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DOMESTIC VIOLENCE REPORT™

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Courtesy of the PINK Concussion Task Force and the
Editors of *Domestic Violence Report*

Domestic Violence Report is published bimonthly for domestic violence shelters, advocates, scholars, researchers, prosecutors, law enforcement, and legal and counseling professionals serving victims of intimate partner violence. The editors have made a copy of this special issue free for PINK Task Force members.

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Ohio Coalition Works to Address Brain Injury in DV Programs

by Rachel Ramirez

Introduction

Domestic violence programs provide safety, support, and life-saving services. It is critically important that all domestic violence survivors, including those with disabilities, can access and benefit from program services. In recognition of the importance of addressing mental health and brain injury disabilities, the Office on Victims of Crime Vision 21 Initiative selected the Ohio Domestic Violence Network (ODVN) as one of two coalitions in the United States to implement this work through its grant project, OVC FY 2016 Enhancing Access and Attitudinal Changes in Domestic Violence Shelters for Individuals With Disabilities (2016-XV-GX-K012). ODVN used two strategies for this project: (1) equipping local DV program staff to accommodate the needs of survivors and (2) building collaboration with agencies and organizations that work with mental health and brain injury to increase access to services.

Due to the requirements of the project, ODVN, in collaboration with research partner Dr. Julianna Nemeth, Assistant Professor at the College of Public

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Implications of Brain Injury in Abused Women for Advocacy and Health Care

by Jacquelyn Campbell, Jill Messing, Michelle Patch, Audrey Bergen & Andrea Cimino

There is growing research showing that abused women are frequently subjected to repeated head and serious facial injuries as well as strangulation, all of which can cause brain injury with potential long-term chronic neurological symptoms. Prevalence estimates vary with head injuries measured in some samples and strangulation in others while no large scale or population-based studies measure both. In one fairly large study of 732 ethnically diverse abused women to whose homes police were called for domestic violence, 20.3% reported having been “blacked out” from being hit on the head at some

time by the abuser and 23.8% had been choked to unconsciousness by the abuser.¹ The alteration in consciousness signifies a serious enough injury to be considered traumatic brain injury (TBI) according to many definitions. For instance, the American Committee of Rehabilitation Medicine definition is “A traumatically induced physiological disruption of brain function, as manifested by at least one of the following: any loss of consciousness; any loss of memory for events immediately before or after the accident; any alteration in

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About This Issue . . .

We are pleased to present this special issue on the intersections between Traumatic Brain Injury (TBI) and Domestic Violence. Survivors commonly suffer repeated blows to the head and strangulation. This frequent, undiagnosed problem has significant long-term health implications. This special issue includes articles by prominent experts in the country, including Jacquelyn Campbell and Eve Valera who, in their respective articles, discuss the implications of TBI screening for mental health and legal professionals, Rachel Ramirez who discusses innovative services of the Ohio state domestic violence coalition, and Gael Strack and Casey Gwinn, who explain the role of Family Justice Centers in formulating a multi-sector approach to meet survivors’ physical health, behavioral health, and social service needs.

D. Kelly Weisberg, *DVR Editor*

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mental state at the time of the accident (e.g., feeling dazed, disoriented, or confused); focal neurologic deficit(s) that may or may not be transient.”² Research has long documented that abused women have significantly more self-reported neurological symptoms (trouble concentrating, memory loss, dizzy spells, seizures, vision problems, hearing problems) than women who

sustained at least one head and/or facial injury (many had experienced multiple) and/or had been “choked/strangled” by their abuser.⁴ Percentage of the injury in the two samples were:

- 4% and 11% reported a broken/dislocated jaw;
- 5% and 17.5% a head injury with damage to the ear;
- 7.5% and 28.8% a head injury with loss of consciousness;
- 14% and 16.5% dental injuries;

Because many long-term neurological symptoms often co-occur with PTSD symptoms, many abused women have been treated for years for PTSD and other mental health problems without also being diagnosed and treated for their brain injuries.

are not abused.³ However, only recently have we been able to attribute those neurological symptoms to the causal mechanism of TBI.

