



Sexual Violence: A Healthcare Priority for EMS Providers

National Sexual Assault Conference

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Presentation compiled by:

Judy Henderson, MEd. Mgt.
Training Coordinator

Nevada Coalition to End Domestic and Sexual Violence

775.828.1115 ext. 44

judyh@ncedsv.org; www.ncedsv.org

NCEDSV Online Healthcare Toolkit

www.ncedsv.org/resources/healthcare-toolkit



A Call to Action

It is critical that health care providers understand how to respond to victims of intimate partner violence including sexual assault by conducting health and safety assessments, interventions, documentation, and referrals.

Futures Without Violence

Intimate partner violence is the “only category of crime in which the perpetrator frequently remains on the scene, expecting no negative consequences and actually perceiving intervention as a violation of their rights.”

~ EMS Response to Domestic Violence



Rationale for Healthcare Intervention

- **American College of Emergency Physicians Policy** states...“that training in the evaluation and management of victims of IPV should be incorporated into the initial and continuing education of EMS personnel. This training should include the recognition of victims and injuries, an understanding of the patterns of abuse and how this affects care, scene safety, preservation of evidence and documentation requirements.”

“Several months ago, I was told by a rape crisis counselor that, “A lot of rape cases are lost because of EMTs.” EMS providers work well at addressing the patient’s medical needs, but often fail to comprehend or meet a patient’s emotional needs, causing a withdrawal of cooperation from within judicial process. EMS education also leaves large gaps in knowledge needed to help preserve biological evidence and maintain the chain of custody of evidence taken into our possession. EMS providers play an important role whether or not an immediate life threat is present.”

Provide Emotional First Aid When Responding to Sexually Assaulted Patients, JEMS, 2015

Role of EMTs and Paramedics

- Patient may be more candid with you than with law enforcement
- You may be the only witness to the home environment
- Assess and document injuries:
Identification of IPV can be the first step in interrupting the progression of violence
- You can empower the survivor/your patient with support to promote healing, reassure privacy & confidentiality, educational information, and community-based resources





Presentation Objectives



Objectives

1. Determine the scope of the problem as it relates to EMS healthcare response;
2. Define intimate partner violence (IPV) including sexual assault;
3. Identify the common medical conditions associated with IPV including sexual assault; and
4. Discuss the guiding principles for an improved EMS response through a trauma-informed lens. This includes safety for the first responders, routine screening, intervention, documentation, and making appropriate referrals to community-based sexual assault advocacy services; and
5. Scenarios will be used to increase participant's understanding of these key principles followed by a discussion of first steps in developing a successful partnership with first responders.



Terminology

IPV & SA Definitions



A Working Definition for Intimate Partner Violence (IPV)

IPV is a **PATTERN** of assaultive and coercive behaviors that may include:

- Inflicted physical injury
- Psychological/Emotional abuse
- Sexual assault
- Economic coercion
- Progressive social isolation
- Stalking
- Deprivation of medical care & medications
- No access to or destruction of assistive devices
- Intimidation/Threats

These behaviors can be committed by an adult or adolescent with the goal to establish or maintain **POWER** and **CONTROL** by one partner over the other.

Defining Sexual Violence

- A sexual act that is committed or attempted by another person **WITHOUT FREELY GIVEN CONSENT** of the victim or against someone who is unable to consent or refuse.
 - **Forced or alcohol/drug facilitated penetration** of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else;
 - **Non-physically pressured unwanted penetration;**
 - **Intentional sexual touching;** or
 - **Non-contact acts of a sexual nature.**

Source: Centers for Disease Control & Prevention 2014

Sexual Violence

- Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party.
- Sexual violence involves a lack of freely given consent as well as situations in which the victim is unable to consent or refuse:
 - Consent Words or overt actions by a person who is legally or functionally competent to give informed approval, indicating a freely given agreement to have sexual intercourse or sexual contact.
 - **Inability to Consent** A freely given agreement to have sexual intercourse or sexual contact **could not occur because of the victim's age, illness, mental or physical disability, being asleep or unconscious, or being too intoxicated** (e.g., incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs.
 - Inability to Refuse Disagreement to engage in a sexual act was precluded because of the **use or possession of guns or other non-bodily weapons, or due to physical violence, threats of physical violence, intimidation or pressure, or misuse of authority.**



