PCADV
PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE

pennsylvania
OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING

SERVING FAMILIES WHO ARE EXPERIENCING DOMESTIC VIOLENCE

A Toolkit for Family Support Staff and Domestic Violence Programs to Better Understand How Our Agencies Can Collaborate to Provide Resources to Survivors

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TOOLKIT INTRODUCTION

The Pennsylvania Coalition Against Domestic Violence (PCADV) and Office of Child Development and Early Learning (OCDEL) recognize that domestic violence is a public and community health epidemic. We understand that the more education that is available to family support workers and Family Support staff on the issue of domestic violence the better prepared they will be when working with survivors. We also recognize that domestic violence advocates rely on community partnerships for support when working with survivors and their families. The goal of this toolkit is to educate family support workers and Family Support staff on how domestic violence may impact the clients and families they serve while screening for intimate partner violence. It also aims to provide domestic violence programs with a deeper understanding of the OCDEL network and the services their programs provide within all communities across the Commonwealth. Communities are stronger together, and the better we understand how our agencies can collaborate to provide resources to survivors, the closer we come to ending domestic violence.

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Pennsylvania Family Support Mission Statement: All Pennsylvania families will have access to a statewide system of high-quality family support services that will, in partnership with families and communities, strengthen, support, and promote maternal and early childhood health, safety, development, and education.

Babies don't come with instruction manuals, and sometimes it can be hard to make decisions when it comes to their care. A new baby can be stressful if you don't have help. In Pennsylvania, Home Visiting services can be a great answer for families who are looking for help. Visits are based on the needs of the parent and child and are different for every family. Professionally trained home visitors can provide information and help families with:

- Prenatal care
- Caring for a new baby
- Breastfeeding
- Sleeping
- Child development
- Health and nutrition
- Family supports

Home Visiting services may also help your family:

- Improve your health.
- Create plans for education or a new job.
- Use a positive parenting approach.
- Reduce stress that can lead to child neglect or abuse.
- Think about how big you'd like your family to become, and how fast you'd like your family to grow.
- Connect with other resources in your community.

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FAMILY SUPPORT PROGRAMS IN PA

Maternal Infant and Early Childhood Home Visiting ("MIECHV")

The MIECHV program was initially established to continue the delivery of voluntary early childhood home visiting program services in response to a statewide need's assessment. This program is a shared commitment to comprehensive family services, coordinated and comprehensive voluntary statewide home visiting programs, and effective implementation of high-quality evidence-based practices by the Health Resources and Services Administration and the Administration for Children and Families. MIECHV funding is designed to:

1. Strengthen and improve the programs and activities carried out under Title V of the Social Security Act
2. Improve coordination of services for at-risk communities
3. Identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities

This federal funding currently supports four Evidence-Based Home Visiting (EBHV) programs across the Commonwealth:

- Parents as Teachers (PAT)
- Healthy Families America (HFA)
- Early Head Start (EHS)
- Nurse-Family Partnership (NFP)

State Funding

The Commonwealth has made significant investments in EBHV programs. The first three Nurse-Family Partnership sites in Pennsylvania were started in 1999 through the Pennsylvania Commission on Crime and Delinquency. By 2001, then Governor Tom Ridge and the Department of Human Services worked together to fund 20 more sites. NFP is an EBHV program for first-time, low-income mothers.

State funding currently supports NFP home visiting programs across the Commonwealth.

Starting in state fiscal year ("SFY") 2017-18, the Commonwealth increased its investment in EBHV by an additional $5 million. In SFY 2018-19, an additional $4 million was invested in EBHV and Family Support Programs for families experiencing a substance or opioid specific use disorder. In SFY 2019-20, an additional $5 million was invested in EBHV and Support Services for Families.

These expansions of EBHV have allowed the Commonwealth to fund the following six evidence-based home visiting programs:

- Parents as Teachers
- Healthy Families America
- Early Head Start
- NFP
- SafeCare Augmented
- Family Check-Up

The expansion funding also provides enhanced supports to families such as:

- Parent Support and Education Groups and Classes
- Peer Specialists
- Community Organizers and Case Workers

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Family Centers (FCs)

Pennsylvania FCs are a vehicle for integrating and providing community-based supports and services to help children and families become healthy, safe, and self-sufficient. FCs focus on providing early childhood education services and supports to families with young children, prenatal through age 5, in order to prevent child abuse and neglect. State funds support both Family Support Services offered uniquely as each FC location and the implementation of the Parents as Teachers evidence-based home visiting model at all FCs.

Promoting Responsible Fatherhood ("PRF")

The Department, in coordination with other Commonwealth agencies, launched the PRF initiative in 1999. Studies have shown that involved fathers provide practical support in raising children and serve as models for their development. Children with involved, loving fathers are more likely to do well in school, have healthy self-esteem, and exhibit empathy and pro-social behavior. A majority of these funded PRF programs are located in FCs. PRF programs help fathers:

- Strengthen positive father-child engagement
- Improve employment and economic mobility opportunities
- Improve healthy relationships, including couple, co-parenting, and marriage

Definitions

Home Visiting: High-quality early childhood home visiting programs and family support programs that promote maternal, infant and early childhood health, safety and development, and strong parent-child relationships. Participation in home visiting and Family Support services is offered on a voluntary basis to pregnant women or families with children prenatal through kindergarten age.

Family Support staff: Recognizing the family as the child's first teacher, the Family Support staff (home visitor) works in the homes of participating families, building positive relationships with them to support their caregiver roles. People are employed to visit the home for various purposes depending on the sponsoring agency and/or programs. It may be for the purpose of direct instruction or evaluation of the child, parenting education, communication as a home/school liaison, parent advocacy, or for providing early intervention services.

The Family Support staff (home visitor) has knowledge of child development and an understanding and appreciation of the families' social, economic, and cultural background. They also have knowledge of the specific areas of focus of the program such as health, parent education, or special education services. Communication and interpersonal skills are vital to this position along with problem solving and confidentiality. Family Support staff (home visitor) display acceptance and respect for each caregiver or family's unique culture and perspectives and a cooperative spirit with coworkers. Family Support staff also approach their work from a caregiver or family strengths perspective rather than a deficit perspective.

The qualifications for home visitor vary widely depending on the sponsoring agency and the purpose of the program.

Resource: https://www.earlychildhood.org/cdrg/exp_positions_p10.cfm

PA is working to redefine the definition of Family Support Staff/Home Visitor. There will be a future update for this toolkit. Sign up to receive toolkit update notifications at pcadv.org.

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INTIMATE PARTNER VIOLENCE SCREENING

MIECHV Performance Measure 14: Intimate Partner Violence Screening Indicator – Percent of primary caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) within six months of enrollment using a validated tool.

- All primary caregivers should be screened for IPV regardless of relationship status while enrolled in Evidence-Based Home Visiting or Family Support Programs.
- IPV refers to physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner. An intimate partner is a person with whom one has a close personal relationship that can be characterized by the following: emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, and familiarity and knowledge about each other's lives. *(Reference: Centers for Disease Control and Prevention. Injury Prevention and Control: Division of Violence Prevention, 2015.)*
- Although IPV screenings must occur within six months of enrollment, there is no specific time frame for when the referral should occur. The referral can occur in a different reporting period than the screening. The screening and referral can occur when safe for the caregiver and Family Support Program staff member.

For more info on Measurement 14 please visit:

https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/Federal_Home_Visiting_Program_Performance_Indicators_and_Systems_Outcomes_Summary.pdf

MIECHV Performance Measure 19: Intimate Partner Violence Referrals – Percent of primary caregivers enrolled in home visiting with positive screens for IPV (measured using a validated tool) who receive referral information for IPV.

- Family Support staff are expected to provide referral information regardless of whether or not the primary caregiver previously received a referral for services prior to enrolling in the home visiting program.
- OCDEL Performance Measure Reporting: Period of screening for OCDEL PM Collection purposes – within six months of caregiver enrollment. However, the screening can happen at any time based on the approved screening tool's timeline.