The most persuasive studies in this regard do not show definitive causality and are not probability samples, but they do give us considerable evidence when taken together. In two fairly large samples of abused women, 538 African Americans and 309 Canadian, 50% of one sample and 65.5% of the second had “probable TBIs,” having

- 14% and 23% an eye injury;
- 61.2% and 16% a facial injury; and
- 18% choking/strangulation (U.S. sample only).

Women who had experienced at least one of these injuries (many had experienced multiple of these injuries) were considered to have a “probable TBI.” In both samples, the women with a probable TBI had significantly more and more frequent neurological symptoms than the abused women

without a probable TBI, even controlling for PTSD and depression in the American sample and persisting over five years in the Canadian sample. In another study, 99 abused women experiencing mild (68%), moderate to severe (10%) or anoxic (27%) or multiple (50%) brain injuries from an abuser were assessed for neuropsychological pathology as well as mental health symptoms. Among 57 of these women, brain injury severity was significantly negatively associated with measures of memory, learning, and cognitive flexibility and positively associated with PTSD, depression, and other mental health symptoms. This is one of the few studies that actually used measures of cognition versus self-reported neurological symptoms.

We also hear from advocates in domestic violence programs that abused women are having many of those long-term neurological symptoms. Because the symptoms are often co-occurring with PTSD symptoms, many have been treated for years for PTSD and other mental health problems. Other systems (such as child welfare or legal) may misinterpret abused women missing appointments or failing to follow through on plans to achieve goals as an inability to prioritize, not caring, or not being “ready” to take action when, in reality, these are

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To See or Not to See: Concussions Behind Closed Doors

by Eve Valera*

When most people hear about concussions, they tend to think of athletes, military personnel, or perhaps a friend who was in a car or bicycle accident. Over the past years, there has been a growing awareness of the negative effects of concussions, and the importance of protecting the brains of athletes and military personnel from concussions, and especially *repetitive* concussions. What was once just a “bump on the head” is now considered to be a potentially serious and dangerous concussion or mild traumatic brain injury (mTBI) for these groups of people.

Whereas, this is all a step in the right direction with respect to head trauma in athletics and the military, there is one group of people that is being largely left out of this conversation, namely women who have sustained concussions by being beaten by their partners—women who have experienced intimate-partner violence (IPV). Unfortunately for these women, these concussions tend to occur “behind closed doors,” which among other factors contributes to the lack of attention and care these women need and deserve. In this commentary, I will discuss my beliefs about this issue and provide a hypothetical scenario in an effort to raise awareness so that appropriate stakeholders—including lawyers, judges, police officers, paramedics and domestic violence advocates—are in a better position to effectively work with women who have experienced IPV.

(Please note that, in this commentary, I refer to instances where women are abused by men because those are the cases that I have been able to study thus far. In no way is this a suggestion

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that this is the only type of partner violence that occurs.)

The Concussions That We See and Recognize

While watching the World Cup, I remember seeing a player get kicked in the head when both his head and another player’s foot went for the ball. As the kicked player lay there on the field, I wondered how serious the hit was. He was helped off the field and it appeared that he had sustained a concussion. Everyone could see the force involved with that collision. On another occasion, watching American Football, I saw a player sustain a hard

and lacerations on my face, it was clear that I had smashed my face into the pavement at least once.

Concussion stories such as these are fairly common, and the general public has come to expect and—more or less—recognize a concussion in these situations. It would be understandable that the athletes and I may have certain difficulties after our concussions. We may not remember what happened or be confused, off-balance, disoriented, or “out-of-it” immediately after the incident. In the following days, we may expect to experience headaches, need more sleep, not be able to think as well or clearly as we usually do, and possibly

It is critical for relevant stakeholders—including legal, judicial, law enforcement and social work personnel—to consider the possibility of IPV-related TBI in every woman who has experienced IPV.

hit after which his head bounced off the ground. He too lay there and then was helped off the field. He did not come back into the game. Once again, everyone saw the hit and knew that he had sustained a concussion. In this case, the concussion protocol was put into effect, which meant that he would only be returned to play once his concussion symptoms had resolved.