Scope of the Problem

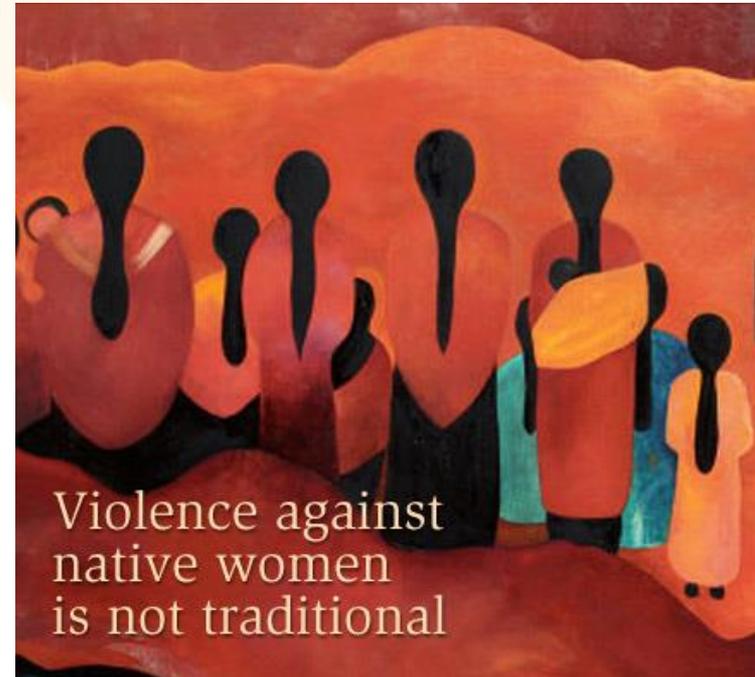


Statistics in the U.S.

- One out of three women have experienced physical violence by an intimate partner at some point in their lives. Nearly 80% of women report verbal abuse. CDC 2010
- It's estimated that 1 in 5 college women and 1 in 16 college men will be sexually assaulted before graduation. Krebs CP et al, The campus sexual assault study. National Criminal Justice Reference Service 2007
- Approx. 1 in 5 women have been raped in their lifetimes & almost 50% of American women have experienced sexual assault other than rape. CDC 2010
- For every 100 sexual assaults, there are only 32 that lead to police reports. Of these reports there are only two felony convictions with as few as two rapists spending just a single day in prison. RAINN Reporting Rates 2009

Statistics - Native Americans

- Native American women suffer IPV at 50% higher rates than other ethnicities. DOJ 2004
- 55% of women and 43.2% of men reported experiencing physical violence by an intimate partner.
NIJ May 2016; CDC 2010
- 86% of Native American women who report sexual violence say they were attacked by a non-Native man.



Source: National Task Force
to End Domestic Violence

Statistics – Pregnancy



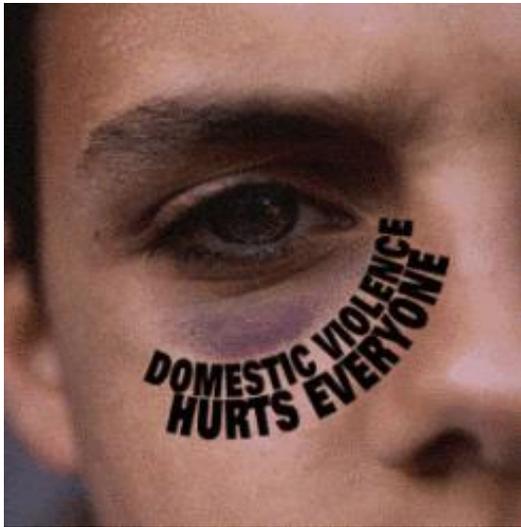
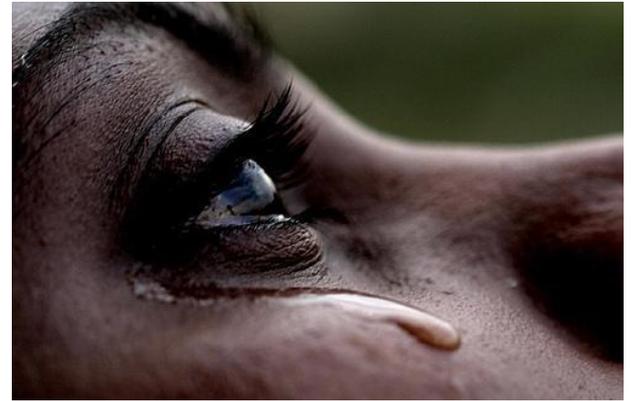
- 40% of pregnant women who have been exposed to abuse report that their pregnancy was unintended, compared to just 8% of non-abused women.
Hathaway et al 2000

- Approximately 1 in 5 young women said they experienced pregnancy coercion & 1 in 7 experienced active interference with contraception (birth control sabotage.)
National Crime Victim Survey 2005



