical education related to evidence-based protocols, and need for validated screening instruments and standardization of processes that promote action and provide victim assistance.

Key words: Human trafficking; Sex trafficking; Emergency services; Triage

Jean Dowling Dols is Professor University of the Incarnate Word, San Antonio, TX.

Diana Beckmann-Mendez is DNP Program Director, Nurse Practitioner Program Coordinator and Associate Professor, University of the Incarnate Word, Ila Faye Miller School of Nursing, San Antonio, TX.

Jessica McDow is Doctor of Nursing Practice Student, University of the Incarnate Word, Ila Faye Miller School of Nursing, San Antonio, TX.

Katherine Walker is Research Program Director, University of the Incarnate Word, Ila Faye Miller School of Nursing, San Antonio, TX.

Michael D. Moon, *Member, San Antonio Chapter,* is Professor, University of the Incarnate Word, Ila Faye Miller School of Nursing, San Antonio, TX.

For correspondence, write: Jean Dowling Dols, PhD, RN, NEA-BC, FACHE, University of the Incarnate Word, Ila Faye Miller School of Nursing, 4301 Broadway CPO 300, San Antonio, TX 78209; E-mail: Dols@uiwtx.edu

J Emerg Nurs 2019;■:1-12.
0099-1767

https://doi.org/10.1016/j.jen.2019.07.002

Introduction

Human trafficking is defined, according to the United Nations, as having 3 components.[1] First, human trafficking is an act in which the person is recruited, transported, transferred, harbored, or received. Second, human trafficking includes use of means such as threat, force, coercion, abduction, fraud, or deception. Third, human trafficking has a purpose of exploitation.[1] Human-trafficking victims are people of any age, race, sex, and socioeconomic status.[2] Victims may feel trapped to provide nonconsensual services or arrangements that include sex, labor, domestic servitude, or forced marriage.[2] On a global scale, it is estimated there are 40.3 million victims of human trafficking, 25% of whom are children.[2] The United States is one of the most prolific countries for traffickers in the world.[3] Traffickers prey upon those individuals seeking new opportunities and those escaping adversity, violence, or economic problems. California, Texas, and Florida, along with cities such as Los Angeles, New York, and Miami, are some of the highest human trafficked areas in the United States.[4,5] According to the United Nation's Global Report on Trafficking in Persons, which uses reports by national authorities to study patterns and flow in trafficking,[6] most trafficking in North America is sex trafficking (71%), with about 65% of trafficking victims being women.[6] According to the National Human Trafficking Hotline, there have been a total of 45,308 human-trafficking cases reported to the US hotline from 2007 to June 30, 2018.[5] In 2017, there were 8,524 human-trafficking cases reported to the National Human Trafficking Hotline, with 792 of these cases in Texas.[5] These existing reports and statistics must be interpreted in light of the limitations of convenience sampling and difficulty enumerating often-hidden victims in the process of being illegally exploited and vulnerable to violence.

There are several barriers to identifying human-trafficking victims and providing intervention and referrals. The clandestine nature of the industry creates challenges in locating offenders and victims.[7] Human trafficking takes many forms, and victims rarely self-identify, especially pediatric victims.[8] Lack of education contributes to the failure to identify human-trafficking victims, as many service providers are unaware of this problem.[9] By failing to recognize victims of human trafficking, opportunities to identify victims and provide resources to those victims are reduced.[10] Furthermore, victims may struggle to leave these situations because of psychological trauma; attachment to their trafficker; dependence; or fear of destitution, arrest, or ostracism.[8,11] Other barriers include cultural and linguistic differences.[11] One of the greatest opportunities for stopping human trafficking lies with health care workers.

Victims report a high incidence of health issues such as physical abuse, sexually transmitted infections, malnourishment, and psychological trauma.[4,10] When a victim seeks medical attention, this presents a rare opportunity to identify victims.[7,12] Therefore, health care facilities, especially emergency departments, become the venue for identifying victims of human trafficking, providing a potential safe haven for victims.[7] To combat human trafficking, health care workers need to be educated on how to identify victims, how to approach suspected victims, and what actions to take once a victim is identified, particularly in those areas of the country where human trafficking is rampant.

REVIEW OF LITERATURE

Human trafficking is a massive global issue that has detrimental effects on public health.[7] One of the challenges in research development stems from the nature of this criminal industry.[7] The secretive, evasive nature of human trafficking makes current and generalizable research difficult to achieve.[13] Regardless of the challenges, more information regarding human trafficking and its health implications is an urgent necessity. In the 2018 Report on Trafficking in Persons, the US Department of State specifically recommended increased screening of vulnerable populations for human trafficking.[14] In recent years, there has been an aggressive pursuit of human-trafficking research to help formulate evidence-based practices for health care workers, increase awareness, and encourage action to identify and protect victims.[13,15]

There are noteworthy accomplishments in tool development. In 2011, the National Human Trafficking Resource Center published a document delineating a method to assess victims for potential signs of human trafficking.[16] Although useful and developed to recognize all types of trafficking, the document also stated that the tool was not tailored to every program and should be appropriately modified for each program's specific environment.[16] Then, in 2014, Simich et al published a tool to assist social service providers, law enforcement, health care, and shelter workers in identifying human-trafficking victims.[17] Eighty-seven percent of the tool's questions were determined to be significant predictors of human trafficking.[17] In 2018, the Department of Health and Human Services (DHHS) published a screening toolkit and guide for adult victims of human trafficking that was designed specifically for health care workers.[18] However, the tool remains unvalidated at

this time. The guide also mentions 8 other tools for human-trafficking assessment, most of which focus on child victims.[18] These recent developments show great improvement in national awareness of human trafficking and provide potentially useful resources for health care workers. However, health care still lacks a standardized, validated human-trafficking tool, and there is little research regarding the health of victims.[15]Although recent accomplishments encourage change, there is still a great need for improvement in human-trafficking recognition.

PURPOSE

This research study was designed to identify the actions currently taken by ED clinicians and providers to identify, assess, and intervene for victims of trafficking. The purpose of this study was to identify and describe the current strategies for identification, assessment, and intervention for human-trafficking victims in the emergency departments in 47 South Texas counties.

Methods

STUDY DESIGN AND SURVEY

This descriptive study used a survey design to collect information identifying current ED practices related to human trafficking. The study used a brief survey of 23 questions developed by the nurse researchers, based on a review of the literature and expertise with ED processes and care. The survey focused on the type of emergency department, providers, and clinical staff; methods used to screen adult and child human-trafficking victims; and results, including number of positive screens, characteristics of individuals with positive screens, strategies helpful to identify human-trafficking victims, and the actions taken following identification.

The list of nurse leaders contacted to answer the survey was obtained by calling the emergency departments and requesting names and e-mail addresses of emergency nurse leaders. Institutional Review Board (IRB) approval was obtained before deploying the survey. The survey was deployed using a sequential set of strategies including an online survey tool, e-mailed survey, and phone survey with reminders in the same format. Participants were informed that participation in the research was voluntary, and survey completion indicated consent. Surveys could be answered anonymously. To promote response to the surveys, each leader participating in the survey was entered in a drawing for a gift certificate.

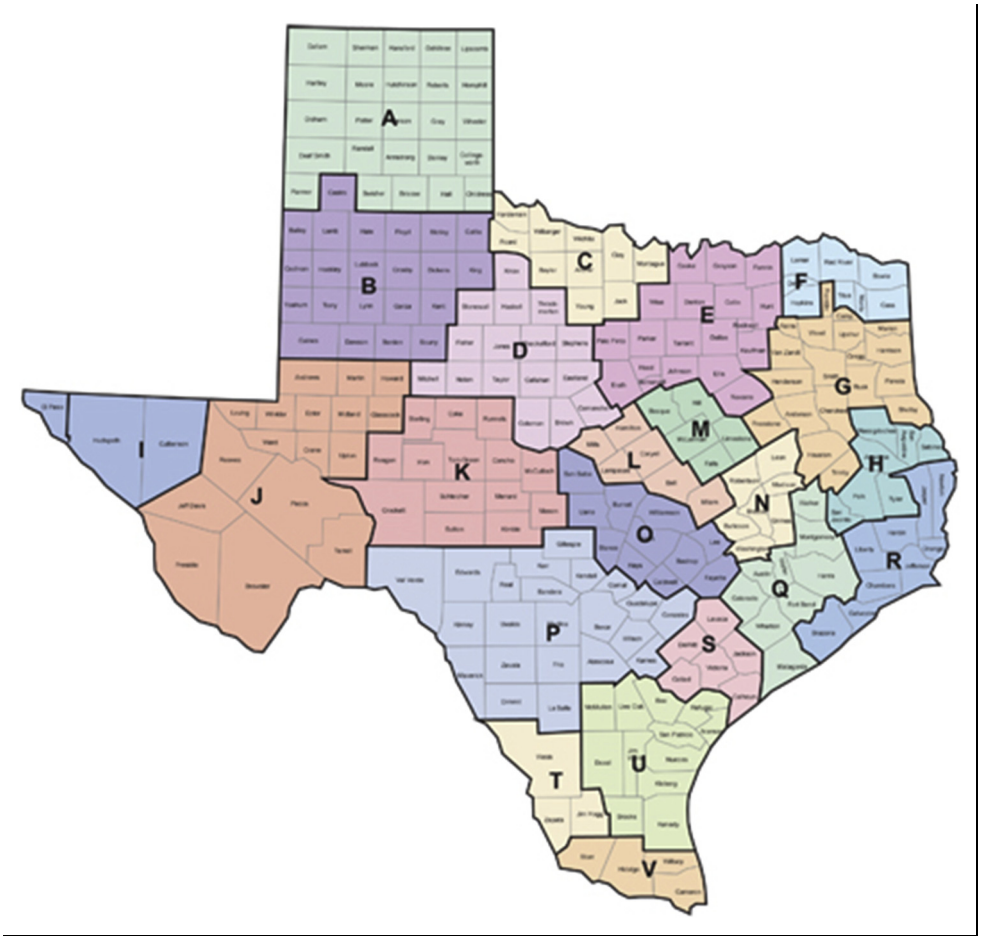
SETTING

Texas is divided into 22 trauma service areas (TSAs) (Figure). Regional advisory councils are designated by the Texas Department of State Health Services (TDSHS) to develop, implement, and maintain regional trauma and emergency health care systems in each TSA.[19] For this study, the setting included emergency departments in 5 South Texas TSAs including Southwest Texas TSA (P), Golden Crescent TSA (S), Seven Flags TSA (T), Coastal Bend TSA (U), and Lower Rio Grande Valley TSA (V). These regions include a mixture of urban, suburban, and rural areas. The 2 largest counties are Bexar, with 1.9 million residents (largest city: San Antonio), and Hidalgo, with 0.8 million residents (largest city: McAllen). A substantial number of the counties are considered border counties (n = 21, 44.7%), as they are located within 100 kilometers of the Rio Grande River on the US border of Mexico.[20] The South Texas region is a major corridor for human trafficking because of its proximity to the Mexican border and connections to major interstate highways (Interstate 10 and Interstate 35) for the continuous transport of victims to new markets and large cities including San Antonio and Houston.[21] The population in the 47 counties is 5,103,477 (Table 1).[22,23] Collectively, residents in the counties are primarily white (85.2% to 98.8%) and predominately Hispanic, with the majority (n = 28, 59.6%) of the counties being more than 50% Hispanic.[22] The counties have a high percentage of people who are poor, with impoverished persons ranging from 8.0% to 35.4% of the population per county and with 49.0% (n = 23) of the counties having greater than 20% of the population impoverished.[22] The population of the counties has a median age ranging from 28.1 to 52.7 years.[22] Texas is one of the 5 youngest states in the United States, with a median age of 33.6 years.[22] Within these 47 counties, there are 99 emergency departments.

Results

Twenty-seven of the 99 emergency departments in the 5 trauma service areas responded to the survey for a 27.3% response rate (Table 2). Responses were received by online survey (n = 13), by e-mail (n = 7), and by phone (n = 7). Spam filters blocking the online survey software e-mails prompted the researchers, with IRB approval, to directly email surveys and then use phone calls to reach nonresponders to offer a direct e-mail format or phone survey.

E-mail addresses changed with the turnover of ED leaders and finding a convenient time to complete the survey



FIGURE

Trauma Service Areas in Texas (Permission to print: Texas Department of Health and Human Services).

verbally prompted the option to enable the leader to select email or verbal survey response. Seven of the responding ED leaders stated that their emergency departments were American College of Surgeons (ACS) trauma-designated level 4, 2 were designated level 3, 1 was designated level 2, and 17 had no ACS trauma designation. Seven of the responding ED leaders stated that their emergency departments were designated by the Southwest Texas Regional

TABLE 1

2015 population statistics by trauma service area

TSA	Population	Land square miles	Population density/square mile
P – Southwest Texas	2,688,869	26,688	100.72
S – Golden Crescent	177,257	4,949	35.82
T – Seven Flags	289,295	5,495	52.65
U – Coastal Bend	597,898	11,552	51.76
V – Lower Rio Grande Valley	1,350,158	4,276	315.75
Total	5,103,477	52,960	96.36

TABLE 2
Responses by trauma service area (n = 27)

TSA	Counties	Border Counties	EDs	Responses	Response Rate/No. ED
P - Southwest Texas	22	10	65	17	26.2%
S - Golden Crescent	6	0	6	1	16.7%
T - Seven Flags	3	3	4	1	25%
U - Coastal Bend	12	4	11	3	27.3%
V - Lower Rio Grande Valley	4	4	13	4	30.8%
Not indicated	County not identified			1	
Total	47 Counties 21 Border Counties		99	27	27.3%

TSA, trauma service area.

Advisory Council (STRAC) as certified regional trauma and emergency health care system level 4, 2 were certified as level 3, 1 was certified as level 2, and 17 had no STRAC designation.

The facilities were staffed by varying combinations of both providers and clinical staff members. Each of the emergency departments responding had physicians (n = 27, 100%) and various other providers including nurse practitioners (n = 15, 55.6%) and physician assistants (n = 15, 55.6%). Every responding emergency department had RNs (n = 27, 100%) and various clinical staff including licensed vocational/practical nurses (n = 8, 29.6%), sexual assault nurse examiners (SANE) (n = 4, 14.8%), social workers (n = 6, 22.2%), radiology technologists or laboratory technologists (n = 2, 7.4%), registered paramedic (n = 1, 3.7%), and no clinical nurse specialists (CNS).

ADULT HUMAN-TRAFFICKING SCREENING

Eleven (40.7%) of the responding 27 emergency departments screened adults to identify human-trafficking victims. ED screening included a variety of methods (Table 3). The most frequent method of screening adults for human trafficking reported by emergency departments was asking questions during triage regarding the patient's feelings of safety. Sixteen (59.3%) of the 27 emergency departments did not screen adults to identify human-trafficking victims. After answering "No" to the question "Do you formally

TABLE 3
ED assessment methods for adult (n = 11) and child (n = 10) human trafficking

Assessment methods	Screen for adult human trafficking N (%)	Screen for child human trafficking N (%)
Triage questions on feelings of safety	4 (36.4)	0 (0)
Safety screening	0 (0)	2 (20)
Triage questions, but depending on age are answered by parents/caregivers	0 (0)	2 (20)
One question: Are they in a relationship in which they are afraid or have been abused?	2 (18.2)	1 (10)
Screening questions during assessment	1 (9.1)	1 (10)
Screen patients for abuse and neglect. Nursing is also trained to assess for adult/child protective service cases	1 (9.1)	1 (10)
Clinical presentation and thorough history	1 (9.1)	1 (10)
No details provided regarding assessment	2 (18.2)	0 (0)
We look for signs of no eye contact with caregiver bringing them in	0 (0)	1 (10)
Ask Border Patrol/Customs for background information	0 (0)	1 (10)

TABLE 4
Actions of emergency departments not screening for human trafficking: adult (n = 16), children (n = 17)

Actions taken in emergency departments when not screening for HT	EDs without HT screening for adults	EDs without HT screening for children
	N (%)	N (%)
Safety screening questions asked but not specific to HT (including questions about abuse, neglect, domestic violence, and suicidal/homicidal ideation)	5 (31.3)	2 (11.8)
No details provided regarding actions taken in the emergency department	5 (31.3)	5 (29.4)
HT screening is not done (for children and/or adults or both)	2 (12.5)	5 (29.4)
HT suspected based on patient assessment or symptoms	0 (0)	2 (11.8)
Identification is based on assessment done by providers and nurses	2 (12.5)	1 (5.9)
Identification is based on knowledge	1 (6.3)	1 (5.9)
Dependent on situations and presentations	1 (6.3)	1 (5.9)

HT, human trafficking.

screen adults to identify human-trafficking victims?" many of the nurse leaders reported an action performed but clarified that the action did not screen for human trafficking (Table 4).

Based on the unique staffing mix of each emergency department, the leaders identified that the following providers and staff performed screening in the emergency departments for human trafficking: physicians (37.0%), nurse practitioners (14.8%), physician assistants (14.8%), RNs (66.7%), licensed vocational/practical nurses (7.4%), and SANE (3.7%).

If adults were screened for human trafficking, the most likely times and places for the screening to be done were during triage (55.6%), after the patient was placed in a room (37.0%), during the provider evaluation (25.9%), and when discharging a patient (3.7%). None of the responding emergency departments identified an adult human-trafficking victim in 2017. One (3.7%) identified several victims who had already been identified by another agency, stating, "I had a runaway female yesterday. Typically, they're young, female, Hispanic, 20s, sexual trafficking. They're also very open once they've been identified. I had one girl talk for 5 hours straight."

CHILD HUMAN-TRAFFICKING SCREENING

Ten (37.0%) of the 27 emergency departments screened children to identify human-trafficking victims. Screening by these emergency departments included a variety of methods (Table 3). Many responses were duplication of the methods to screen adults for human trafficking. Seventeen (63.0%) of the 27 emergency departments did not screen children to identify human-trafficking victims. After answering "No" to the question "Do you formally screen children to identify human-trafficking victims?" respondents identified several methods they used that were not specific to human trafficking but rather were focused on generalized safety concerns or assessment findings as part of the providers' and staff's routine processes (Table 4).

Based on the unique staffing mix of each responding emergency department, the leader of emergency departments that screened for child human trafficking identified the following providers and staff as performing the screenings for child victims of human trafficking: physicians (51.8%), nurse practitioners (14.8%), physician assistants (18.5%), RNs (63.0%), licensed vocational/practical nurses (3.7%), SANE (3.7%), and social workers (3.7%).

If children were screened for human trafficking, the most likely times and places identified for the screening to be done were during triage (48.1%), after the patient was placed in a room (33.3%), during the provider evaluation (22.2%), and when discharging a patient (3.7%). One respondent noted that the screening must be done when the minor is alone, separated from the adult. Twenty-six (96.3%) of the emergency departments did not identify a child human-trafficking victim in 2017. One (3.7%) emergency department identified 10 children who were human-trafficking victims. One emergency department received 5 child-trafficking victims identified by another agency: "They are brought in by border patrol or customs with background information on their situation."

Four (14.8%) of the emergency departments have identified child-trafficking victims previously, although not in the last year. These ED leaders stated that they were helped in identifying the child human-trafficking victims by their "physical appearance, behavior, body language, and eye

contact;" "suspicious events and history;" and as a result of "training and staff education." One ED leader stated that they are a "border hospital, so we get lots of patients with border patrol and bad situations. We, as a department, don't label patients as human-trafficking victims or not; we just treat them and call the police if there are any suspicions of abuse or trouble with the law. We don't get to follow up with the patients to see if the issue actually was human trafficking; so we do screen for abuse, but not specifically human trafficking." One ED leader identified that despite education, staff find it "difficult to act…due to staff anxiety."

ADULT AND CHILD HUMAN-TRAFFICKING SCREENING

Of the 14 hospitals screening for individuals being trafficked, 7 screened for both adults and children. Four (14.8%) screened adults exclusively, and 3 (11.1%) screened children exclusively. If a trafficking victim was identified, the emergency departments identified actions they would take including consulting with a social worker (15.4%), reporting to police (30.8%), and referring to a battered women's shelter (7.7%). None identified that they would contact hospital spiritual care, chaplain services, or a community faith leader (eg, pastor, rabbi, elder, imam). Several emergency departments received victims of human trafficking identified by border patrol. SANE identified 10 child-trafficking victims at 1 site in 2017. Several ED leaders stated that there were no routine processes or formal assessments for human trafficking, but rather human-trafficking assessments were merely based on symptoms and complaints. Several respondents noted that required notices were posted in the waiting and examination rooms within the department, and annual continuing education modules on identifying victims were held. An interest in screening for human trafficking was expressed by several ED leaders. A legal concern regarding child-trafficking victims that was reported in the returned surveys included a statement that it was a health insurance portability and accountability act (HIPAA) violation to report the issue to police because reporting required patient consent. A misconception reported was that trafficked children would be young, nervous, have visible injuries, and be accompanied by older men.

Discussion

Despite being identified as a high traffic area,[4,5] very few ED leaders responding to the survey reported ED identification of human-trafficking victims in 2017. ED screening processes reported are inconsistent with differences in the individuals performing the screenings, the location and timing of the screenings, education of clinical staff, patient education provided, and assessments performed. Respondents did not identify a standard method or tool for screening; rather, many use questions to determine the person's safety or assess the individual.

Victims rarely self-identify, and the failure to recognize victims eliminates the opportunity to provide resources.[8,10] Only 40.7% of the emergency departments specifically screened adults for human trafficking, with most ED clinical staff using 1 or more safety questions as their screening tools. Of the 59.3% of the emergency departments that did not screen adults specifically for human trafficking, several screened only children; some focused on domestic violence or abuse/neglect screening; others asked questions about safety in general, but clarified that it was not specific to screening for human trafficking; and others offered no information on any actions taken in the emergency department related to human-trafficking screening.

Emergency nurses must be cognizant of the legal reporting requirements for both child and adult maltreatment, abuse, and human-trafficking victims in their state or country of practice. Although the screening of these victims may be similar, the individual situation may require additional considerations beyond current standard assessments to differentiate the victim's circumstances.

Emergency nurses in the United States are mandated reporters for child and elder abuse. Clarity of the conceptual definition of human trafficking[1] vs other forms of suspected maltreatment or abuse—followed by education—is needed to enable providers and clinical staff to identify differences in screening, identification, referral, and treatment for child abuse, intimate partner violence, and child and adult human trafficking.[8] The failure to identify human-trafficking victims may be attributed to lack of provider and staff education as well as failure to use tools specifically designed to identify human-trafficking victims.[9,15]

Key change agents to build new processes and provide knowledge and skills to improve human-trafficking victim identification include staff such as forensic nurses (SANE), clinical nurse specialists, and chaplains. In this study, 10 children were identified as trafficking victims in 1 emergency department. This identification occurred through the forensic nurse examination, which was performed by RNs educated to recognize the signs and symptoms of human trafficking. ED leaders responding to the survey did not list CNS in their staffing mix. One of the foundational skills of a CNS includes gap analysis, which could provide the needed activity to differentiate current

TABLE 5
Human-trafficking tools

Author	Year	Screening	Setting	Design
International Organization for Migration and United Nations Office on Drugs and Crime[27]	2006	Screening interview form on the International Organization for Migration for the Identification of Victims of Trafficking	To combat international human trafficking through the sharing of knowledge among political, legal, and civic arenas	102 questions
Polaris Project[28]	2010	Human trafficking medical assessment tool	For medical professionals	Flowchart
Praed Foundation[29]	2010	Child and Adolescent Needs and Strengths (CANS) commercially sexually exploited assessment Children and adolescents	Child welfare professionals or clinical interviews	72 validated questions
Shared Hope International[30]	2010	To identify youth and reduce the risk of retraumatization	Service providers and clinicians, and juvenile justice employees For experienced professionals only	42 questions Available for purchase
National Human Trafficking Resource Center[31]	2011	Human trafficking tool for educators Students	To assist educators in identifying risk factors and indicators of human trafficking and how to respond.	Flowchart
Polaris Project[32]	2011	Human trafficking assessment tools	For airlines and airports	Flowchart
Indiana Protection for Abused and Trafficked Humans (IPATH) Task Force[33]	2012	Human trafficking identification, screening tool and report	For individuals who are likely to encounter victims such as those who work in law enforcement, health care, charities, and youth organizations	Tool consists of three segments: initial screening, detailed interview, and human trafficking report
Covenant House[34]	2013	Human Trafficking Interview and Assessment Measure (HTIAM-14) for homeless and exploited youth	Child welfare professionals, clinical interviewers	14 questions
Ohio Human Trafficking Task Force[35]	2013	For mental health screenings of incarcerated victims	For the Ohio Department of Rehabilitation and Corrections and the Ohio Department of Youth Services	11 questions (6 for the initial mental health screen, 5 for the mental health professionals to ask after referral from prison staff)

Loyola University Chicago Center for the Human Rights of Children[36]	2014	Childright: New York Child Trafficking Rapid Screening Instrument (RST)	Social service agencies	10 questions
Vera Institute of Justice[37]	2014	Trafficking victim identification tool All ages, domestic and foreign-born, for sex and labor trafficking	For social service providers, law enforcement, healthcare and shelter workers	Long version available (26 questions) and short version (16 questions)
Michigan Department of Health and Human Services and Genesee County Medical Society[38]	2015	Adult and child tools for suspected victims	Initial screening tool for suspected adults and children of human trafficking. Assists healthcare providers in determining whether referral to social work or law enforcement is necessary.	Adult tool (7 questions) Child tool (9 questions)
West Coast Children's Clinic (community pediatric mental health clinic)[40]	2016	Commercial Sexual Exploitation Identification Tool (CSE-IT) Children and youth (ages 10 and older)	Professionals who work with children, such as social service providers, healthcare professionals, law enforcement, educators, and charity workers	40 Questions Score 0-23
United States Conference of Catholic Bishops[39]	2017	Stop Human Trafficking and Exploitation. Protect, Help, Empower, and Restore Dignity (SHEPHERD) toolkit	For raising awareness and identifying victims in parishes and the community by learning about human trafficking from the Catholic perspective	Email **MRSShepherd@usccb.org** to request the SHEPHERD toolkit and leader's guide
Urban Institute[41]	2017	Pretesting a human trafficking screening tool in the child welfare and runaway and homeless youth systems Child Welfare (CW) and Runaway and Homeless Youth (RHY)	A tool that addresses a diverse youth population	85 questions

continued

TABLE 5
Continued

Author	Year	Screening	Setting	Design
United States Department of Health and Human Services[18]	2018	Adult human trafficking screening tool Adult victims of labor and sex trafficking	To screen and identify potential victims via face-to-face interview between a trained, trauma-informed clinician and a client For public health, behavioral health, health care, and social work professionals	8 Questions
Covenant House[42]	2019	Quick Youth Indicators for Trafficking (QYIT) screening tool for sex and labor trafficking	Social service providers who screen for human trafficking in runaway and homeless youth Does not require a trained expert to administer	4 questions

and best practices in the effort to improve screening and identification of human-trafficking victims.[24] Although individuals from pastoral/spiritual care may be requested by ED clinicians to participate in patient care to listen to patients, meet them in their current situation, and de-escalate situations,[25] requests for a pastor for a trafficked victim was not 1 of actions reported by the ED leaders surveyed.

Emergency nurses are in a key position to identify and intervene to stop human trafficking and provide resources to the victims. As reported by Gibbons and Stoklosa, emergency departments are regarded as safe havens for victims of human trafficking who may present with a compendium of injuries and health issues, the ED clinical staff needs to be ready to identify and support victims.[7,10]

Limitations

The study was limited by its regional focus on south Texas emergency departments. Although findings are difficult to generalize, given the specific geographic location, the area was chosen because of its proximity to the US/Mexico border and easily accessible interstate highways.

The convenience sample, low response rate, and data collection that relied on 1 ED leader at each site having comprehensive information are additional limitations. There was interference in the timely collection of data, owing to high turnover in ED leaders, spam filters blocking the distribution of the online survey or link, and difficulty reaching leaders by phone at convenient times to participate in the study. The survey was not designed to collect individual contextual information—such as patient age, situation, language spoken—and permission to report in their responses to external services (eg, police, women's shelters). Use of interpreter services was not addressed in this study.

Implications for Emergency Nurses

Emergency nurses may be the first health care professionals that trafficking victims come in contact with, which puts them in a unique position to recognize and intervene.[12,26] Emergency nurses and clinical staff need specific, valid screening and assessment tools focused on human-trafficking victims, as screening processes for human trafficking in emergency departments are often inconsistent. Emergency nurses in the United States are mandated to report child abuse; all states have reporting laws for elder

abuse. Emergency nurses need to be aware of the legal requirements and implications for reporting other maltreatment of children, child human trafficking, and potential adult human-trafficking victims to legal authorities, which may vary substantially by state and country. Further research is needed to validate screening tools (Table 5)[18,27-42] and evaluate the impact of standardizing ED processes for human-trafficking screening and assessment.

Conclusions

Missed opportunities to intervene in human trafficking are due, in part, to barriers in identification. This study provides information regarding the current status of human-trafficking screening in south Texas. Few human-trafficking victims are currently identified in the south Texas emergency departments.

Identification of possible victims and connection to resources is needed to combat the human-trafficking crisis. Increasing the awareness, knowledge, and skills of ED staff and providers is required for change. Valid screening tools and use of standardized processes for human-trafficking victim identification, assessment, and referral are high priorities.

Author Disclosures

Funding was provided by the University of the Incarnate Word Office of Research and Graduate Studies. Conflicts of interest: none to report.