OCDEL approved IPV screening tools:

http://www.pa-home-visiting.org/wp-content/uploads/2019/08/Intimate-Partner-Violence-Screening-Assessment-Tools.pdf

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PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE

PCADV

Founded in 1976, the Pennsylvania Coalition Against Domestic Violence is the oldest statewide domestic violence coalition in the nation. Each year, free and confidential services are provided to nearly 90,000 victims of domestic violence through a network of 59 community-based programs serving all 67 counties in the Commonwealth. For more information, visit pcadv.org.

DOMESTIC VIOLENCE

Domestic violence is a pattern of coercive behavior used by one person to gain power and control over another in an intimate or familial relationship.

Many terms are used interchangeably to describe and discuss domestic violence. It may also be referred to as: abuse, domestic violence, battery, intimate partner violence, or family, spousal, relationship or dating violence. This toolkit will primarily use domestic violence and intimate partner violence.

Domestic violence can be characterized by many types of abuse, including:

EMOTIONAL ABUSE

FINANCIAL ABUSE

PHYSICAL VIOLENCE

SEXUAL VIOLENCE

STALKING

VERBAL ABUSE

For more information about tactics of abuse, please visit the PCADV website:
https://www.pcadv.org/about-abuse/types-of-abuse/
or reach out to your local domestic violence program.

Find your local domestic violence program
https://www.pcadv.org/find-help/find-your-local-domestic-violence-program/

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DOMESTIC VIOLENCE AND MATERNAL HEALTH

Sexual violence is one of the methods an abusive partner might use to maintain control over their partner, and sexual and/or reproductive coercion are two distinct tactics that have a direct impact on maternal health.

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

- Repeatedly pressuring a partner to engage in sexual activity when they do not want to
- Threatening to end a relationship if a person does not engage in sexual activities
- Forced non-condom use or not allowing other prophylaxis use
- Removing a condom during sex without consent, or "stealthing"
- Intentionally exposing a partner to a sexually transmitted infection (STI) or human immunodeficiency virus (HIV)
- Threatening retaliation if notified of a positive STI result
- Not respecting a partner's requests to slow down or stop during sexual encounters

Reproductive coercion includes behaviors aimed to maintain control in a relationship by manipulating the reproductive health of a partner. These behaviors can include:

- Birth control/contraception sabotage
- Pregnancy pressure and coercion
- Controlling pregnancy outcomes
- Dishonesty regarding contraception use

Many individuals who experience domestic violence also experience an escalation in physical abuse during pregnancy. Abusive partners may feel a loss of control during pregnancy as attention shifts away from them and on to the baby. Tactics such as emotional abuse, manipulation, and threats of self-harm or violence can lead to a drastic increase in production of stress hormones during pregnancy. Specific health risks associated with abuse during pregnancy include:

- High blood pressure
- Pre-term delivery
- Low birth weight
- Increased risk of infection during pregnancy
- Post-partum difficulties

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In addition to this, an increase in physical violence can cause severe health issues such as maternal shock, which disrupts proper distribution of blood throughout the tissues and organs, and placental abruption; the separation of the placenta from the uterus. Traumatic brain injury (TBI) is another serious health risk, as abusive partners using physical control tactics may hit their partners in the head, violently shake or strangle them to avoid leaving noticeable indications of harm on the body.

PCADV Medical Advocacy Program

PCADV sponsors the Medical Advocacy Project which supports training and systems advocacy between domestic violence programs and their local health care providers.

For more information on the impact of strangulation and TBI, you can connect with your local domestic violence program or contact PCADV.

https://www.pcadv.org/initiatives/medical-advocacy-program/

These methods of control can be seen in adolescent relationships, as well as those between adults, which is why it is important to provide resources and education on the health impact of domestic violence to all patients and caregivers.

DOMESTIC VIOLENCE AND CHILDREN

Research shows that exposure to violence, especially during childhood, adolescence, and young adulthood can significantly increase the likelihood of serious physical, emotional, and behavioral health problems.

Children who have experiences with domestic violence are often not recognized as victims by parents and/or caregivers or are unknown by observers and professionals. Children can experience domestic violence both directly as a victim and indirectly either as a means of control or as a witness to or victim of abuse. Many children are affected by hearing threats to the safety of their caregiver, regardless of whether it results in physical injury.

Children who live with domestic violence are also at increased risk to become direct victims of child abuse and are at an increased risk of becoming perpetrators themselves. Children who have been exposed to domestic violence often learn destructive lessons about the use of violence and power in relationships. Children may learn that it is acceptable to exert control or relieve stress by using violence, or that violence is in some way linked to expressions of intimacy and affection.

Children also associate experienced abusive tactics with their view of adulthood, and that this is how adults behave.

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Various abusive tactics can be used that directly or indirectly impact children, including:

PHYSICAL
Pinching, hitting, twisting arms, pushing, shaking, strangulation

SEXUAL
Incest, sexualizing children's behavior, sexual touching/kissing, exposing child to adult sexual activity and/or sexualized talk

EMOTIONAL
Isolation from peers or family, name calling, shaming children, being inconsistent, using child to get/give info to non-offending parent or caregiver

THREATS
Threats to abandon, to commit suicide, cause physical harm, confinement, or harm to their loved ones

FINANCIAL
Withholding basic needs/money to control behavior, withholding child support, using child as economic bargaining method

INTIMIDATION
Instilling fear through looks, actions, gestures, or property damage, yelling, being violent to other caregiver/pets, using institutions to threaten and coerce like punishment from God, the police, to go to a psych ward, be placed in a foster home, school

USING ADULT PRIVILEGE
Using larger body size to intimidate, treating child as a servant, excessive punishments, denying input in custody or visitation, interrupting the child when they are trying to exert their own decision making

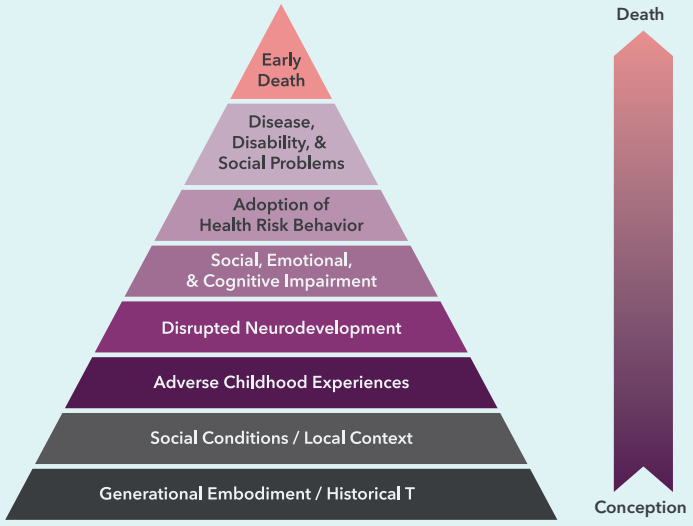
Not all children exposed to violence are affected equally or in the same ways. Exposure to domestic violence has also been linked to poor school performance. Children who grow up with domestic violence may have impaired ability to concentrate; difficulty in completing schoolwork; and lower scores on measures of verbal, motor, and social skills.

Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE) Study was one of the largest investigations ever conducted on the links between childhood maltreatment and later-life health and well-being; measuring traumatic or stressful life events experienced before age 18. In the Philadelphia ACEs researchers found that almost seven in 10 adults had experienced one ACE and one in five had experienced four or more. As the number of ACEs increases, so does the risk factor for negative health outcomes.

Learn more at about ACE at https://www.pcadv.org/ace-handount/

Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan



Source: https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016.