On yet another occasion, I was racing my son to the mailbox while riding on his toy scooter (non-motorized but far too small for me) and the next thing I remembered was me facing the other direction picking myself up off the ground while blood dripped from my forehead. As my son was too far ahead of me, no one was there to see whether I sustained a brief loss of consciousness or suffered amnesia for the moments during and surrounding the fall. Nonetheless, it was clear that I had sustained a concussion once I arrived in a panic back at the house and could not tell my husband exactly what had happened. It was rather unnerving that I could not remember how my face had gotten so disfigured, but from the visible bruises

need more help doing everyday tasks. A medical professional knowledgeable about concussions should advise us to take it easy for the next few days, ease up on tasks or behaviors that aggravate the symptoms, and get more sleep as needed. By following this advice, the concussive symptoms are likely to resolve more quickly than if no symptom-based modification of behavior occurs. In short, appropriately modifying behavior is critical for optimal and rapid recovery from a concussion. However, before modification of behavior can occur, relevant parties need to recognize that a concussion has actually occurred. For concussions that occur “behind closed doors” a lack of recognition is likely to be the first major barrier to recovery and understanding.

The Concussions We Are Missing

Concussions that occur behind closed doors, and possibly in such a way that no marks are left behind, may go completely unrecognized. As a result, post-concussive symptoms and behav-

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iors may be misinterpreted and left untreated. It is my belief that this may be the case for many women sustaining concussions or mTBIs from IPV. Because IPV usually occurs “behind closed doors,” the hit or force to the head is typically not observed by any outsiders (in contrast to what occurs in athletics where many people observe it). Also, as brain injuries can occur with no visible external injuries, there may be no evidence (unlike my case above) that a brain injury has occurred. What is ultimately observable are a range of post-concussive symptoms¹ that could easily be misinterpreted as intoxication, untruthful, unreliable and/or uncooperative behavior, non-compliance, and

porches (Valera & Kucyi, 2017). Furthermore, women who have experienced IPV commonly report a range of symptoms that are consistent with post-concussive symptoms (e.g., headaches, irritability, poor concentration, forgetfulness, sleep disturbances). For example, we recently showed that 63% of the women interviewed met criteria for post-concussive syndrome in reporting at least three of the 16 possible post-concussive symptoms asked about (Valera & Kucyi, 2017). Putting all of these data together, we have a sizable amount of evidence that women who are seen in law enforcement, legal, or help-seeking settings, may very well have suffered from at least one mTBI/concussion from her partner. As such, identifying whether a woman has exper-

by helping to understand the cause of the symptoms.

What Does an mTBI Behind Closed Doors Look Like?

Similarly to above, someone suffering an mTBI behind closed doors may experience the symptoms of feeling disoriented, confused, distractible, dizzy, off-balance, or irritable. They may also have these and or other symptoms that persist for days or weeks later. However, when the mTBI is not observed by an external party—as is often the case for women who suffer IPV-related TBIs—the interpretation of these symptoms and the subsequent management of the TBI could be very different.

Let’s consider a possible scenario in which a woman suffers an mTBI from her partner behind closed doors. A neighbor hears yelling and arguing from the house next door, and calls the police to investigate. When the officers arrive at the scene, they see a woman who appears off balance, irritable, and disoriented. Whereas she states that she cannot really recall what happened, the abuser is calm and able to provide a consistent account of what occurred. He says it was just a verbal argument but the argument is over. The woman, having no visible injuries, says she is ok and the police leave. The woman assumes she is “out of it” because of the heated argument that just occurred. She remembers that he pushed her against the bedroom wall very forcefully, but then cannot figure out when and why she went into the kitchen. In the following days, she has headaches and still “does not feel right,” it seems to take her longer to do things so she works even harder at getting things done and then feels even worse after pushing herself. She may feel depressed and frustrated which makes life at home even more difficult. In this hypothetical scenario, the woman sustained a concussion when her head smashed against the wall in the bedroom and she has post-traumatic amnesia for when she stumbled into the kitchen to escape the abuser (which is why she cannot figure out how she got into the kitchen). However, as the mTBI was not observed by anyone but the abuser, it was not recognized as such an injury. Ultimately, an mTBI unobserved by an external

Someone suffering an mTBI behind closed doors may experience the symptoms of feeling disoriented, confused, distractible, dizzy, off-balance, or irritable.

laziness (among others). For women who have sustained IPV-related mTBIs, misinterpreting behaviors as such can have serious implications for recovery as well as shelter assistance and legal decisions. Therefore, it is critical for relevant stakeholders—including legal, judicial, law enforcement and social work personnel—to consider the possibility of IPV-related TBI in every woman who has experienced IPV.