NCEDSV
Nevada Coalition to **END** Domestic and Sexual Violence

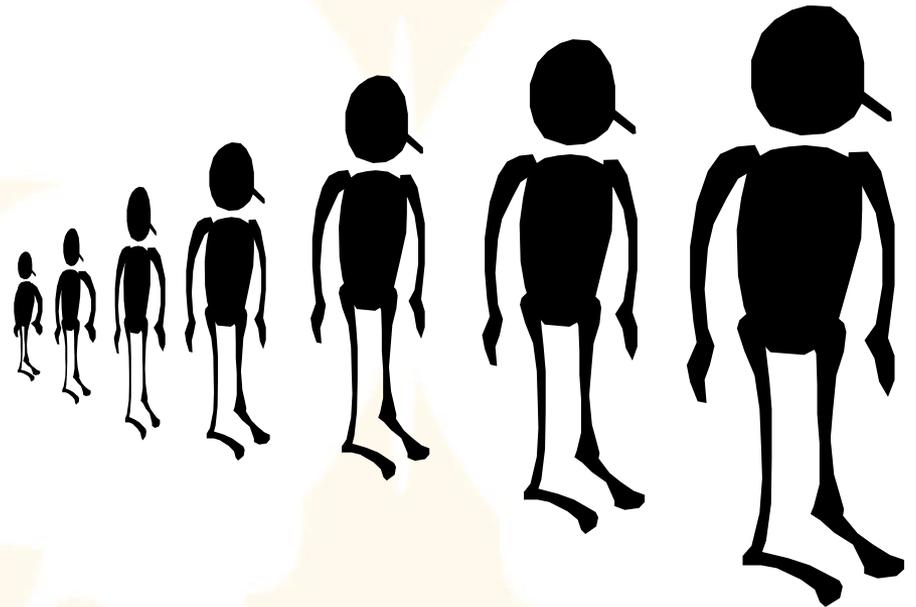
Dynamics of the IPV Relationship



Demographics

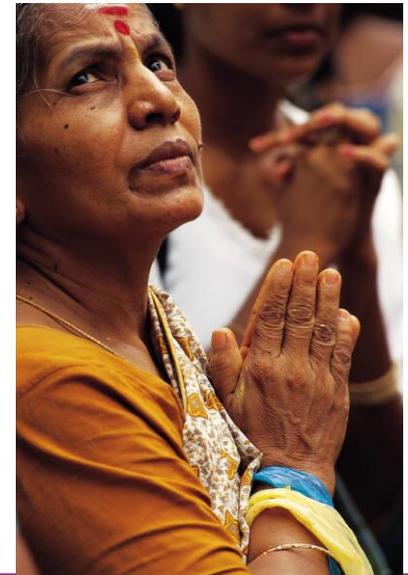
Anyone can be a perpetrator or victim of IPV.
They come from all groups, regardless of:

- Race/Ethnicity
- Culture
- Class
- Education
- Occupation
- Age
- Physical Ability
- Gender Identity
- Sexual Orientation (LGBTQ+)
- Personality Traits