REFERENCES

1. United Nations Office on Drugs and Crimes. *What is Human Trafficking?* https://www.unodc.org/unodc/en/human-trafficking/faqs.html#What_is_human_trafficking. Accessed June 24, 2019. Published 2019.
2. United States Department of Homeland Security. *What is human trafficking? Blue Campaign*. https://www.dhs.gov/blue-campaign/what-human-trafficking. Accessed April 19, 2019. Published 2016.
3. Coppola JS, Cantwell R. Health professional role in identifying and assessing victims of human labor trafficking. *J Nurs Pract*. 2016;12(5):e193-e200. https://doi.org/10.1016/j.nurpra.2016.01.004.
4. Ernewein C, Nieves R. Human sex trafficking: recognition, treatment, and referral of pediatric victims. *J Nurs Pract*. 2015;11(8):797-803.
5. National Human Trafficking Hotline. *Hotline Statistics by State*. https://humantraffickinghotline.org/states. Accessed April 19, 2019. Published 2018.
6. United Nations Office on Drugs and Crime. *Global Report on Trafficking in Persons*. https://www.unodc.org/unodc/data-and-analysis/glotip.html. Accessed April 19, 2019. Published 2018.
7. Gibbons P, Stoklosa H. Identification and treatment of human trafficking victims in the emergency department: a case report. *J Emerg Med*. 2016;50(5):715-719. https://doi.org/10.1016/j.jemermed.2016.01.004.
8. Greenbaum J, Crawford-Jakubiak JE. Committee on Child Abuse and Neglect. Child sex trafficking and commercial sexual exploitation: health care needs of victims. *Pediatrics*. 2015;135(3):566-574. https://doi.org/10.1542/peds.2014-4138.
9. Institute of Medicine and National Research Council of the National Academies. *Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States*. https://www.ojjdp.gov/pubs/243838.pdf. Accessed March 3, 2019. Published 2013.
10. Beck ME, Lineer MM, Melzer-Lange M, Simpson P, Nugent M, Rabbitt A. Medical providers' understanding of sex trafficking and their experience with at-risk patients. *Pediatrics*. 2015;135(4):e895-e902. https://doi.org/10.1542/peds.2014-2814.
11. Pascual-Leone A, Kim J, Morrison O. Working with victims of human trafficking. *J Contemp Psychol*. 2017;47(1):51-59. https://doi.org/10.1007/s10879-016-9338-3.
12. Donohue S, Schwein M, LaVallee D. Educating emergency department staff on the identification and treatment of human trafficking victims. *J Emerg Nurs*. 2018;45(1):16-23. https://doi.org/10.1016/j.jen.2018.03.021.
13. Cannon AC, Arcara J, Graham LM, Macy RJ. Trafficking and health: a systematic review of research methods. *Trauma Violence Abuse*. 2018;19(2):159-175. https://doi.org/10.1177/1524838016650187.
14. United States Department of State. *Trafficking in Persons Report 2018*. https://www.state.gov/documents/organization/282798.pdf. Accessed April 19, 2019. Published 2018.
15. Zimmerman C, Kiss L. Human trafficking and exploitation: a global health concern. *PLoS Med*. 2017;14(11): e1002437. https://doi.org/10.1371/journal.pmed.1002437.
16. National Human Trafficking Resource Center. *Comprehensive Human Trafficking Assessment*. https://humantraffickinghotline.org/sites/default/files/Comprehensive%20Trafficking%20Assessment.pdf. Accessed April 19, 2019. Published 2011.
17. Simich L, Goyen L, Powell A, Mallozzi K. *Improving Human Trafficking Victim Identification: Validation and Dissemination of a Screening Tool*. United States Department of Justice. National Institute of Justice; NCJ246712:16-455. https://www.ncjrs.gov/pdffiles1/nij/grants/246712.pdf. Accessed March 3, 2019. Published June 2014.
18. United States Department of Health and Human Services. *Adult Human Trafficking Screening Tool and Guide*. https://www.acf.hhs.gov/sites/default/files/otip/adult_human_trafficking_screening_tool_and_guide.pdf. Accessed April 19, 2019. Published 2018.
19. Texas Department of Health Services. Regional Advisory Council. https://www.dshs.texas.gov/emstraumasystems/etrarac.shtm#v. Accessed April 19, 2019. Published 2019.

20. Texas Department of State Health Services. *Map of DSHS Border Area*. https://www.dshs.state.tx.us/borderhealth/border_health_map.shtm. Accessed March 3, 2019. Published 2017.
21. Texas Department of Public Safety. *Assessing the Threat of Human Trafficking in Texas: A State Intelligence Estimate*. https://www.dps.texas.gov/director_staff/media_and_communications/2014/txHumanTraffickingAssessment.pdf. Accessed April 19, 2019. Published 2014.
22. Texas Association of Counties. *The County Information Program*. http://www.txcip.org/tac/census/index.php. Accessed April 19, 2019. Published 2019.
23. United States Census Bureau. *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018*. http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk8. Accessed April 19, 2019. Published 2018.
24. Rettig AE, LaRue J, Pearson E. The clinical nurse leader and the clinical nurse specialist. *J Emerg Nurs*. 2017;43(4):356-357. https://doi.org/10.1016/j.jen.2017.04.006.
25. Bodemann C. Seeing eye to eye: becoming the chaplain in the emergency department of a level I trauma center. *J Emerg Med*. 2015;48(6):751-753. https://doi.org/10.1016/j.jemermed.2014.12.054.
26. Emergency Nurses Association. *Human Trafficking Awareness in the Emergency Care Setting: Joint Position Statement*. https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/humantraffickingpatientawareness.pdf?sfvrsn=cd0ad835_14. Accessed March 18, 2019. Published 2018.
27. International Organization for Migration. Screening interview form of the International Organization for Migration for the Identification of Victims of Trafficking. https://www.unodc.org/documents/human-trafficking/Toolkit-files/08-58296_tool_6-6.pdf. Accessed June 25, 2019. Published 2006.
28. Polaris Project. Medical Assessment Tool. https://www.traffickingresourcecenter.org/sites/default/files/Assessment%20Tool%20-%20Medical%20Professionals.pdf. Accessed June 25, 2019. Published 2010.
29. Praed Foundation. Child Adolescent Needs and Strengths: Commercially Sexually Exploited (CANS-CSE). http://praedfoundation.org/general-manuals-cans. Accessed June 25, 2019. Published 2010.
30. Shared Hope International. Intervene Resource Package Practitioner Guide and Intake Tool. https://sharedhope.org/product/intervene-identifying-and-responding-to-americas-prostituted-youth. Accessed June 25, 2019. Published 2010.
31. National Human Trafficking Resource Center. Tools for Educators. https://humantraffickinghotline.org/sites/default/files/Educator%20Assessment%20Tool.pdf. Accessed June 25, 2019. Published 2011.
32. Polaris Project. Human Trafficking Assessment Tool for Airlines and Airports. https://humantraffickinghotline.org/sites/default/files/Assessment%20Tool%20-%20Airlines%20%26%20Airports.pdf. Accessed June 25, 2019. Published 2011.
33. Indiana Protection for Abused and Trafficked Humans Task Force. Human Trafficking Identification: Screening Tool and Report. https://www.ismanet.org/pdf/news/HumanTraffickingScreeningTool.pdf. Accessed June 25, 2019. Published 2012.
34. Covenant House. Homelessness, Survival Sex, and Human Trafficking: As Experienced by the Youth of Covenant House New York. https://humantraffickinghotline.org/sites/default/files/Homelessness%2C%20Survival%20Sex%2C%20and%20Human%20Trafficking%20-%20Covenant%20House%20NY.pdf. Accessed June 25, 2019. Published 2013.
35. Ohio Human Trafficking Task Force. Human Trafficking Screening Tool. https://humantrafficking.ohio.gov/links/Screening-Tool.pdf. Accessed June 25, 2019. Published 2013.
36. Loyola University Center for the Human Rights of Children. Childright: New York Child Trafficking Rapid Screening Instrument (RST). https://www.luc.edu/media/lucedu/chrc/pdfs/ChildRight_RapidScreeningInstrument_CHRC_FNALDRAFT_JULY%20(1).pdf. Accessed June 25, 2019. Published 2014.
37. Vera Institute of Justice. Improving human trafficking victim identification: Validation and Dissemination of a Screening Tool. https://www.ncjrs.gov/pdffiles1/nij/grants/246712.pdf. Accessed June 25, 2019. Published 2014.
38. Michigan Department of Health and Human Services & Genesee County Medical Society. Human Trafficking Victim Identification Toolkit for Physicians and Other Medical Professionals. http://gcms.org/Bulletins/2015_10_01%20-%20Human%20Trafficking%20Victim%20Identification%20Toolkit.pdf. Accessed June 25, 2019. Published 2015.
39. United States Conference of Catholic Bishops Migration and Refugee Services. National Slavery and Human Trafficking Prevention Month & Day of Prayer Toolkit. http://dev.usccb.org/about/anti-trafficking-program/become-a-shepherd-tool-kit.cfm. Accessed June 25, 2019. Published 2017.
40. WestCoast Children's Clinic. Commercial Sexual Exploitation Identification Tool (CSE-IT). http://www.westcoastcc.org/wp-content/uploads/2016/09/WCC-CSE-IT2.0andUserManual-9.22.16.pdf. Accessed June 25, 2019. Published August 2016.
41. Urban Institute. Pretesting a Human Trafficking Screening Tool in the Child Welfare and Runaway and Homeless Youth Systems. https://www.urban.org/sites/default/files/publication/93596/pretesting_tool_1.pdf. Accessed June 25, 2019. Published 2017.
42. Chisolm-Straker M, Sze J, Einbond J, White J, Stoklosa H. Screening for human trafficking among homeless young adults. https://www.sciencedirect.com/science/article/pii/S0190740918307540. Accessed June 25, 2019. Published March 2019.

Preventive Medicine 114 (2018) 164–167

Contents lists available at ScienceDirect

Preventive Medicine

journal homepage: www.elsevier.com/locate/ypmed

Review Article

Multi-level prevention of human trafficking: The role of health care professionals

V. Jordan Greenbaum[a,*], Kanani Titchen[b], Ingrid Walker-Descartes[c], Anastasia Feifer[d], Corey J. Rood[e], Hiu-fai Fong[f]

[a] Stephanie V. Blank Center for Safe and Healthy Children, Children's Healthcare of Atlanta, International Centre for Missing and Exploited Children, 975 Johnson Ferry Rd, NE, Ste 350, Atlanta, GA 30342, United States of America
[b] Children's Hospital at Montefiore, 3415 Bainbridge Ave, Bronx, NY 10467, United States of America
[c] Maimonides Children's Hospital at Maimonides Medical Center, 4802 Tenth Avenue, Brooklyn, NY 11219, United States of America
[d] Harbor-UCLA Medical Center, Department of Pediatrics, K.I.D.S. Hub, 1000 W. Carson St., Bldg. N-26, Torrance, CA 90502, United States of America
[e] University of Utah School of Medicine, Center for Safe and Healthy Families, Primary Children's Hospital, 81 N Mario Capecchi Dr, Salt Lake City, UT 84113, United States of America
[f] Division of General Pediatrics, Boston Children's Hospital, Department of Pediatrics, Harvard Medical School, 21 Autumn St, Boston, MA 02215, United States of America

ARTICLE INFO

Keywords:
Human trafficking
Community medicine
Social determinants of health
Child sexual abuse

ABSTRACT

As a major public health issue, human trafficking (HT) affects individuals, families, communities, and societies around the world. A public health approach to combating HT has been advocated. Such an approach seeks to prevent HT by engaging diverse stakeholder groups in addressing risk factors at multiple levels. As a key stakeholder group, health care professionals (HCPs) play a critical role in HT prevention. Herein, we use the Centers for Disease Control (CDC) Social-Ecological Model as a framework to present potential HT prevention strategies for health care professionals. As clinicians, HCPs may deliver tailored interventions to patients and families to address individual- and relationship-level risk factors for HT in the health care setting. As educators, advocates, and researchers, HCPs may collaborate across sectors to implement community- and society-level prevention strategies. Such strategies may include enhancing awareness of HT through education; advocating for local and national policies that promote community health and wellness; combating social or cultural norms that contribute to HT; and building a strong evidence-base to guide future HT prevention programs. Guided by the CDC Social-Ecological Model, we recommend that HCPs use their diverse skills to target risk factors for HT at multiple levels and thereby expand their impact in preventing this form of exploitation.

1. Introduction

Human trafficking (HT) involves the forced exploitation of others, typically for sexual or labor purposes (United Nations Human Rights, 2000). As a major public health issue, it affects individuals, families, communities, and societies around the world (United Nations Office on Drugs and Crime, 2016). HT victims experience injuries, infections, untreated chronic disease, and mental health problems (Goldberg et al., 2016; Lederer and Wetzel, 2014; Zimmerman et al., 2003). Families of victims are traumatized by separation, social stigma, and lasting multigenerational health effects (Chisolm-Straker and Stoklosa, 2017). Further, HT has a corrosive effect on communities and societies, undermining local morals and values (Chisolm-Straker and Stoklosa, 2017).

Given these significant consequences, a public health approach to combatting HT has been advocated (Institute of Medicine and National Research Council, 2013). Such an approach seeks to prevent HT by engaging diverse stakeholder groups in addressing risk factors for HT at multiple levels (Mercy et al., 1993). The Centers for Disease Control (CDC) Social-Ecological Model (Centers for Disease Control and Prevention, n.d.) illustrates how factors at the individual, relationship, community, and society levels interact to influence risk for violence, and posits that prevention strategies are most sustainable when they target factors at each of these levels. As a key stakeholder group, health care professionals (HCPs) play a critical role in HT prevention. Although recent publications have urged HCPs to improve identification and treatment of HT victims (Diaz et al., 2014; Greenbaum and

* Corresponding author.
E-mail address: Jordan.greenbaum@choa.org (V.J. Greenbaum).

https://doi.org/10.1016/j.ypmed.2018.07.006
Received 8 February 2018; Received in revised form 26 May 2018; Accepted 4 July 2018
Available online 05 July 2018
0091-7435/

Crawford-Jakubiak, 2015; Todres and Clayton, 2014), the role of HCPs extends far beyond screening and medical care. With diverse skills as clinicians, educators, advocates, and researchers, HCPs are uniquely positioned to engage in broader prevention efforts that target populations across the risk continuum and seek to mitigate multi-level contributors to HT.

Herein, we use the CDC Social-Ecological Model as a framework to present potential HT prevention strategies for HCPs. First, we discuss how HCPs may incorporate prevention strategies into their clinical work with patients and families in the health care setting. Next, we highlight how HCPs may collaborate across sectors to implement community- and society-level prevention strategies in education, advocacy, and research.

2. Targeting prevention at the individual and relationship levels

As clinicians, HCPs can prevent HT by identifying potential victims when they present for medical care and delivering tailored, risk-based interventions. This requires HCPs to be familiar with risk factors that increase vulnerability for HT and that may be revealed during routine history-taking. Such individual- and relationship-level risk factors are well described in the literature (Chisolm-Straker and Stoklosa, 2017; Institute of Medicine and National Research Council, 2013; Titchen et al., 2016; Gibbons and Stoklosa, 2016; Greenbaum and Bodrick, 2017; Loyola University New Orleans's Modern Slavery Research Project, n.d.; United States Department of State, 2016). Some of the more common, empirically supported, and readily identifiable risk factors are listed in Table 1. Although HT screening tools for use in health care settings are only in the early stages of development (West Coast Children's Clinic, n.d.; Greenbaum et al., 2015), they may be used to assist HCPs with assessing key individual-level risk factors (e.g., runaway behavior, substance abuse, risky sexual activity). A detailed social history may then be used to reveal important relationship-level risk factors for HT (e.g., family violence, peer involvement in commercial sex).

After identifying individual- and relationship-level risk factors, HCPs may then deliver tailored interventions to patients and families (Table 1). To target behaviors associated with HT across the risk spectrum, HCPs may provide general anticipatory guidance about healthy sexual relationships and internet safety as well as more specific education about high-risk situations for HT, common recruitment techniques, and resistance strategies. Role-plays and motivational interview techniques (Gibbie and Lubman, 2012) may assist patients and families with developing resilience skills and investing in change. Individuals are often recruited into HT with promises of something desirable such as love, money, shelter, food, and employment (Reid, 2016). Thus, HCPs may provide risk-specific resources to patients who lack familial support, adequate housing, socioeconomic stability, and other basic needs as a strategy to reduce their vulnerability for HT recruitment. Given the logistical constraints of delivering interventions within the health care system (e.g., time, personnel), HCPs should leverage various resources within and outside of their practice setting. For example, they may use informational posters, brochures, videos, websites, and social media resources to supplement face-to-face anticipatory guidance and education. HCPs should partner with social workers and community health workers to more comprehensively meet the basic and psychosocial needs of patients and families. In addition, HCPs must be knowledgeable about community organizations that serve individuals with risk factors for HT (e.g., LGBTQ support programs, mental health agencies, substance abuse programs, and shelters) and how to link individuals safely to such organizations. HCPs should develop policies and protocols within their systems to streamline HT screening, assessment, and response to ensure a systematic approach to identification and intervention.

3. Targeting prevention at the community and society levels

Beyond clinical work with patients and families, HCPs may engage in community- and society-level prevention efforts as educators, advocates, and researchers. Risk factors for HT at the community and society levels include limited awareness of HT, insufficient multi-sector collaboration, community dysfunction, social or cultural norms, and limited evidence base for HT risk/resilience factors and prevention strategies (Table 1).

To address limited awareness of HT within the health care community, there have been increasing efforts to enhance education and training of HCPs about HT (Ahn et al., 2013). A variety of educational resources are now available for use by HCPs and trainees (Table 2). HCPs should take advantage of these resources to actively build their own knowledge base and teach others. To enhance awareness of HT in the broader community, HCPs must consider approaches beyond direct education of patients within the clinic setting. For example, HCPs may help adolescents and young adults create networks for peer-to-peer discussion about HT risk factors, prevention strategies, and local resources. Such an approach has proven to be effective for reducing suicide behaviors among high-school youth (Wasserman et al., 2010). Given the widespread use of mobile devices, social media, and related technologies (UNICEF, n.d.), HCPs should consider incorporating these tools in educational efforts targeting adolescents and young adults.

Insufficient multi-sector collaboration has been reported as a barrier to HT identification, intervention, and service provision (Institute of Medicine and National Research Council, 2013). As such, HCPs have been encouraged to establish partnerships with mental health, education, legal, public service, commercial, and government organizations to develop coordinated systems of surveillance and response (Institute of Medicine and National Research Council, 2013). HCPs should leverage these partnerships for prevention efforts as well. Multidisciplinary collaboration can help expand the reach of educational efforts, strengthen legislative advocacy efforts, and promote innovative research.

Because HT often occurs within the context of other community problems (Institute of Medicine and National Research Council, 2013), HCPs should utilize their expertise to advocate for policies and programs that promote community health and wellness, child welfare, gender equality, and violence prevention. Furthermore, they should work to combat social or cultural norms (e.g., gender-based discrimination and violence, sexualization of children, intolerance of sexual minorities) that may contribute to HT. Finally, HCPs should conduct and/or support research on factors influencing HT risk to inform the development and evaluation of effective prevention programs.

4. Conclusions

Beyond identification and treatment of HT victims, HCPs can play an important role in preventing HT. Guided by the CDC Social-Ecological Model, we recommend that HCPs use their diverse skills to target risk factors for HT at multiple levels. As clinicians, HCPs may deliver tailored interventions to patients and families to address

Table 1
Individual-, relationship-, community- and society-level human trafficking (HT) prevention strategies.

Individual- and relationship-level risk factors (United Nations Office on Drugs and Crime, 2016; Goldberg et al., 2016; Centers for Disease Control and Prevention, n.d.; Loyola University New Orleans's Modern Slavery Research Project, n.d.; Ahn et al., 2013; Wasserman et al., 2010; UNICEF, n.d.)	Example of prevention strategy
History of maltreatment, child welfare involvement, family violence family dysfunction (mental health disorders, substance abuse)	·Provide resources for evidence-based, trauma-informed programs to address prior abuse/neglect, promote positive parenting, prevent maltreatment, and/or mitigate associated impairment (Macmillan et al., 2009) ·Liaise with child welfare professionals to optimize family-centered service delivery in the health care and community settings (e.g., intimate partner violence services, evidence-based mental health services for family members, substance abuse rehabilitation)
LGBTQ status	·Provide resources for LGBTQ-specific emergency shelters, housing, suicide prevention and crisis intervention services, including hotline information ·Identify and address bullying of LGBTQ individuals https://www.stopbullying.gov/prevention/index.html ·Encourage peer support through LGBTQ community centers, local groups, and online communities Gay, Lesbian & Straight Education Network: https://www.glsen.org Genders & Sexualities Alliance Network: https://gsanetwork.org/ It Gets Better Project: https://itgetsbetter.org/ ·Promote family support and acceptance of LGBTQ individuals Parents, Families, and Friends of Lesbians and Gays: https://www.pflag.org Encourage medical and other service providers to carry readily identifiable symbols or signage that clearly acknowledge acceptance of all gender and sexual orientation identifying individuals.
Homelessness, runaway, and “thrown-away” status	·Provide housing resources including emergency shelter for immediate needs; housing and rent subsidy programs for longer-term housing stability; and housing attorneys to assist with housing placement and eviction threats, ·Provide resources for food insecurity, including local soup kitchens, Supplemental Assistance and Nutrition Program (SNAP), and Women, Infants and Children (WIC) ·Identify co-occurring mental health and substance abuse problems and refer to treatment and rehabilitation programs
Migrant and refugee status	·Refer to organizations that provide immediate relief and aid, protection, and ongoing advocacy for immigrants and refugees, for example: The International Committee of the Red Cross: https://www.icrc.org/en The International Rescue Committee: https://www.rescue.org ·Link to specialized refugee clinics ·Provide information on obtaining federal benefits through Continued Presence and appropriate visas (e.g., “T-visas” or “U-visas” in the U.S.) Become familiar with federal and state law and policy regarding mandatory reporting of unaccompanied minors
High-risk behavior in individuals and peers (e.g., substance abuse, sexual activity)	·Provide anticipatory guidance about substance use, healthy sexual relationships, and internet safety ·Provide education about HT including high-risk situations, common recruitment techniques, and resistance strategies ·Refer to mentoring or peer programs that promote healthy behaviors
Family poverty or unemployment	·Refer to government and community assistance programs such as WIC, SNAP, Medicaid, Children’s Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), and Low-Income Home Energy Assistance Program (LIHEAP) https://www.usa.gov/benefits ·Refer to programs for GED and college placement, job skills training, and professional attire donation

Community- and society-level risk factors	Example of prevention strategy
Limited awareness of HT in the health care and general communities	·Enhance knowledge of HCPs and general public about HT identification and intervention through direct education and public health campaigns (e.g., using peer-to-peer networks, social media tools)
Insufficient collaboration across multiple sectors that serve potential HT victims	·Partner with organizations in mental health, education, legal, public service, commercial, and government sectors to develop coordinated prevention efforts
Community dysfunction (e.g., crime, poverty, legal/political corruption, social upheaval, lack of resources)	·Advocate for local and national policies and programs that promote community health and wellness, child welfare, gender equality, and violence prevention ·Support [and provide targeted education to] community programs that address social determinants of health and HT risk factors (e.g. IPV and homeless shelters, immigrant/refugee centers, parenting programs)
Social or cultural norms (e.g., gender-based discrimination and violence, sexualization of children, intolerance of sexual minorities)	·Provide education to HCPs and general public about challenging these norms within their personal and professional settings (e.g., adopt gender-neutral forms, support anti-bullying programs)
Limited evidence base on risk/resilience factors and effective prevention strategies	·Conduct and support research on HT to guide the development and evaluation of prevention programs

Table 2
Educational resources for human trafficking.

Organization	Website
Office on trafficking in persons SOAR to health and wellness training	https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training
HEAL trafficking	https://healtrafficking.org/
Physicians Against the Trafficking of Humans (PATH)	http://www.doc-path.org/
Futures without violence	https://www.futureswithoutviolence.org/
National Human Trafficking Resource Center	https://humantraffickinghotline.org/nhtrc-hhs-online-trainings
United Nations Office on Drugs and Crime Human Trafficking Knowledge Portal	https://www.unodc.org/cld/en/v3/htms/index.html

individual- and relationship-level risk factors for HT in the health care setting. As educators, advocates, and researchers, HCPs may collaborate with stakeholders from different sectors to implement community- and society-level prevention strategies. Such strategies may include enhancing awareness of HT through education; advocating for local and national policies that promote community health and wellness; combating social or cultural norms that contribute to HT; and building a strong evidence-base to guide future HT prevention programs. By adopting a comprehensive, multi-level approach, HCPs may greatly expand their impact in preventing HT.

Declarations of interests

Drs. Greenbaum, Titchen, Walker-Descartes, Feifer, Rood and Fong have no conflicts of interest to disclose.

Acknowledgements

No funding source.

Ethics committee approval

No IRB approval was sought for this viewpoint article.

Authors' contributions

All authors participated in the conceptualization of the manuscript. Dr. Greenbaum, Dr. Feifer, and Dr. Walker-Descartes wrote the first draft of the manuscript. All authors critically reviewed and revised the manuscript for important intellectual content.

References

Ahn, R., Alpert, E.J., Purcell, G., Konstantopoulos, W.M., McGahan, A., et al., 2013. Human trafficking: review of educational resources for health professionals. Am. J. Prev. Med. 44, 283–289.

Centers for Disease Control and Prevention The social-ecological model: a framework for prevention. Available at. https://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html, Accessed date: 29 August 2017.

Chisolm-Straker, M., Stoklosa, H., 2017. Human Trafficking Is a Public Health Issue: A Paradigm Expansion in the United States. Springer International, Cham, Switzerland.

Diaz, A., Clayton, E.W., Simon, P., 2014. Confronting commercial sexual exploitation and sex trafficking of minors. JAMA Pediatr. 168, 791–792.

Gibbie, T., Lubman, D.I., 2012. Motivational interviewing techniques: facilitating behavior change in the general practice setting. Aust. Fam. Physician 41, 660–666.

Gibbons, P., Stoklosa, H., 2016. Identification and treatment of human trafficking victims in the emergency department: a case report. J. Emerg. Med. 50, 715–719.

Goldberg, A.P., Moore, J.L., Houck, C., Kaplan, D.M., Barron, C.E., 2016. Domestic minor sex trafficking patients: a retrospective analysis of medical presentation. J. Pediatr. Adolesc. Gynecol. http://dx.doi.org/10.1016/j.jpag.2016.08/010. (Epub ahead of print).

Greenbaum, J., Bodrick, N., 2017. AAP committee on child abuse and neglect, AAP section on international health. Global human trafficking and child victimization: policy statement. Pediatrics 140, e20173138.

Greenbaum, J., Crawford-Jakubiak, J., 2015. Committee on child abuse and neglect. Child sex trafficking and commercial sexual exploitation: health care needs of victims. Pediatrics 135, 566–574.

Greenbaum, V.J., Dodd, M., McCracken, C., 2015. A short screening tool to identify victims of child sex trafficking in the health care setting. Pediatr. Emerg. Care 23.

Institute of Medicine and National Research Council, 2013. Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States. The National Academies Press, Washington, D.C.

Lederer, L., Wetzel, C., 2014. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. Ann. Health Law 23, 61–91.

Loyola University New Orleans's Modern Slavery Research Project Labor and sex trafficking among homeless youth: a ten-city study executive summary. Available at. https://covenanthousestudyorg/landing/trafficking/docs/Loyola-Research-Resultspdf, Accessed date: May 2018.

Macmillan, H.L., Wathen, C.N., Barlow, J., Fergusson, D.M., Leventhal, J.M., Taussig, H.N., 2009. Interventions to prevent child maltreatment and associated impairment. Lancet 373, 250–266.

Mercy, J.A., Rosenberg, M.L., Powell, K.E., Broome, C.V., Roper, W.L., 1993. Public health policy for preventing violence. Health Aff. 12, 7–29.

Reid, J.A., 2016. Entrapment and enmeshment schemes used by sex traffickers. Sex. Abus. 28, 491–511.

Titchen, K.E., Douglas, K., Martinez, K., White, K., 2016. Ovarian cystadenoma in a trafficked patient. Pediatrics 137, e20152201.

Todres, J., Clayton, E.W., 2014. Responding to the sexual exploitation of minors. N. Engl. J. Med. 370, 1282–1283.

UNICEF Children in a digital world: the state of the world's children. Available at. https://wwwuniceforg/sowc2017/, Accessed date: December 2018.

United Nations Human Rights, 2000. Protocol to prevent, suppress and punish trafficking in persons especially women and children, supplementing the United Nations convention against transnational organized crime. Available at. http://wwwohchrorg/EN/ProfessionalInterest/Pages/ProtocolTraffickingInPersonsaspx, Accessed date: 7 July 2017.

United Nations Office on Drugs and Crime, 2016. Global report on trafficking in persons. United Nations publications, Sales No E16IV6. Available at. http://www.unodc.org/documents/data-and-analysis/glotip/2016_Global_Report_on_Trafficking_in_Persons.pdf, Accessed date: 23 May 2018.