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Other ways a child may present domestic violence-related trauma symptoms include:

- Experience confusion and impact their ability to trust the people in their lives.
- Worry about the future or feel anxiety over never knowing what is coming next.
- Side with the abusive partner in order to stay safe, recognizing where the power lies in the family.
- Try to protect the abused caregiver, even to the point of physically coming between the adults.
- Have a difficult time focusing while at school because they are worried about what is happening at home.
- Have an impulse to get away because home feels like a dangerous place.
- Feel guilty or believe that the abuse is their fault.
- Experiment with alcohol, drugs, overeating, or self-harm to cope with their feelings.
- Sudden mood swings: rage, fear, anger, or withdrawal
- Bed wetting – especially if it begins in a child who has been dry
- Sexual activities with toys or other children

ADOLESCENT RELATIONSHIP ABUSE

1 in 10

ADOLESCENTS REPORT EXPERIENCING PHYSICAL VIOLENCE FROM A PEER OR PARTNER

Adolescent relationship abuse, more commonly referred to as teen dating violence, involves many of the same methods and tactics as those seen in unhealthy or abusive adult relationships. One in 10 adolescents report experiencing some form of physical violence from a peer or partner in the past year and experience the highest rates of stalking compared to other age groups *(Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance-United States, 2011 MMWR 2012;61(4):10., Baum, Katrina, Catalano, Shannan, Rand, Michael and Rose, Kristina. 2009. Stalking Victimization in the United States. U.S. Department of Justice Bureau of Justice Statistics)*. Young girls age 12-19 are shown to experience high rates of sexual coercion and violence that can impact their sexual and reproductive health *(Truman, Jennifer and Rand, Michael. 2010. Criminal Victimization, 2009. U.S. Department of Justice Bureau of Justice Statistics)*.

Exposure to violence, be it in the home between adult caregivers or in their own relationships with peers, can lead to unhealthy coping behaviors such as:

- Drug and alcohol abuse
- Smoking or vaping
- Poor attendance at school
- Suicidal thoughts or attempts
- Eating disorders
- Risky sexual behavior

Unhealthy and abusive relationship tactics often look the same for teens as they do for adults but may be overlooked by caregivers and adults who do not take romantic relationships between adolescents seriously. Methods that involve sexting and online abuse may go undetected by caregivers, but can have a devastating impact on youth experiencing abuse. Taking steps to raise awareness about adolescent relationship abuse, such as distribution of materials about dating violence and sexual/reproductive health and regular education around these topics, have been shown to decrease unhealthy relationship behaviors in adolescents.

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Strong partnerships between domestic violence and sexual assault advocates, health care providers, counselors, and support staff in schools are a good way to make sure teens not only have the written resources they need to identify their risk, but also feel more comfortable connecting with the people that can help them most.

When adults take steps to prevent adolescent relationship abuse, it sends a message to teens that they are valued, and they are not alone in their experiences, which makes it much easier for them to get the help they need.

MALE VICTIMS/SURVIVORS

The movement to end domestic violence began with a focus on violence against women, perpetrated by men. Program names and services reflect that focus. While the majority of those seeking services from PCADV's domestic violence programs are still women, this binary approach excludes male victims/survivors.

26% **GAY MEN** | **37%** **BISEXUAL MEN** | **29%** **HETEROSEXUAL MEN**

EXPERIENCED RAPE, PHYSICAL VIOLENCE, AND/OR STALKING BY AN INTIMATE PARTNER.

Although the data continues to show that girls and women are disproportionately impacted by intimate partner violence (IPV), boys and men are also victims. A reliable ongoing source of statistics on the prevalence of lifetime victimization of women and men is the National Intimate Partner and Sexual Violence Survey (NISVS), including this 2016 infographic.

The NISVS 2010 Key Findings on Victimization by Sexual Orientation indicates 26% of gay men, 37% of bisexual men, and 29% of heterosexual men experienced rape, physical violence, and/or stalking by an intimate partner.

Common barriers to men seeking services include:

- Social/cultural stigma
- Don't recognize or define their experience as IPV
- Not believed, or face suspicion, when calling a domestic violence hotline or law enforcement
- No representation in domestic violence program outreach materials
- Fear of being "outed" as gay/bisexual/transgender
- Not routinely screened for IPV by health care professionals

Federal laws require that all survivors must have access to services such as shelter, counseling, support group, and legal. Best practice dictates that PCADV domestic violence programs must provide comparable trauma-informed services to men, based on their individual needs. Many programs are changing their names and outreach materials, hiring male staff, sheltering on-site, and including male survivors in support groups.

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INTIMATE PARTNER VIOLENCE IN LATER LIFE

Family support workers and Family Support staff may be visiting households where there is a grandparent present- either as the child(ren)'s caregiver, or as a member of the household. Though you may not be directly working with them, they may be experiencing domestic violence as well. Intimate Partner Violence in Later Life (IPVILL) is the physical, financial, sexual, and/or emotional abuse of an individual aged 60 and older by a current or former intimate partner, spouse, or family member.

What does IPVILL look like?

Physical: hitting; pinching; restraining; forcing the survivor to take medication against their will; breaking of bones; hiding walkers, chairs, glasses, hearing aids, dentures, and other assistive devices

Sexual: forcing the survivor to perform sex acts or watch pornography; sexually touching or molesting the older adult survivor while caregiving during toileting or bathing routines; taking unsolicited nude; sexual photos or videos of the older adult and selling them or posting them online without permission

Emotional: manipulation; isolation; treating an older survivor like an infant; threatening to withdraw, destroy, or hide important paperwork relating to immigration status, passports, ID cards, and/or health care cards; threatening to withhold hormones like testosterone injections for transgender or nonbinary older adults or withholding other non-gender specific mediations like insulin or pain killers

Financial: illegally misusing the older adult survivor's money, property, and/or assets; abusing and/or exploiting power of attorney or guardianship; holding the older adult hostage for use of finances, assets, property and/or benefits; using finances as a coercive bargaining tool for daily care, food, etc.

How do we spot IPVILL?

- Lack of social connections and support
- Unexplained bruising or broken bones
- Lack of basic hygiene
- No or limited access to adequate food and/or clothing
- Unexplained weight loss
- Unexplained lack of funds
- Missing medications
- Seemingly over or under medicated
- Suddenly pulled from enjoyable activities
- Missing or broken medical equipment

PCADV program staff and volunteers are not mandated reporters of elder abuse in the state of Pennsylvania. If you have any questions about reporting responsibilities, please refer to your agency's policy.

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DOMESTIC VIOLENCE AND MENTAL HEALTH

Source: Cave, NCDVTMH, 2017.

When working with survivors who are experiencing emotional distress, mental health crises, and/or psychiatric disabilities, it is imperative to deliver accessible, trauma-informed services. As advocates, our experiences with survivors can be shaped by our own beliefs, values, and expectations. Knowing what survivors believe and find helpful can provide valuable information about what supports we can offer when someone is in distress.

To identify the connections between interpersonal violence, trauma, and the many ways that emotional distress is expressed, we must remember to:

- Honor each person's wholeness
- Provide culturally responsive support
- Preserve dignity and choice
- Use person-first language
- Avoid retraumatization
- Be present and non-judgmental
- Remain connected and caring
- Provide access to our services and supports

Often our sense of responsibility for or worry about the care and safety of self and others interferes with empathy, patience, and understanding. Sometimes we may not know what would actually be helpful and someone experiencing distress may not be able to tell us in that moment. Mental health conditions can and do coexist with the emotional distress of trauma. With different points of view and not knowing or understanding what someone is experiencing, it is challenging to know how to help.

Our whole system, which includes bodies, brains, and emotions, is wired for survival. Our brain is constantly sorting information and making decisions about what is safe and not safe all the time. Information comes in from our environments and from within ourselves. The information is not neutral. It is shaped by past experience, current emotional state and instincts. Fight, flight, or freeze are typical responses. Freeze often occurs when fight or flight is not possible.