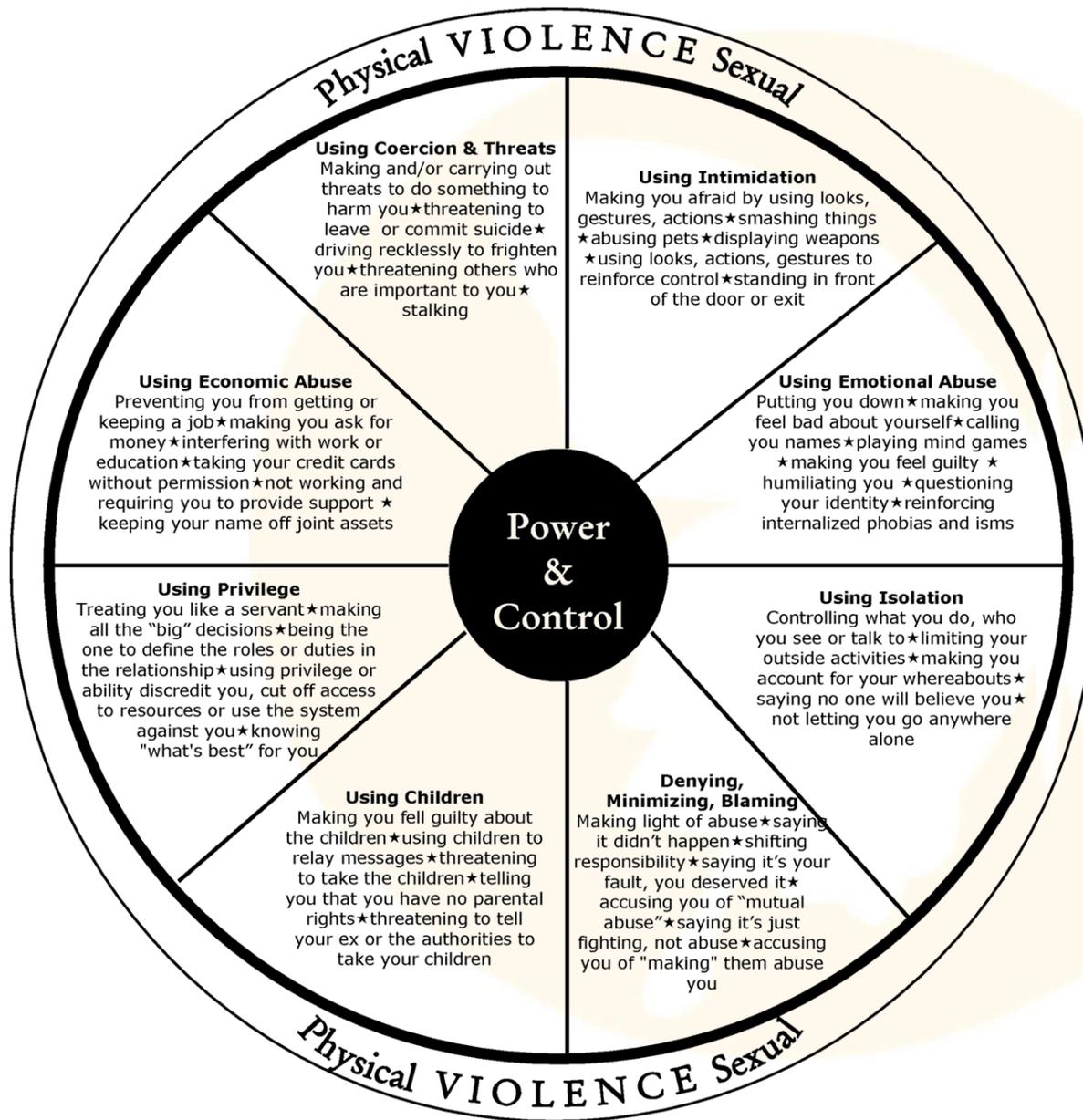




“Power and Control Wheel”



Power and Control Wheel



This wheel is gender-neutral & was adapted from the Domestic Abuse Intervention Project Duluth, Minnesota.



Sexual Violence

- Makes demeaning remarks about intimate body parts
- Looks or touches the partner sexually in ways that make them feel uncomfortable
- Bruises around breasts or genital area, vaginal/anal bleeding, torn or bloody underwear
- Takes advantage of physical/mental illness or disability to engage in sex
- Sexual contact that is forced (rape/sodomy)
- Sexual assault/violent actions meant to humiliate, terrorize, and degrade the victim

Sexual Violence

- Coerced nudity; exhibitionism (masturbation, indecent exposure)
- Forces partner to watch pornography on TV and/or the computer – taking photos of sexual acts that are explicit & exploitative
- Not using protection from STIs
- Using spiritual practices such as doctoring & sweat lodges to take advantage of closed surroundings to commit sexual acts. Uses their status as spiritual advisors or traditional healer to engage in sex to “heal” the woman or they will use “bad” medicine against them



Barriers for IPV Victims:
Addressing the Most
Common Question,
“Why don’t they just
leave?”



Why Doesn't My Patient Just Leave?



“My doctor asked me why I just didn't leave in a very irritated, demeaning way. He looked at me like I was stupid. It never occurred to him that I had left, but that my husband just tracked me down again. He doesn't know my husband keeps threatening to kill the kids and me if I leave. I am afraid and I am scared.”

Barriers to Leaving for IPV Victims

History of having received inappropriate and **victim-blaming responses** from family & friends, faith leaders, healthcare providers, law enforcement, counselors

- “Why don’t you just leave?” “You are stupid for staying with him.” “What did you do to deserve this?”
- “You’ve made your own bed now lie in it.”
- “You need to pray about becoming a better wife.”
“Your role as a wife is to serve your husband and your family.” “Never deny your husband.”

Barriers to Leaving

- **Without intervention, violent episodes tend to recur and escalate in intensity**
- Typically, victims may leave 7-8 times before they perceive they are safe enough and establish resources to make the break
- **DISABILITY:** fear of losing health insurance, fear of institutionalization, physically restrained when denied access to wheelchair, no access to doctor, caregiver, and/or medication. If the victim has a disability, it may take on the average 12 times before they feel safe enough and establish resources

**The most dangerous time for a victim,
is when they decide to leave the relationship!**



Common Medical Conditions & Injuries Associated with IPV including Sexual Assault

More than broken bones and black eyes



HIV/AIDS Migraines
Flashbacks Kidney Infections Suicidal Behavior
Circulatory Conditions Sleep Disturbances
Chronic Pain Gastrointestinal Disorders Unintended Pregnancy
Bladder Infections Irritable Bowel Sexually Transmitted Infections
Anxiety Central Nervous System Disorders Unintended Pregnancy
Cardiovascular Disease Pelvic Inflammatory Disease
Asthma Depression Gynecological Disorders
Fibromyalgia Post Traumatic Stress Disorder
Joint Disease Sexual Dysfunction
Headaches

(Centers for Disease Control and Prevention)

Common Medical Conditions

- Chronic back, chest, and abdominal pain
- Frequent, painful headaches – migraines
- Frequent indigestion, ulcers, diarrhea, or constipation, spastic colon – symptoms of irritable bowel syndrome
- Chronic pelvic pain--sexual discomfort, sexual dysfunction and pelvic infection
- Multiple injuries in different stages of healing



Common Medical Conditions



- Exacerbation of diabetes symptoms
- Anxiety, depression – “normal responses to abnormal, violent living conditions”
- Psychosomatic illnesses
- Sexually transmitted infections, HIV
- Depressed immune function
- High blood cholesterol, hypertension, heart attack, heart disease and stroke