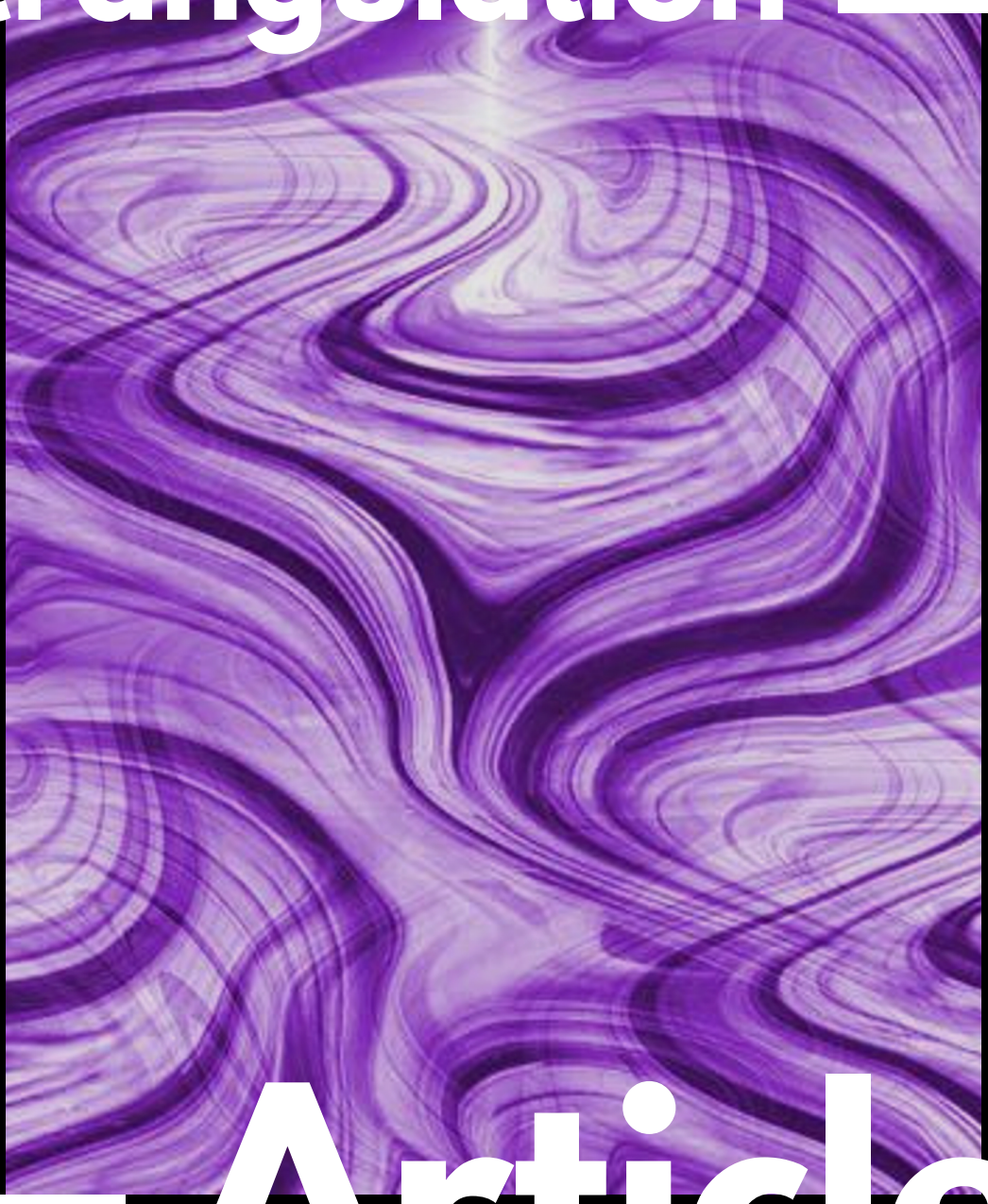
United States Department of State, 2016. Trafficking in persons report. Accessed at. http://www.state.gov/documents/organization/258876.pdf, Accessed date: 26 July 2016.

Wasserman, D., Carli, V., Wasserman, C., Apter, A., Balazs, J., et al., 2010. Saving and empowering young lives in Europe (SEYLE): a randomized controlled trial. BMC Public Health 10, 1092–1106.

West Coast Children's Clinic Commercial sexual exploitation identification tool (CSE-IT): version 2.0. Available at. http://wwwwestcoastccorg/cse-it/, Accessed date: 29 August 2017.

Zimmerman, C., Yun, K., Shvab, I., Watts, C., Trappolin, L., Mea, Treppete, 2003. The Health Risks and Consequences of Trafficking in Women and Adolescents: Findings from a European Study. London School of Hygiene and Tropical Medicine (LSHTM), London.

Strangulation



Articles

JAMA Otolaryngology–Head & Neck Surgery | Review

Recognition and Documentation of Strangulation Crimes
A Review

Michael Armstrong Jr, MD; Gael B. Strack, Esq

IMPORTANCE Strangulation accounts for 10% of violent deaths in the United States and 15% to 20% of deaths associated with domestic violence. However, strangulation deaths represent only a small fraction of nonfatal strangulation assaults, which occur with daily frequency in medium to large US cities. Careful evaluation and documentation of strangulation injuries may identify life-threatening medical conditions, and may facilitate prosecution of strangulation crimes.

OBSERVATIONS The most recent article on strangulation identified in the otolaryngology literature was published in 1989, leaving a generation of head and neck surgeons without current guidance regarding this injury. However, strangulation is a common form of intimate partner violence. Among the 300 cases of strangulation reviewed in San Diego in 1995, most survivors (94%) were women who were strangled by a male member of their own household. Many state laws require evidence of injury to prosecute felony strangulation, but as shown in the review of 300 cases, most survivors (97%) were strangled with the perpetrator's hands, leaving little to no sign of injury in most cases. Survivors may seek an otolaryngology consultation with complaints of hoarseness, sore throat, respiratory disturbance, or accidental injury to the neck. A thorough head and neck examination may reveal marks on the neck, facial petechiae, and neck swelling. Fiberoptic laryngoscopy is recommended to look for petechiae and swelling in the airway. Chest radiographs may demonstrate postobstructive edema, and computed tomography of the neck may demonstrate vascular injuries. The most sensitive test for subtle strangulation injuries is magnetic imaging of the neck. Careful examination and documentation can provide critical evidence for the prosecution of these crimes.

CONCLUSIONS AND RELEVANCE Otolaryngologists should be knowledgeable of the subtle patterns of injury and potentially life-threatening complications of strangulation and should consider domestic violence in women presenting with throat complaints or bruises on the neck.

JAMA Otolaryngol Head Neck Surg. 2016;142(9):891-897. doi:10.1001/jamaoto.2016.0293
Published online June 16, 2016.

CME Quiz at jamanetworkcme.com and CME Questions page 932

Author Affiliations: Richmond ENT, Richmond, Virginia (Armstrong); Department of Otolaryngology, Virginia Commonwealth University, Richmond (Armstrong); Department of Nursing, Virginia Commonwealth University, Richmond (Armstrong); Training Institute on Strangulation Prevention, Alliance for HOPE International, San Diego, California (Strack); California Western School of Law, San Diego (Strack).

Corresponding Author: Michael Armstrong, Jr, MD, Richmond ENT, Ste 110, 8700 Stony Point Pkwy, Richmond, VA 23235 (drarmstrong@richmondent.com).

Any person who, without consent, impedes the blood circulation or respiration of another person by knowingly, intentionally, and unlawfully applying pressure to the neck of such person resulting in the wounding or bodily injury of such person is guilty of strangulation, a Class 6 felony.
-Code of Virginia § 18.2-51.6.

In the Commonwealth of Virginia, felony strangulation is defined as intentional obstruction of blood circulation or respiration by application of pressure to the neck, resulting in wounding or bodily injury (Code of Virginia § 18.2-51.6). However, studies of strangulation survivors indicate that most survivors do not have documented injuries, and many do not seek medical care. For those who do seek help, an otolaryngologist can play a critical role in the evaluation and forensic examination of the survivor. However, there is very little research on strangulation injuries outside of the disciplines of forensic pathology and emergency medicine. We have found only 1 major case series of strangulation injuries (112 fatal, 59 nonfatal) described in the otolaryngology literature.[1] In the 30 years since that publication, we have have found only 1 single case report of strangulation in an otolaryngology journal.[2] This review was prompted when one of the authors (M.A.) was consulted as an expert witness in a strangulation trial.

Report of Cases

Case 1

A woman in her 30s was picking up her child from her estranged husband when an argument erupted. He threatened to kill her and squeezed her neck with his thumbs across her trachea, pressing down on her carotid arteries until she lost consciousness. When she recovered, he placed her in a choke hold with his arm around her

neck. A bystander interrupted the assault and allowed the wife to escape. The police took her reluctantly to a local emergency department, where she was evaluated and photographed by a forensic nurse examiner. The patient initially complained of difficulty breathing, hoarseness, sore throat, and dysphagia. A computed tomograph (CT) of the neck was negative, and symptoms were resolving. She was discharged without follow-up.

Case 2

In an unrelated case, a woman in her 20s was seen in an emergency department. She reported that she was brutally beaten by her husband and dragged by the neck, but she did not mention being "choked." She complained of pain in the neck, face, and ribs and had multiple contusions. The emergency department physician documented pain, tenderness, and a small abrasion on the neck. No photographs were taken. A CT of the neck was negative, and she was released.

Case Follow-up

In the first case, the forensic nurse examiner clearly documented the history and physical examination results but was not permitted to testify as an expert. The emergency department physician had not documented any injury. The expert witness (M.A.) testified that the medical findings were consistent with strangulation, but acknowledged that the medical records alone could not prove strangulation. The husband pled guilty to misdemeanor assault, but was acquitted on the felony strangulation charge because the prosecution was unable to prove that an injury occurred as a result of the strangulation.

In the second case, the defendant pled guilty to domestic violence—a class 6 felony because it was his third such conviction. However, the treating emergency department physician was not willing to testify to strangulation based on the medical record. The prosecuting attorney accepted the guilty felony plea for repeated domestic assault and dropped the strangulation charge.

Historical Context

After the murders of 2 teenage girls in San Diego, California, the San Diego City Attorney's office conducted an extensive study of 300 "choking" cases submitted for misdemeanor prosecution.[3-5] Before their murders, each teenager had previously reported to police that she had been choked, but neither case had been prosecuted. This study resulted in a series of articles on strangulation that was published in the *Journal of Emergency Medicine* in 2001.[3-8] The San Diego Family Justice Center[9] was opened in 2002, followed by the Training Institute on Strangulation Prevention[10,11] in 2011 to formally educate police investigators and health care workers in the evaluation and prevention of strangulation injuries (a documentation chart for nonfatal strangulation for use by health care professionals is shown in **Figure 1** and **Figure 2**). As experts in soft-tissue surgery and injuries of the neck, otolaryngologists should be cognizant of the patterns of injury and the symptoms of strangulation. Otolaryngologists should be prepared to evaluate these patients and to testify on their behalf when needed.

Definitions

Strangulation is generally defined as the sustained impairment of air or blood flow through the neck as a result of external pressure. Obstruction of air or blood flow through the neck can result in *asphyxia*, which is an injury or medical condition caused by hypoxia. Strangulation should be distinguished clinically from *choking*, which most properly refers to an internal obstruction of the airway, such as a foreign body, mass, or laryngospasm. Other causes of asphyxia include drowning due to immersion in a liquid, suffocation from directly covering the airway, and environmental oxygen deprivation, such as from combustion or an enclosed space.

Strangulation is categorized among 4 principal methods. *Manual strangulation*, or *throttling*, is performed by applying direct pressure with the hands or arms around the neck. Manual strangulation accounts for most cases of strangling in domestic assaults.[3] *Ligature strangulation*, or *garroting*, is performed by tightening a cord or a ropelike ligature around the neck. *Hanging* is defined as suspending the body weight from a cord or a ropelike ligature around the neck. *Postural strangulation* has also been described, in which body weight or pressure against an object causes pressure on the neck without a ligature.

Pathophysiologic Features

Strangulation may occur with occlusive pressure that impedes ventilation, arterial blood flow, or venous return. The probability of injury or death depends on the location, duration, and amount of pressure applied. Well-placed massage directly to the carotid body can cause instantaneous syncope and cardiac dysrhythmia through vagal reflexes. More commonly, throttling assaults result in diffuse circumferential compression of the internal and external jugular veins. The Training Institute on Strangulation Prevention[11] teaches that venous compression is easily achieved with about 2 kg of manual force applied to the lateral neck, and the carotid arteries can be occluded with 5 kg of force applied to the anterior neck, compressing the arteries against the lateral processes of vertebrae C4-C6. About 15 kg of force can compress the trachea, and 30 kg can compress the vertebral arteries. However, these numbers are not based on manual strangulation, but on cadaver studies of hanging performed by French forensic pathologist Paul Brouardel in 1897.[12] The actual force required to compress vascular structures will vary significantly depending on the thickness of the neck and the strength of the neck musculature.[5] Pressure equals force divided by the surface area; intuitively, direct thumb pressure of only 3 psi on the carotid arteries should exceed a systolic blood pressure of 155 mm Hg. Head and neck surgeons should be aware that the jugular veins can be painlessly compressed during manual examination of the neck.[13] By contrast, an automotive safety study demonstrated that fresh cadaver larynxes can sustain a static weight of 16 kg without fracture.[14] We can conclude that airway compression is less likely than vascular compression, but it can be achieved easily by an assailant placing his body weight on the anterior neck of the victim or by use of a ligature. If the force is applied over a very narrow surface area—a clothesline ligature as opposed to a broad belt, for example—then much less force is necessary. Brouardel[12] also demonstrated convincingly that hanging generally does not injure the trachea or the larynx because the noose invariably slides above the larynx to the mandible and compresses the soft tissues in the hypopharyngeal airway.

Although hanging is no longer a common method of capital punishment in the United States, the selfie generation has provided

Figure 1. Documentation Chart for Nonfatal Strangulation—History

History:

How was the patient strangled?

☐ One hand (R or L) ☐ Two hands ☐ Forearm (R or L) ☐ Knee/Foot

☐ Ligature (Describe): _____

☐ How long? ____ seconds _____ minutes or Can't remember?

☐ From 1 to 10, how hard was the suspect's grip? (low): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (high)

☐ Continuous pressure? ☐ Increased pressure?

☐ From 1 to 10, how painful was it? (low): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (high)

☐ Multiple attempts: _____ ☐ Multiple methods:_____

Could the patient breathe, talk and/or scream?

Is the suspect **RIGHT** or **LEFT** handed? (Circle one)

What did the suspect say while he was strangling the patient, before and/or after?

Was she simultaneously smothered while being strangled? Shaken? Straddled? Restrained?

Head pounded against wall, floor or ground? (Possible concussion)

Where did the incident occur (Any corroborating evidence/possible sexual assault)?

Any visual changes (describe)?

Any hearing changes (describe)?

Any breathing changes (describe)?

Any changes in consciousness (describe)?

What did the patient think was going to happen?

How or why did the suspect stop strangling her?

Any witnesses?

What was the suspect's demeanor? Describe suspect's facial expression during strangulation?

Describe prior strangulation? Prior domestic violence? Prior threats? Prior intimidation?

Clip and copy

Adapted with permission from the Training Institute on Strangulation Prevention and California District Attorneys Association.[10]

unexpected new insight into death by strangulation. By reviewing video recordings of 14 fatal hangings (4 suicidal, 1 homicidal, and 9 erotic), the Working Group on Human Asphyxia[15] observed that victims lost consciousness within about 10 seconds of vascular occlusion. Almost simultaneous onset of convulsions was followed by a decerebrate rigidity that progressed to decorticate rigidity within the first minute. Respiratory effort and breathing sounds continued for about 2 minutes, at which time the body was generally flaccid, except for isolated muscle twitches that were observed for about 4 minutes after hanging. The continuation of respiratory sounds confirmed that airway obstruction was not the initial cause of asphyxiation and death in most cases.[15]

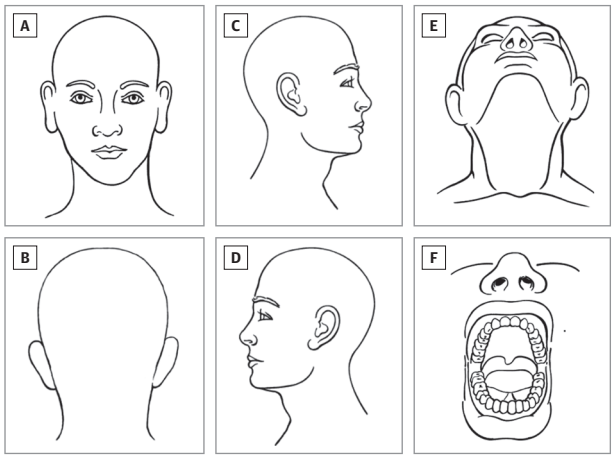
The physiology of strangulation is completely different from the desaturation that occurs during a difficult intubation or airway emergency. While a well-oxygenated, apneic adult may sustain tissue oxygenation for more than 2 minutes, bilateral carotid artery occlusion can cause brain damage within this time.[13] As with reconstructive flap failures, venous occlusion causes not only ischemia but also engorgement of the blood vessels and extravasation into the tissues (petechiae). Petechiae occur within 20 to 30 seconds of bilateral

Figure 2. Documentation Chart for Nonfatal Strangulation—Physical Examination

Physical Examination

Breathing Changes	Voice or Vision Changes	Swallowing Changes	Behavioral Changes	Other
☐ Difficulty breathing ☐ Hyperventilation ☐ Unable to breathe Other:	☐ Raspy voice ☐ Hoarse voice ☐ Coughing ☐ Unable to speak ☐ Vision changes	☐ Trouble swallowing ☐ Painful to swallow ☐ Pain to throat ☐ Nausea/vomiting ☐ Drooling	☐ Agitation ☐ Amnesia ☐ PTSD ☐ Hallucinations ☐ Combativeness	☐ Dizzy or faint ☐ Headaches ☐ Urination ☐ Defecation ☐ Hearing changes

Use diagrams to mark visible injuries



Face	Eyes and Eyelids	Nose	Ear	Mouth
☐ Red or flushed ☐ Pinpoint red spots (petechiae) ☐ Scratch marks	☐ Petechiae to **R** and/or **L** eyeball (circle one) ☐ Petechiae to **R** and/or **L** eyelid (circle one) ☐ Bloody red eyeball(s)	☐ Bloody nose ☐ Broken nose (ancillary finding) ☐ Petechiae	☐ Petechiae (external and/or ear canal ☐ Bleeding from ear canal	☐ Bruising ☐ Swollen tongue ☐ Swollen lips ☐ Cuts/abrasions (ancillary finding)
Under Chin	**Chest**	**Shoulders**	**Neck**	**Head**
☐ Redness ☐ Scratch marks ☐ Bruise(s) ☐ Abrasions	☐ Redness ☐ Scratch marks ☐ Bruise(s) ☐ Abrasions	☐ Redness ☐ Scratch marks ☐ Bruise(s) ☐ Abrasions	☐ Redness ☐ Scratch marks ☐ Fingernail marks ☐ Bruise(s) ☐ Swelling ☐ Ligature mark	☐ Petechiae ☐ Hair pulled ☐ Bump ☐ Skull fracture ☐ Concussion

To All Health Care Providers: Having been advised of my right to refuse, I hereby consent to the release of my medical/dental records related to this incident to local law enforcement, my attorney, my advocate, the District Attorney's Office and/or the City Attorney's Office.

Patient Signature: _____ Date: _____

Adapted with permission from the Training Institute on Strangulation Prevention, *The Investigation and Prosecution of Strangulation Cases*, Appendices 71,72. https://www.cdaa.org/wp-content/uploads/Strangulation-Manual.pdf

Adapted with permission from the Training Institute on Strangulation Prevention and California District Attorneys Association.[10]
PTSD indicates posttraumatic stress disorder.

venous occlusion and may be more immediately damaging to the brain than arterial compromise.[13] Based on the observations of seizures and posturing among the video recordings, it appears that brain injury occurs within the first minute of hanging.[15] Among survivors, cerebral edema may result in subsequent brainstem herniation and further injury. Survivors may also develop anoxic encephalopathy days after the injury. The most sensitive areas of the brain include the hippocampus, dentate nucleus, and cerebellar Purkinje cells. Persistent vegetative coma or brain death may ensue while other body systems continue to function.[5]

Clinical Evaluation of the Survivor

Symptoms and physical findings after strangulation may be difficult to detect without specific training and careful examination. The seriousness of the internal injury may take hours to be appreciated, and delayed death has been reported.[5] In a study of 300 domestic violence cases[3] in which the survivor reported being choked, 67% of victims reported no symptoms after the incident. Only 18% of patients reported pain and 5% reported changes in breathing. Only 2% reported difficulty with swallowing and only 1% reported voice changes. Most patients had no visible injury on

physical examination by the police officer, and only 15% (45 of 300 patients) had injuries that were visible in photographs. Most survivors (95%) did not seek medical attention within the first 48 hours.[3]

Those who do seek medical attention may complain of difficulty breathing, neck pain, sore throat, and/or dizziness. At least one-third complain of hoarseness, dysphagia, neck swelling, and tinnitus. In another study,[7] only 7 of 41 survivors referred to a hospital-affiliated women's shelter recalled loss of consciousness. Loss of consciousness and loss of bowel or bladder continence are indicative of brain dysfunction and potentially lethal strangulation.[16] Loss of consciousness may be underestimated by victims, because a victim is by definition unaware when fully unconscious. Anxiety or hyperventilation may be discounted by medical personnel, and hoarseness may be incorrectly attributed to screaming or to tobacco use. Delayed complications may include insomnia, anxiety, depression, and other symptoms of posttraumatic stress disorder.[4] Swelling in the neck and airway compromise may develop up to 48 hours later. Stanley and Hansen[17] described 3 strangulation survivors who presented 1 to 4 days after the strangulation attempt. Two had laryngeal fractures and one had an abscess. Kuriloff and Pinkus[2] described another patient who presented with stridor and a neck abscess 36 hours after being strangled. None of these 4 patients had recognized injuries immediately after the assault, but all 4 required an emergency tracheotomy.[2,17] Overnight hospital observation is recommended to monitor the airway, evaluate for mental health issues, consult social services, and make plans for future safety. Further evaluation by neurosurgery or otolaryngology may also be indicated.[18]

Results of a physical examination may reveal petechiae in the skin, conjunctiva, or other mucosal surfaces. Petechiae may be caused by asphyxia from strangulation, aspiration, suffocation, drowning, or any number of causes. The presence of petechiae does not prove strangulation, but in the presence of a clinical history of strangulation, petechiae are a sign of a serious, life-threatening attack.[16,19] Contusions may be visible from the assailant's fingers and especially the thumbs, which are the strongest part of the hand. Fingernail scratches may be present from the victim's defensive efforts. Ligature marks are characteristic of the object used and will typically be horizontal in ligature strangulation cases but travel obliquely in the case of hanging. The presence of these findings does not prove strangulation, and the absence of these findings does not exclude the possibility of strangulation, even in fatal cases.[5,20] Photographic documentation of even the smallest lesions can be critical in criminal trials.

Diagnostic testing may include immediate pulse oximetry and chest radiography to exclude postobstructive pulmonary edema. Any patient with hoarseness, respiratory distress, or neck swelling should undergo evaluation with fiber-optic laryngoscopy or a CT scan of the neck to assess the airway and to rule out a soft-tissue hematoma. The patient should be intubated if progressive airway swelling or respiratory distress is present. If vascular injury or thrombosis is suspected, a CT arteriogram of the neck is more sensitive than carotid Doppler ultrasonography and nearly as sensitive as selective arteriography.[16] Patients with evolving neurologic signs require a thorough neurovascular workup, including vascular studies and brain imaging.[4] All patients with a history of unconsciousness, loss of bowel or bladder control, facial petechiae, or swelling of the airway or neck have survived a life-threatening strangulation and should be observed in the emergency department or hospital for 12 to 24 hours.[19]

Plane radiographs of the neck may reveal free air in the soft tissue or a fracture of the hyoid, but these findings are quite rare with isolated strangulation. Cervical spine fractures and dislocations are also extremely rare, except after a severe beating or when hanged after being dropped from a height.

In the one otolaryngology series on strangulation, Line et al[1] reviewed their experience with strangulation hospital admissions and autopsy cases across 11 or 12 years in Los Angeles. This series included only the most severely injured and excluded those treated and released from the emergency department as well as any who did not seek medical care. Forty-eight of 59 hospitalized survivors (81%) had been hanged, 25 of them while in police custody or in jail. Seventeen (29%) required intubation and 5 (8%) required cardiopulmonary resuscitation. Only 3 of the survivors (5%) had immediately life-threatening laryngeal injuries, but the authors described several examples of more subtle laryngeal and hyoid fractures. Ninety percent of the survivors (53 of 59) were men. By contrast, 84 of 112 victims of fatal strangulation (75%) were women. Laryngeal fractures were common on autopsy and twice as likely in deceased women (53%) as in deceased men (25%). Neck injuries were also more common after manual strangulation (37 of 57 [65%]) compared with suicidal hangings and ligature strangulation (13 of 52 [25%]). Given the frequency of laryngeal injuries in this population, the authors recommended routine CT scans on strangulation survivors.[1]

Magnetic resonance imaging provides the most sensitive method of documenting an injury to the neck, with swelling or edema seen in 31 of 56 strangulation survivors (55%) in a 2009 Swiss study.[19] Patients with injuries deep to the platysma were more likely to have ocular petechiae on examination or to report loss of consciousness. Although magnetic resonance imaging is not routinely used for emergency medical management and has not been shown to affect patient care, it is a very sensitive tool for documenting deep injuries to the neck that might not be visible on results of a physical examination. This documentation may become an important piece of evidence in a criminal trial.

Intimate Partner Violence

Intimate partner violence affects millions of women and men in the United States each year. The Centers for Disease Control and Prevention[21] report that 22.3% of women and 14.0% of men have experienced physical violence from an intimate partner in their lifetime. Intimate partners are defined as current or former spouses, boyfriends, girlfriends, dating partners, or ongoing sexual partners. Violent acts may include physical or psychological abuse, unwanted sexual advances, and stalking.[21] In 2013, the Attorney General of Virginia reported 34 836 emergency protective orders in family abuse cases and more than 65 000 hotline calls for domestic and sexual violence.[22] In addition, 122 family and intimate partner homicides occurred in 2013. Henrico County, Virginia, a suburb of Richmond, with less than 300 000 residents, had sufficient evidence to file strangulation charges in 155 intimate partner violence cases from September 1, 2014, through August 31, 2015 (Deputy Commonwealth's Attorney Nancy Oglesby, oral communication,

September 24, 2015). Although these statistics provide some light on the scope of the problem in Virginia, they do not capture the large number of threats and assaults that are not reported by victims.

Among the 300 cases of strangulation reviewed in San Diego in 1995,[3] 99% of the defendants were male. In most cases (94%), the defendant was the current husband (25%), current boyfriend (43%), or parent of her child (26%). Only 6% of defendants were described as a former husband, boyfriend, or roommate. Eighty-nine percent of these couples had a history of domestic violence. Ninety-seven percent of the victims reported manual strangulation, whereas only 3% reported the use of a ligature. Children were reported to have witnessed 41% of the incidents.[3]

Domestic strangulation is more than simple assault and battery. It is an effort to demonstrate absolute control of life and death over another. A survey of 62 women seeking asylum in 2 domestic violence women's shelters in Dallas, Texas, and Los Angeles, California,[7] reported that 68% acknowledged a history of strangulation and that 93% of the attackers lived in the same household as the survivor. Eighty-seven percent of strangulation survivors reported death threats. Most of these had been strangled on more than 1 occasion. With repeated episodes, the injuries escalate; injuries to the neck and throat and neurologic injuries were more common in women who had been strangled multiple times.[8] A case-control study in which the families of murder victims were interviewed regarding prior domestic violence[23] concluded that if a man strangles a woman, even just once, she is 7.5 times more likely to become a homicide victim (odds ratio, 7.48; 95% CI, 4.53-12.35).

Today, it is unequivocally understood that strangulation is one of the most lethal forms of domestic violence. Strangulation can produce minor injuries, bodily injury, or immediate or delayed death. Signs of life-threatening or near-fatal strangulation may include sight impairment, loss of consciousness, urinary or fecal incontinence, and petechiae. However, the evidence of the assault can be difficult to detect. The best medical evidence of strangulation is derived from post mortem examination of the body.[5,12,20] An autopsy affords the ability to examine all of the tissues of the neck, superficial and deep, and to track the force vector that produced the injuries. Given the significant risk for death and the very real terror experienced by survivors and their young witnesses, experts have successfully lobbied that strangulation be treated as a felony, not a misdemeanor.[18]

Unintentional Strangulation Deaths

Unintentional death may also occur owing to intentional strangulation performed to achieve a euphoric state or to enhance orgasmic pleasure. The "choking game" is intended to achieve brief euphoria without drugs through self-inflicted hypoxia. The practice is believed to have resulted in 82 deaths of adolescents from 1995 to 2007 in the United States, with a mean age of 13 years.[24] Many of these children had experimented with hypoxia in groups or through discussions with schoolmates. Fatality victims were generally found alone, without a suicide message, having strangled themselves by hanging.[24] In an anonymous survey of 7757 Oregon eighth graders, one-third were familiar with the choking game, and more than 1 in 20 had participated in intentional hypoxia.[25]

Autoerotic hypoxia is practiced primarily by men, but occasionally by women or by couples, with the expectation of intensifying orgasmic pleasure. Practitioners are typically adults who most commonly hang themselves with their feet in reach of the floor. Self-recorded videos of fatal strangulations indicate that victims may lose consciousness within 10 seconds of neck constriction and then become unable to rescue themselves.[15] The incidence of autoerotic fatalities may be underestimated, because families have been known to alter the scene of death to suppress evidence of autoeroticism.