Why Should We Consider the Possibility of an mTBI in Every Woman Who Has Experienced IPV?

Although good epidemiological data are lacking, current estimates of women sustaining TBIs from their partners are high. My own work shows rates of 74% and 51% respectively for single and repetitive TBIs sustained by a partner (Valera & Berenbaum, 2003). Most of these TBIs were mild TBIs.

Other data indicate that up to 90% of injuries women sustain are to the neck and higher (Arosarena, et al., 2009; Wu, Huff & Bhandari, 2010). Women report being hit in head with fists or hard objects (e.g., bats), having their heads slammed against hard objects (e.g., floors, walls and car windows), having their heads stomped on, and being thrown down stairs and off

rienced an IPV-related TBI is critical in determining the most appropriate way to interact with and support a woman who has experienced IPV.

What Does an mTBI Look Like?

When someone sustains an mTBI or concussion, they may immediately experience a number of symptoms, including feeling disoriented, confused, distractible, dizzy, off-balance, or irritable. They may have a headache, feel tired, or have an inconsistent recollection of what has happened. When the mTBI is observed by an external party, these symptoms may be appropriately interpreted as resulting from the blow to the head. There is usually concern for the welfare and health of the person who has suffered the mTBI, and medical attention may be sought. In the ensuing days, the concussed individual may be advised to “listen to their body” to guide how much to do, and to stop behaviors that aggravate the post-concussive symptoms. The concussed individual may continue to feel his or her initial symptoms, as well as need more sleep, feel depressed, not be able to “think straight,” or may have a tough time “getting anything done.” However, appropriate acute management of the mTBI should facilitate the recovery process and reduce frustration

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Family Justice Centers Point Way to Address Survivors' Medical Needs

by Casey Gwinn & Gael Strack*

Tanika's Story

Tanika was strangled by her husband in San Diego. Police were called to her home. At the scene, Tanika had no visible injuries and was not sure if she had lost consciousness. Nevertheless, her husband was arrested for placing her in a "chokehold" during his assault. Tanika declined paramedics at the scene. Days later she came to the San Diego Family Justice Center seeking to obtain a restraining order against her husband. Because police, prosecutors, and advocates were co-located in the Family Justice Center, she was offered the chance to connect with her detective on the case, Sylvia Vella. Sylvia was specially trained in the dynamics and physiology of non-fatal strangulation assaults after attending our four-day course at the Training Institute on Strangulation Prevention.

Detective Vella noted during her follow up contact with Tanika, four days after the assault, she had a small bruise behind her right ear, but no other visible injury. Tanika was a nurse and felt there was no need for further medical intervention or examination. She said she felt fine. But Sylvia was concerned: First, the bruise indicated a potential sternocleidomastoid injury—a possible tear to the muscle that controls turning one's head.

Also, she was concerned that the mechanism—a rear chokehold—might have included an upward pulling motion making a carotid dissection more likely. Detective Vella and Tanika talked about it and Tanika felt she was OK. But Sylvia Vella would not take "no" for an answer. She urged Tanika to go to Scripps Mercy Hospital for a Computed Tomography Angiography (CTA) imaging test. Scripps is the only Level One Trauma Center in San Diego. Tanika delayed for two days but finally agreed to go to the hospital, six days after the assault.¹

neck trauma and was asymptomatic, Tanika would have likely suffered a major stroke and may have died. The doctor would have faced a major malpractice lawsuit.

Today, our Training Institute on Strangulation Prevention has successfully advocated for the CTA to become the gold standard for evaluating arterial injuries in strangulation assault victims.² We also now know that the chances of a strangled victim suffering a carotid dissection is one in 47³ as opposed to less than one in 1,000 as previously suggested in 1990.⁴

Professionals are integrating their services under one roof—police officers, prosecutors, advocates, doctors, nurses, therapists, and others—to allow survivors of domestic and sexual violence to come one place for help.