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Trauma, especially chronic and ongoing abuse, violence, and oppression, brings about changes to our survival system. We become more tuned in to possible danger, which can be lifesaving, our systems aren't built to be "on" like this all the time. We develop ways of coping with it and adapting to it. Some of the ways people cope are misunderstood or seen as harmful, uncooperative, or risky. And in our work, it can be challenging to remain compassionate and empathetic. Some of these behaviors include:

- Being overwhelmed by or having strong reactions to seemingly "minor" irritants
- Scanning for danger, worry that something bad will happen
- Numbing, checking out
- Not being able to "get over" thoughts, feelings, and body sensations that are experienced
- Disengaging and avoiding interactions
- Minimizing or compartmentalizing

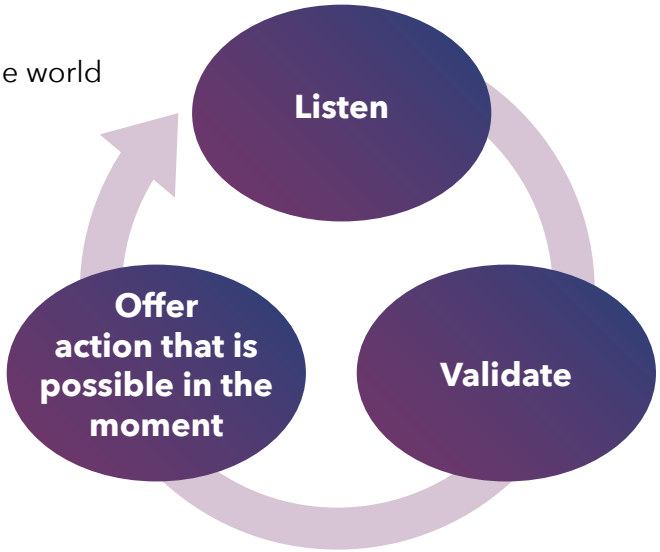
One way to support is by planning ahead when the individual is not in crisis. You can respond with curiosity and compassion in the following ways:

Ask ahead of time (during intake, as part of conversations):

- When you are overwhelmed or distressed, what does that look like?
- What usually helps to prevent feeling overwhelmed?
- Is there anything that helps once you are already feeling that way?
- Are there things we can do to support you to calm, focus, care for yourself?

If you are working with a client who is experiencing crisis and cannot tell us what they need:

- One staff person leads
- Make a connection
- Be clear, calm, and focused
- Consider what people want for themselves
- Create space
- Take your time – as if you have all the time in the world
- Stay collaborative and offer choices
- Use simple, concise language
- Neither fuel nor challenge beliefs



For more information on the Working for Kids Program, please visit:

http://workingforkids.com

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DOMESTIC VIOLENCE AND SUBSTANCE USE

Source: Warshaw, NCDVTMH, December, 2013.

By definition, coercion is the use of force or manipulation to control an intimate partner's thoughts, actions, and behaviors through violence, intimidation, threats, degradation, isolation, and/or surveillance. In the context of intimate partner violence, coercion can involve financial, psychological, physical, sexual, reproductive, and other kinds of abuse to undermine and control an intimate partner.

When we talk about **substance coercion**, it's important to think about it in two ways:

1

The abusive partner targeting an existing addiction to exploit the vulnerabilities associated with it. Stigma associated with substance abuse facilitates the successful use of these tactics, which include:

- Making survivors use substances or use more than they want
- Controlling access to alcohol or drugs
- Inducing withdrawal symptoms
- Isolating partner from recovery and other helping resources
- Sabotaging recovery efforts
- Threats to discredit their partners with friends, family, helping professionals, and the courts. (If you leave/tell, I'll tell them that you smoke, drink etc.)
- Using drug history as threat (deportation, arrest, Children & Youth Services, custody, job, etc.)
- Blaming abusive behavior on partner's use to benefit from: Lack of gender-specific services with substance use issues & Societal beliefs re: women & addiction

These tactics include efforts to intentionally undermine their partner's:

- Sanity (wow, you need a beer to relax, etc.)
- Sobriety
- Control their medication
- Sabotage their recovery
- Interfere with their treatment

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2

The abusive partner using substances to maintain power and control over their partner. These tactics include:

- Coercing survivors into illegal activities (dealing, stealing, trading sex for drugs)
- Forcing or coercing partner to use (e.g. dirty needles, cottons, noxious substances) or watch their partner use
- Justifying sexual abuse or other forms of violence based on drug use

Survivors of domestic violence and living with substance abuse issues face unique challenges. They are attempting to survive in a world that condemns both their substance use and their choice of partner.

1. Stigma around DV and around SU compounds these risks. Concerns exist with custody and CYS, the criminal justice system and/or ICE involvement impact help seeking
2. Abusers use these issues to control their partners and discredit them with sources of support
3. Abusers control treatment and medication and sabotage recovery
4. Abusers actively undermine their partners' sanity, sobriety, and parenting
5. Domestic and sexual violence and other trauma associated with increased substance/ opioid use and other mental health effects.

It's important to remember that substance use is a response to an underlying problem—due to the heavy stigma attached to the way that society views survivors and views substance use, it places the individuals at a place of predisposed objectification.

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COLLABORATION

Partnerships between OCDEL programs and PCADV programs are fundamental to prevention of and intervention for domestic violence. Collaborating at the local level is key to building capacity to fully support survivors. Cross education allows staff from both systems an opportunity to connect and understand the best ways to develop protocols, make warm referrals, and engage in professional development. Use this sample Memorandum of Understanding (MOU) as a starting point for partnerships between domestic violence programs and health care providers.

Find your local DV Program

pcadv.org/program-locator

Find your local FS/HV Program

http://www.eita-pa.org//uploads/presentations/pafamilysupport/index.html#/lessons/UXYAWLQd091DXlJ5mlZM0VN72k9Tk-rY

Lists of local domestic violence programs and lcoal FS/HV programs can also be found in the corresponding program list handout.

PROTOCOL/POLICY DEVELOPMENT

Prevent, Assess, and Respond: A Domestic Violence Toolkit for Health Centers & Domestic Violence Programs *(from Futures without Violence)*

Health centers are key to violence prevention. They can use this toolkit to build a comprehensive and sustainable response to domestic violence and sexual assault (DV/SA) in partnership with DV/SA advocacy programs to:

- Improve how your health center identifies and responds to DV/SA and promotes prevention
- Develop proactive partnerships with local DV/SA advocacy programs to address the health needs of patients and connect them to health centers for care

Download the toolkit at

https://www.pcadv.org/ipv-health-partners-toolkit/

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OCDEL

Pennsylvania Evidence-Based Home Visiting: IPV Trainings & Education		
EBHV Model	**Does this model REQUIRE IPV training?**	
Early Head Start (EHS)	NO	
Healthy Families America (HFA)	YES	
Nurse-Family Partnership	NO	
Parents as Teachers (PAT)	NO	
Self-Care Augmented	**Model:** NO	**Agency:** YES

Early Head Start (EHS)

Performance Standards are broader and don't necessarily speak specifically to DV/IPV, Head Start and Early Head Start programs have quite a bit of resources for supporting staff that they, and anyone else, can access on the Early Childhood Learning and Knowledge Center (ECLKC) through ACF at https://eclkc.ohs.acf.hhs.gov/search/eclkc?q=violence.

Regulations:

1302.80 Enrolled pregnant women.

(a) Within 30 days of enrollment, a program must determine whether each enrolled pregnant woman has an ongoing source of continuous, accessible health care – provided by a health care professional that maintains her ongoing health record and is not primarily a source of emergency or urgent care – and, as appropriate, health insurance coverage.

(b) If an enrolled pregnant woman does not have a source of ongoing care as described in paragraph (a) of this section and, as appropriate, health insurance coverage, a program must, as quickly as possible, facilitate her access to such a source of care that will meet her needs.