Legal Considerations

For many years, police and prosecutors have failed to treat nonfatal strangulation assaults as serious crimes owing to a lack of visible injury, a lack of medical training, and a lack of strangulation laws. If strangulation cases were prosecuted at all, they were only prosecuted as simple misdemeanors.[10] Strack and colleagues[3] observed that 85% to 90% of domestic violence cases in San Diego from 1990 to 1997 were handled as misdemeanors, because no intent to injure or kill was documented. The Diana Gonzalez Strangulation Prevention Act of 2011 was a landmark legislation in California that made domestic strangulation with even minor injury a felony (California Penal Code §273.5). As of April 2015, strangulation is a felony in at least 39 states.[26]

Careful documentation of external and internal injury is critical to criminal prosecution of these crimes. In Virginia, strangulation is considered a class 6 felony that can carry a term of 1 to 5 years, whereas domestic assault and battery constitute a misdemeanor with a maximum sentence of 1 year in prison. The difference between a misdemeanor and a felony depends on the documentation of a wound or injury caused by the pressure applied to the neck of the victim. At present, most strangulation cases in Richmond have still been handled as misdemeanors. However, subsequent to the case reports described herein, the Virginia Court of Appeals has ruled that internal injuries may occur without visible cuts or bruises on the neck and that "even a momentary 'black out' caused by pressure to the neck is sufficient to constitute a bodily injury."[27(p9)]

Physicians should become familiar with their own state and federal laws regarding privacy and reporting of domestic violence. Whenever possible, physicians should obtain consent from the patient for all examinations, photographs, and radiographs and treat these records as protected health information. All states require reporting of suspected child abuse and most states require reporting of abuse against dependent and elderly adults. Crimes committed with a weapon, such as a knife or gun, are also reportable in most states. However, only 5 states mandate reporting of intimate partner violence, and none specifically mandate reporting of strangulation.[28] In situations without mandatory reporting, physicians should obtain the patient's permission before contacting law enforcement authorities. A hospital-based social worker or forensic nurse specialist can be very helpful in guiding patient choices.

The US Health Insurance Portability and Accountability Act permits disclosure of protected health information when required by law (as above), but also in cases of domestic abuse if the patient agrees to disclosure. In the absence of such agreement, the physician may disclose protected health information "to the extent the disclosure is expressly authorized by statute or regulation and: (A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the

individual or other potential victims."[29(p756)] In the absence of a clear and present danger, physicians should refrain from speaking to law enforcement without the patient's consent.

Conclusions

Strangulation is a common form of intimate partner violence in which the aggressor asserts the ability to control life or death over another. Most cases involve females at the hands of a male household member, often in the presence of her children. Those strangled may experience physical pain, terror, and a sense of impending death. Unless the assault is witnessed by another adult, most strangulation survivors fail to report the attack to authorities or medical personnel. Those who seek care usually have limited physical findings to document the attack. The absence of visible trauma makes it difficult to obtain a felony conviction and often results in failure to pursue any legal remedy. Repeated strangulation is associated with an increased risk for brain injury or death by murder.

Otolaryngologists should be prepared to evaluate survivors of strangulation within 48 to 72 hours, at which time hoarseness, bruising, or other temporary injury may be most evident. Examining physicians should take great care to document the history of the injury and any physical findings that might describe a wound or injury to the neck.

ARTICLE INFORMATION

Accepted for Publication: February 12, 2016.

Published Online: June 16, 2016. doi:10.1001/jamaoto.2016.0293.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Armstrong reported receiving personal fees for expert testimony from the Commonwealth of Virginia. Ms Strack receives personal income from the Strangulation Training Institute and from related speaking engagements. No other disclosures were reported.

Additional Contributions: Nancy Oglesby, JD, Deputy Commonwealth's Attorney for Henrico County, Virginia, reviewed the manuscript and provided guidance and current statistics on the frequency of strangulation in the county. She was not compensated for this role.

REFERENCES

1. Line WS Jr, Stanley RB Jr, Choi JH. Strangulation: a full spectrum of blunt neck trauma. *Ann Otol Rhinol Laryngol*. 1985;94(6, pt 1):542-546.

2. Kuriloff DB, Pincus RL. Delayed airway obstruction and neck abscess following manual strangulation injury. *Ann Otol Rhinol Laryngol*. 1989:98(10):824-827.

3. Strack GB, McClane GE, Hawley D. A review of 300 attempted strangulation cases, part I: criminal legal issues. *J Emerg Med*. 2001;21(3):303-309.

4. McClane GE, Strack GB, Hawley D. A review of 300 attempted strangulation cases, part II: clinical evaluation of the surviving victim. *J Emerg Med*. 2001;21(3):311-315.

5. Hawley DA, McClane GE, Strack GB. A review of 300 attempted strangulation cases, part III: injuries in fatal cases. *J Emerg Med*. 2001;21(3):317-322.

6. Taliaferro E, Mills T, Walker S. Walking and talking victims of strangulation: is there a new epidemic? a commentary. *J Emerg Med*. 2001;21(3):293-295.

7. Wilbur L, Higley M, Hatfield J, et al. Survey results of women who have been strangled while in an abusive relationship. *J Emerg Med*. 2001;21(3):297-302.

8. Smith DJ Jr, Mills T, Taliaferro EH. Frequency and relationship of reported symptomology in victims of intimate partner violence: the effect of multiple strangulation attacks. *J Emerg Med*. 2001;21(3):323-329.

9. Family Justice Center Alliance. Web page. http://www.familyjusticecenter.org/. Accessed August 27, 2015.

10. Training Institute on Strangulation Prevention and California District Attorneys Association. The investigation and prosecution of strangulation cases. https://www.cdaa.org/wp-content/uploads/Strangulation-Manual.pdf. Published 2013. Accessed September 7, 2015.

11. Training Institute on Strangulation Prevention. Online strangulation training. http://www.strangulationtraininginstitute.com/training/online-strangulation-training/. Accessed August 16, 2015.

12. Brouardel P. *La pendaison, la strangulation, la suffocation, la submersion*. Paris, France: IB Bailliere et Fils; 1897:36-45.

13. Hawley DA. Death by strangulation or suffocation. In: San Diego, CA: Training Institute on Strangulation Prevention; Sacramento: California District Attorneys Association. *The Investigation and Prosecution of Strangulation Cases*. 2013:63-80. https://www.cdaa.org/wp-content/uploads/Strangulation-Manual.pdf. Published 2013. Accessed September 7, 2015.

14. Travis LW, Olson NR, Melvin JW, Snyder RG. Static and dynamic impact trauma of the human larynx. *Trans Sect Otolaryngol Am Acad Ophthalmol Otolaryngol*. 1975;80(4, pt 1):382-390.

15. Sauvageau A, Laharpe R, King D, et al; Working Group on Human Asphyxia. Agonal sequences in 14 filmed hangings with comments on the role of the type of suspension, ischemic habituation, and ethanol intoxication on the timing of agonal responses. *Am J Forensic Med Pathol*. 2011;32(2):104-107.

16. Stapczynski JS. Strangulation injuries. *Emerg Med Rep*. 2010;31(17):193-203.

17. Stanley RB Jr, Hanson DG. Manual strangulation injuries of the larynx. *Arch Otolaryngol*. 1983;109(5):344-347.

18. Taliaferro E, Hawley D, McClane G, Strack G. Strangulation in intimate partner violence. In: Mitchell C, ed. *Intimate Partner Violence: A Health-Based Perspective*. New York, NY: Oxford University Press; 2009:217-236.

19. Christe A, Thoeny H, Ross S, et al. Life-threatening versus non–life-threatening manual strangulation: are there appropriate criteria for MR imaging of the neck? *Eur Radiol*. 2009;19(8):1882-1889.

20. Ely SF, Hirsch CS. Asphyxial deaths and petechiae: a review. *J Forensic Sci*. 2000;45(6):1274-1277.

21. Breiding MJ, Basile KC, Smith SG, Black MC, Mahendra R. Intimate partner violence surveillance: uniform definitions and recommended data elements, version 2.0. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. http://www.cdc.gov/violenceprevention/pdf/intimatepartnerviolence.pdf. Published 2015. Accessed September 7, 2015.

22. Herring MA. 2014 Annual report on domestic and sexual violence in Virginia. http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD12015/$file/RD1.pdf. Published December 29, 2014. Accessed November 28, 2015.

23. Glass N, Laughon K, Campbell J, et al. Non-fatal strangulation is an important risk factor for homicide of women. *J Emerg Med*. 2008;35(3):329-335.

24. Centers for Disease Control and Prevention (CDC). Unintentional strangulation deaths from the "choking game" among youths aged 6-19 years—United States, 1995-2007. *MMWR Morb Mortal Wkly Rep*. 2008;57(6):141-144.

25. Centers for Disease Control and Prevention (CDC). "Choking game" awareness and participation among 8th graders—Oregon, 2008. *MMWR Morb Mortal Wkly Rep*. 2010;59(1):1-5.

26. Pritchard AJ, Reckdenwald A, Nordham C. Nonfatal strangulation as part of domestic violence: a review of research [published online December 30, 2015]. *Trauma Violence Abuse*.

27. *Ricks v Commonwealth and Chilton v Commonwealth*, 290 Va 470, 778 SE2d 332 (2015).

28. Moskop JC, Marco CA, Larkin GL, Geiderman JM, Derse AR. From Hippocrates to HIPAA: privacy and confidentiality in emergency medicine, part I: conceptual, moral, and legal foundations. *Ann Emerg Med*. 2005;45(1):53-59.

29. Department of Health and Human Services. §164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required. 45 CFR Subtitle A (October 1, 2004 edition). https://www.gpo.gov/fdsys/pkg/CFR-2004-title45-vol1/pdf/CFR-2004-title45-vol1-sec164-512.pdf. Accessed January 17, 2016.

TRAUMA, VIOLENCE, & ABUSE
2017, Vol. 18(4) 407-424

DOI: 10.1177/1524838015622439
journals.sagepub.com/home/tva
SAGE

Nonfatal Strangulation as Part of Domestic Violence: A Review of Research

Adam J. Pritchard[1], Amy Reckdenwald[1], and Chelsea Nordham[1]

Abstract

This article reviews recent scholarship around the issue of nonfatal strangulation in cases of domestic violence. In the mid-1990s, the San Diego City Attorney's Office began a systematic study of attempted strangulation among 300 domestic violence cases, becoming one of the first systematic research studies to specifically examine the prevalence of attempted strangulation as a form of injury associated with ongoing domestic violence. Prior to this time, most of the research into strangulation was conducted postmortem, and little was known about the injuries and signs of attempted strangulation among surviving victims. This article reviews the research that has since been conducted around strangulation in domestic violence cases, highlighting topics that are more or less developed in the areas of criminology, forensic science, law, and medicine, and makes recommendations for future research and practice.

Keywords

strangulation, choking, domestic violence, intimate partner violence, survivors, forensic medical examination

Key Points of the Research Review

- The current review focuses on non-fatal strangulation, a phenomenon that is a recently identified issue within the context of domestic violence, and the recent developments in the areas of criminology, forensic science, law, and medicine.
- Though early research efforts heavily contributed to advances in practice at the law enforcement level and legislative reforms making strangulation in many states a felony, scholarly investigation of non-fatal strangulation is a neglected area of research.
- The response by criminal justice, medical, forensic, and legal professions have improved; however systemic shortcomings when dealing with strangulation as part of domestic violence are identified.
- There is a need for clear, standardized definitions and measures of strangulation to be used in research and practice. A comprehensive definition of strangulation is introduced.
- Advances is practice (e.g., development of coordinated responses, training of criminal justice and medical personnel, utilize expertise of medical professionals) and research (e.g., efficacy of strangulation as part of universal screening for domestic violence, impact of legislative changes) can help victims and support prosecution.

Introduction

Over the past two decades, there has been increasing attention paid to the problem of strangulation within domestic violence cases among medical professionals, law enforcement, legislators, and researchers. While strangulation was previously recognized primarily as a mode of homicide, investigation of nonfatal incidents of strangulation within the context of domestic violence has only recently attracted the attention of policy makers and researchers despite shelter personnel and domestic violence advocates' longtime awareness of this issue (Taliaferro, Mills, & Walker, 2001). When strangulation is used in the context of domestic violence, it is essentially a live demonstration of power and control over another individual's life or death. The act of strangulation demonstrates to a victim that the perpetrator can end their life whenever he or she chooses (Nemeth, Bonomi, Lee, & Ludwin, 2012; Thomas, Joshi, & Sorenson, 2014). As strangulation is typically accompanied by death threats, gasping for breath, loss of consciousness, and can result in a delayed death, the incidence of strangulation is a critical concern for personnel who respond medically and legally to domestic violence (Campbell, 2002; Coker, Smith, & Fadden, 2005; Funk & Schuppel, 2003; Joshi, Thomas, & Sorenson, 2012; Malek et al., 2000; McClane, Strack, & Hawley, 2001; Messing, Thaller, & Bagwell, 2014; Sheridan & Nash, 2007; Smith, Mills, & Taliaferro, 2001; Strack, McClane, & Hawley, 2001; Taliaferro et al., 2001; Wilbur et al., 2001).

[1] Department of Sociology, University of Central Florida, Orlando, FL, USA

Corresponding Author:
Adam J. Pritchard, Department of Sociology, University of Central Florida, 4000 Central Florida Blvd, Orlando, FL 32816, USA.
Email: adam.pritchard@ucf.edu

This review examines scholarly research literature on nonfatal strangulation across the areas of criminology/domestic violence, forensic science, law, and medicine. Efforts by practitioners have, to date, far outpaced the scholarly investigation of nonfatal strangulation; the scholarly study of nonfatal strangulation is a neglected area of research leaving much to be desired with respect to proper definitions, methodological rigor, and systematic efforts to situate nonfatal strangulation theoretically and with respect to measuring outcomes and long-term effects. This review highlights the challenges of improving research on this topic. First, we highlight the recent history of strangulation in practice as it has emerged from criminal justice and medical research within the broader area of domestic violence, and how these changes have rapidly led to legal and prosecutorial changes. Next, we offer a comprehensive definition of strangulation and note the inconsistencies of terminology used throughout the literature. This review then considers the research implications within the key areas of criminology, forensic science, law, and medicine that could immediately serve to enhance, support, and improve these areas of practice. Finally, implications for practice and research, including integration between these other domains and other practical contexts like advocacy and mental health are discussed.

History of Domestic Violence Strangulation and Responses

Much of the attention and progress made within law enforcement practice, legislation, and research in the past 15 years was catalyzed by one key study of 300 victims of nonfatal strangulation reported by San Diego District Attorney Gael Strack, Dr. George McClane, and Dr. Dean Hawley (2001). In their study, 89% of the strangulation victims had suffered from a history of domestic violence, and yet in 50% of the cases there were no visible injuries related to the strangulation assault. Among the documented injuries, 35% were too minor to photograph adequately, and only 15% of the 300 cases had injuries where a photograph of high enough quality could be used as evidence in the prosecution of the case. When the results of their efforts were published in a special issue of *The Journal of Emergency Management*, a discussion began among researchers and practitioners who recognized that nonfatal strangulation in domestic violence was different and more prevalent than previously understood (Hawley, McClane, & Strack, 2001; McClane et al., 2001; Smith et al., 2001; Strack et al., 2001; Taliaferro et al., 2001). This landmark study was an eye-opener to the criminal justice community and heavily contributed to new protocols and procedures for law enforcement, as well as legal reforms regarding strangulation (see Strack & Gwinn, 2011, for a short review). Efforts immediately began to further ascertain the prevalence and seriousness of nonfatal strangulation in a number of jurisdictions. For instance, Queensland's police department found a significant representation of strangulation in their requests for protections, particularly in cases of attempted murder, and a survey of women in domestic violence shelters and intervention centers in Texas and Los Angeles found that more than half had experienced strangulation multiple times (Douglas & Fitzgerald, 2013, 2014; Wilbur et al., 2001).

Other domestic violence experts found similarly striking results when strangulation was considered in the context of their work. Homicide researchers, for instance, found that a prior history of strangulation was a serious risk factor in domestic violence-related femicide (Campbell, Glass, Sharps, Laughon, & Bloom, 2007; Glass et al., 2008). The risk of homicide was found to be 7.48 times higher for women who had experienced strangulation (Glass et al., 2008). Over the same period, fatality review teams have played a key role in developing statutes and evidence that treat strangulation as a separate crime from assault and as infliction of serious injury or death (Douglas & Fitzgerald, 2014). Thus, the phenomenon of nonfatal strangulation is a recently identified issue. This emerging area of research and policy is complicated by differences in terminology (''choking'' vs. ''strangling''), as well as by societal views of physical violence and injury. Particularly in the legalistic view of physical evidence of crime, many strangulation victims do not meet legal standards of physical injury due to exhibitions of invisible and delayed injuries, and victims may not immediately seek medical care (Joshi et al., 2012; Strack et al., 2001; Wilbur et al., 2001). Research addressing these issues and other factors relating to strangulation has expanded greatly since this field of study began.

Emergence of Legal Response to Domestic Violence Strangulation

The impact of the San Diego study did not just transform practices at the law enforcement level; several changes also occurred with respect to the legal response to strangulation in domestic violence cases. Historically (and presently in a few U.S. states), prosecutors have been forced to try nonfatal strangulation cases under existing statutes, often as assault or battery. Although the risk of death from strangulation places it on the same level in seriousness as most felony assaults, there are many difficulties prosecuting nonfatal strangulation to the highest degree under existing statutes (Laughon, Glass, & Worrell, 2009). These difficulties lie in proving intent (*mens rea*) and the ability to prosecute with a lack of physical evidence which is typical of strangulation cases (Laughon et al., 2009). The heightened awareness from early efforts (Strack et al., 2001) that nonfatal strangulation is different and more serious than was previous thought has resulted in states enacting separate legislation that specifically addresses strangulation in the context of domestic violence and many states have made it a felony offense.

Despite legislative changes that are moving in a positive direction, there are issues with the legal response regarding strangulation (Douglas & Fritzgerald, 2013, 2014; Laughon et al., 2009; Verdi, 2013). Laughon, Glass, and Worrell (2009) examined 13 state laws addressing intimate partner strangulation which existed at the time of the study and found wide variations in states' statutory approaches. Seven of the

Table 1. Current Status of Strangulation Statutes by the U.S. State.

States	Year Amended	Offense Type	Charge Statute	Charge Category
Alabama	2011	Class B Felony	Domestic violence by strangulation or suffocation	Domestic violence
Alaska	2005	Felony assault in the first, second, third degree; misdemeanor fourth degree	Assault	Assault
Arizona	2012	Class 3 Felony; Class 2 Felony if victim is less than 15 years of age	Aggravated assault	Assault
Arkansas	2009	Class D Felony	Aggravated assault on a family or household member	Assault
California	2011	Felony	Domestic violence by strangulation	Domestic violence
Colorado	N/A	Felony	Felony with deadly weapon (hands), second degree assault, first degree assault, murder	Domestic violence
Connecticut	2007	First degree (Class C Felony) second degree (Class D Felony) third degree (Class A Misdemeanor)	Strangulation	Domestic violence
Delaware	2010	Felony	Unknown	Domestic violence
Florida	2007	Felony	Domestic battery by strangulation	Domestic Violence
Georgia	2014	Felony	Aggravated assault	Assault
Hawaii	2011	Class C Felony	Abuse of family or household members	Domestic violence; abuse
Idaho	2005	Felony	Attempted strangulation	Domestic violence
Illinois	2009	Class 2 Felony	Aggravated domestic battery	Domestic violence
Indiana	2006	Class D Felony; Level 6 Felony	Strangulation	Battery
Iowa	2012	Misdemeanor, Class D Felony	Domestic abuse assault	Domestic violence; assault
Kansas	2014	Level 6 Felony	Aggravated battery	Battery
Kentucky	N/A	Felony; misdemeanor	Assault	Assault
Louisiana	2007	Up to 3 years in prison	Domestic abuse battery by strangulation	Domestic violence
Maine	2012	Class B crime	Aggravated assault	Assault
Maryland	2014	First degree Felony rape, first degree Felony sexual offense	Rape; sexual offense	Rape; sexual offense
Massachusetts	2006	Felony	Attempt to murder	Attempt to murder
Michigan	2013	Felony	Assault by strangulation or suffocation	Assault
Minnesota	2005	Felony	Domestic assault by strangulation	Domestic violence
Mississippi	2010	Subsequent conviction-Felony	Aggravated domestic violence	Domestic violence
Missouri	2000	Class D Felony	Domestic assault	Domestic violence
Montana	N/A	N/A	N/A	N/A
Nebraska	2004	Class 3 Felony; Class 4 Felony	Strangulation	Strangulation
Nevada	2009	Class A, B, and C Felonies	Battery with intent to commit a crime; battery; domestic violence battery	Domestic violence
New Hampshire	2010	Class B Felony	Assault	Assault
New Jersey	N/A	N/A	N/A	N/A
New Mexico	N/A	N/A	N/A	N/A
New York	2010	Misdemeanor; class C and class D Felony	Criminal obstruction of breathing or blood circulation; strangulation	Strangulation
North Carolina	2004	Class H Felony	Assault	Assault
North Dakota	N/A	N/A	N/A	N/A
Ohio	N/A	N/A	Factors to be considered when setting bail; bail schedule; appearance by video conferencing equipment	Bail
Oklahoma	2004	Felony	Domestic abuse by strangulation	Domestic violence
Oregon	2003	Class A misdemeanor; class C Felony	Strangulation	Strangulation
Pennsylvania	1990	Misdemeanor; Felony	Child abuse	Child abuse
Rhode Island	2012	Misdemeanor; Felony	Domestic assault by strangulation; domestic battery by strangulation	Domestic violence
South Carolina	2011	Unknown	Vulnerable adult	Adult protection

(continued)

Table 1. (continued)

States	Year Amended	Offense Type	Charge Statute	Charge Category
South Dakota	2012	Class C Felony	Aggravated assault	Assault
Tennessee	2011	Felony	Aggravated assault	Assault
Texas	2009	first or second degree Felony	Aggravated assault	Assault
Utah	2011	Misdemeanor; Felony	Child abuse	Child abuse
Vermont	2006	Felony	Aggravated assault	Assault
Virginia	2011	Class 6 Felony	Strangulation by another	Strangulation
Washington	2007	Class B Felony	Assault	Assault
West Virginia	2008	Unknown; first degree robbery	Arrest in domestic violence matters; robbery; attempted robbery	Domestic violence; robbery
Wisconsin	2011	Class H Felony	Strangulation and suffocation	Strangulation and suffocation
Wyoming	2011	Felony	Strangulation of a household member	Domestic violence

laws included separate statutes that specifically addressed a new offense of strangulation, while the other six included existing laws in which language had been added to include strangulation as a general form of battery. In 12 of the 13 states, strangulation is classified as a felony; however, penalties vary widely (i.e., 20 years to 1 year of imprisonment) as does the clarity of the laws, and the specific criteria of who qualifies as a victim under each law. Laughon et al. (2009) argue that in order to have a criminal justice response that is commensurate with the seriousness of this form of violence, all states need to add strangulation statutes with language that clearly defines strangulation, includes a broad range of relationships, and are not limited to adults.

As of April 2015, 43 states have a statute explicitly addressing adult strangulation in some form,[1] and two states (New Jersey and Ohio) are currently considering legislation to add strangulation statutes. Of these, 19 states' strangulation statutes are specific to domestic violence, while most others have in the past decade added strangulation to existing statutes of assault, aggravated assault, attempted murder, or rape statutes. Table 1 provides an overview of the state of current U.S. statutes, including whether or not the strangulation statutes are specific to domestic violence or apply to other groups (e.g., all adults, children only). All of these statutes were added or amended after 2000, so strangulation statutes are a relatively new criminal justice phenomenon; therefore, there has been limited research examining the impact of these laws. Evaluations that have been conducted tend to be positive, though some problems are already evident. WATCH, a Minnesota organization that monitors the handling of cases involving violence against women and children, evaluated the strengths and weaknesses of Minnesota's 2005 strangulation legislation (Minn Stat § 609.2247 (2005)), which made strangulation during a domestic violence incident a felonious assault (Anderson, M. L., 2009; Francis, 2008; Wolfgram, 2007). Two reviews were conducted; the first was conducted 6 months after the law was implemented (Wolfgram, 2007) and the second was conducted 2 years after the implementation of the law (Anderson, M. L., 2009). Results from both reviews were based on statewide charging statistics, a review of felony and misdemeanor domestic strangulation cases, a survey from domestic violence service providers, and interviews with criminal justice personnel in Hennepin County. The report stated that the law has had a positive impact on victim safety, offender accountability, and awareness of the seriousness of this type of violence; however, results also indicate that improvements can be made in the training for criminal justice personnel which is important for later prosecution as well as to ensure proper medical treatment is provided to victims.

Terminology

Most studies on strangulation do not explicitly offer a simple definition of strangulation; however, there does appear to be a general understanding across fields including criminology, law, forensic science, and medicine as to what constitutes strangulation, though some put more focus on modality while others focus on mechanism of injury. Based on our review, we offer the following general definition:

Strangulation is the external compression of a person's neck and/or upper torso in a manner that inhibits that person's airway or the flow of blood into or out of the head. The resulting injuries can include but are not limited to blocking of the airway (asphyxia), blocking of the jugular vein or carotid arteries (cerebral hypoxia), blood pressure–related injuries (cardiac arrest, aneurysm, or stroke), or structural damage to the neck (trachea, thyroid cartilage, or hyoid bone). Common modes of strangulation can include manual strangulation using the hands, arms (e.g., a ''choke hold''), or legs (e.g., a ''triangle choke''), ligature strangulation using an object on or around the neck, hanging using a combination of a ligature and the victim's body weight, or postural strangulation by sitting on or holding a person in a bodily position that prevents breathing.

Of note within the literature is the inconsistent or imprecise use of certain terminology to describe strangulation. For instance, the early review by McClane and colleagues noted the need in practice to distinguish between the terms ''throttling'' (or external strangulation) and choking (technically referring to an internal obstruction within the throat; McClane et al.,

Table 2. Empirical Studies Concerning Strangulation by Research Area.

Author/Authors (Year)	Sample	Topic
	Criminology and Domestic Violence	
Bullock, Bloom, Davis, Kilburn, and Curry (2006)	1,000 pregnant women in clinical trial	Abuse reports by Medicaid patients
Campbell, Webster, and Glass (2009)	310 femicide cases; 324 abused women	The danger assessment
Campbell et al. (2003)	220 femicide victims; 343 abused women	Risk factors for femicide
Coggins and Bullock (2003)	9 battered women	Sexual coercion and domestic violence
Coker, Smith, and Fadden (2005)	1,152 women patients at family practice	Disabilities at work for women
Glass et al. (2008)	506 attempted and completed homicides cases; 427 abused women	Non-fatal strangulation as risk factor for homicide
Maier (2012)	39 SANE nurses	Rape victims' revictimization
Messing, Thaller, and Bagwell (2014)	432 women at police scene for domestic violence	Sexual abuse
Nemeth, Bonomi, Lee, and Ludwin (2012)	17 heterosexual couple jail phone call records	Sexual infidelity and strangulation
Straus, Hamby, Boney-McCoy, and Sugarman (1996)	317 students	Revised Conflict Tactics Scale
Thomas, Joshi, and Sorenson (2014)	22 women in domestic violence shelters	Coercive control and strangulation
Tjaden and Thoennes (2000)	8,000 men, 8,000 women; NVAWS data	Prevalence of violence against women
Weisz, Tolman, and Saunders (2000)	177 survivors of domestic violence	Predictions of domestic violence risk
Wheeler (2012)	17,171 arrest events	Strangulation cases 10 months after enactment of law in NY
Wilbur et al. (2001)	62 women at domestic violence shelters	Strangulation among women in shelters
	Forensic Science	
Anscombe and Knight (1996)	1 femicide victim	Death in manual strangulation
Christe et al. (2010)	56 clinical cases of strangled women survivors	MRI for strangulation
Christe et al. (2009)	56 clinical cases of strangled women survivors	MRI for strangulation
Clarot, Vaz, Papin, and Proust (2005)	2 victims of strangulation	Delayed death from strangulation
Davison and Williams (2012)	1 femicide victim	Trauma to hyoid bone
Fineron, Turnbull, and Busuttil (1995)	2 victims of strangulation	Strangulation X-rays
Holbrook and Jackson (2013)	172 forensic patient records	Alt. light source to assess strangulation
Klopfstein, Kamber, and Zimmermann (2010)	160 female patients in Emergency hospital	Documentation of DV patients
Line, Stanley, and Choi (1985)	112 dead; 59 surviving-otolaryngologist records	Strangulation injuries
Maxeiner (1998)	191 cases of homicidal strangulation	Strangulation injuries
Plattner, Bolliger, and Zollinger (2005)	134 forensic cases	Classification of strangulation degrees of severity
Pollanen, Bulger, and Chiasson (1995)	13 cases of dead hyoid bone fractured patients	Hyoid bone fractures from strangulation
Pollanen and Chiasson (1996)	20 cases of homicidal strangulation	Hyoid bone fractures from strangulation
Sadler (1994)	1 adult and 1 child strangulation homicide records	Concealed homicidal strangulation
Shields, Corey, Weakley-Jones, and Stewart(2010)	102 living strangulation victim cases	Living victims of strangulation
Ubelaker (1992)	Unspecified number—forensic files	Hyoid fractures and strangulation
Yen et al. (2007)	14 survivors of strangulation—MRI image analysis	Forensic radiology classification for strangulation victims
	Legal	
Strack, McClane, and Hawley (2001)	300 domestic violence cases	Strangulation cases
Anderson, M.L. (2009)	96 domestic felony strangulation cases	Strangulation laws
Douglas and Fitzgerald (2013)	656 mutual protective order court files	Mutual IPV protective orders
Douglas and Fitzgerald (2014)	656 court files involving protective orders	Strangulation and Legal Response
Wolfgram (2007)	59 felonies; 17 misdemeanors; 16 surveys of victims; 18 interviews criminal justice personnel	Review of first 6 months of MN strangulation law's implementation
	Medical	
Brink (2009)	1,106 violence victims in hospital	Injury to head, neck, and face
Funk and Schuppel (2003)	1 victim of strangulation—medical chart	Strangulation injuries

(continued)

Table 2. (continued)

Author/Authors (Year)	Sample	Topic
	Medical	
Joshi, Thomas, and Sorenson(2012)	17 strangled women	Health and health care for strangulation victims
Kuriloff and Pincus (1989)	1 strangled patient	Delayed airway obstruction & neck abscess from manual strangulation
Malek et al. (2000)	3 victims of strangulation—patient records	Internal carotid artery injury
McCauley et al. (1995)	1,952 female patients	DV in primary care
Mitchell, Roach, Tyberg, Belenkie, and Sheldon(2012)	24 Police officers	Vascular neck constraint-unconsciousness
Owens and Ghadiali (1991)	1 Judo player	Judo as anoxic brain damage
Porr, Laframboise, and Kazemi(2012)	1 case study of hospital file	Trauma hyoid bone fracture
Smith, Mills, and Taliaferro (2001)	101 abused women in hospital system	Symptoms of multiple strangulation attacks
Sommers et al. (2009)	120 female patients	Skin color in sexual forensic exam
Yamasaki, Takase, Takada, and Nishi (2009)	10 autopsy cases of cervical arteries	Cervical arteries from hanging

Note. NVAWS = National Violence Against Women Survey; IPV = intimate partner violence; DV = domestic violence.