Dr. Kimberly Peck saw Tanika in the Emergency Room and assessed her minor bruising behind her ear, but there was no other significant symptomatology. Tanika explained Detective Vella's concern about a possible internal injury. The doctor was skeptical. Tanika told Dr. Peck that she did not think she could go back to the San Diego FJC and face Detective Vella unless she did an imaging test. Dr. Peck was annoyed but ordered the test. The doctor was so certain there would be no positive findings that she prepared her discharge instructions without even receiving the findings. Tanika waited to be discharged until the results came back. The doctor was wrong. The finding was positive. Tanika had bi-lateral carotid dissections on both sides of her neck. She was minutes, days, or weeks from a massive stroke and permanent brain damage or death. Blood thinners for nine months were all that was required to save Tanika's life.

Had the doctor failed to order a life-saving CTA and discharged her home, because she had no visible

Family Justice Centers: Integrated, Trauma-Informed, Hope-Centered Approaches for Survivors

Today, across America, communities are developing Centers like the San Diego Family Justice Center where professionals are integrating their services under one roof—police officers, prosecutors, advocates, doctors, nurses, therapists, and others—to allow survivors of domestic and sexual violence to come one place for help. With Family Justice Centers in 40 states and 25 countries, research is documenting the power of integrated, trauma-informed, hope-centered approaches that allow survivors to come one place for assistance.

We created the first Family Justice Center in San Diego, CA in 2002. But the framework for the San Diego Family Justice Center was first laid in 1990 when we co-located professionals from seven agencies in the San Diego City Attorney's Office. Early on in our work as prosecutors,

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*Casey Gwinn is the former elected San Diego City Attorney and now serves as the President of Alliance for HOPE International. In 2018, he received the Ronald Wilson Reagan Public Policy Leadership Award from the U.S. Department of Justice. Casey's newest book, *Hope Rising: How the Science of HOPE Can Change Your Life*, co-authored with Dr. Chan Hellman, focuses on the transformational power of increasing measurable hope in the lives of trauma survivors. Email: Casey@allianceforhope.com

Gael Strack served as the first director of a Family Justice Center in the United States. She has been previously recognized as the San Diego County Bar Association Attorney of the Year and now serves as the Chief Executive Officer of the Alliance. Email: gael@allianceforhope.com For more information about the work of Casey Gwinn or Gael Strack, go to www.allianceforhope.com.

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survivors started talking about wanting to come one place for help. We applied the Coordinated Community Response approach of Ellen Pence in Duluth and started working on consistent protocols for police officers, prosecutors, advocates, and batterers' intervention programs but we felt it should go further by creating a multi-sector collaborative under one roof. Between 1990 and 2002, we colocated, at least on a part-time basis, detectives, prosecutors, community-based and system-based advocates, child trauma advocates, and civil legal service providers. Though our model

have to go the Emergency Room for their medical needs. Given the choice between a trauma-informed, kind, caring, supportive environment of a Family Justice Center and the chaos, delays, and crisis of a hospital emergency room, what victim would ever choose an emergency room? We knew then what research has now confirmed: victims do not want to seek medical services in a hospital setting.⁵ We also knew that victims were not just experiencing strangulation assault-related injuries. They were experiencing traumatic brain injuries from other types of assaultive behavior as well. Recent research has identified those injuries include skin and soft tissue injuries,

high-risk victims coming into Family Justice Centers ranging from 60-80%, it is imperative that clinical assessments be conducted for these survivors.⁷

Who is providing the needed medical services in Family Justice Centers? Some Centers are using sexual assault nurse examiners (forensic nurses) to conduct domestic violence examinations. Others are using registered nurses and providing them with the specialized training they need. When primary care is being offered, it is doctors, physician's assistants, and nurse practitioners taking the lead role with survivors.⁸

In more than 200 Focus Groups conducted with survivors of domestic and sexual violence since 2004, we have consistently heard survivors talk about the waiting times, chaos, and the impersonal nature of hospital emergency rooms across the United States. Survivors are often reluctant to even go to a private doctor's office, knowing that no other services for violence or abuse are available there. When offered the chance to receive non-acute medical care in a Family Justice Center medical unit instead of an emergency room, 100% of survivors in our focus groups have expressed a desire to come to a Family Justice Center rather than an acute care hospital setting.