(c) A program must facilitate the ability of all enrolled pregnant women to access comprehensive services through referrals that, at a minimum, include nutritional counseling, food assistance, oral health care, mental health services, substance abuse prevention and treatment, and emergency shelter or transitional housing in cases of domestic violence.

(d) A program must provide a newborn visit with each mother and baby to offer support and identify family needs. A program must schedule the newborn visit within two weeks after the infant's birth.

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1302.53 Community partnerships and coordination with other early childhood and education programs.

(a) Community partnerships. (1) A program must establish ongoing collaborative relationships and partnerships with community organizations such as establishing joint agreements, procedures, or contracts and arranging for on-site delivery of services as appropriate, to facilitate access to community services that are responsive to children's and families' needs and family partnership goals, and community needs and resources, as determined by the community assessment.

(2) A program must establish necessary collaborative relationships and partnerships, with community organizations that may include:

(i) Health care providers, including child and adult mental health professionals, Medicaid managed care networks, dentists, other health professionals, nutritional service providers, providers of prenatal and postnatal support, and substance abuse treatment providers;

(ii) Individuals and agencies that provide services to children with disabilities and their families, elementary schools, state preschool providers, and providers of child care services;

(iii) Family preservation and support services and child protective services and any other agency to which child abuse must be reported under state or tribal law;

(iv) Educational and cultural institutions, such as libraries and museums, for both children and families;

(v) Temporary Assistance for Needy Families, nutrition assistance agencies, workforce development and training programs, adult or family literacy, adult education, and post-secondary education institutions, and agencies or financial institutions that provide asset-building education, products and services to enhance family financial stability and savings;

(vi) Housing assistance agencies and providers of support for children and families experiencing homelessness, including the local educational agency liaison designated under section 722(g)(1)(J)

(ii) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431 et seq.);

(vii) Domestic violence prevention and support providers; and,

(viii) Other organizations or businesses that may provide support and resources to families.

Healthy Families America (HFA)

HFA requires that all staff are trained on domestic violence within 12 months of hire. IPV/DV training includes indicators of IPV/DV, dynamics of IPV/DV, Interventions, strategies for working with families and children (effects on children), and resources.

Nurse-Family Partnership (NFP)

Nurse Family Partnership Intimate Partner Violence Education—Currently, the education is not mandatory but highly recommended. The course is very comprehensive, with about 18 hours of content. Per NFP's National Service Office (NSO) Part 3 is planned to be released in about a month, and the NSO NFP educational team is working on nursing practice videos related to working with clients who are experiencing IPV. There is no solid timeline for the video, yet.

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Parents as Teachers (PAT)

PAT doesn't have prescribed mandatory training on IPV (no specific course). They do have a Quality Standard about having a protocol. Standard: The affiliate has and trains its staff on written protocols that address how parent educators are expected to respond to and follow-up on the following: Child abuse and neglect; Mental health issues; Intimate Partner Violence (IPV); Substance abuse. PAT does encourage agencies to have professional development provided to parent educators (PAT home visitors) from local IPV providers and from the Institute for Family Support.

Measurement Criteria: The affiliate has written protocols for all four of the topics listed in the standard that have been in effect for at least three months prior to submission of the self-study. Each protocol must address:

- Expected screening and/or response to the issue(s)
- Expected consultation/reporting (to supervisor and if applicable, parties outside the affiliate)
- Expected documentation in the family file or program/supervisor files
- Expected follow-up with the family

The Mental Health Issues protocol can be broader than depression screening but does not have to be. In addition, all staff receive initial training in the implementation of all of the protocols and then an annual review, with particular attention to anything that has changed or been added. The annual review could be done during a staff meeting.

PCADV

Screening and Warm Referral

Family support staff are often required to assess the individuals and families they work with for various health concerns. Medical issues are typically screened for during an intake with new patients, as well as social determinants of health. A social determinant of health could be how often an individual has access to nutritious food, or if they have a safe place to live. Domestic violence is also a health factor that family support staff will need to screen for, but this can be a difficult topic to discuss for both the staff person and the individual. A "checklist" style screening has been the standard for most medical assessments, but as more research is done on the methods that work best to help individuals experiencing domestic violence, it often falls short for several reasons:

- Disclosure is the only way to access help
- Questions are different depending on which screening tool is being used
- Places responsibility on the survivor to trust it is safe to disclose abuse
- Does not provide additional education or support beyond the checklist

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Conversational and education-based screening methods allow Family Support Staff to adapt a checklist style screening in a trauma-informed, survivor-centered way. This can help create rapport with clients while providing everyone access to domestic violence resources regardless of disclosure of abuse.

Conversational means that instead of going through a checklist and asking for a "yes" or "no," Family Support Staff can discuss domestic violence and the questions associated with in their screening tool in a way that is invitational and informal instead of clinical and demanding. Education based means that Family Support Staff can focus on educating caregivers about domestic violence and its impact on health, as well as the resources and support available to individuals who experience domestic violence. This method provides access to support for everyone, regardless of whether they disclose abuse or not. There are some basic steps to consider when adapting your screening to a conversational and education based style:

1. Introduce the topic gently, but directly- "Because domestic violence can impact the health of those experiencing it, I like to talk with everyone I work with about their safety at home …is it OK if we talk about your relationship for a few minutes?"
2. Ask questions in an invitational and trauma sensitive manner- " I know these questions can be a little awkward to answer, so if you don't feel comfortable you can just ask to pass on anything you don't want to talk about, OK?"
3. Make adjustments so that questions feel more comfortable for you- instead of asking "Has anyone hit, kicked, slapped, or beaten you?" try something like "Relationships can get physical sometimes…does your partner ever hurt you? Have they ever threatened to?"
4. Validate the responses you get, even if you are concerned that they are not telling you everything that's going on- "I'm glad to hear no one is hurting you at home, that can be really scary. Just so you know, if you or anyone you know ever experiences abusive behavior there's a number you can call to get help whenever you need it…even if you just need to talk to someone."

Remember that domestic violence can happen to anyone, so talk to everyone about the health of their relationship and provide resources as a regular part of your interaction with families. It can be frustrating when you know abuse is happening, or strongly suspect it, but the survivor is not ready to leave the situation or even admit that it's happening.

Resources for Supportive Screening and Referral

Remember that your best resource for developing trauma-informed, survivor-centered procedures are the domestic violence programs in your area. Your local domestic violence program can provide free training on conversational screening and technical assistance on how to best engage in warm referral. They can also provide you with additional resources to share with caregivers!

Use this link to access PCADV's online domestic program directory:

https://www.pcadv.org/find-help/find-your-local-domestic-violence-program/

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The PEARR Screening Method

The PEARR Screening Method is an excellent resource to help Family Support Staff engage in domestic violence screening in a way that is conversational and education based:

PEARR Tool

Trauma-Informed Approach to Victim Assistance in Health Care Settings

In partnership with HEAL Trafficking and Pacific Survivor Center, CommonSpirit Health developed the PEARR Tool to guide health professionals on how to provide **trauma-informed assistance** to patients who may be experiencing abuse, neglect, or violence. The PEARR Tool is based on a **universal education approach** which focuses on educating patients about violence prior to, or in lieu of, screening patients with questions. The goal is to have an informative, yet developmentally-appropriate, conversation with patients in order to create a natural context for patients to share their own experiences and possibly accept further assistance.

**A double asterisk indicates points at which this conversation may end. Refer to the bottom of this page for additional steps. 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, this may be an indicator of abuse, neglect, or violence.** Strategies to speak with patient alone: Suggest the need for a private exam. For virtual or telephonic visits, request patient moves to a private space but proceed with caution as patient may not be alone.** **Note: Companions are not appropriate interpreters,** regardless of communication abilities. If patient indicates preference to use companion as interpreter, see your facility's policies.** Also, explain **limits of confidentiality** (e.g., mandated reporting); however, do not discourage patient from disclosing victimization. Patient should feel in control of disclosures. Mandated reporting includes requirements to report concerns of abuse, neglect, or violence to designated state or local 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 common in our society, and violence has a big impact on our health, safety, and well-being." **Use 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? Would you like to speak with [insert advocate/service provider] to receive additional information for you **or someone you know?"**** If physically alone with patient and you observe indicators of victimization, **ASK** about concerns. Example: "I've noticed [insert risk factor/indicator]. You don't have to share details with me, but I'd like to connect you with resources if you're in need of assistance."** 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).