Drug/Alcohol Facilitated Sexual Assault (DFSA)



- Offender deliberately tries to induce a state of intoxication and/or incapacitation by administering substance without knowledge or consent
- Offender exploits voluntary intoxication or incapacitation

Some Common DFSA Drugs

- Alcohol
- Benzodiazepines
- Flunitrazepam (Rohypnol®)
- Diazepam (Valium®)
- Alprazolam (Xanax®)
- Barbiturates
- Anti-depressants
- GHB-Gamma Hydroxybutyrate
- Over the counter (OTC) Drugs (Zzzzquil)

Common Injury Presentations

- Recurring or unexplained injuries; bruises
- Multiple injuries in different stages of healing
- Injuries in areas covered by clothing
- Injuries suggestive of defensive posture, such as forearm bruising
- Injuries to head (spongy scalp), neck, breasts, or abdomen
- Pattern injuries from burns or blunt trauma from fists, linear objects such as bats, belts, etc.
- Orofacial/Dental trauma
- Injury during pregnancy



At 18 weeks
the baby
started kicking.
At 22 weeks so
did the father.



Abuse During Pregnancy Results in Complications:



- High blood pressure
- Vaginal bleeding; 1st & 2nd trimester bleeding
- Severe nausea
- Kidney & urinary track infections
- Low weight gain
- Anemia
- Maternal rates of depression
- Suicide attempts
- Tobacco, alcohol, & illicit drug use
- Miscarriage
- Pre-term delivery

EMS Injury Documentation

- Great detail and accuracy
- Double-check to make sure no errors
- Right/Left errors are common
 - reference patient’s right or left side
- Include soft tissue injuries, size, shape, type of injury such as abrasion, laceration or incision
- Patient’s report may be subpoenaed for court, and inaccuracies can be damaging – Never use terms like “alleged” or “supposed.” If patient uses the term “rape” put in quotations. Use your patient’s language.



Why does my patient refuse medical care or may not want to report?

- **Without intervention, violent episodes tend to recur and escalate in intensity. Fear of what will happen next and who will be hurt now?**
- Paralyzing emotions: fear of being judged, viewed as liars, fear interrogation and forensic physical examination, cost of medical care, self-blame, too scared to fight
- For male victims, shame and secrecy. Male victims may question their sexual orientation because when a man is rectally assaulted, pressure on the prostate can produce an erection and even orgasm, which may be confusing to male victims. Creates fear & confusion.
- If college age, fear of getting punished for underage drinking and being re-victimized by criminal or college justice systems (Title IX)



Strangulation & Traumatic Brain Injury



Strangulation & TBI

- 40-92% of victims suffer physical injuries to the head; nearly half report they have experienced strangulation.

Campbell, et al The Effects of IPV and Probable TBI on Central Nervous System Symptoms, 2018

- In a sample of 53 victims, 92% reported having received blows to the head in the course of their violence; 40% reported loss of consciousness.
Jackson, et al TBI: A Hidden Consequence for Battered Women, 2002

Strangulation



- Manual strangulation – most common method used
- Ligature strangulation
- Hanging



Pronounced petechiae in the whites of the eyes and on the cheeks/face.

More than 2/3 of IPV victims are strangled at least once! The average is 5.3 times per victim.



Petechiae located inside the eyelid.







Documentation Chart for Attempted Strangulation

Breathing Changes	Voice Changes	Swallowing Changes	Behavioral Changes	Other
<ul style="list-style-type: none"> • Difficulty breathing • Hyperventilation • Unable to breath • Other 	<ul style="list-style-type: none"> • Raspy voice • Hoarse voice • Coughing • Unable to speak 	<ul style="list-style-type: none"> • Trouble swallowing • Painful to swallow • Neck pain • Nausea • Vomiting 	<ul style="list-style-type: none"> • Agitation • Amnesia • PTSD • Hallucinations • Combativeness 	<ul style="list-style-type: none"> • Dizzy • Headaches • Fainted • Urination • Defecation

(San Diego City Attorney's Office with Drs. George McClane and Dean Hawley)

I was strangled in Santa Monica, CA on July 24, 2007, to the point that I had blacked out. When the Santa Monica paramedics arrived on-scene, they said that my vital signs were stable. Neither the Santa Monica police nor the paramedics suggested that I go to the hospital. I did not go to the hospital. The perpetrator, the man I had been in a relationship with, was arrested for attempted murder within the hour. And then he was released sometime within the next 48 hours. I was never notified. No explanation to me. He nearly murdered me that night.

Anonymous; August 2, 2010



The Role of EMS



EMS Guiding Principles

1. Treat patients with dignity, respect and compassion and with sensitivity to age, culture, ethnicity and sexual orientation, while recognizing that IPV is unacceptable in any relationship.
2. Recognize that the process of leaving a violent relationship is often a long and gradual one.
3. Attempt to engage patients in long-term continuity of care within the health care system, in order to support them through the process of attaining greater safety and control of their lives.
4. Regard the safety of victims and their children as priority.