2001). Some have used the term choking to distinguish "incomplete strangulation" from fatal strangulation (e.g., Campbell, 2002) or throttling to specifically distinguish manual strangulation (e.g., Taliaferro et al., 2001). Other variable terms include ligature or "garroting" (e.g., Funk & Schuppel, 2003) or simply hanging. Others include "choke hold" to describe manual strangulation with a forearm instead of hands, or "postural" strangulation due to body position like an assailant compressing the chest of a victim (Faugno, Waszak, Strack, Brooks, & Gwinn, 2013). Some legal statutes (for instance, Rhode Island's 2012 law) also include descriptions of what is technically "suffocation," or the prevention of breathing by covering the nose and/or mouth, within their statutory definition of strangulation (Verdi, 2013); indeed, suffocation may only vary slightly from strangulation if an attempted choke hold, for instance, results in an attacker placing a forearm across the face instead of the neck. The inconsistent usage and lack of clear, precise, and explicit definitions of the terminology used in published research (as well as in practice) is one area that can and should be immediately improved.

Implications for Research

While most efforts to address nonfatal strangulation in domestic violence cases have taken place in law enforcement, forensic investigation and medical examination, and legal practice, there has also been an expansion of academic research into strangulation. This section of our review highlights four key areas of significant growth in the literature: criminology and domestic violence research, forensic science research, legal research, and medical research (summarized in Table 2).

Criminology and Domestic Violence Research

Since Strack, McClane, and Hawley's (2001) groundbreaking study, research on criminological aspects of nonfatal strangulation has expanded. A growing number of research studies show that the use of strangulation is frequent in the context of domestic violence (Glass et al., 2008; Hawley et al., 2001; Joshi et al., 2012; McClane et al., 2001; Smith et al., 2001; Strack et al., 2001; Sutherland, Bybee, & Sullivan, 2002; Taliaferro et al., 2001; Wilbur et al., 2001) and often experienced multiple times (Joshi et al., 2012; Thomas et al., 2014; Wilbur et al., 2001). Research has also begun establishing the prevalence, risk factors, injuries, and symptoms associated with nonfatal strangulation within abusive relationships (Bullock, Bloom, Davis, Kilburn, & Curry, 2006; Campbell et al., 2007; Coker et al., 2005; Glass et al., 2008; Joshi et al., 2012; Messing et al., 2014; Nemeth et al., 2012; Smith et al., 2001; Strack et al., 2001; Thomas et al., 2014; Wilbur et al., 2001). Likewise, efforts have also been made to understand the dynamics and motives behind this gendered form of violence (Nemeth et al., 2012; Thomas et al., 2014).

However, research on domestic violence strangulation is fraught with methodological issues which make assessing the magnitude of the problem difficult. Comparisons across studies are problematic, because there are great variation in study populations, comparison groups, and a lack of consensus regarding the definition and/or measurement of strangulation. Also, much of this research has relied on law enforcement, clinical or small shelter samples (e.g., Bullock et al., 2006; Joshi et al., 2012; Messing et al., 2014; Nemeth et al., 2012; Smith et al., 2001; Strack et al., 2001; Thomas et al., 2014; Wilbur et al., 2001) which may not be representative of those that are not detected or choose not to seek help. Furthermore, controlled studies are scant in the literature focusing on nonfatal strangulation (for an exception, see Glass et al., 2008) and even when used results may not be generalizable to all victims. For instance, Glass et al.'s (2008) case–control study was limited to urban women making generalizations to women living in other areas problematic. Also, the majority of studies use self-report data, which raises concerns about recall (Glass et al., 2008;

Joshi et al., 2012; Messing et al., 2014; Nemeth et al., 2012; Smith et al., 2001; Thomas et al., 2014; Wilbur et al., 2001). Finally, strangulation is often reported secondary as part of a discussion on various types of physical abuse used within a violent relationship (Coker et al., 2005; Messing et al., 2014; Nemeth et al., 2012).

Despite methodological issues, findings from this line of research have discovered prevalence rates far higher than previous population-based studies. For example, Wilbur et al.'s (2001) study was the first study to specifically address strangulation as a method used in domestic violence situations and found strangulation to be quite prevalent as a method of abuse. From a survey of 62 women at domestic violence shelters and intervention centers in Texas and California, they found that not only was strangulation common in abusive relationships but that many women had experienced multiple previous strangulation events. Specifically, they found that 68% of women reported having a history of being strangled by their intimate partner and many of these women also reported surviving multiple strangulation attempts with the average number being 5.3 times. The National Intimate Partner and Sexual Victimization Survey (NISVS) found that 9.7% of women and 1.1% of men reported that a partner harmed them by choking or suffocating them (National Center for Injury Prevention and Control Centers for Disease Control and Prevention [NCIPC], 2011). Whereas, the National Violence Against Women Survey (NVAWS) found a lifetime prevalence of 7.7% for women, and 3.9% for men for any type of offender on the item ''choked or attempted to drown'' and 6.1% for women and 0.5% for men on the same item when the offender was an intimate partner (Tjaden & Thoennes, 2000). Though relatively little research has to date been conducted on nonfatal strangulation, the inconsistency between this body of research and other domestic violence prevalence studies suggests either that strangulation may be most appropriately characterized as a previously understudied element of high-risk domestic violence situations or that the full extent of its prevalence has not been properly investigated in the population.

In addition to prevalence estimates, Wilbur et al.'s (2001) study was also influential in defining the occurrence of strangulation within the cycle of violence. Their results indicated that abuse escalates over time, with strangulation typically occurring later in the progression of violence in the relationship. Threats of death were common among the women who had been strangled, with 87% reported being threatened. The majority experienced physical and verbal abuse in addition to the strangulation (68%). Threats and co-occurrence of other forms of violence along with strangulation is also evident in more recent studies (Messing et al., 2014). For instance, in their study of 432 women recruited at the scene of police-involved intimate partner violence incidents, Messing, Thaller, and Bagwell (2014) found that those who had experienced sexual abuse or forced sex were also more likely to experience strangulation and have their life threatened.

Research on domestic violence has examined the short-term and long-term health consequences of intimate partner violence (Coker et al., 2005; for review, see Campbell, 2002). Adding to this body of research, scholars have presented a vast array of injuries as well as negative health consequences associated particularly with nonfatal strangulation within abusive intimate partner relationships (Coker et al., 2005; Joshi et al., 2012; Strack et al., 2001; Wilbur et al., 2001; see reviews by Hawley et al., 2001; Sheridan &Nash, 2007; Taliaferro et al., 2001). Various physical and neurological symptoms including difficulty swallowing, scratches, edema of the neck, memory loss, headaches, loss of consciousness, paralysis, strokes, and other internal injuries that can lead to death are apparent in the literature (Coker et al., 2005; Joshi et al., 2012; McClane et al., 2001; Sheridan & Nash, 2007; Smith et al., 2001; Strack et al., 2001; Taliaferro et al., 2001; Wilbur et al., 2001). Furthermore, experiencing nonfatal strangulation can have devastating psychological effects (Smith et al., 2001). Not only is strangulation a symbol of power and control over the victim's life or death but being strangled is incredibly painful as well. Following the assault victims report experiencing nightmares, depression, post-traumatic stress disorder, and suicide ideation (Smith et al., 2001). Smith, Mills, and Taliaferro (2001) also considered the long-term effects of repeated strangulation, suggesting that multiple strangulation attempts on separate occasions are associated with increased frequency of negative symptomology that affects physical and mental health. Despite the expression of these symptoms few seek medical help after strangulation (Joshi et al., 2012; Strack et al., 2001; Wilbur et al., 2001), and very little research has explicitly investigated the psychological effects of strangulation as a part of abuse.

Theoretically, research has shown that strangulation is a highly gendered form of domestic violence, with females largely being the victims and males being the abusers of this violent type of assault (Thomas et al., 2014). Research also argues that the use of coercive control within abusive relationships is gendered (Anderson, K. L., 2009; Stark, 2007), where women are more vulnerable to these tactics. A small body of literature has begun to emerge examining strangulation as a mechanism of coercive control that males use over their female intimate partners (Nemeth at al., 2012; Thomas et al., 2014). Using Dutton and Goodman's (2005) conceptualization of coercive control, Thomas, Joshi, and Sorenson (2014) conducted focus groups and interviews with 17 women staying at a domestic violence shelter. Jealously, fear of ending the relationship, and failure to meet the offender's demands were common triggers of strangulation by their partners. Strangulation was not always an attempt to kill the victim. The women perceived their partners using strangulation as a way to exert power and control over them during and after the assault. Research has shown that experiencing strangulation once can instill enough fear in the victim that the abuser can maintain control without ever having to commit subsequent abuse (Johnson & Leone, 2005). Furthermore, Nemeth, Bonomi, Lee, and Ludwin (2012) found that strangulation was used as a method of control in abusive relationships and was often triggered by sexual infidelity concerns within the context of alcohol or drug use (Nemeth et al., 2012).

Over the years, numerous clinical scales/screens have been developed to assess current or past occurrence of domestic violence (see Strauchler et al., 2004, for summary of scales) or to predict the risk of future domestic violence and/or homicide (Campbell, 1986; Campbell, Webster, & Glass, 2009; Kropp, 2009; Kropp, Hart, Webster, & Eaves, 1994); however, research has shown that many of the scales lack content and predictive validity and that there is wide variation between the scales (Strauchler et al., 2004). In their review of 16 clinical domestic violence scales, Strauchler et al. (2004) show that physical abuse is heavily focused on in the scales; though, very few items in the scales address strangulation. Also, those that do address strangulation use the term ''choke'' rather than ''strangle.'' It is legally important that ''strangle'' or ''strangulation'' is used in referring to the violent act, since choking can also describe obstruction by a small object in the throat (McClane et al., 2001). Findings from focus groups and interviews of 17 women in a domestic violence shelter indicate that survivors' interpretations of choking and strangling differ from the medical definitions (Joshi et al., 2012). Many participants viewed choking as happening when someone used their hands as the weapon, whereas strangling occurred when another object was used (e.g., rope or belt). Understanding these and other types of distinctions made by survivors may be critical, since some researchers have suggested that survivors' own predictions of risk of severe domestic should be included in prediction instruments (Weisz, Tolman, & Saunders, 2000).

One of the most widely used risk assessment instruments for intimate partner homicide is the Danger Assessment (Campbell, 1986 [original 15 item]; Campbell et al., 2009 [revised 20 item], with the original 15-item assessment as well as the revised 20-item assessment validated in the literature (Campbell, 1995; Campbell et al., 2009). Though strangulation is acknowledged as an important risk factor for intimate partner homicide in assessment instruments, a limited body of research underscores the seriousness of strangulation as a potentially lethal form of violence prevalent in the context of domestic violence (see Campbell et al., 2007 for a review, Glass et al., 2008). Using a case–control design, Glass et al. (2008) were the first to systematically examine strangulation in both attempted and completed femicide records between 1994 and 2000 in 11 cities and showed that prior nonfatal strangulation is an important risk factor for femicide (Glass et al., 2008). Specifically, they found that the odds of being killed by an intimate partner were 7.48 times higher for women who had been previously strangled by their abusive partner than those who had not.

Forensic Science Research

Because most forensic investigations related to strangulation involved homicide or suspicious deaths, the examination of evidence related to nonfatal strangulation incidents was very sparse in the literature. The majority of forensic research on manual strangulation is conducted postmortem (Anscombe & Knight, 1996; Clarot, Vaz, Papin, & Proust, 2005; Davison & Williams, 2012; Hawley et al., 2001; Maxeiner, 1998; Pollanen, Bulger, & Chiasson, 1995; Pollanen & Chiasson, 1996; Sadler, 1994; Stanley & Hanson, 1983; Ubelaker, 1992) and discusses injuries that can only be extensively evaluated at autopsy.[2] Some of this literature recognizes the significance of understanding strangulation within the context of domestic violence (Clarot et al., 2005; Davison & Williams, 2012; Hawley et al., 2001) with the results emphasizing the importance that careful examination in identifying previous trauma has in aiding prosecutors trying to show a history of violence in an abusive relationship (Davison & Williams, 2012).

A few studies have since been published that examine strangulation among surviving victims (Brink, 2009; Christe et al., 2009, 2010; Holbrook & Jackson, 2013; Plattner, Bolliger, & Zollinger, 2005; Shields, Corey, Weakley-Jones, & Stewart, 2010; Yen et al., 2007). For instance, Plattner, Bolliger, and Zollinger (2005) conducted a retrospective analysis of 134 nonfatal strangulation cases examined at the Institute of Forensic Medicine of Berne, Switzerland between the years 1987 and 2002. In establishing evaluation criteria in nonstrangulation cases, Plattner et al. (2005) examined whether symptoms could be related to the ''fierceness'' of the strangulation as it relates to intensity of the assault and duration. Their examination led to a classification of three degrees of severity by symptoms (light, moderate, and severe or life-threatening strangulation), with light strangulation expressed as skin abrasions and/or redness of the neck and life-threatening strangulation presented as petechial bleedings with or without the loss of conscience (Plattner et al., 2005). Further, using radiological signs on MRI, Christe and colleagues (2009, 2010) assessed the severity of nonfatal strangulation of 56 victims and were able to classify 27% of the victims as survivors of life-threatening strangulation.

A limited body of research examines surviving victims of strangulation in the context of domestic violence (Brink, 2009; Holbrook & Jackson, 2013; Shields et al., 2010) and the majority is descriptive in nature. For instance, Shields, Corey, Weakley-Jones, and Stewart (2010) conducted a 10-year case (1998–2007) review of 102 victims who had survived strangulation at a State Medical Examiner's Officer serving southern Indiana and Kentucky. Results showed many similarities with previous research (Strack et al., 2001; Wilbur et al., 2001). The majority of the cases involved an intimate partner assailant (79%), with 83% using manual strangulation. Many of the victims had a history of abuse within their relationship (38%). Almost all suffered another form of violence in addition to the strangulation and 36% reported that their partner threatened to kill them. One surprising difference between the previous studies was the high percentage of victims that sought medical attention for their symptoms (68%). Another study examined head, neck, and face injuries of 1,106 victims of violence who were admitted at either the Accident and Emergency Department or the Institute of Forensic Medicine in Aarus, Denmark, during a 1-year time period (1999–2000) and found 19% of these women suffered from neck injuries, and 10% reported being a victim of strangulation (Brink, 2009). Results further suggest that injuries to the head, neck, and face are markers for intimate violence among women, with many of the women's

injuries inflicted by a current or former partner. Other research has been influential in advances in identification of strangulation injuries. In their study of 172 patients of a Forensic Nurse Examiner Program who reported strangulation in the context of domestic violence and/or sexual assault, Holbrook and Jackson (2013) found an alternative light source to be an important technology in identifying invisible injuries of strangulation that would aid in the successful prosecution of strangulation cases.

Though forensic investigations have been essential in recognizing patterns of injuries distinctive of strangulation (Brink, 2009; Christe et al., 2009, 2010; Clarot et al., 2005; Davison & Williams, 2012; Plattner et al., 2005; Sadler, 1994; Stanley & Hanson, 1983; Ubelaker, 1992), methodological issues are present making generalizations and comparisons between studies difficult. This body of literature is divided between small case studies of forensic examinations (Clarot et al., 2005; Davison & Williams, 2012; Sadler, 1994; Stanley & Hanson, 1983; Ubelaker, 1992) and larger scale clinical studies of forensic files or patients (Brink, 2009; Christe et al., 2009, 2010; Holbrook & Jackson, 2013; Maxeiner, 1998; Plattner et al., 2005; Pollanen et al., 1995; Pollanen & Chiasson, 1996; Shields et al., 2010; Yen et al., 2007); however, there is tremendous variability across clinical study populations. For instance, a few small-scale studies examined forensic cases of surviving victims of strangulation for magnetic imagining purposes (Christe et al., 2009 [56 cases]; Yen et al., 2007 [14 cases]), while a larger scale study, though not exclusively examining strangulation, examined injuries to 1,106 victims admitted to one of the two clinical settings (Brink, 2009). Furthermore, adequate controls are lacking from study designs including case history of prior strangulation incidents, comorbidity with other forms of victimization or injury, or psychosocial correlates.

Despite this new found awareness of the importance of examining nonfatal strangulation in the context of domestic violence, research suggests the quality of forensic documentation is still lacking and insufficient for criminal prosecution (Klopfstein, Kamber, & Zimmermann, 2010). Challenges associated with current detection and measurement techniques regarding strangulation have been discussed (Baker & Sommers, 2008). Though advances in forensic examinations have led to an increase in documenting injury prevalence, there are issues in injury measurement and classification. There is a need for standardized definitions of injuries to prevent the use of injury types interchangeably (Sheridan & Nash, 2007) and a need to better define, quantify and classify injury severity by length of time since the injury (Sommers et al., 2009). Also, research has indicated the need for further examinations of the role of skin color in injury detection (Sommers et al., 2009), encouragement of exhaustive medical evaluations which include a detailed history of violence, and an understanding of delayed symptoms of strangulation as well as the risk of a delayed death (Clarot et al., 2005).

Legal Research

Attention to the legal aspects of strangulation in domestic violence cases has also expanded greatly since the San Diego City Attorney's Office study. As part of their original study, Strack and colleagues (2001) examined evidence collection and prosecution for 300 domestic violence strangulation cases from among cases handled by the City Attorney's Office. They were able to identify only a few factors related to legal aspects of these cases: Lack of corroboration for strangulation or uncertainty about the primary aggressor led to 25% of the cases being rejected for prosecution; there was a lack of visible injuries in 50% of cases, with an additional 35% of cases having injuries too minor for police to effectively photograph; and 89% of cases had a known history of domestic violence. Even without specific mention of strangulation in California criminal statutes, the changes made by the San Diego study demonstrated that better training for law enforcement and medical personnel could improve evidence quality and dramatically increase prosecution at higher rates and at higher levels than before.

By 2009, 13 U.S. states had implemented specific language referring to strangulation in criminal statutes, most often making the crime a felony (10 states) and in 6 states (FL, ID, LA, MN, MO, and OK) specifically making reference to intimate partner violence or domestic violence (Laughon et al., 2009). In our own examination of state statutes for this article, at least 39 U.S. states with strangulation-specific language now allow in some way for the prosecution of adult strangulation as a felony as of April 2015, with 19 states specifically referencing domestic violence or household members as victims (see Table 1 for a breakdown by state). Douglas and Fitzgerald (2014) attribute the expansion of antistrangulation statutes in the United States to widespread participation in fatality review teams, highlighting the key roles played by intimate partner violence advocates and researchers in developing the language making domestic violence strangulation a stand-alone crime in many U.S. states. By contrast, Canadian and Australian criminal statutes regarding strangulation for the most part qualify strangulation in ways that limit applicability to domestic violence; for instance, the Canadian *Criminal Code* and statutes in some Australian jurisdictions define strangulation as criminal only when used as a means to commit or facilitate another indictable offense, or only when the attack results in unconsciousness (Douglas & Fitzgerald, 2014). The U.S. statutes, on the other hand, are all relatively new and have been developed around the now well-established linkages between domestic violence strangulation and homicide risk (see, e.g., Verdi, 2013, on the recent changes in Rhode Island). Unlike weapon-related assaults, manual strangulation is harder to prosecute as felony assault without some evidence to establish an intent (*mens rea*) to inflict serious injury or death; however, quality evidence from both researchers and fatality review teams establishing the lethality risks specific to strangulation in domestic violence cases have helped states develop intimate partner violence specific statutes resolving this ambiguity (Laughon et al., 2009).

At least two high-quality studies have been conducted to evaluate the impacts of strangulation statutes in practice. In a research brief from New York State's Division of Criminal

Justice Services, Wheeler (2012) evaluated the application of New York's 2010 statutory changes which added three types of strangulation offenses (NY State Penal Law §§ 121.11-121.14; criminal obstruction of breathing or blood circulation a class A misdemeanor, Strangulation in the 2nd a class D felony, and Strangulation in the 1st a class C felony). Wheeler (2012) examined 17,171 arrest records and arraignments of strangulation cases within the first 20 months of the law's enactment. Results showed that offenders are being arrested and held accountable; however, 80% of the charges were for criminal obstruction of breathing or blood circulation, a misdemeanor. Furthermore, the examinations of arrest decisions indicated the possibility of racial bias with 45.9% of the offenders arrested being black and 21.1% being Hispanic.

The second high-quality review of strangulation law was conducted by Verdi (2013), who examined a 2012 revision to Rhode Island domestic law which made nonfatal domestic partner strangulation a felony punishable by up to 10 years in prison. Strangulation is defined as "knowing and intentionally impeding normal breathing or circulation of the blood by applying pressure on the throat or neck or by blocking the nose or mouth of another person, with the intent to cause that person harm" (RI Gen L §11-5-2.3 (2012)). Proving intent to kill the victim is not necessary under this definition, as is proving "serious bodily injury," which is an important distinction since research has shown that nonfatal strangulation injuries are mostly internal (Funk & Schuppel, 2003; Strack et al., 2001). As with other states' statutes, RI's statute only applies to domestic relations (family or household members); however, Verdi (2013) notes that the statute does includes three factors that allow courts to consider relationships that are not addressed in the statute (length of relationship, type of relationship, and the frequency of interaction). Though an important step in the right direction, criticism does exist regarding enacting separate strangulation statutes with some arguments being that a separate statute is unnecessary when nonfatal strangulation can be tried under existing statutes, additional laws will create excessive prosecution, offenders will be charged less severely under new laws than if they were charged under existing statutes as felony assault, and new laws will give prosecutors too much leverage and allow for prosecution without objective proof of injury (for further details of these arguments, see Verdi, 2013). Verdi argues that these criticisms "fail to see the necessity of the Statute" (274) and that the effectiveness of these laws will depend on the education of criminal justice system personnel as well as the community.

Despite the development of strangulation statutes throughout the United States and abroad, research like these two studies on the impact of these legal changes is still generally lacking. With the notable exceptions of the original San Diego Study (Strack et al., 2001) and the series of studies in Queensland, Australia (Douglas & Fitzgeral, 2013, 2014), most empirical studies of the legal aspects of strangulation rely on limited samples of very small cases in a single jurisdiction (e.g., Francis, 2008; Wolfgram, 2007). A systematic, comparative investigation of across various aspects of the legal system is necessary to significantly advance this area. Despite the paucity of empirical work, several research reviews exist which suggest some practical directions for these future inquiries.

Several research studies have indicated that the quality of medical evidence is a central factor in the criminal justice system's ability to move forward with strangulation cases, and for domestic violence cases in general (Baker & Sommers, 2008; Laughon et al., 2009; Strack et al., 2001). Baker and Sommers (2008) summarize the role of forensic medical examinations at various stages of the legal process, which also appear to be critical for identifying and prosecuting strangulation:

> Although minor injuries are more difficult to detect, they are important from a criminal justice standpoint. Physical injuries found during the forensic examination play a significant role at multiple decision-making points throughout the criminal justice process. The survivor's decision to report, law enforcement's decision to file a complaint, the prosecutor's decision to file charges, and the judge's or jury's decision to convict are influenced by the presence or absence of physical injury. (p. 228)

In their call for increased standardization in measuring and recording injuries during intimate partner violence medical exams in ways that will produce better quality evidence (for instance, including components of sexual assault forensic exams), they also note that it has been common to collapse head/neck/face injuries into a single measurement category used by medical professionals primarily as an indicator for potential intimate partner violence (231). Forensic medical research that could support prosecution of strangulation cases may also be limited by a very simple fact: Recent medical literature on strangulation in domestic violence cases has been less concerned with issues of measurement and detection important to law enforcement and instead has focused on the serious and potentially long-term health consequences for nonfatal strangulation.

Medical Research

Prior to the San Diego study, much of the medical research on strangulation injuries was focused on postmortem examinations of homicide victims or related injuries in hanging victims of suicide (e.g., Iserson, 1984). For instance, several studies focused on describing specific circumstances associated with strangulation injuries such as fractures of the hyoid bone in the neck (Pollanen et al., 1995; Pollanen & Chiasson, 1996; Ubelaker, 1992). These studies identified physiological factors associated with the likelihood of a hyoid fracture such as ossification, which is less common in children, or bone length (Pollanen et al., 1995; Pollanen & Chiasson, 1996), or highlighted harder to detect injuries to the larynx and associated cartilage or mucosa (Maxeiner, 1998). Studies have also provided case reports of delayed death due to strangulation (Anscombe & Knight, 1996). As primarily postmortem and forensic medical research, this early research sought to distinguish injuries by strangulation modality (e.g., manual strangulation vs. ligature or hanging) and timing (e.g., perimortem, antemortem, or postmortem).

Prior to the 1980s, little research had been conducted on survivors of strangulation injuries (Taliaferro et al., 2001). The general presumption had been that strangulation forces sufficient for causing structural injury were typically also sufficient to cause death (Stanley & Hanson, 1983). A limited body of research among surviving victims of strangulation can be found in the early medical literature (e.g., Iserson, 1984; Line, Stanley, & Choi,1985; Stanley & Hanson, 1983); however, it wasn't until the early 2000s when a body of literature emerged showing surviving victims of strangulation to be more common than was indicated in the literature, particularly in the context of domestic violence (Hawley et al., 2001; McClane et al., 2001; Smith et al., 2001; Strack et al., 2001; Taliaferro et al., 2001). Nevertheless, a few case studies were published documenting serious strangulation-related injuries such as hyoid fractures occurring in surviving victims of strangulation (Fineron, Turnbull, & Busuttil, 1995; Iserson, 1984; Line et al., 1985; Stanley & Hanson, 1983). At least one article considered the reported symptom of feeling a ''choking sensation'' in a study designed to distinguish clinical characteristics of recent domestic violence (defined as experiences reported in the past year) from symptoms reported by other female patients; however, this particular measure was not found to be significant (McCauley et al., 1995). Only after the systematic review of medical records for 300 survivors of strangulation by George McClane and colleagues during the San Diego study did researchers seriously begin to consider that surviving strangulation with more than minor injuries might be far more common that previously assumed (McClane et al., 2001). Despite a few early calls for developing treatment protocols among otolaryngologists (Kuriloff & Pincus, 1989; Stanley & Hanson, 1983), McClane and colleagues were unable to locate any formal protocol for clinical evaluation of strangulation survivors despite a literature review which even included translations of non-English language research (p. 313). The San Diego study was a watershed moment in the medical literature; they attempted for the first time to articulate a comprehensive list of strangulation symptoms and recommended a set of specific medical procedures to detect and document strangulation injuries among survivors.

The 2001 issue of *The Journal of Emergency Management* (21:3) featuring the publication of the San Diego study also included research and commentary by Ellen Taliaferro and her colleagues (Smith et al., 2001; Taliaferro et al., 2001), which helped to set the agenda for much of the subsequent medical and criminological research into nonfatal strangulation. At the time of that publication, Taliaferro, Mills, and Walker (2001, pp. 294–295) raised a number of key questions for future research, including:

1. How prevalent is strangulation?
2. What should the medical protocols be for patient care?
3. What are long-term health consequences of strangulation?
4. Are strangulation-trained individuals (e.g., military) more likely to use these techniques during domestic violence?
5. Should strangulation be a felony due to its potential lethality?
6. Could undocumented intimate partner violence explain stroke or transient ischemic episodes among younger women?