R R RESPECT & RESPOND

4. If patient denies victimization or declines assistance, respect patient's wishes. If you have **concerns about patient's safety,** offer hotline card or other information in event of emergency (e.g., local shelter, crisis hotline). Otherwise, if patient accepts/requests assistance, **arrange personal introduction** with local victim advocate/service provider or **assist patient with calling 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 personnel (e.g., nurse supervisor, security), **complete mandated reporting,** and continue **trauma-informed health services.** Whenever possible, **schedule follow-up appointments** to continue building rapport and to monitor patient's health, safety, and well-being.

View the full PEARR Tool at https://www.pcadv.org/csh-pearr-tool-tel-field-fa3/.

If you are interested in learning more about how you can create policies and protocols to help support survivors of domestic violence use the link below to download the Futures Without Violence IPV Health Partners Toolkit:

http://www.nnoha.org/nnoha-content/uploads/2018/12/IPV-Health-Partners-Toolkit-4.24.pdf

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MANDATED REPORTING

NFP Feedback: In PA per ACT 31, Registered Nurses are required to complete an initial 3-hour education and ongoing 2-hour training related to mandated reporting as part of renewing their license (every 2 years).

https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Pages/Act-31.aspx

As mandated reporters of child abuse, you have the legal obligation to report suspected child abuse and neglect. The Child Protective Services Law (CPSL) requires mandated reporters to make a report when they have reasonable cause to suspect abuse. Reasonable cause is generally seen as more than a hunch and is typically based on an individual either witnessing or receiving a credible disclosure of child abuse or neglect. Mandated reporters do not determine what is/is not abuse/neglect, but the CPSL provides guidance about what actions constitute child abuse under the law to assist advocates in making mandated reports when necessary.

The following acts constitute Child Abuse under the CPSL:

- Causing bodily injury to a child through any recent act or failure to act.
- Fabricating, feigning, or intentionally exaggerating or inducing medical symptom or disease which results in a potentially harmful medical evaluation or treatment to the child through any recent act.
- Causing or substantially contributing to serious mental injury to a child through any act or failure to act or a series of such acts or failures to act.
- Causing sexual abuse or exploitation of child through any act or failure to act.
- Creating a reasonable likelihood of bodily injury to a child through any recent act or failure to act.
- Creating a likelihood of sexual abuse or exploitation of a child through any recent act or failure to act.
- Causing serious physical neglect of a child.
- Causing the death of the child through any act or failure to act.
- Engaging a child in a severe form of trafficking in persons or sex trafficking, as those terms are defined under section 103 of the Trafficking Victims Protection Act of 2000 (114 Stat. 1466, 22 U.S.C. § 7102).

The Trafficking Victims Protection Act of 2000

https://www.govinfo.gov/content/pkg/PLAW-106publ386/pdf/PLAW-106publ386.pdf#:~:text=To%20combat%20trafficking%20in%20persons,women%2C%20and%20for%20other%20purposes

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The CPSL also provides additional specific acts that would constitute abuse regardless of whether there is any resulting injury or condition.

These recent acts include any of the following:

- Kicking, biting, throwing, burning, stabbing, or cutting a child in a manner that endangers the child
- Unreasonably restraining or confining a child, based on consideration of the method, location or the duration of the restraint or confinement
- Forcefully shaking a child under 1 year of age
- Forcefully slapping or otherwise striking a child under 1 year of age
- Interfering with the breathing of a child
- Causing a child to be present during the operation of a methamphetamine laboratory, provided that the violation is being investigated by law enforcement
- Leaving a child unsupervised with an individual, other than the child's parent, who the parent knows or reasonably should have known was required to register as a Tier II or III sexual offender or has been determined to be a sexually violent predator or sexually violent delinquent

Therefore, if you have reasonable cause (i.e. more than a hunch or a suspicion) to suspect any of these acts are occurring to an identifiable child a Childline report must be made. As indicated by language, what constitutes child abuse is more than routine corporal punishment or a questionable environment/caregiving of the child; they are overt acts of violence that may result in serious injury or death. Without such language, Child and Youth Services could find themselves inundated with reports that do not sufficiently allege child abuse. Again, mandated reporters are not tasked with determining whether an incident occurred or whether the actions alleged meet a certain standard, this is a task for CYS and law enforcement agencies. If a mandated reporter witnesses or receives a credible disclosure alleging an identifiable child is a victim of any of the above actions they must report it.

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SAFETY PLANNING

Safety planning is a fundamental aspect of domestic violence support and advocacy. Safety planning is assessing the level of risk and danger to the survivors of domestic violence, a collaboration between the adult survivor and the advocate, identifying other system professionals that can support the safety plan, and is an on-going, evolving process as risk factors change.

Safety planning is a process. This process begins with an understanding that the process is not just about "physical safety." Rather, it can be the mechanism by which advocates use to begin to address the underlying core dynamics of domestic violence. The very process of making a safety plan helps give the victim/survivor a sense that she or he does have some control over their life. A safety plan encourages individuals to think about the realities of their situation and to understand the dynamics and patterns of the violence they have endured. Above all, safety plans should be individualized, taking into account age, ability, marital status, whether children are involved, geographic location, and resources available.

First and foremost, safety planning should never be scripted, i.e. where an advocate simply reads off a set of questions and asks the victim/survivor to fill in the answers or to merely hand a piece of paper with a list of things that they can do, like: hide an extra set of car keys, hide important documents in a safe place, etc.

Leaving is not always the safest course of action. No contact does not necessarily reduce risks. It may be necessary to have a plan for safety in and out of the violent relationship. There are various types of safety planning and additional things to consider, i.e. pets, emotional and mental health, pregnancy, children, safety while staying, safety while leaving, and safety after leaving.

PCADV and OCDEL recognize that Family Support staff are not domestic violence advocates, and the intent of this toolkit is to inform rather than instruct. This is one of the benefits of building a partnership with your local domestic violence program, which can provide support and continuing education on all of the topics highlighted in this toolkit. If you are in an immediate safety situation during a home visit, please refer to your agency's policy regarding risk reduction and emergency response. Do not practice (or plan) beyond your role/knowledge, always refer to domestic violence programs, who are experts in this field.

Find your local program:
https://www.pcadv.org/find-help/find-your-local-domestic-violence-program/

Safety planning is a process, and must be individualized.

Leaving is not always the safest course of action.

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SAFETY PLANNING WITH A CLIENT

Trauma-informed safety planning is asking NOT What's wrong with you? INSTEAD What's happened to you? Be aware that discussing a safety plan requires the survivor to discuss trauma – this may be painful and emotionally overwhelming. Being trauma-informed recognizes that survivors, staff, and others they interact with may be affected by trauma they have experienced at some point in their lives.

Trauma-informed programs are welcoming and inclusive and based on principles of:

- Respect
- Dignity
- Inclusiveness
- Trustworthiness
- Choice
- Collaboration
- Empowerment
- Safety

They are designed to attend to both physical and emotional safety, to avoid re-traumatizing those who seek services.

LISTEN: What are they saying, what are they not saying, how are they saying it? Pay attention to nonverbal queues. It's a genuine conversation, not a checklist.

INFORM: What information do you have for them? Why is this important for them to know? What's next?

It is important to let the survivor lead, respect their voice and choice, to recognize the survivor's comfort level, consider the survivor's perspective from their cultural context, avoid passing judgment, resist interrupting them, make sure your body language is receptive, offer information and assistance.