They didn't say it was an IPV call...

- Many of these calls are not identified as IPV
- Evaluate EVERY call, EVERY patient, and where there is a need for law enforcement involvement
 - Scene Safety Assessment
 - Patient Safety Assessment
- Police officers state that IPV calls are one of the most dangerous and unpredictable
- EMS should treat these calls the same way...dangerous and volatile
- Do not hesitate to return to the ambulance to discuss options and/or notify the police to secure the scene



Responding to IPV Calls

Know yourself well when it comes to responding to these calls:

- What are my limitations, my strengths, family history of abuse, my own personal history?
- Will I be triggered by observing, screening, and caring for this patient or their children?
- Access care for vicarious trauma.

“You can’t pour from an empty cup.
Take care of yourself first.”



Responding to IPV Calls

Upon approach and entry - BE SAFER and look for:

- Obvious dangers in approaching the residence
- Condition of yard/outside the building for position of lawn furniture/tools/chemicals
- Presence and condition of children and pets
- Number of adults at the scene, where are they located?
- Weapons or potential weapons on the scene
- Evidence of substance abuse

Responding to IPV Calls

- Previous calls to this address
- History of suspicious calls
- Stay alert. Wait & listen as you approach: Do you hear yelling or sounds of a struggle?
- Upon arrival to establish trust, make sure you identify yourself as EMS providers
- Were you met at the door or denied entry by someone who says the victim is fine & does not need medical care? Other attempts to conceal information?
- Keep your partner/crew members in sight at all times and never split the team
- Consider using cell phone vs. radio that could be monitored

Scene and Patient Safety

- Identify all possible exits for escape; let occupants lead the way & maintain a safe distance
- Potential problem areas:
 - Kitchen: variety of potential weapons (knives, glass, pots & pans)
 - Bedrooms: may contain concealed weapons and fewer escape routes
 - Bathrooms: no escape route
- Do NOT ask questions regarding possible violence and no display of sympathy should be made until after the patient is in the ambulance and away from the abuser
- No safety in numbers, no scene is ever “secure” and removal of the patient is the surest way to provide safety for all



EMS Response

Recognizing IPV, Sexual Assault (SA) & Speaking with the Patient



Is your response trauma-informed?

Trauma-informed Care: Strengths-based service delivery grounded in responsiveness to the **impact of trauma**, emphasizing **physical, psychological, and emotional safety for survivors and providers**, and promoting **survivor empowerment**.

Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings, Elizabeth K. Hopper, Ellen L. Bassuk, and Jeffrey Olivet, 2009

Using a Trauma-informed Approach to Serving Survivors

- Trauma physically changes our brain
 - Triggers chemicals
 - Chemicals influence perception, reaction, and memory
 - Memory becomes fragmented
 - Memory is stored in the brain differently
 - We do not control how the brain and body responds to trauma

Main Stress Chemicals Released

- Catecholamine (Natural Adrenaline)
- Corticosteroids (Energy)
- Opioids (Natural Morphine)
- Oxytocin (Good Feelings)
 - Hormones surge – increased heart rate, blood pressure, hyperventilation
 - Digestive & immune functions shut down
 - Superfocused on sensory details
 - Fight, Flight, Freeze – also Dissociation
- 96 hours to process and release out of the body

First Impressions Matter!

- The tone of the first meeting with the patient may set the tone for the rest of their medical care, contact with hospital personnel including SANE, and potential involvement with the criminal justice process.
- “By being empathic, patient, and respectful, you can contribute to the immediate and long term recovery of the victim.”

IACP Sexual Assault Issues and Concept Paper 2004

Victim Concerns & Fears

- Victim's concerns & fears:
 - “No one will believe me.”
 - “I can't believe this is happening.”
 - “It's my fault...” “I am so ashamed...”
- Law Enforcement Part 1 Video, IACP
<https://video.search.yahoo.com/search/video?fr=tightropetb&p=law+enforcement+sexual+assault+trauma+response+training#id=2&vid=8573e5ffa2e98c95c3b53251ffa4b19a&action=click>
- Helpful to know: What is the meaning of this experience to them? Whether experienced or witnessed.
- “The victim's health, safety, and wellness is a priority.”

Recognizing IPV & Sexual Assault

- Key component → patient interview & their medical care
- **What if you can't get the victim alone to assess injuries?** Suspected abuser (partner, caregiver) and/or bystanders are “hovering” over the victim or answering on behalf of the victim
 - Ask them to retrieve something like a towel or blanket
 - Ask them to step into another room due to HIPAA law. Medical information cannot be heard by anyone else and you cannot treat the patient because of their proximity

Recognizing IPV & Sexual Assault

- Be aware that the abuser may be eavesdropping even if they are in another room. If children are near by the abuser may interrogate them after you leave.
- Abuser may demand care while refusing transport & attempt to control the patient's interaction with EMS – never hesitate to call for assistance from law enforcement, but do so away from abuser
- Ask permission to approach survivors & wait for them to accept EMS help
- Explain in advance each & every move EMS makes
- **Family members should NOT be used to interpret!**

Speaking with the IPV & SA Patient

- While your assessment is routine, it can be traumatic, degrading and may become a life changing event for the patient/victim
- Set the tone for your evaluation:
 - The patient/victim will assess your body language, demeanor and verbal language for your reaction and understanding
 - Positioning below the line of sight can be less intimidating to victims (sit or kneel)
 - Ask questions in a non-judgmental, non-threatening way. Explain the rationale for questions particularly when preserving evidence, (i.e., get consent before removing clothing.)