Many of these questions have begun to be investigated in clinical practice and research. Building on the initial clinical recommendations of McClane, Strack, and Hawley (2001), further recommendations on best practices for clinical evaluation and treatment have been developed (Faugno et al., 2013; Funk & Schuppel, 2003; Plattner et al., 2005), as well as an expansion of forensic and medical research into injury detection techniques for specific modalities or using specific diagnostic technologies like MRI (Christe et al., 2010; Clarot et al., 2005; Davison & Williams, 2012; Mitchell, Roach, Tyberg, Belenkie, & Sheldon, 2012; Yamasaki, Takase, Takada, & Nishi, 2009). In a clinical sample of 101 women presenting to a Dallas victim intervention center and emergency facilities, Smith and colleagues (2001) classified patients by the number of reported strangulation events, suggesting a cumulative ''dose-related'' effect of multiple strangulation events leading to presentation of more serious symptoms. Notably, Plattner and colleagues (2005) have proposed a typology of strangulation injury severity, while both Funk and Schuppel (2003) and more recently Faugno, Waszak, Strack, Brooks, and Gwinn(2013) have created comprehensive reviews or guidelines for clinical practice.

Research has also expanded more generally on the topic of nonfatal strangulation. For instance, there have been a few calls for considering strangulation among the domestic violence symptoms that could be present among dental patients (Gwinn, McClane, Shanel-Hogan, & Strack, 2004). There has also been expansion of research into social aspects of patient care such as the inclusion of strangulation or choking in health care screening for domestic violence (Klopfstein et al., 2010; Laughon, Renker, Glass, & Parker, 2008; Strauchler et al., 2004), and a few small, shelter-based studies corroborating what advocates have long contended; that the prevalence of strangulation may be very high among battered women (Coggins & Bullock, 2003; Joshi et al., 2012; Taliaferro et al., 2001; Wilbur et al., 2001). Strangulation has also begun to play a much more significant role in lethality assessment, becoming a key consideration when identifying risk factors for domestic violence femicide (Campbell, 2002; Campbell et al., 2003, 2007). Finally, newer case studies and forensic medical research (described previously in this article) have also been avenues for expansion in the medical literature.[3]

The medical literature, in general, suffers from the same methodological limitations as the criminology and domestic violence research described above, including the lack of standardized definitions and measures. With the exception of a few strangulation-specific studies (Funk & Schuppel, 2003; Joshi et al., 2012; Smith et al.,2001), most of the large or high-quality samples reviewed here measure choking or strangulation with a single-scale item reported in aggregate as simply

one of many forms of severe violence in studies examining domestic violence more broadly (e.g., McCauley et al., 1995; Tjaden & Thoennes, 2000; NCIPC, 2011). The strangulation-specific studies are typically self-selected, shelter, or single-case studies that rely on existing measures from existing medical records (e.g., patient files, autopsy reports). Without the ability to clearly distinguish strangulation injuries and impacts from other types of domestic violence-related injuries, or to compare single-incident strangulation with multiple-incident injury patterns, the ability to reliably describe the health effects of strangulation is severely limited within the extant literature.

Recommendations for Advancing Practice and Research

Based on our review of the recent literature on the topic of nonfatal strangulation in domestic violence cases, we call for five specific recommendations to advance the field:

1. Develop better coordinated responses for nonfatal strangulation within local communities.
2. Train first responders and other service personnel to recognize, respond, and collect critical evidence in strangulation incidents.
3. Utilize the expertise of medical professionals to help victims and support prosecution.
4. Expand research to determine the efficacy of strangulation as a part of universal domestic violence screening in medical and mental health settings.
5. Expand research on the legal system to evaluate the effectiveness of statutory definitions and prosecution strategies for strangulation cases.

These five recommendations focus on practical response strategies that are possible given the current state of knowledge, while highlighting limitations that need to be addressed by researchers to continue each approach. Each recommendation is explained in detail in the subsequent sections.

1. Develop better coordinated responses for nonfatal strangulation within local communities.

The San Diego study demonstrated that nonfatal strangulation can be effectively addressed by the legal and medical systems when coordination and training occur on a jurisdictional level, even before state-level statutes were available. Today, most U.S. states have statutory support for the prosecution of nonfatal strangulation; however, it is unknown how effectively local communities are able to investigate and prosecute these cases. Survivors of strangulation may be known to law enforcement, but many present in other clinical and service settings, from shelters to dental clinics. The societal response to strangulation can best be improved through an integrated response including law enforcement, medical professionals, mental health professionals, legal professionals, domestic violence advocates, and sexual assault advocates, as well as through the development of best practices and the implementation of widespread cultural change and awareness. Coordination between the various points of contact for a survivor can help to address important concerns like the systemic revictimization of survivors when multiple actors are involved (Maier, 2012; Plichta, 2007). A better understanding of the psychological and neurological impacts of strangulation assaults is critical for helping victims cope with the impacts of events often experienced as potentially lethal assaults (Joshi et al., 2012). Coordinated evidence collection across service sites can also aid prosecutors in evidence-based prosecution, rather than relying primarily on victim testimony or patrol officers to substantiate strangulation claims. Researchers also have an important role in these multiagency projects to support the community's efforts through evaluation, training, and education. Researchers are also essential for disseminating effective models, interventions, paradigms, and best practices to a wider audience.

2. Train first responders and other service personnel to recognize, respond, and collect critical evidence in strangulation incidents.

Not all physical violence in domestic violence and intimate partner violence can be identified and rectified in a similar manner. Physical violence varies in seriousness, modality, and symptomology. Strangulation injuries are not easily detected if examining personnel are not trained to question and identify its specific expressions; first responders and other service providers must be aware of the seriousness of invisible injuries and also to be aware of medical services available to help survivors avoid long-term health complications or possible death. Law enforcement, medical professions, and legal professionals are accustomed to securing physical evidence for the conviction of an offender for an alleged assault, but strangulation typically eludes standard evidence collection methods due to the internal or subtle nature of many strangulation injuries (Strack et al., 2001). An integrated response, supported by high-quality research findings, can prepare responders to focus on the most prevalent signs and symptoms of strangulation incidents (Laughon et al., 2009; Strack et al., 2001). Emergency medical personnel and law enforcement can visibly detect and document redness, cuts, thumbprints, red marks, and defensive injuries when responding to domestic violence calls (Funk & Schuppel, 2003; O'Dell, 2007; Strack et al., 2001), screen for invisible symptoms when strangulation is suspected (e.g., confusion, slurred speech, involuntary urination, voice changes, agitation due to hypoxia), and can be prepared to make referrals to experts (e.g., forensic nurse examiners) if possible. With training, emergency medical services and law enforcement can learn to screen an individual for strangulation injuries when, for example, a domestic violence victim appears confused or intoxicated, since victims of strangulation may experience loss of consciousness, paralysis, difficulty speaking (sore throat and difficulty swallowing), memory loss, and headaches (Smith et al., 2001). Victims may not only be physically unresponsive or difficult to communicate with, but also experiencing PTSD symptoms related to the fear of death and/or shocking reality of

the extreme coercive control recently exerted upon them (Joshi et al., 2012; McClane et al., 2001; Smith et al., 2001; Thomas et al., 2014). If strangulation is detected, well-trained law enforcement can document the modality, duration, appearance of symptoms, the victim's experience of the event, and threats made to the victim, which can provide cause for arrest and critical evidence for felony prosecution (Strack et al., 2001). When trained in coordination with other community agencies, emergency medical services and law enforcement can also connect the victim to advocates who can provide the victim with resources/options, emotional support, and techniques for living with abuse and persisting with prosecution if the victim desires. Likewise, mental health counselors and other advocates should develop protocols to screen for strangulation when treating domestic violence survivors, because there is also a risk that survivors minimize the significance of these assaults or fail to realize the significant health risks associated with this type of attack.

3. Utilize the expertise of medical professionals to help victims and support prosecution.

A clear strength of the emerging literature on nonfatal strangulation is within the growing body of medical research. Considering the increasing availability of forensic nurses (e.g., Sexual Assault Nurse Examiners (SANE), Sexual Assault Response Teams (SART)) and their present role in sexual assault cases, the extension of this investigative paradigm to include strangulation cases is possible. Many law enforcement agencies already have working relationships with forensic nurses. Medical screening for strangulation can start with emergency medical personnel and law enforcement officers initially screening and referring a victim for a forensic medical exam at domestic violence scenes. A forensic nurse examiner can document the symptoms and visible injuries of the victim for legal evidence. Research clearly demonstrates that forensic medical documentation can very strongly support the victim, law enforcement officers, and prosecutor in holding an offender legally responsible (Baker & Sommers, 2008; Laughon et al., 2009; Strack et al., 2001). Medical screening for strangulation could also take place when victims visit their dentists, family physicians, or emergency rooms and display distinct strangulation injuries, and also when injuries such as petechiae are visible on the inner and outer parts of the mouth, tongue, cheeks, and lips, which might otherwise be unseen (Kenney, 2006).

4. Expand research to determine the efficacy of strangulation as a part of universal domestic violence screening in medical and mental health settings.

The research reviewed in this article strongly suggests that when medical and legal systems respond appropriately to strangulation in domestic violence cases, the prosecution of these cases can be improved. However, what is less clear is the extent to which knowledge and screening for strangulation in other domestic violence cases is warranted, and in particular within mental health settings where no law enforcement or medical are directly involved.

While this review finds some evidence to support broader screening for strangulation among domestic violence survivors (e.g., high strangulation prevalence in a few small shelter samples), more clinical, psychological, and community-based research is needed to determine whether or not strangulation is prevalent enough to warrant inclusion in universal domestic violence screening in health care or mental health settings, as some have advocated (Strauchler et al., 2004). If possible, any effort to screen for strangulation should also seek to connect the possibility of strangulation to incidents characterized by controlling abuse, sexual abuse, forced sex, escalating violence in a relationship, co-occurrence with drugs or alcohol, issues of sexual infidelity, and death threats (Campbell et al., 2003; Joshi et al., 2012; Messing et al., 2014; Wilbur et al., 2001).

5. Expand research on the legal system to evaluate the effectiveness of statutory definitions and prosecution strategies for strangulation cases.

Over the past 15 years, most states have implemented or included strangulation as a serious offense within criminal statutes. Even when not yet explicitly named in the statute, some states like Kentucky or Colorado have developed strategies for prosecuting strangulation as a form of manual assault, or like Ohio consider strangulation as a condition for bail.[4] Clear and inclusive definitions of strangulation acts as well as of the precise injuries and symptoms of strangulation assist in categorizing strangulation as a serious offense due to the intent to harm and cause serious health consequences for the victim (Verdi, 2013). Specifically, more research is needed to evaluate the differences between states that made strangulation a domestic violence–specific crime versus those which more broadly prosecute strangulation as assault or aggravated assault. Statutory language (e.g., differing definitions of strangulation) should also be examined, in order to evaluate whether or not these definitions in practice are too broad or too narrow. Likewise, a few states specify strangulation as a form of attempted murder, which may limit the applicability of statutes to domestic violence cases where strangulation is perceived by the victim primarily as a form of coercive control rather than attempted homicide (Thomas et al., 2014). Again, comparative or legal case study research can shed light on these concerns.

Given the newness of most strangulation statutes, research should also seek to determine whether or not legal actors from attorneys and prosecutors to judges need to be educated on the nature of strangulation, particularly when in jurisdictions that define strangulation as attempted murder. Research clearly establishes that strangulation is a risk factor for domestic violence femicide, with one study reporting strangulation as the method of attack in 90% of attempted murders of women (Campbell, 2002; Campbell et al., 2003; Douglas & Fritzgerald, 2013, 2014). Attorneys, prosecutors, judges, and juries should be educated about the uniqueness of strangulation injuries and the occurrence of delayed symptoms and death that

may not be documented as dangerous at the time of the event or medical examination (Anscombe & Knight, 1996; Clarot et al., 2005). Legal intervention in violent events such as strangulation can shift the culture of victims being vulnerable by holding the offender accountable and valuing the treatment of the victim in regard to legal protection and advisement of their health and lethality risks.

Additional Directions for Research

In addition to the practical recommendations made above which seek to identify areas where both practice and research could develop in mutually beneficial ways, there are a number of issues within the research literature that could help to advance the study of nonfatal strangulation in general.

First, there is an immediate need for clear, standardized definitions and measures of strangulation that can be utilized across, or specific to, a wide variety of fields including criminology, medicine, mental health counseling, and criminal justice. In this article, we have put forth one broad definition, but it is clear from our review that the boundaries of such a definition may still need to be refined depending on the needs of various professionals. In our review, we identified a wide range of terminology used to describe strangulation, and noted that there are very few standardized methodological or theoretical approaches to this phenomenon. Much of the extant literature involves small samples or case studies, and measures tend to rely on information recorded in official records (e.g., patient files, autopsy reports, and police reports) rather than purposively created to understand this phenomenon. While prevalence of strangulation has been estimated by large, high-quality samples, these studies often measure strangulation with a single item among many items designed to estimate domestic violence victimization. The qualitative research reviewed here indicates that strangulation may be more complicated than just another manifestation of serious violence; more research is needed to understand the unique properties of coercive control and the psychological correlates faced by survivors whose abusers utilize strangulation as a tactic of coercive control.

Empirically speaking, there are a number of other mechanisms resulting in strangulation-like injuries (e.g., suffocation, drowning, hanging, and compression asphyxiation) that may, from a medical standpoint, make these injuries essentially the same. In criminal justice, however, different harm mechanisms may or may not be utilized in similar ways as strangulation to cause bodily harm or coercive control, and thus the context would be more important than injury symptomology. Hanging, for instance, may exhibit similar injuries to strangulation but would not be handled in the same way by law enforcement. In legal terms, some state statutes include both strangulation and suffocation in the same statute, particularly when those laws are also used to prosecute child abuse cases. Similarities and differences in these types of cases deserve attention from scholars. Furthermore, research should try to determine if common language mistakes like confusing choking with ''strangulation'' or confusing ''abrasions'' with ''petechiae'' could be detrimental to prosecution when these errors are made in police reports or medical exams. In our review and definition, strangulation was examined narrowly in the context of adult domestic violence, but if child abuse or stranger assaults are considered there may be additional factors that are important to consider.

Due to the association with domestic violence and shelter samples, most research on strangulation has focused on female victims. There is at present little evidence to suggest that men are frequent victims of strangulation in domestic violence; however, it is certain that men do suffer from these types of injuries as well, and from nonintimate offenders. With the growing popularity of mixed martial arts (MMA), which focuses heavily on submission grappling and judo choke holds, it is increasingly likely that law enforcement will encounter strangulation injuries associated with violent assaults between men. At least a few case studies have been published noting strangulation injuries in men due to participation in martial arts (Owens & Ghadiali, 1991; Porr, Laframboise, & Kazemi, 2012), and it is possible that mixed martial artists could prove to be a readymade population in which to study the effects of repeated strangulation (and strangulation in conjunction with blunt force head trauma) without the additional ethical and safety concerns present when conducting research on victims of domestic violence. Alternatively, one could also speculate that the widespread popularity of MMA (which is also increasingly being taught to police, security, and military personnel) may be associated with a rise in strangulation prevalence that may help to explain the recent growth in attention to nonfatal strangulation. However, no research has attempted to evaluate this hypothesis, let alone explicitly seek to identify the prevalence or patterns of nonfatal strangulation as a phenomenon within domestic violence or in general.

Finally, there is a need to develop reliable measures of nonfatal strangulation in order to determine prevalence rates. There are at present gaping disparities between rates of strangulation among specific at-risk women in the few extant studies on the topic. National domestic violence surveys have sometimes grouped strangulation in with other types of injuries when reporting prevalence rates (e.g., ''choke or attempt to drown you?'' from the NVAWS, or ''being beaten, burned, or choked'' in NISVS), measured prevalence with a single nondescriptive item, and used the more colloquial term ''choke'' instead of strangulation, a limitation also shared by the widely used CTS2, a.k.a., the Revised Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman,1996). Even so, the national study results are consistent with the findings of smaller studies indicating that intimate strangulation is a very serious issue that disproportionately affects women; for instance in the NVAWS approximately 79% of women experienced choking or attempted drowning at the hands of an intimate, compared to only 20% of men (Tjaden & Thoennes, 2000). Given the disparities between prevalence rates in different sample types, a problem admittedly not uncommon in domestic violence research, this area of research would benefit greatly from an attempt to develop and validate one or more items to

standardize a measure of strangulation. This is particularly important, given recent qualitative research that suggests a number of factors that influence strangulation survivors' perceptions of and use of certain terminology to identify the incident (Joshi et al., 2012; Thomas et al., 2014).

Conclusion

Since the publication of the landmark San Diego County study on nonfatal strangulation, there has been an incredible response by criminal justice, medical, forensic, and legal professionals to raise awareness and address systemic shortcomings when dealing with strangulation as a part of domestic violence. Much of this work has been greatly advanced by the authors through The Training Institute on Strangulation Prevention (http://www.strangulationtraininginstitute.com). In the past 15 years, most U.S. states and several nations around the world have begun to take steps to address this problem that disproportionately impacts women in intimate relationships. Research on this topic has also expanded, opening several new avenues for advancement in knowledge, practice, training, and education. In this review, we have highlighted the history and key recent developments relevant to the study of nonfatal strangulation in the areas of criminology, forensic science, law, and medicine in hopes of providing some direction to this emerging area of research.

Summary Tables

Critical findings. Awareness of nonfatal strangulation as a part of domestic violence has improved dramatically in the past 15 years; most U.S. states now have or are developing statutes to address the strangulation.

- Medical and forensic research has found that strangulation injuries may be more serious and less visible than previously understood.
- Research shows that coordination between practitioners can improve services to strangulation victims and prosecution of offenders.
- Some research suggests that strangulation may be more prevalent in high-risk domestic violence cases, and more research is needed to examine this potentially lethal form of abuse.

Implications for practice, policy, and research

- Many states have elevated domestic violence strangulation to a felony by creating new statutes, yet more evaluation at the policy level is needed to determine the effectiveness of different statutory types.
- Strangulation-specific training, particularly for medical practitioners and criminal justice personnel, can be extremely impactful for helping victims and dramatically improving the ability to prosecute cases under these new statutes.
- Research and practice in this area can be improved by using standardized definitions and developing standardized measures of strangulation, and providing training to key law enforcement, legal, mental health, and medical personnel.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Notes

1. The authors searched all online U.S. state statutes for the term ''strangulation'' in preparation for this manuscript, noting the type of statute (e.g., domestic violence, assault, and child abuse) in which the language appears and the year the statute was added or amended.
2. For a comprehensive list of early forensic and medical studies on strangulation injuries or the investigation of strangulation-related crimes, see the appendix of the manual published by the Training Institute on Strangulation Prevention and California District Attorneys Association (2013). *The Investigation and Prosecution of Strangulation Cases* (www.strangulationtraininginstitute.com).
3. Researchers outside of medicine have also taken up some of the future directions suggested by Taliaferro et al. (2001); notably (Bergin & Berkowitz, 2012) regarding strangulation and domestic violence in the military, and the vast expansion of felony prosecution of strangulation described in this article's legal section.
4. The Training Institute on Strangulation Prevention (http://www.strangulationtraininginstitute.com).

References

Anderson, K. L. (2009). Gendering coercive control. *Violence Against Women*, *15*, 1444–1457.

Anderson, M. L. (2009). *WATCH Report Part II: The Impact of Minnesota's Felony Strangulation Law: May, 2009*. Minneapolis, MN: WATCH. Retrieved April 6, 2015, fromhttp://www.stopvaw.org/uploads/strangulation_report_ii_-_resource.pdf

Anscombe, A. M., & Knight, B. H. (1996). Case report. Delayed death after pressure on the neck: Possible causal mechanisms and implications for mode of death in manual strangulation discussed. *Forensic Science International*, *78*, 193–197. doi:http://dx.doi.org/10.1016/0379-0738(95)01886-7

Baker, R. B., & Sommers, M. S. (2008). Physical injury from intimate partner violence: Measurement strategies and challenges. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *37*, 228–233. doi:10.1111/j.1552-6909.2007.00226.x

Bergin, A., & Berkowitz, R. (2012). Domestic violence in military families: Non-fatal strangulation. *Maryland Medicine*, *13*, 19–29.

Bullock, L., Bloom, T., Davis, J., Kilburn, E., & Curry, M.A. (2006). Abuse disclosure in privately and Medicaid-funded pregnant

women. *Journal of Midwifery and Women's Health*, *51*, 361–369. doi:10.1016/j.jmwh.2006.02.012

Brink, O. (2009). When violence strikes the head, neck, and face. *The Journal of Trauma*, *67*, 147–151. doi:10.1097/TA.0b013e318182f77 f

Campbell, J. C. (1986). Nursing assessment for risk of homicide with battered women. *Advances in Nursing Science*, *8*, 36–51.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, *359*, 1331–1336. doi:http://dx.doi.org/10.1016/S0140-6736(02)08336-8

Campbell, J. C., Glass, N., Sharps, P. W., Laughon, K., & Bloom, T. (2007). Intimate partner homicide: Review and implications of research and policy. *Trauma, Violence, and Abuse*, *8*, 246–269. doi:10.1177/1524838007303505

Campbell, J. C. (1995). *Assessing Dangerousness*. Newbury Park, CA: Sage

Campbell, J. C., Harris, M. J., & Lee, R. K. (1995). Violence research: An overview. *Scholarly Inquiry for Nursing Practice: An International Journal*, *9*, 105–126.

Campbell, J. C., Webster, D., & Glass, N. (2009). The danger assessment: Validation of a lethality risk assessment instrument for intimate partner femicide. *Journal of Interpersonal Violence*, *24*, 653–674. doi:10.1177/0886260508317180

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., & . . . Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health*, *93*, 1089–1097.

Christe, A., Oesterhelweg, L., Ross, S., Spendlove, D., Bolliger, S., Vock, P., & Thali, M. J. (2010). Can MRI of the neck compete with clinical findings in assessing danger to life for survivors of manual strangulation? A statistical analysis. *Legal Medicine*, *12*, 228–232. doi:http://dx.doi.org/10.1016/j.legalmed.2010.05.004

Christe, A., Thoeny, H., Ross, S., Spendlove, D., Tshering, D., Bolliger, S., . . . Oesterhelweg, L. (2009). Life-threatening versus non-life-threatening manual strangulation: Are there appropriate criteria for MR imaging of the neck? *European Society of Radiology*, *19*, 1882–1889. doi:10.1007/s00330-009-1353-2

Clarot, F., Vaz, E., Papin, F., & Proust, B. (2005). Fatal and non-fatal bilateral delayed carotid artery dissection after manual strangulation. *Forensic Science International*, *149*, 143–150. doi:http://dx.doi.org/10.1016/j.forsciint.2004.06.009

Coggins, M., & Bullock, L. F. C. (2003). The wavering line in the sand: The effects of domestic violence and sexual coercion. *Issues in Mental Health Nursing*, *24*, 723–738. doi:10.1080/01612840305322

Coker, A.L., Smith, P.H., & Fadden, M.L. (2005). Partner violence and disabilities preventing work. *Journal of Women's Health*, *14*, 829–838.

Davison, A. M., & Williams, E. J. (2012). Microscopic evidence of previous trauma to the hyoid bone in a homicide involving pressure to the neck. *Forensic Science, Medicine, and Pathology*, *8*, 307–311. doi:10.1007/s12024-012-9316-3

Domestic Assault by Strangulation, Minn. Stat. § 609.2247 (2005).

Domestic Assault by Strangulation, R.I. Gen Law § 11-5-2.3 (2012).

Douglas, H., & Fitzgerald, R. B. (2013). Legal processes and gendered violence: Cross-applications for domestic violence protection orders. *University of New South Wales Law Journal*, *36*, 13–12.

Douglas, H., & Fitzgerald, R. B. (2014). Strangulation, domestic violence and the legal response. *The Sydney Law Review*, *36*, 231–254.

Dutton, M.A., & Goodman, L.A. (2005). Coercion in intimate partner violence: Toward a new conceptualization. *Sex Roles*, *52*, 743–756. doi:10.1007/s11199-005-4196-6

Faugno, D., Waszak, D., Strack, G. B., Brooks, M. A., & Gwinn, C. (2013). Strangulation forensic examination: Best practice for health care providers. *Advanced Emergency Nursing Journal*, *35*, 314–327. doi:10.1097/TME.0b013e3182aa05d3

Fineron, P. W., Turnbull, J. A., & Busuttil, A. (1995). Fracture of the hyoid bone in survivors of attempted manual strangulation. *Journal of Clinical Forensic Medicine*, *2*, 195–197. doi:http://dx.doi.org/10.1016/1353-1131(95)90003-9

Francis, K. (2008). Minnesota's new domestic abuse strangulation statute. *Bench and Bar of Minnesota*, *65*, 26.

Funk, M., & Schuppel, J. (2003). Strangulation injuries. *WMJ: Official Publication of the State Medical Society of Wisconsin*, *102*, 41–45.

Glass, N., Laughon, K., Campbell, J., Wolf, A.D., Block, C.R., Hanson, G., . . . Taliaferro, E. (2008). Non-fatal strangulation is an important risk factor for homicide of women. *Journal of Emergency Medicine*, *35*, 329–335. doi:10.1016/j.jemermed.2007.02.065

Gwinn, C., McClane, G. E., Shanel-Hogan, K. A., & Strack, G. B. (2004). Domestic violence: No place for a smile. *Journal of the California Dental Association*, *32*, 399–409.

Hawley, D. A., McClane, G. E., & Strack, G. B. (2001). A review of 300 attempted strangulation cases Part III: Injuries in fatal cases. *The Journal of Emergency Medicine*, *21*, 317–322. doi:10.1016/S0736-4679(01)00401-2

Holbrook, D.S., & Jackson, M.C. (2013). Use of an alternative light source to assess strangulation victims. *Journal of Forensic Nursing*, *9*, 140–145. doi:10.1097/JFN.0b013e31829beb1e

Iserson, K. V. (1984). Strangulation: A review of ligature, manual, and postural neck compression injuries. *Annals of Emergency Medicine*, *13*, 179–185. doi:http://dx.doi.org/10.1016/S0196-0644(84)80609-5

Johnson, M.P., & Leone, J. M. (2005). The differential effects of intimate terrorism and situational couple violence. *Journal of Family Issues*, *26*, 322–349. doi:10.1177/0192513X04270345

Joshi, M., Thomas, K. A., & Sorenson, S. B. (2012). "I didn't know I could turn colors": Health problems and health care experiences of women strangled by an intimate partner. *Social Work in Health Care*, *51*, 798–814. doi:10.1080/00981389.2012.692352

Kenney, J. P. (2006). Domestic violence: A complex health care issue for dentistry today. *Forensic Science International*, *159*, S121–S125. doi:10.1016/j.forsciint.2006.02.025

Klopfstein, U., Kamber, J., & Zimmermann, H. (2010). "On the way to light the dark": A retrospective inquiry into the registered cases of domestic violence towards women over a six year period with a semi-quantitative analysis of the corresponding forensic documentation. *Swiss Medical Weekly*, *140*, w13047. doi:10.4414/smw.2010.13047

Kropp, P. R. (2009). Intimate partner violence risk assessment. In J. L. Ireland, C. Ireland, & P. Birch (Eds.), *Violent and sexual offenders: Assessment, treatment and management*. Cullompton, England: Willan Publishing.

Kropp, P.R., Hart, S.D., Webster, C.W., & Eaves, D. (1994). *Manual for the spousal assault risk assessment guide* (pp. 43–67). Vancouver: British Columbia Institute on Family Violence.

Kuriloff, D. B., & Pincus, R. L. (1989). Delayed airway obstruction and neck abscess following manual strangulation injury. *Annals of Otology, Rhinology and Laryngology*, *98*, 824–827. doi:10.1177/000348948909801014

Laughon, K., Glass, N., & Worrell, C. (2009). Review and analysis of laws related to strangulation in 50 States. *Evaluation Review*, *33*, 358–369. doi:10.1177/0193841x09337481

Laughon, K., Renker, P., Glass, N., & Parker, B. (2008). Revision of the abuse assessment screen to address nonlethal strangulation. *JOGNN: Journal of Obstetric, Gynecologic and Neonatal Nursing*, *37*, 502–507. doi:10.1111/j.1552-6909.2008.00268.x

Line, W. S. Jr., Stanley, R. B. Jr., & Choi, J. H. (1985). Strangulation: A full spectrum of blunt neck trauma. *Annals of Otology, Rhinology and Laryngology*, *94*, 542–546.

Malek, A.M., Higashida, R.T., Halbach, V.V., Dowd, C.F., Hatouros, C.C., Lempert, T.E., & . . . Stoney, R. (2000). Patient presentation, angiographic features, and treatment of strangulation-induced bilateral dissection of the cervical internal carotid artery. *Journal of Neurosurgery*, *92*, 481–487. doi:10.3171/jns.2000.92.3.0481

Maier, S. L. (2012). Sexual assault nurse examiners' perceptions of the revictimization of rape victims. *Journal of Interpersonal Violence*, *27*, 287–315. doi:10.1177/0886260511416476

Maxeiner, H. (1998). ''Hidden'' laryngeal injuries in homicidal strangulation: How to detect and interpret these findings. *Journal of Forensic Sciences*, *43*, 784–791.