SAFETY PLANNING FOR YOURSELF

Adapted from Vermont http://dcf.vermont.gov/sites/dcf/files/DCF/docs/HV-DV-VT-Guide.pdf

- Trust your instincts; establish check-in time with your office
- Park with the front of your vehicle pointed toward the exit
- Observe and listen before knocking on the door or entering a household
- Do not enter the home until you see your participant at the door
- Position yourself in the home so that you have a clear path to the exit
- Always be aware of your surroundings and look for behavioral cues that something is amiss
- Keep your phone handy so that it is not hard to call for help if needed
- Keep your keys handy so that you don't need to dig for them if you need to leave quickly
- Know the address where you are at in case you need to call 911
- Ask who is home when you arrive and ask the participant if they are expecting anyone
- Establish a DV protocol for the agency with the DV shelter; including cross training

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SELF-CARE

When working in a field that is so steeped in trauma, it is important to take care of yourself. Self-care is not just about engaging in surface level pleasurable activities like bubble baths, yoga, or eating your favorite ice-cream; it's about creating a call to action for serious self-reflection and self-awareness to replenish your emotional energy in a meaningful way.

THREE TYPES OF SELF-CARE

BASICS

- Change of clothing daily
- Drinking fluids frequently (whatever feels best)
- Showering/bathing
- Medications/vitamins are being taken at their same time daily
- Nap/sleep as the body sees fit
- Developing a routine

AT WORK

- Work setting/comfortable space
- Setting break times/using break times
- Adjusting expectations as needed/reprioritizing things (as you can)
- Regular reflective supervision

OUTSIDE OF WORK

- Need to have an outside of work! You are giving yourself a routine and limitation/give yourself a hard-quitting time, a weekend, SET BOUNDARIES around your work space only being accessed during work hours
- Give yourself permission to set boundaries around the types communication with people you talk to. Do you have the capacity to handle this conversations?
- Seek therapy
- Engage in rejuvenating activities such as meditation, prayer, or relaxation

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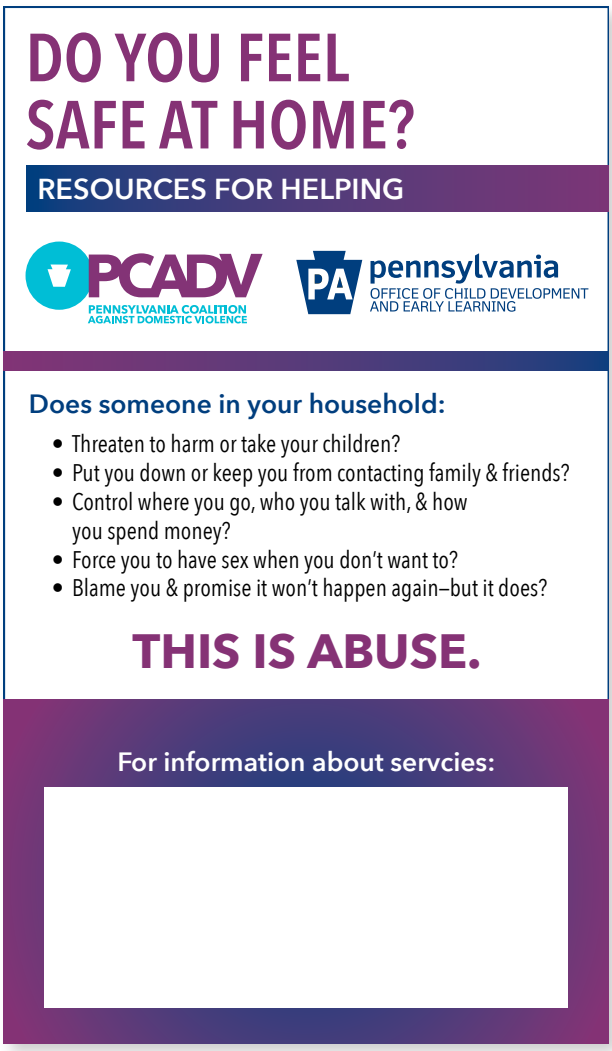
RESOURCE - PALM CARDS

Pennsylvania Coalition Against Domestic Violence (PCADV) through its partnership with the Office of Child Development and Early Learning (OCDEL) have created this resource for use by OCDEL programs. This card can be used to talk with clients about domestic violence. The card, which is meant to be shared with clients, includes referral information.



DO YOU FEEL SAFE AT HOME?

RESOURCES FOR HELPING

PCADV PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE

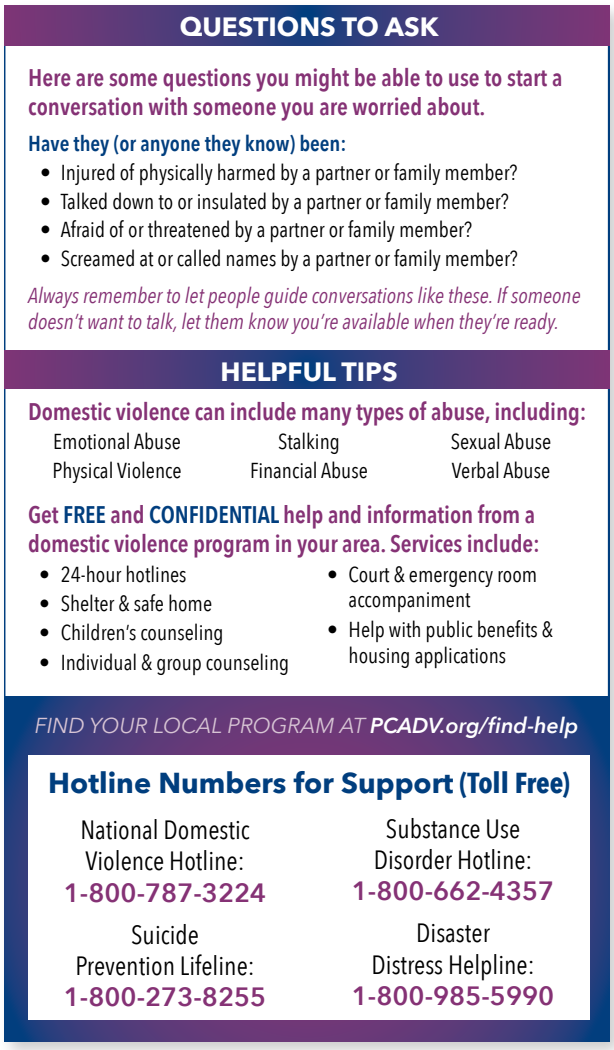
PA pennsylvania OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING

Does someone in your household:

- Threaten to harm or take your children?
- Put you down or keep you from contacting family & friends?
- Control where you go, who you talk with, & how you spend money?
- Force you to have sex when you don't want to?
- Blame you & promise it won't happen again–but it does?

THIS IS ABUSE.

For information about servcies:



QUESTIONS TO ASK

Here are some questions you might be able to use to start a conversation with someone you are worried about.

Have they (or anyone they know) been:

- Injured of physically harmed by a partner or family member?
- Talked down to or insulated by a partner or family member?
- Afraid of or threatened by a partner or family member?
- Screamed at or called names by a partner or family member?

Always remember to let people guide conversations like these. If someone doesn't want to talk, let them know you're available when they're ready.