Routinely Screen & Ask Privately...

- “We often see people with injuries such as yours, which are caused by someone they know. Could this be happening to you?”
- “You seem frightened and anxious. Has someone hit you or tried to injure you in any way?”
- “Do you ever feel unsafe at home?” “I am concerned for your safety.”
- Is there a partner from a previous relationship who is making you feel unsafe?”
- **Reassure and empower with consistent and supportive messages.**

SUPPORT

Positive Disclosure - What now?



- Thank the patient for sharing
- Convey empathy for the patient who has experienced fear, anxiety, and shame
- Validate that relationship abuse is a health issue that you can help with
- Let them know you will support them unconditionally without judgment
- Ask patient if they have immediate safety concerns and discuss options.
- Refer to a D/SV advocate for safety planning and additional support
- Encourage follow up with healthcare provider

Positive Disclosure

One line scripts



- “I am so sorry this happened. It is not okay. I believe you. This is more common than you may realize. You are not alone.”
- “This is not your fault. Nothing you did caused this. Someone else made a choice to hurt you.”
- “What you’re telling me makes me worried about your safety and health.”
- “Can we take you to the hospital or exam facility?”
- “Would you like me to explain options and resources that patients/survivors are often interested in hearing about?”
- “Some survivors find talking to an advocate or counselor to be helpful.”
- “What else can I do to be helpful? Is there another way I can be helpful?”

Supporting Survivors: What NOT to Say



- “That does not sound like rape to me...”
- “Remember this is an alleged assault.”
- “How late were you out?”
- “What were you wearing?”
- “What did you expect would happen after drinking so much alcohol or taking drugs?”
- “You should call the police.”
- “You are definitely in an abusive relationship.”
- “Your partner is crazy, you need to break up with them.”
- “What did you do to set them off?”
- “So what happened after that, and what happened after that?”

Supporting Survivors: Reminders

- Assess in a confidential location
- Following a traumatic event, giving a patient choices gives them back control.
- Ask only pertinent questions to not overload them when sharing their story. Listen carefully & document using quotations when applicable.
- DO NOT make a promise you cannot keep.
“The police department will protect you...”
- Assess lethality and escalating danger



Ask About Animals



The Lives You Save Might Include Your Own



Domestic Violence
(No Suspect History of Animal Abuse)

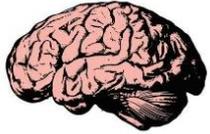
Domestic Violence
(Suspect History of Animal Abuse)



Suspect Has Access to Gun

31%

68%



Suspect Abuses Substances and/or Has Mental Illness

47%

74%



Suspect Has Strangled Victim

47%

76%



Victim Fears Suspect Will Kill Them

35%

78%

Asking About Animal Abuse Can Save A Life!

Campbell, A. M., Thompson, S. L., Harris, T. L., & Wiehe, S. E. (2018). Intimate Partner Violence and Pet Abuse: Responding Law Enforcement Officers' Observations and Victim Reports From the Scene. *Journal of Interpersonal Violence*.

<https://doi.org/10.1177/0886260518759653>

Andrew@campbellresearchandconsulting.com

Important Tips

- DO NOT tell them to leave & everything will be fine.
- Victims are at much higher risk of being killed (75%) after they leave. Leaving has to be very carefully planned.
- Referrals to advocacy programs and/or national hotlines/helplines are essential for safety planning.



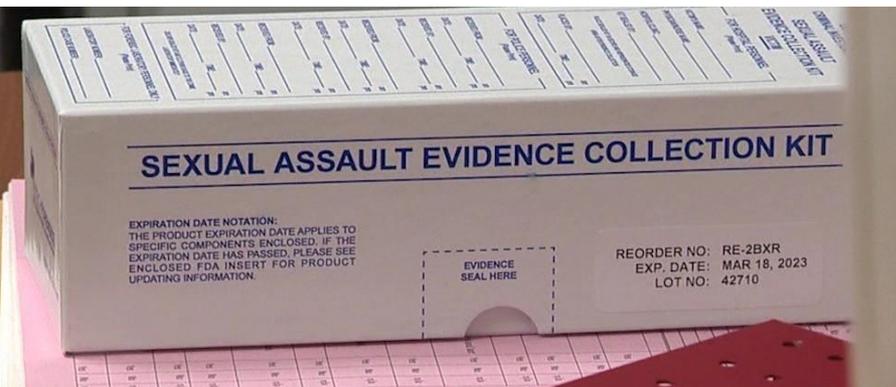
Additional Considerations

- **If the patient answers “no”**
 - Be aware of physical and behavioral clues
 - Provide first aid
 - Document any inconsistencies
 - Make referrals discreetly (FWV Safety Cards)
- **Transport vs. Non-Transport**
 - If patient accepts transport, consider advising hospital security
 - Explain medical consequences to the patient for not receiving medical care
 - Offer follow-up counseling and emotional support through SANEs or SAFEs working at health clinics/hospitals that specialize in sexual assault services



Crime Scene Considerations & Preserving SA Evidence

EMS's primary focus is to ensure safety, find and manage life threats but do not overlook importance of providing emotional support and preserving evidence of a crime to help assure justice for the survivor.