McCauley, J., Kern, D. E., Kolodner, K., Dill, L., Schroeder, A. F., Dechant, H. K., & . . . Derogatis, L. R. (1995). The ''Battering syndrome'': Prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Annals of Internal Medicine*, *123*, 737–746. doi:10.7326/0003-4819-123-10-199511150-00001

McClane, G. E., Strack, G. B., & Hawley, D. (2001). A review of 300 attempted strangulation cases—Part II: Clinical evaluation of the surviving victim. *Journal of Emergency Medicine*, *21*, 311–315. doi:http://dx.doi.org/10.1016/S0736-4679(01)00400-0

Messing, J. T., Thaller, J., & Bagwell, M. (2014). Factors related to sexual abuse and forced sex in a sample of women experiencing police-involved intimate partner violence. *Health and Social Work*, *39*, 181–191. doi:10.1093/hsw/hlu026

Mitchell, J. R., Roach, D. E., Tyberg, J. V., Belenkie, I., & Sheldon, R. S. (2012). Mechanism of loss of consciousness during vascular neck restraint. *Journal of Applied Physiology*, *112*, 396–402. doi:10.1152/japplphysiol.00592.2011

National Center for Injury Prevention and Control Centers for Disease Control and Prevention. (2011). *The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report*. Atlanta, GA: Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., and Stevens, M.R.

Nemeth, J.M., Bonomi, A.E., Lee, M.A., & Ludwin, J.M. (2012). Sexual infidelity as trigger for intimate partner violence. *Journal of Women's Health*, *21*, 942–949. doi:10.1089/jwh.2011.3328

O'Dell, A. (2007). Why do police arrest victims of domestic violence? The need for comprehensive training and investigative protocols. *Journal of Aggression, Maltreatment and Trauma*, *15*, 53–73. doi:10.1080/10926770802097210

Owens, R. G., & Ghadiali, E. J. (1991). Judo as a possible cause of anoxic brain damage. A case report. *The Journal of Sports Medicine and Physical Fitness*, *31*, 627–628. doi:10.1055/s-0030-1267502

Plattner, T., Bolliger, S., & Zollinger, U. (2005). Forensic assessment of survived strangulation. *Forensic Science International*, *153*, 202–207. doi:http://dx.doi.org/10.1016/j.forsciint.2004.09.106

Plichta, S. B. (2007). Interactions between victims of intimate partner violence against women and the health care system: Policy and practice implications. *Trauma, Violence, and Abuse*, *8*, 226–239. doi:10.1177/1524838007301220

Pollanen, M. S., Bulger, B., & Chiasson, D. A. (1995). The location of hyoid fractures in strangulation revealed by xeroradiography. *Journal of Forensic Sciences*, *40*, 303–305. doi:10.5999/aps.2014.41.1.93

Pollanen, M. S., & Chiasson, D. A. (1996). Fracture of the hyoid bone in strangulation: Comparison of fractured and unfractured hyoids from victims of strangulation. *Journal of Forensic Sciences*, *41*, 110–113. doi:10.1016/S0379-0738(98)00024-3

Porr, J., Laframboise, M., & Kazemi, M. (2012). Traumatic hyoid bone fracture – a case report and review of the literature. *The Journal of the Canadian Chiropractic Association*, *56*, 269–274. doi:10.1177/1941738111419963

Sadler, D.W. (1994). Concealed homicidal strangulation first discovered at necropsy. *Journal of Clinical Pathology*, *47*, 679–680. doi:10.1136/jcp.47.7.679

Sheridan, D.J., & Nash, K.R. (2007). Acute injury patterns of intimate partner violence victims. *Trauma, Violence, and Abuse*, *8*, 281–289. doi:10.1177/1524838007303504

Shields, L. B. E., Corey, T. S., Weakley-Jones, B., & Stewart, D. (2010). Living victims of strangulation: A 10-year review of cases in a metropolitan community. *American Journal of Forensic Medicine and Pathology*, *31*, 320–325. doi:10.1097/PAF.0b013e3181d3dc02

Smith, D. J. Jr., Mills, T., & Taliaferro, E. H. (2001). Frequency and relationship of reported symptomology in victims of intimate partner violence: The effect of multiple strangulation attacks. *The Journal of Emergency Medicine*, *21*, 323–329. doi:http://dx.doi.org/10.1016/S0736-4679(01)00402-4

Sommers, M.S., Fargo, J.D., Baker, R.B., Fisher, B.S., Buschur, C., & Zink, T. (2009). Health disparities in the forensic sexual assault examination related to skin color. *Journal of Forensic Nursing*, *5*, 191–200. doi:10.1111/j.1939-3938.2009.01054

Stanley, R. B. Jr., & Hanson, D. G. (1983). Manual strangulation injuries of the larynx. *Archives of Otolaryngology (Chicago, Ill.: 1960)*, *109*, 344–347.

Stark, E. (2007). *Coercive control: How men entrap women in personal life*. New York, NY: Oxford University Press.

Strack, G. B., & Gwinn, C. (2011). On the edge of a homicide: Strangulation as a prelude. *Criminal Justice*, *26*, 32–37.

Strack, G. B., McClane, G. E., & Hawley, D. (2001). A review of 300 attempted strangulation cases -Part I: Criminal legal issues. *Journal of Emergency Medicine*, *21*, 303–309. doi:http://dx.doi.org/10.1016/S0736-4679(01)00399-7

Strangulation and Related Offenses, N.Y. Penal Law §§ 121. 11–121.14 (2010).

Strauchler, O., McCloskey, K., Malloy, K., Sitaker, M., Grigsby, N., & Gillig, P. (2004). Humiliation, manipulation, and control: Evidence of centrality in domestic violence against an adult partner. *Journal of Family Violence*, *19*, 339–354. doi:10.1007/s10896-004-0679-4

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues*, *17*, 283–316. doi:10.1177/019251396017003001

Sutherland, C. A., Bybee, D. I., & Sullivan, C. M. (2002). Beyond bruises and broken bones: The joint effects of stress and injuries on battered women's health. *American Journal of Community Psychology*, *30*, 609–636. doi:10.1023/A:1016317130710

Taliaferro, E., Mills, T., & Walker, S. (2001). Walking and talking victims of strangulation. Is there a new epidemic? A commentary. *The Journal of Emergency Medicine*, *21*, 293–295. doi:http://dx.doi.org/10.1016/S0736-4679(01)00397-3

Thomas, K. A., Joshi, M., & Sorenson, S. B. (2014). "Do you know what it feels like to drown?": Strangulation as coercive control in intimate relationships. *Psychology of Women Quarterly*, *38*, 124–137. doi:10.1177/0361684313488354

Tjaden, P., & Thoennes, N. (2000). *Full report of the prevalence, incidence, and consequences of violence against women* (NCJ 183781). Washington, DC: National Institute of Justice, Office of Justice Programs.

Ubelaker, D. H. (1992). Hyoid fracture and strangulation. *Journal of Forensic Sciences*, *37*, 1216–1222. doi:10.1016/j.legalmed. 2010. 01.002

Verdi, N. M. (2013). Releasing the stranglehold on domestic violence victims: Implications and effects of Rhode Island's domestic assault strangulation statute. *Roger Williams University Law Review*, *18*, 255–284.

Weisz, A. N., Tolman, R. M., & Saunders, D. G. (2000). Assessing the risk of severe violence: The importance of survivors' predictions. *Journal of Interpersonal Violence*, *15*, 75–90. doi:10.1177/088626000015001006

Wheeler, A. (2012). *Arrests and arraignments involving strangulation offenses: Nov. 11, 2010-June 30, 2012*. New York: New York State Divison of Crime Justice Services. Retrieved April 6, 2015, from http://www.criminaljustice.ny.gov/pio/research-update-strangulation-apr2012.pdf

Wilbur, L., Higley, M., Hatfield, J., Surprenant, Z., Taliaferro, E., Smith, D. J. Jr., & Paolo, A. (2001). Survey results of women who have been strangled while in an abusive relationship. *The Journal of Emergency Medicine*, *21*, 297–302. doi:http://dx.doi.org/10.1016/S0736-4679(01)00398-5

Wolfgram, H. (2007). *The impact of Minnesota's felony strangulation law*. Minneapolis, MN: WATCH. Retrieved April 6, 2015, fromhttp://www.mincava.umn.edu/documents/strangulationreport/Strangulation%20cover%20final%201-24-07.pdf

Yamasaki, S., Takase, I., Takada, N., & Nishi, K. (2009). Measurement of force to obstruct the cervical arteries and distribution of tension exerted on a ligature in hanging. *Legal Medicine*, *11*, 175–180. doi:10.1016/j.legalmed.2009.03.007

Yen, K., Vock, P., Christe, A., Scheurer, E., Plattner, T., Schön, C., . . . Dirnhofer, R. (2007). Clinical forensic radiology in strangulation victims: Forensic expertise based on magnetic resonance imaging (MRI) findings. *International Journal of Legal Medicine*, *121*, 115–123. doi:10.1007/s00414-006-0121-y

Author Biographies

Adam J. Pritchard, PhD, is an Assistant Professor at the Department of Sociology at the University of Central Florida and previously worked as the Research Coordinator for the University of Kentucky's Center for Research on Violence Against Women. He has published research on topics which include campus victimization, fear of crime, homicide, stalking, and systemic responses to domestic violence including the effectiveness of protective orders, battered women's incarceration, and women's perceptions of social services.

Amy Reckdenwald, PhD, is an Assistant Professor at the Department of Sociology at the University of Central Florida. Her current research interests include violent victimization and offending; particularly as it relates to intimate partner homicide, domestic violence, homicide-suicide, and sexual violence. Her work has appeared in journals such as *Criminology, Journal of Criminal Justice, Homicide Studies, Feminist Criminology*, and *Violence and Victims*.

Chelsea Nordham, MA, is a doctoral student in the Department of Sociology at the University of Central Florida. She has worked as a research intern in domestic violence strangulation prevention. Her main research and teaching interests include critical criminology, deviance, and sociology of family.

RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION

Prepared by **Bill Smock, MD** and **Sally Sturgeon, DNP, SANE-A**
Office of the Police Surgeon, Louisville Metro Police Department
Endorsed by the **National Medical Advisory Committee**: Bill Smock, MD, Chair; Cathy Baldwin, MD; William Green, MD; Dean Hawley, MD; Ralph Riviello, MD; Heather Rozzi, MD; Steve Stapczynski, MD; Ellen Tailiaferro, MD; Michael Weaver, MD

GOALS:
1. Evaluate carotid and vertebral arteries for injuries
2. Evaluate bony/cartilaginous and soft tissue neck structures
3. Evaluate brain for anoxic injury

Strangulation patient presents to the Emergency Department

History of and/or physical exam with ANY of the following:

- **Loss of Consciousness** (anoxic brain injury)
- **Visual changes**: "spots", "flashing light", "tunnel vision"
- **Facial, intra-oral or conjunctival petechial hemorrhage**
- **Ligature mark or** neck **contusions**
- **Soft tissue neck injury/swelling of the neck/carotid tenderness**
- **Incontinence** (bladder and/or bowel from anoxic injury)
- **Neurological signs or symptoms** (LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorders, stroke-like symptoms.)
- **Dysphonia/Aphonia** (hematoma, laryngeal fracture, soft tissue swelling, recurrent laryngeal nerve injury)
- **Dyspnea** (hematoma, laryngeal fractures, soft tissue swelling, phrenic nerve injury)
- **Subcutaneous emphysema** (tracheal/laryngeal rupture)

Consider administration of one 325mg aspirin if there is any delay in obtaining a radiographic study

Recommended Radiographic Studies to Rule Out Life-Threatening Injuries*
(including delayed presentations of up to 1 year)

- **CT Angio of carotid/vertebral arteries** (***GOLD STANDARD*** for evaluation of vessels and bony/cartilaginous structures, less sensitive for soft tissue trauma) ***or***
- **CT neck with contrast** (less sensitive than CT Angio for vessels, good for bony/cartilaginous structures) ***or***
- **MRA of neck** (less sensitive than CT Angio for vessels, best for soft tissue trauma) ***or***
- **MRI of neck** (less sensitive than CT Angio for vessels and bony/cartilaginous structures, best study for soft tissue trauma) ***or***
- **MRI/MRA of brain** (most sensitive for anoxic brain injury, stroke symptoms and inter-cerebral petechial hemorrhage)
- **Carotid Doppler Ultrasound** (***NOT RECOMMENDED:*** least sensitive study, unable to adequately evaluate vertebral arteries or proximal internal carotid)

*References on page 2

History of and/or physical exam with:

- **No LOC** (anoxic brain injury)
- **No visual changes**: "spots", "flashing light", "tunnel vision"
- **No petechial hemorrhage**
- **No soft tissue trauma to the neck**
- **No dyspnea, dysphonia or odynophagia**
- **No neurological signs or symptoms** (i.e. LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorder, stroke-like symptoms)
- And **reliable home monitoring**

Discharge home with detailed instructions, including a lethality assessment, and to return to ED if: neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens

(-) Continued ED/Hospital Observation (based on severity of symptoms and reliable home monitoring)

(+)
- Consult Neurology Neurosurgery/Trauma Surgery for admission
- Consider ENT consult for laryngeal trauma with dysphonia
- Perform a lethality assessment per institutional policy

REFERENCES

(Recommendations based upon case reports, case studies, and cited medical literature)

1. Christe A, Thoeny H, Ross S, et al. Life-threatening versus non-life-threatening manual strangulation: are there appropriate criteria for MR imaging of the neck?. Eur Radiol 2009;19: 1882-1889
2. Christe A, Oesterhelweg L, Ross S, et al. Can MRI of the Neck Compete with Clinical Findings in Assessing Danger to Life for Survivors of Manual Strangulation? A Statistical Analysis, Legal Med 2010;12:228-232
3. Yen K, Thali MJ, Aghayev E, et al. Strangulation Signs: Initial Correlation of MRI, MSCT, and Forensic Neck Findings, J Magn Reson Imaging 2005;22:501-510
4. Stapczynski JS, Strangulation Injuries, Emergency Medicine Reports 2010;31(17):193-203
5. Yen K, Vock P, Christe A, et al. Clinical Forensic Radiology in Strangulation Victims: Forensic expertise based on magnetic resonance imaging (MRI) findings, Int J Legal Med 2007;121:115-123
6. Malek AM, Higashida RT, Halback VV, et al. Patient Presentation Angiographic Features and Treatment of Strangulation-Induced Bilateral Dissection of the Cervical Carotid Artery: Report of three cases, J Neurosurg 2000;92(3):481-487
7. Di Paolo M, Guidi B, Bruschini L, et al. Unexpected delayed death after manual strangulation: need for care examination in the emergency room, Monaldi Arch Chest Dis 2009;Sep;71(3):132-4
8. Dayapala A, Samarasekera A and Jayasena A, An Uncommon Delayed Sequela After Pressure on the Neck: An autopsy case report, Am J Forensic Med Pathol 2012;33:80-82
9. Hori A, Hirose G, Kataoka, et al. Delayed Postanoxic Encephalopathy After Strangulation, Arch Neurol 1991;48:871-874
10. Iacovou E, Nayar M, Fleming J, Lew-Gor S, A pain in the neck: a rare case of isolated hyoid bone trauma, JSCR 2011;7(3)
11. Oh JH, Min HS, Park TU, Sang JL, Kim SE, Isolated Cricoid Fracture Associated with Blunt Neck Trauma; Emerg Med J 2007;24:505-506
12. Gill JR, Cavalli DP, Ely SF, Stahl-Herz J, Homicidal Neck Compression of Females: Autopsy and Sexual Assault Findings, Acad Forensic Path 2013;3(4):454-457
13. Sethi PK, Sethi NK, Torgovnick J, Arsura E, Delayed Left Anterior and Middle Cerebral Artery Hemorrhagic Infarctions After Attempted Strangulation, A case report; Am J Forensic Med Pathol 2012;33:105-106
14. Clarot F, Vaz E, Papin F, Proust B, Fatal and Non-fatal Bilateral Delayed Carotid Artery Dissection after Manual Strangulation, Forensic Sci Int 2005;149:143-150
15. Molack J, Baxa J, Ferda J, Treska V, Bilateral Post-Traumatic Carotid Dissection as a Result of a Strangulation Injury, Ann Vasc Surg 2010;24:1133e9-1133e11
16. Plattner T, Bollinger S, Zollinger U, Forensic Assessment of Survived Strangulation, Forensic Sci Int 2005;153:202-207
17. Miao J, Su C, Wang W, et al. Delayed Parkinsonism with Selective Symmetric Basal Ganglia Lesion after Manual Strangulation, J Clin Neurosci 2009;16:573-575
18. Purvin V, Unilateral Headache and Ptosis in a 30-Year-Old Woman, Surv Ophthalmol 1997;42(2):163-168
19. Nazzal M, Herial NA, MacNealy MW: Diagnostic Imaging in Carotid Artery Dissection: A case report and review of current modalities; Ann Vasc Surg 2014;28;739.e5-739.e9
20. Chokyu TT, Miyamoto T, Yamaga H, Terada T, Itakura T: Traumatic Bilateral Common Carotid Artery Dissection Due to Strangulation: A case report; Interventional Neuroradiology;12:149-154, 2006

This project is supported all or in part by Grant No. 2016-TA-AX-K067 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

STRANGULATION
ASSESSMENT CARD

v 10.12.18

SIGNS

- Red eyes or spots (Petechiae)
- Neck swelling
- Nausea or vomiting
- Unsteady
- Loss or lapse of memory
- Urinated
- Defecated
- Possible loss of consciousness
- Ptosis – droopy eyelid
- Droopy face
- Seizure
- Tongue injury
- Lip injury
- Mental status changes
- Voice changes

SYMPTOMS

- Neck pain
- Jaw pain
- Scalp pain (from hair pulling)
- Sore throat
- Difficulty breathing
- Difficulty swallowing
- Vision changes (spots, tunnel vision, flashing lights)
- Hearing changes
- Light headedness
- Headache
- Weakness or numbness to arms or legs
- Voice changes

CHECKLIST

S **Scene & Safety**. Take in the scene. Make sure you and the victim are safe.

T **Trauma**. The victim is traumatized. Be kind. Ask: what do you remember? See? Feel? Hear? Think?

R **Reassure & Resources**. Reassure the victim that help is available and provide resources.

A **Assess**. Assess the victim for signs and symptoms of strangulation and TBI.

N **Notes**. Document your observations. Put victim statements in quotes.

G **Give**. Give the victim an advisal about delayed consequences.

L **Loss of Consciousness**. Victims may not remember. Lapse of memory? Change in location? Urination? Defecation?

E **Encourage**. Encourage medical attention or transport if life-threatening injuries exist.

TRANSPORT

If the victim is **Pregnant** or has life-threatening injuries which include:

- Difficulty breathing
- Difficulty swallowing
- Petechial hemorrhage
- Vision changes
- Loss of consciousness
- Urinated
- Defecated

DELAYED CONSEQUENCES

Victims may look fine and say they are fine, but just underneath the skin there would be internal injury and/or delayed complications. Internal injury may take a few hours to be appreciated. The victim may develop delayed swelling, hematomas, vocal cord immobility, displaced laryngeal fractures, fractured hyoid bone, airway obstruction, stroke or even delayed death from a carotid dissection, blood clot, respiratory complications, or anoxic brain damage.

Taliaferro, E., Hawley, D., McClane, G.E. & Strack, G. (2009), Strangulation in Intimate Partner Violence. *Intimate Partner Violence: A Health-Based Perspective.* Oxford University Press, Inc.

This project is supported all or in part by Grant No. 2014-TA-AX-K008 awarded by the Office on Violence Agaist Women, U.S. Dept. of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

ADVISAL TO PATIENT

- After a strangulation assault, you can experience internal injuries with a delayed onset of symptoms. These internal injuries can be serious or fatal.
- Stay with someone you trust for the first 24 hours and have them monitor your signs and symptoms.
- Seek medical attention or call 911 if you have any of the following symptoms: difficulty breathing, trouble swallowing, swelling to your neck, pain to your throat, hoarseness or voice changes, blurred vision, continuous or severe headaches, seizures, vomiting or persistent cough.
- The cost of your medical care may be covered by your state's victim compensation fund. An advocate can give you more information about this resource.
- The National Domestic Violence Hotline number is **1-800-799-SAFE.**

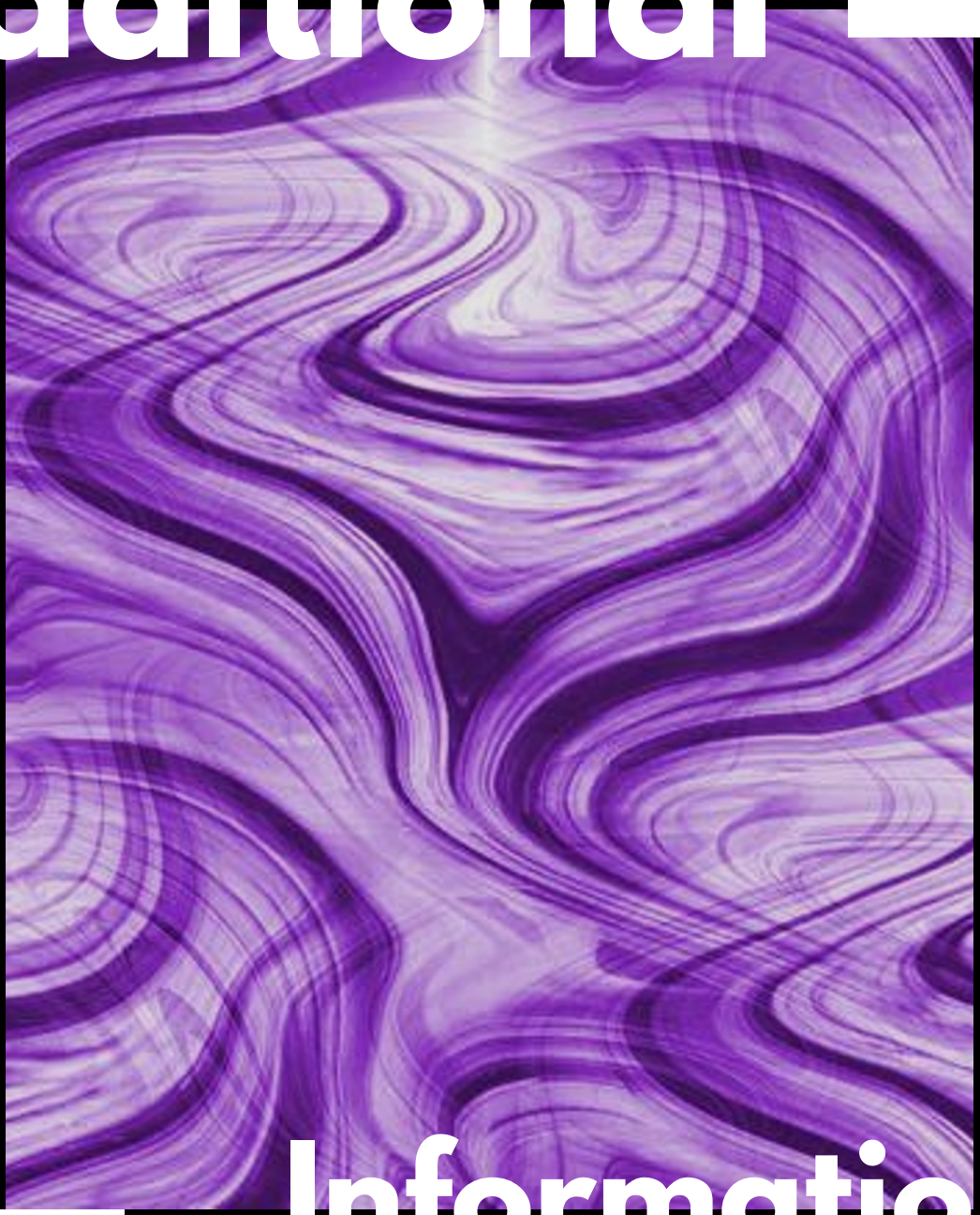
NOTICE TO MEDICAL PROVIDER

- The Medical Advisory Board of the Training Institute on Strangulation Prevention has developed recommendations for the radiologic evaluation of the adult strangulation victim. In patients with a history of a loss of consciousness, loss of bladder or bowel control, vision changes or petechial hemorrhage, medical providers should evaluate the carotid and vertebral arteries, bony/cartilaginous and soft tissue neck structures and the brain for injuries. A list of medical references is available at www.strangulationtraininginstitute.com
- Life-threatening injuries include evidence of petechial hemorrhage, loss of consciousness, urination, defecation and/or visual changes. If your patient exhibits any of the above symptoms, medical/radiographic evaluation is strongly recommended. Radiographic testing should include: a CT angiography of carotid/vertebral arteries (most sensitive and preferred study for vessel evaluation) or CT neck with contrast, or MRA/MRI of neck and brain. Strangled patients with arterial injuries can present with strokes months or years post-strangulation.
- ED/Hospital observation should be based on severity of symptoms and reliable home monitoring.
- Consult Neurology, Neurosurgery and/or Trauma Surgery for admission.
- Consider an ENT consult for laryngeal trauma with dysphonia, odynophagia, dyspnea.
- Discharge home with detailed instructions to return to ED if neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens.

TRAINING INSTITUTE on STRANGULATION PREVENTION

StrangulationTrainingInstitute.com

Additional Information

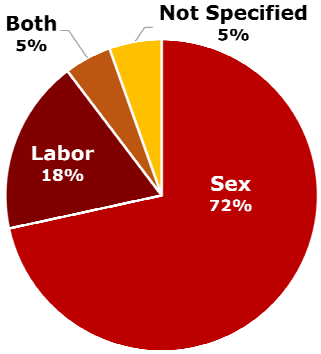


HUMAN TRAFFICKING

Human Trafficking- the exploitation of individuals using force, fraud, or coercion (violence, manipulation, debt bondage, threats, lies, etc.) to make them provide labor/services or engage in commercial sex. Note: when a minor (<18 years) is made to engage in commercial sex, *regardless* of the use of force, fraud, or coercion, it is human trafficking.

Figure 1. Texas human trafficking cases reported to the National Human Trafficking Hotline (NHTH), 2012-2017 (n= 3,172)

Figure 2. Types of human trafficking among Texas cases reported to the NHTH, 2012-2017 (n=3,172)



Types of labor:
domestic, landscaping, factory, farming, construction, door-to-door sales, health and beauty, food service, and begging/peddling

Venues for commercial sex:
fake massage/spa businesses, online ads, escort services, bars/clubs, truck stops, hotels/motels, and residential brothels

Tarrant County ranks 7th among Texas counties in the number of students (850) attending public schools within 1,000 feet of suspected illegal massage businesses

Figure 3. Locations of Texas human trafficking cases reported to the NHTH, 2017

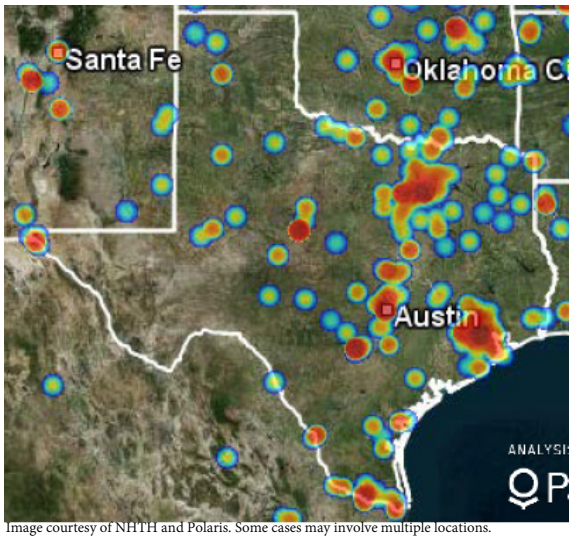


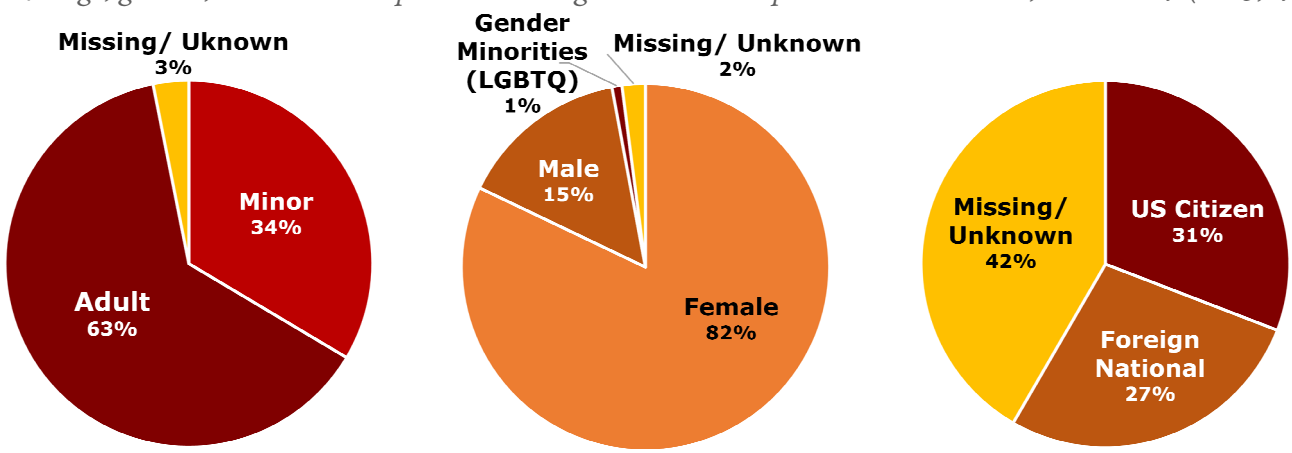
Image courtesy of NHTH and Polaris. Some cases may involve multiple locations.