HELPFUL TIPS

Domestic violence can include many types of abuse, including:

Emotional Abuse	Stalking	Sexual Abuse
Physical Violence	Financial Abuse	Verbal Abuse

Get FREE and CONFIDENTIAL help and information from a domestic violence program in your area. Services include:

- 24-hour hotlines
- Shelter & safe home
- Children's counseling
- Individual & group counseling
- Court & emergency room accompaniment
- Help with public benefits & housing applications

FIND YOUR LOCAL PROGRAM AT ***PCADV.org/find-help***

Hotline Numbers for Support (Toll Free)

National Domestic Violence Hotline: 1-800-787-3224	Substance Use Disorder Hotline: 1-800-662-4357
Suicide Prevention Lifeline: 1-800-273-8255	Disaster Distress Helpline: 1-800-985-5990

Download the fillable cards

https://www.pcadv.org/ocdel-palm-cards_digital-text-box.pdf

Download the print version

https://www.pcadv.org/ocdel-palm-cards_print.pdf

You can order physical copies of the card by contacting Jessa Winas at jwinas@pcadvc.org.

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PCADV PROGRAMS

ONLINE PROGRAM LOCATOR

PCADV has a statewide network of direct-service, local domestic violence programs that are ready to help.

A Safe Place
Forest and Warren Counties

A Way Out
Potter County

A Woman's Place
Bucks County

Abuse & Rape Crisis Center
Bradford County

Alice Paul House
Indiana County

Alle-Kiski Area HOPE Center
Allegheny & Westmoreland Counties

AWARE
Mercer County

Blackburn Center
Westmoreland County

C.A.P.S.E.A.
Elk and Cameron Counties

Center for Victims
Allegheny County

Centre Safe
Centre County

Community Action/Crossroads Project
Jefferson and Clearfield Counties

Congreso De Latinos Unidos
Philadelphia County

Crisis Center North
Allegheny County

Crisis Shelter of Lawrence County
Lawrence County

Domestic Abuse Project of Delaware County
Delaware County

Domestic Violence Center of Chester County
Chester County

Domestic Violence Intervention of Lebanon County
Lebanon County

Domestic Violence Service Center
Luzerne and Carbon Counties

Domestic Violence Services of Cumberland & Perry Counties
Cumberland and Perry Counties

Domestic Violence Services of Lancaster County
Lancaster County

Domestic Violence Services of Southwestern PA
Washington, Greene and Fayette Counties

Family Services/ Domestic Abuse Project of Blair County
Blair County

HAVEN of Tioga County
Tioga County

HAVIN
Armstrong County

Huntingdon House
Huntingdon County

Laurel House
Montgomery County

Lutheran Settlement House
Philadelphia County

PPC Violence Free Network
Venango County

Roads to Peace/Clinton County Women's Center
Clinton County

SAFE (Stop Abuse for Everyone)
Clarion County

Safe Berks
Berks County

Safe Journey
Erie County

SafeNet Domestic Violence Safety Network
Erie County

Schuylkill Women in Crisis
Schuylkill County

Sullivan County Victim Services
Sullivan County

The Abuse Network
Mifflin and Juniata Counties

Transitions of PA
Union, Snyder, and Northumberland Counties

Turning Point of Lehigh Valley
Lehigh and Northampton Counties

Victim Outreach Intervention Center
Butler County

Victims Resource Center
Wyoming County

Victims' Intervention Program
Wayne and Pike Counties

Women Against Abuse
Philadelphia County

Women In Need
Franklin and Fulton Counties

Women In Transition
Philadelphia County

Women's Center & Shelter of Greater Pittsburgh
Allegheny County

Women's Center of Beaver County
Beaver County

The Women's Center, Inc. of Columbia/Montour
Columbia and Montour Counties

Women's Center of Montgomery County
Montgomery County

Women's Help Center
Cambria and Somerset Counties

Women's Resource Center
Lackawanna and Susquehanna Counties

Women's Resources of Monroe County
Monroe County

Women's Services
Crawford County

Your Safe Haven
Bedford County

YWCA Bradford Victims' Resource Center
McKean County

YWCA NorthCentral PA Wise Options
Lycoming County

YWCA of Greater Harrisburg Violence Intervention & Prevention Services
Dauphin County

YWCA of Hanover/Safe Home
Adams County

YWCA York/ACCESS
York County

OCDEL PROGRAMS

INTERATCTIVE ONLINE MAP

ALLEGHENY
Clairton Family Center
Duquesne Family Center
East Allegheny Family Center
Highlands Family Center
Latino Family Center
Lincoln Park Family Center
Mckeesport Family Center
Steel Valley Family Center
Sto-Rox Family Center
Wilkinsburg Family Center
Allegheny Intermediate Unit
Wesley Family Services
Allegheny County Chief Executive Officer Dept of Human Services

ARMSTRONG
Jefferson-Clarion Head Start
Allegheny-Clarion Valley Family Center

BEAVER
Franklin Center of Beaver County

BERKS
Community Prevention Partnership of Berks County
Bedford County Family Center
Berks Community Action Program

BLAIR
Blair County Family Center
Kids First Blair
Family Resource Center of Blair County / United Way of Blair County / Blair County Family Center
Blair County Commissioners

BUCKS
Bucks County Family Center

CAMBRIA
Home Nursing Agency
Beginnings, Inc.

CAMERON
Cameron County Family Center

CARBON
Jim Thorpe Area School District

CHESTER
Chester County Health Dept.
Maternity Care Coalition
Pottstown Family Center/ Family Services of Montgomery Co.
Kennett Square Family Center
Coatesville Family Center
Einstein Medical Center Montgomery
Oxford Family Center
Chester County Commissioners

CLARION
The Guidance Center

CLEARFIELD
Children's Aid Society of Clearfield Co.
Clearfield County Family Center / Cen-Clear

CLINTON
STEP Head Start

COLUMBIA
Columbia/Montour Home Health And Hospice (Central Susquehanna Community Foundation) / Geisinger
Columbia County Family Center

CRAWFORD
Children's Advocacy Center
Community Services of Venango Co.
Union City Family Support Center
Mercer County Family Center

DAUPHIN
Capital Area Head Start
Tri-County Community Action Program/Dauphin Family Center

DELAWARE
The Foundation for Delaware Co.
National Nurse-Led Center Consortium (NNCC)
Delaware County Family Center

ERIE
Erie Family Center
Erie County Health Department
US Committee for Refugees and Immigrants – International Institute of Erie

FAYETTE
Fayette County Community Action Agency, Inc.

FULTON
Fulton County Family Partnership
Central Fulton School District

GREENE
Greene County Family Center
Blueprints

JUNIATA
Tuscarora IU 11

LAKAWANNA
Lackawanna County Commissioners

LANCASTER
Lancaster County Commissioners
Lancaster General Health-Penn Medicine
Lancaster Family Center/ CAP of Lancaster Co.

LAWRENCE
Lawrence County Family Center

LEHIGH
Allentown Family Center

LUZERNE
Maternal and Family Health Services, Inc.
Susquehanna Health Home And Hospice (Divine Providence)
Outreach Center for Community Resources/Scranton Family Center
Greater Nanticoke Area Family Center
Pittston Area Family Center

MCKEAN
McKean County Family Center

MERCER
Mercer County Family Center
SUMMIT Early Learning, Inc.
Farrell Family Center
Sharon Family Center

MONTGOMERY
Montgomery County Health Dept.
Norristown Family Center
Accion Comunal Latinoamericana de Montgomery County
Montgomery County Commissioners

NORTHAMPTON
Visiting Nurses Assoc. of St. Lukes
Community Services for Children Inc
Marvine Family Center
Family Connection of Easton, Inc.

NORTHUMBERLAND
Infant Development Program
Greater Susquehanna Valley United Way

PERRY
Perry County Family Center

PHILADELPHIA
Health Promotion Council

PIKE
Pocono Medical Center

SCHUYKILL
Schuylkill County Commissioners

SNYDER
Union Snyder Community Action Agency

SOMERSET
The Family Center / Somerset Family Center

TIOGA
Service Access Management, Inc.

WAYNE
Wayne County Family Center

WESTMORELAND
Monessen School District Family Center

WYOMING
Wyoming County Human Services
Guthrie Towanda Memorial
HANDS of Wyoming County

YORK
Child Care Consultants, Inc.