Crime Scene Considerations

- Discuss with police ahead of time regarding appropriate protocols for crime scene preservation and evidence collection
- Minimize your effect on potential evidence including all personnel using same entrance & exit
- Avoid touching or disturbing any objects – if moved, report to police
- Do not walk through other footprints, tire marks, or blood stains – if disturbed, document what occurred & notify police
- Advise police of injuries discovered during patient assessment – blood left behind (starting an IV) due to medical procedures can confuse the evidence
- Provide police with your contact information
- Know your resources for sexual assault exams & contacts as well as the process involved for the patient

Preserving SA Evidence

- Victims should be discouraged from engaging in activities that can destroy evidence, such as urinating, defecating, vomiting, douching, removing or inserting a tampon, wiping the genital area or other contaminated body areas, bathing, showering, gargling, brushing teeth, smoking, eating, drinking, chewing gum, changing clothes or taking medications
- Patients retain their rights – if they insist on doing the activities above, educate them on how this may damage the evidence, but **the choice is always theirs**

Preserving SA Evidence

- When cutting clothes, stay at least six inches away from holes, tears, and soiled areas
- Avoid excessive handling of articles that contain body fluids
- Retain all equipment and supplies used in treatment such as bandages, sheets, body fluids such as emesis or tissues that may contain mucous
- Put in immediate police custody. If not possible, notify them EMS has evidence to be transferred. Possible to have officer ride during transport
- Bag separately to avoid cross-contamination. Commercially prepared wet biological evidence bags (Tyvek) are ideal, but may not be stocked on all ambulances. Plastic biohazard bags are acceptable for short-term transportation

Preserving SA Evidence

- Protect evidence from temperature extremes and from direct sunlight
- Do not leave evidence unattended and unsecured, never leave evidence in a hot vehicle, where moisture and mold may develop more quickly
- Proper labeling and handling of biohazard bag can prevent it from being accidentally disposed and will protect chain of custody – must have complete sealed with tape and should be witnessed
- Document chain of custody transfer thoroughly to police investigator (date & time of collection, who, date & time of transfer to whom)



NEXT STEPS:
Scenarios for EMS Providers

HANDOUT:
**Minimal Elements of Domestic
Violence Protocol**



Road to Success



Defining Success

- Don't judge the success of your intervention by the patient's action or lack of action – it is their decision
- Do you have new techniques & tools to prepare for a better response to cases of IPV and sexual assault?
- Did the patient...
 - Have a safe, confidential environment for assessment and possible disclosure?
 - Receive educational material about IPV & SA? FWV Safety Cards, prophylactic treatment for potential pregnancy, sexually-transmitted infections, and mental health
 - Receive information about community-based domestic and sexual violence advocacy resources?



Making Appropriate Referrals to Community-based Domestic and Sexual Violence Programs



Domestic & Sexual Violence Programs

- All services are free and confidential
- All services are focused on safety
- Requests for services must come from the victim
- All services are premised on support, empowerment, sensitive & respectful care and offering options for next steps and resources





National Resources for Survivors & Professionals



<http://>



Hotlines/Helplines

- National Domestic Violence Hotline
1.800.799.7233 www.thehotline.org
- National Sexual Assault Hotline
1.800.656.4873 www.rainn.org
- National Dating Abuse Helpline
1.866.331.9474 Call, chat, & text services
- StrongHearts Native Helpline 1.844.7NATIVE
(1.844.762.8483)
- GLBT National Help Center 1.800.246.7743
- National Human Trafficking Hotline
1.888.373.7888 www.polarisproject.org

National Health Resource Center on Domestic Violence



- Setting specific safety cards for adolescent, HIV, reproductive health, LGBTQ, and more!
- Training curricula
- Clinical guidelines
- State reporting law information
- Documentation tools
- Pregnancy wheels
- Posters

For more information, please visit the [National Health Resource Center on Domestic Violence website](#).

National Health Resource Center

A Project of **Futures Without Violence**

www.futureswithoutviolence.org/health

1.888.Rx.ABUSE (888.792.2873) toll-free;

TTY: 800.595.4889

Monday-Friday 9:00AM-5:00PM PDT

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Questions?

judyh@ncedsv.org

Thank you for the
work you do
supporting survivors.

Please complete the evaluation
for this workshop.