122 patients were identified as possible human trafficking victims during a pilot study at JPS in Tarrant County from May to December 2018

Data are from calls, emails, or webforms communicated to the National Human Trafficking Hotline (NHTH). Data are subject to change and the NHTH cannot verify accuracy. NHTH does not disclose exact data when responses occur less than three times. These data are not a comprehensive representation of human trafficking within an area.

Data sources: Administration for Children and Families– Office on Trafficking in Persons, Centers for Disease Control and Prevention, Children at Risk, JPS, National Human Trafficking Hotline, Polaris Project
Data Brief provided by: Division of Epidemiology and Health Information

Figure 4. Age, gender, and citizenship status among Texas cases reported to the NHTH, 2012-2017 (n= 3,172)



These data from the NHTH are non-cumulative. Cases may involve multiple victims and include males and females, foreign nationals and U.S. citizens, adults and minors. Callers may not provide demographic information.

Anyone can become a victim of human trafficking. Certain factors can increase someone's risk of being trafficked:

Children in Foster Care and Juvenile Justice Systems

Poverty
Debt

Abuse/Neglect
Trauma
Violence

Racial and Ethnic Minorities
Individuals with Disabilities
Gender Minorities (LGBTQ)
Females

Immigrants
Refugees

History of Substance Use Disorder

Homeless
Runaways

How YOU Can Make a Difference...

Share the *National Human Trafficking Hotline* **Call 1-888-373-7888 or Text 233733 [humantraffickinghotline.org]**

Take an online quiz to see how *you* can reduce trafficking demand **[slaveryfootprint.org]**

Recognize the signs of human trafficking **[polarisproject.org/human-trafficking/recognize-signs]**

Raise awareness with *free* materials **[dhs.gov/blue-campaign/request-materials]**

Pick from a list of 10 ways you can help **[acf.hhs.gov/otip/about/ways-endtrafficking]**

Resources and Support in Tarrant County

[childrenatrisk.org] Fort Worth office

[traffick911.com] Tarrant County team

[unboundnow.org] Fort Worth location

Tarrant County Sheriff's Office Human Trafficking Unit: **Call 817-884-2941**

Fort Worth Police Department (FWPD) Human Trafficking Unit: **Call 817-392-4091**

FWPD Tarrant County 5-Stones Taskforce: **Call 817-392-4533**

Crime Stoppers of Tarrant County: **Call 817-469-8477 [469tips.com]**

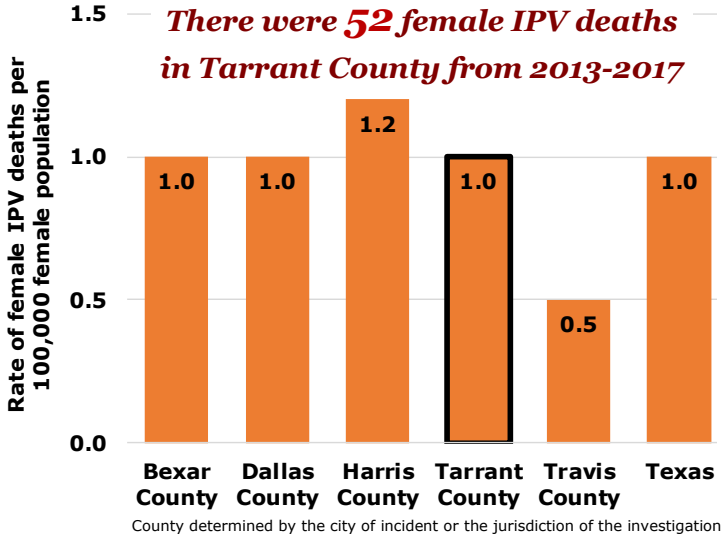
Data sources: Administration for Children and Families– Office on Trafficking in Persons, Centers for Disease Control and Prevention, National Human Trafficking Hotline, Polaris Project
Data Brief provided by: Division of Epidemiology and Health Information

TARRANT COUNTY PUBLIC HEALTH

DATA BRIEF

INTIMATE PARTNER VIOLENCE IN TARRANT COUNTY

Figure 1. Female IPV death rates by geographical location, 2013-2017



Intimate Partner Violence (IPV)

Unhealthy actions or threats between current or previous spouses or dating partners. IPV includes several forms of violence: digital, financial, mental/emotional, physical, sexual, and stalking. IPV varies in severity and how often it occurs. IPV happens in heterosexual and same-sex relationships, and among all gender identities. Many agencies and reports focus on heterosexual female victims of IPV due to current data limitations. However, IPV prevalence rates in LGBTQ communities often exceed others, and LGBTQ victims of IPV face unique barriers when seeking help. IPV is sometimes called Domestic Violence (DV) or a subgroup of Family Violence (FV). FV is between family or household members and can include children.

Figure 2. Proportion of Tarrant County female IPV deaths by age group of victim, 2013-2017

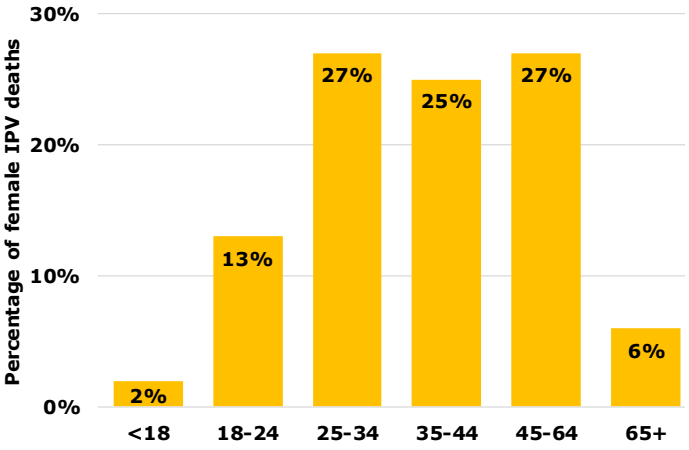


Figure 3. Proportion of Tarrant County female IPV deaths by season of incident, 2013-2017

1 in 3 women in Tarrant County will be affected by IPV at some point in her life

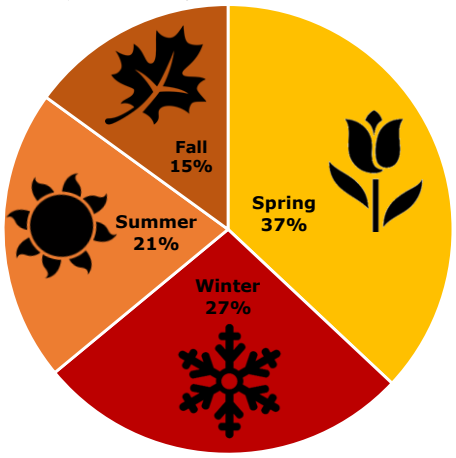


Figure 4. Proportion of Tarrant County female IPV deaths by child outcome, 2013-2017

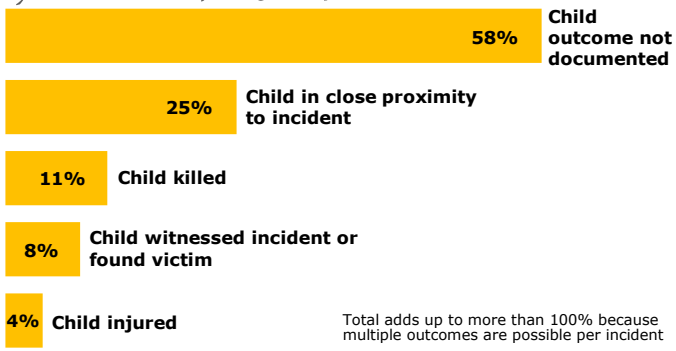
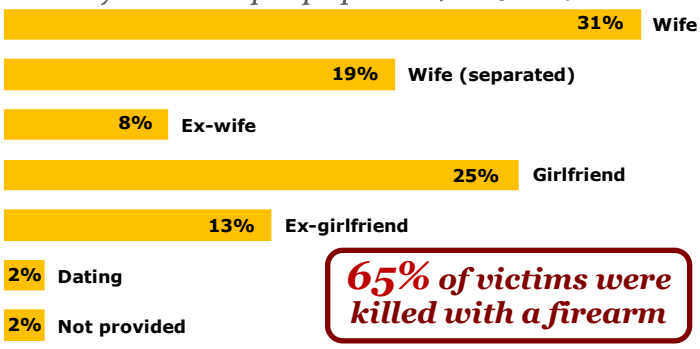


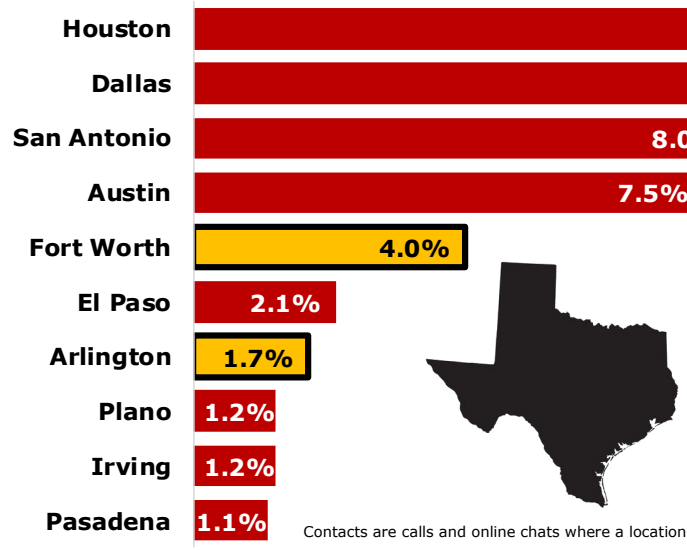
Figure 5. Proportion of Tarrant County female IPV deaths by relationship to perpetrator, 2013-2017



65% of victims were killed with a firearm

Race/ethnicity not provided due to data limitations; deaths represent a female killed by a male intimate partner or a stalking perpetrator who was charged or committed suicide; Data sources: Centers for Disease Control and Prevention, Office on Women's Health, SafeHaven of Tarrant County, Texas Council on Family Violence
Data Brief provided by: Division of Epidemiology and Health Information

Figure 6. Top 10 Texas cities by volume of contacts to the National Domestic Violence Hotline (NDVH), 2017



Contacts are calls and online chats where a location was self-disclosed by the caller/chatter; contacts are not demographic specific

Texas ranks 2nd in contact volume to the National Domestic Violence Hotline

There were 17,394 contacts from Texas in 2017

Types of IPV that Texas victims reported to the NDVH in 2017:

93% Emotional or verbal abuse

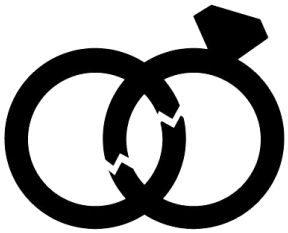
71% Physical abuse

27% Economic or financial abuse

12% Digital abuse

10% Sexual abuse

Relationship Risk Factors for IPV



Financial stress
Conflict, fights, or tension
Possessiveness or jealousy
Isolation or lack of social support
Instability, separations, or divorce
One partner is controlling or dominating the other
Unhealthy relationships or interactions with family

520 patients were identified as possible victims of IPV during a pilot study at JPS in Tarrant County from May 2018 to June 2019

Education and Prevention

- A Call to Men **[acalltomen.org]**
- CDC IPV Technical Package **[cdc.gov/violenceprevention/intimatepartnerviolence/index.html]**
- Futures Without Violence **[futureswithoutviolence.org]**
- IPV Health **[ipvhealth.org]**
- National Domestic Violence Hotline **[thehotline.org]**
- National LGBTQ Institute on IPV **[lgbtqipv.org/]**
- National Resource Center on Domestic Violence **[nrcdv.org/]**
- Office on Women's Health **[womenshealth.gov/relationships-and-safety]**
- SAMHSA: IPV **[integration.samhsa.gov/clinical-practice/intimate-partner-violence]**
- Texas Council on Family Violence **[tcfv.org]**

Resources and Support

National Domestic Violence Hotline **[thehotline.org]**
Call 1-800-799-7233 TTY 1-800-787-3224

SafeHaven of Tarrant County **[safehaventc.org]**
Call 1-877-701-7233

One Safe Place **[onesafeplace.org]**
Call 817-916-4323

The Women's Center of Tarrant County **[womenscentertc.org]**

Texas Health and Human Services **[hhs.texas.gov/services/safety/family-violence-program]**

Data sources: Centers for Disease Control and Prevention, JPS Health Network, National Domestic Violence Hotline,
Data Brief provided by: Division of Epidemiology and Health Information

American Hospital Association™
Advancing Health in America

ICD-10-CM Coding for Human Trafficking

Introduction

Human trafficking is a public health concern many hospitals and health systems are combating every day. It is a crime occurring when a trafficker exploits an individual with force, fraud or coercion to make them perform commercial work or sex.

Data Collection Challenges

While more and more providers are trained to identify and document victims of forced (labor) or sexual exploitation, the existing ICD-10-CM abuse codes fell short of differentiating victims of human trafficking from other victims of abuse. Without proper codes, there was no way for clinicians to classify adequately a diagnosis and to plan for the resources necessary to provide appropriate treatment. This also prevented critical tracking of the incidence and/or reoccurrence of labor or sexual exploitation of individuals.

What's New

As urged by the AHA's Hospitals Against Violence initiative, the first ICD-10-CM codes for classifying human trafficking abuse were released in June 2018. AHA's Central Office on ICD-10, in partnership with Catholic Health Initiatives and Massachusetts General Hospital's Human Trafficking Initiative and Freedom Clinic, proposed the change. Effective FY 2019, unique ICD-10-CM codes are available for data collection on adult or child forced labor or sexual exploitation, either confirmed or suspected. These new codes, which drew support from other hospitals and health systems, may be assigned in addition to other existing ICD-10-CM codes for abuse, neglect and other maltreatment. In addition, new codes are also available for past history of labor or sexual exploitation, encounter for examination and observation of exploitation ruled out, and an external cause code to identify multiple, repeated, perpetrators of maltreatment and neglect.

Required Action

- As coding professionals review a patient's medical record to identify the appropriate ICD-10-CM codes to include, they should be aware of and begin utilizing the ICD-10-CM codes for forced labor and sexual exploitation, listed in Table 1.
- Hospitals and health systems should educate necessary individuals, including physicians, nurses, other health care providers, and coding professionals of the important need to collect data on forced labor or sexual exploitation of individuals.
- Tracking confirmed and suspected cases in the health care system will allow hospitals and health systems to better track victim needs and identify solutions to improve the health of their communities. It also provides another source for data collection to inform public policy and prevention efforts, as well as support the systemic development of an infrastructure for services and resources.

For additional information: Contact **Nelly Leon-Chisen**, RHIA, director of coding and classification, American Hospital Association, *nleon@aha.org*.

Key Terms

Key Terms Related to Human Trafficking Found in Medical Documentation

- Human trafficking
- Labor trafficking
- Sex trafficking
- Commercial sexual exploitation
- Forced commercial sexual exploitation
- Forced prostitution
- Forced sexual exploitation
- Forced labor exploitation
- Exploitation of manual labor
- Exploitation of sexual labor
- Exploitation for manual labor
- Exploitation for commercial sex
- Domestic servitude
- Labor exploitation for domestic work
- Force labor exploitation for domestic work

American Hospital Association™

Advancing Health in America

Table 1
Human Trafficking ICD-10-CM Code Categories

ICD-10-CM Code/ Subcategory	Title
T74.51*	Adult forced sexual exploitation, confirmed
T74.52*	Child sexual exploitation, confirmed
T74.61*	Adult forced labor exploitation, confirmed
T74.62*	Child forced labor exploitation, confirmed
T76.51*	Adult forced sexual exploitation, suspected
T76.52*	Child sexual exploitation, suspected
T76.61*	Adult forced labor exploitation, suspected
T76.62*	Child forced labor exploitation, suspected
Y07.6	Multiple perpetrators of maltreatment and neglect
Z04.81	Encounter for examination and observation of victim following forced sexual exploitation
Z04.82	Encounter for examination and observation of victim following forced labor exploitation
Z62.813	Personal history of forced labor or sexual exploitation in childhood
Z91.42	Personal history of forced labor or sexual exploitation

*Subcategories require additional characters for specific codes. Please refer to ICD-10-CM for complete codes

The AHA has also developed numerous tools and resources to help hospitals and health systems combat human trafficking in their communities.

For access to these resources, please visit *https://www.aha.org/combating-human-trafficking.*

American Hospital Association™
Advancing Health in America

PEARR Tool

Trauma-Informed Approach to Victim Assistance in Health Care Settings

Dignity Health recommends universal education about various forms of abuse, neglect, and violence in all of its health care settings, particularly in settings that offer longitudinal care and services. For urgent and emergency care settings, a universal education approach may be most appropriate and effective when a patient presents with risk factors and/or indicators of victimization. **The PEARR Tool** offers key steps on how to provide such education to a patient and how to offer assistance in a **trauma-informed and victim-centered manner.** A double asterisk ** indicates points at which this conversation may come to an end. Once this conversation ends, refer to the double asterisk ** at the bottom of this page for additional steps. **Note:** The patient's immediate needs (e.g., emergency medical care) should be addressed before use of this tool.

P

Provide Privacy

1. Discuss sensitive topics **alone** and in **safe, private setting** (ideally private room with closed doors). If companion refuses to be separated, then this may be an indicator of abuse, neglect, or violence.** Strategies to speak with patient alone: State requirement for private exam or need for patient to be seen alone for radiology, urine test, etc.

   • **Note:** Companions are not appropriate interpreters, regardless of communication abilities. If patient indicates preference to use companion as interpreter, see your entity's policies for further guidance.**

   • **Note:** Explain **limits of confidentiality** (i.e., mandated reporting requirements) before beginning any sensitive discussion; however, do not discourage person from disclosing victimization. Patient should feel in control of all disclosures. Mandated reporting includes requirements to report concerns of abuse, neglect, or violence to internal staff and/or to external agencies.

E

Educate

2. Educate patient in manner that is **nonjudgmental** and **normalizes** sharing of information. Example: "I educate all of my patients about [fill in the blank] because violence is so common in our society, and violence has a big impact on our health, safety, and well-being." **Use a brochure or safety card** to review information about abuse, neglect, or violence, and offer brochure/card to patient. [Ideally, this brochure/card will include information about resources (e.g., local service providers, national hotlines)]. Example: "Here are some brochures to take with you in case this is ever an issue for you, **or someone you know."** If patient declines materials, then respect patient's decision.**

A

Ask

3. Allow time for discussion with patient. Example: "Is there anything you'd like to share with me? Do you feel like anyone is hurting your health, safety, or well-being?"** If available and when appropriate, use **evidence-based tools** to screen patient for abuse, neglect, or violence.

   • **Note:** All women of reproductive age should be intermittently screened for intimate partner violence (USPSTF Grade B).**

4. If there are indicators of victimization, **ASK** about concerns. Example: "I've noticed [insert risk factor/indicator] and I'm concerned for your health, safety, and well-being. You don't have to share details with me, but I can connect you with resources. Would you like to speak with [insert advocate/service provider]? If not, you can let me know anytime."**

   • **Note: Limit questions** to only those needed to determine patient's safety, to connect patient with resources (e.g., trained victim advocates), and to guide your work (e.g., perform medical exam).

   USPSTF = US Preventive Services Task Force

R R

Respect and Respond

5. If patient denies victimization or declines assistance, then **respect patient's wishes.** If you have **concerns about patient's safety,** offer information about resources that can assist in event of emergency (e.g., local shelter, crisis hotline).** Otherwise, if patient accepts/requests assistance with accessing services, then **provide personal introduction** to local victim advocate/service provider; or, **arrange private setting** for patient to call hotline:

   National Domestic Violence Hotline, 1-800-799-SAFE (7233);
   National Sexual Assault Hotline, 1-800-656-HOPE (4673);
   National Human Trafficking Hotline, 1-888-373-7888 **

** Report **safety concerns** to appropriate staff/departments (e.g., nurse supervisor, security). Also, **REPORT** risk factors/indicators as required or permitted by law/regulation, and continue **trauma-informed** health services. Whenever possible, **schedule follow-up appointment** to continue building rapport and to monitor patient's safety/well-being.

Child Abuse and Neglect

Risk factors include (not limited to): Concerns of domestic violence (DV) in home; parents/guardians exhibiting mental health or substance use disorders; parents/guardians who are overly stressed; parents/guardians involved in criminal activity; presence of non-biological, transient caregivers in home.

Potential indicators of victimization include (not limited to): Slower-than-normal development, failure to thrive, unusual interaction with parent, signs of mental health disorders [e.g., depression, post-traumatic stress disorder (PTSD), self-harm], sudden difficulty in school, medical or physical neglect, sudden changes in behavior, new or unusual fears/anxiety, unexplained injuries (e.g., bruises, fractures, burns – especially in protected areas of child's body), injuries in pre-mobile infants, sexually transmitted infections (STIs).

For additional information, *see Child Welfare Information Gateway: www.childwelfare.gov*

Abuse/Neglect of Vulnerable Adults (e.g., elder and dependent adults)

Risk factors include (not limited to): Concerns of mental health or substance use disorder with caregiver, caregiver exhibits hostile behavior, lack of preparation/training for caregiver, caregiver assumed responsibilities at early age, caregiver exposed to abuse as child.

Potential indicators of victimization include (not limited to): Disappearing from contact; signs of bruising or welts on the skin, burns, cuts, lacerations, puncture wounds, sprains, fractures, dislocations, internal injuries or vomiting; wearing torn, stained, bloody clothing; appearing disheveled, in soiled clothing; appearing hungry, malnourished.

For additional information, *see National Association of Adult Protective Services (NAPSA): napsa-now.org; Centers for Disease Control and Prevention (CDC): cdc.gov/violenceprevention/elderabuse/index.html*

Domestic Violence / Intimate Partner Violence (IPV)

Anyone in a relationship can be a victim of DV/IPV, regardless of age, race, gender, or sexual orientation. **Risk factors** include (not limited to): Low self-esteem, low income, low academic achievement, young age, aggressive/delinquent behavior as youth, heavy alcohol/drug use, depression, anger, and isolation.

Potential indicators of victimization include (not limited to): Injuries that result from abuse or assault, e.g., signs of strangulation, bruises, burns, broken bones; psychological conditions such as anxiety, depression, sleep disturbances; sexual and reproductive health issues, e.g., STIs, unintended pregnancy.

For additional information, *see National DV Hotline: thehotline.org; CDC: cdc.gov/violenceprevention/intimatepartnerviolence/index.html*

Sexual Violence

Anyone can become a victim of sexual violence. Some stats from Rape Abuse & Incest National Network (RAINN): More than 300,000 persons are victimized annually; ages 12-34 are the highest risk years. Female college students (ages 18-24) are three times more likely than women in general to experience sexual violence. One in 33 American men have experienced an attempted or completed rape. And, 21% of transgender, genderqueer, noncomforming (TGQN) college students have been sexually assaulted.

Potential indicators of victimization include (not limited to): STIs, pregnancy, depression, PTSD.

For additional information, *see RAINN: rainn.org; CDC: cdc.gov/violenceprevention/sexualviolence/index.html*

Human Trafficking (e.g., labor and sex trafficking)

Although anyone can be a victim of human trafficking, traffickers often target persons in situations of vulnerability. **Risk factors** include (not limited to): Running away or homelessness (particularly for youth), history of interpersonal abuse or violence, involvement in commercial sex industry, minority/immigrant status.

Potential indicators of victimization include (not limited to): Accompanied by controlling companion; inconsistent history; medical or physical neglect; and submissive, fearful, hypervigilant, or uncooperative behavior.

For additional information, *see National HT Hotline: humantraffickinghotline.org*

As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), **a trauma-informed approach** "includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations." This includes understanding how trauma can impact patients, families, communities, and the professionals attempting to assist them.

The PEARR Tool reflects principles of a trauma-informed and **victim-centered approach.** As described by the US Office for Victims of Crime (OVC), a victim-centered approach is one in which a person's wishes, safety, and well-being are prioritized in all matters and procedures. This includes seeking and maximizing patient input in all decisions.

To learn more, *please see SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach: store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf; See also OVC's Victim-Centered Approach: ovcttac.gov/taskforceguide/eguide/1-understanding-human-trafficking/13-victim-centered-approach/*

Local, Regional, and State Resources/Agencies

County Child Welfare Agency:

County Welfare Agency for Vulnerable Adults:

Sexual Assault Response Team (SART) Center or Child Advocacy Center (CAC):

Local Law Enforcement Agency:

Local FBI Office:

Local DV/IPV Shelter – Program:

Local Runaway/Homeless Shelter:

Local Immigrant/Refugee Organization:

Local LGBTQ Resource/Program:

National Agencies, Advocates, Service Providers

National Human Trafficking Hotline: 1-888-373-7888 (888-3737-888)

National Domestic Violence Hotline: 1-800-799-SAFE (7233)

National Sexual Assault Hotline: 1-800-656-HOPE (4673)

National Teen Dating Abuse Hotline: 1-866-331-9474

National Runaway Safeline for Runaway and Homeless Youth: 1-800-RUNAWAY (786-2929)

StrongHearts Native Helpline: 1-844-7NATIVE (762-8483)

National Suicide Prevention Lifeline: 1-800-273-8255

Dignity Health®

PACIFIC SURVIVOR CENTER

HEAL TRAFFICKING

Notes

RESOURCES FOR CLINICIANS/STAFF

HTTPS://WWW.INTEGRATION.SAMHSA.GOV/CLINICAL-PRACTICE/INTIMATE-PARTNER-VIOLENCE

Recognizing, Preventing, and Addressing IPV

Recognizing IPV as a widespread public health issue, the CDC published a technical package titled **Preventing Intimate Partner Violence Across the Lifespan**. The package presents prevention strategies including fostering healthy relationships, creating protective environments, providing economic supports for families, and supporting survivors.

The online eLearning module, **Domestic Violence: Understanding the Basics**, describes the dynamics and common tactics that characterize domestic violence and provides an overview of the scope and impact on individuals and society. This module was created by **VAWnet.org: An Online Resource Library on Gender-Based Violence**, funded by the Family Violence Prevention and Services Act (FVPSA) Program and in part by the CDC.

Developed by the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) in partnership with the National Resource Center on Domestic Violence (NRCDV), this three-part special collection, **Trauma-Informed Domestic Violence Services** provides an overview of the framework, philosophy, and research supporting trauma-informed approaches to working with survivors and their children; offers practical tools and resources on building capacity to implement trauma-informed programs; and describes resources for building collaboration to ensure that survivors and their children have access to domestic violence and trauma-informed mental health and substance abuse services.

Health centers and domestic and sexual violence advocacy organizations can partner to **support survivor health and prevent violence**. Through cross-trainings and warm referrals, providers and advocates can provide comprehensive coordinated care for survivors and their families.

The NCDVTMH conducted interviews with 45 programs or initiatives engaged in innovative trauma-informed work with survivors of violence and their children. Key themes that emerged from these interviews are summarized within the report, **Promising Practices and Model Programs: Trauma-Informed Approaches to Working with Survivors of Domestic and Sexual Violence and Other Trauma**.

The Office of Planning, Research and Evaluation (OPRE) at the Administration for Children and Families published a summary of research on the prevalence and experiences of IPV titled **Prevalence and Experiences: Intimate Partner Violence Prevalence and Experiences Among Healthy Relationship Program Target Populations**.

A Comprehensive Approach for Community-Based Programs to Address Intimate Partner Violence and Perinatal Depression is a Health Resources and Service Administration (HRSA) toolkit that recognizes the complex interplays of these issues and offers resources to appropriately identify risks and implement interventions.

The Substance Abuse and Mental Health Services Administration's (SAMHSA) overview of **Trauma and Violence** presents a compelling call to effectively address trauma in behavioral healthcare, describing the widespread impacts and costs of traumatic events, especially intimate partner violence. In a more detailed breakout of the **Types of Trauma and Violence**, the resource illuminates the complexities of intimate partner violence and its effects on those who experience it.

IPV Screening and Assessment Tools

Developed by Futures Without Violence National Health Resource Center on Domestic Violence, in partnership with FVPSA, HRSA, and Office on Women's Health, the online toolkit, **IPVHealthPartners.org** offers a comprehensive and sustainable response to intimate partner violence that can be built or adapted in health centers/primary care safety net providers across the U.S. in partnership with local domestic violence, sexual assault and social service organizations to improve the health, wellness, and safety of their clients.

The Family and Youth Services Bureau has launched an **Intimate Partner Violence Screening and Counseling Toolkit** and Counseling Toolkit to support healthcare providers and domestic violence advocates in ensuring the health and safety of the populations that they support.

The HHS Office of Women's Health (OWH) published the factsheet on **Health Care Providers and Screening and Counseling for Interpersonal and Domestic Violence** to answer commonly asked questions that arise when providers introduce screening for intimate partner violence into their practice.

The Agency for Healthcare Research and Quality (AHRQ) has compiled a tool, **Intimate Partner Violence Screening: Fact Sheet and Resources**, to guide providers in their screening and appropriate response to intimate partner violence.

Safety Planning, a computerized safety decision aid, was developed and tested by Johns Hopkins University researchers with Spanish or English-speaking abused women in shelters or domestic violence (DV) support groups. The decision aid provides feedback about risk for lethal violence, options for safety, assistance with setting priorities for safety, and a safety plan personalized to the user.