While the most requested and identified medical needs/services for adult and child survivors involve dental and vision care, our major Health Survey in 2013 found that survivors do not realize the significant health issues they may be experiencing from strangulation and concussive assaults including traumatic brain injury (TBI).⁹ TBI has been defined as "an alteration in brain function or other evidence of brain pathology, caused by an external force that may result in cognitive impairment."¹⁰ TBI can also include anoxic and hypoxic incidents from strangulation.¹¹ Researchers have found that "mild traumatic injury is the most underreported type of TBI as many people do not seek medical attention, often self-diagnosing with a concussion and making a false assumption that the condition will not be associated with further side effects."¹² The numbers are stunning. A new study from The Ohio State University and the Ohio Domestic Violence Network estimates that 81% of

The San Diego Family Justice Center opened on October 10, 2002 and immediately changed the paradigm of how services could be provided to victims of domestic and sexual violence and their children.

was not comprehensive in the 1990s, and did not include medical services, it was clear that we had more capacity to help survivors and coordinate our responses if we lived together under one roof every day.

In 1996, after Casey was elected as the San Diego City Attorney, we committed to figuring out how to create a much larger collaborative framework. It took nearly four years to conduct a community assessment and plan a model, but in October 2002, we opened the largest multi-agency collaborative ever created in the United States—staff from 25 agencies colocated in 40,000 square feet in downtown San Diego. The San Diego Family Justice Center opened on October 10, 2002 and immediately changed the paradigm of how services could be provided to victims of domestic and sexual violence and their children. With the opening of the Center came the creation of the Forensic Medical Unit, a doctor and a nurse working full-time at the Center providing domestic violence forensic exams, screening of children's health issues, and well-baby checks—sponsored by Sharp Healthcare—from right inside the Center. We rejected the notion that victims should

head and neck, neurological and cardiovascular, broken bones, and other types of injuries.⁶ The original Family Justice Center approach to medical services was clearly a new and responsive model for helping survivors.

Our medical services model is now catching on across the country, as more and more Family Justice Centers are opening Forensic Medical Units, Health and Wellness Programs, and even offering Primary Care services. The New Orleans Family Justice Center recently opened the Hope Community Health Clinic offering forensic examinations for domestic and sexual violence victims onsite and Primary Care services for adult and child survivors. Director Mary Claire Landry, who took a community-based sexual assault, domestic violence agency and morphed it into a dynamic Family Justice Center says it this way: "If we are going to give victims hope, we must meet their healthcare needs onsite without sending them off to the Emergency Room for help." While victims in need of acute care must go to an Emergency Room, most victims don't need a trauma center to address their health issues after domestic and sexual violence. With strangulation rates of

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PINK Concussions Task Force Brings Together Brain Injury and DV/IPV Experts

by Katherine Snedaker*

The numbers of women who have brain injury inflicted by a violent partner are estimated to be staggeringly high—higher than NFL players or those who are injured in military service. As brain injury from domestic violence/intimate partner violence (DV/IPV) has been rarely discussed in medical conferences or in news stories, an international taskforce was launched in 2019 by the non-profit, PINK Concussions to change the status quo. This article will discuss the origins, mission, and available resources of this taskforce as it serves to connect brain injury researchers and frontline DV/IPV practitioners worldwide as well as serve as a resource for reporters writing articles on this topic.

PINK Concussions was a natural host for this task force as it was originally founded in 2012 as a website to serve as an information hub to bring together brain injury research from the sport, domestic violence, and military research silos. PINK Concussions became a 501(c)(3) non-profit charity in 2015, and in 2016, hosted the first stand-alone medical research summit on brain injury in women which included experts presenting brain injury research from the sports, domestic violence, and military fields.

Beginning to Study Brain Injury in Women

Brain injury in men has been explored in research as well as in the press for centuries through the lenses of sports and military service. From the battlefield to the sporting arena, the specific focus on this injury in men has left women out of the conversation, research, and media coverage, especially around the topic of brain injury from domestic violence.

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As awareness of sex and gender-based differences in brain injury has grown in the last decade, there is emerging new research on women's brain injury in both sport and military concussion research. And with the publication of this new research, the press is starting to respond and write more articles about women and brain injury.

Alongside the larger conversation about female athletes and brain injury, there is a fledgling group of

ideas, both groups were, for the most part, publishing and presenting within their own silos.

This task force was created to bridge this gap and to improve the lives of those impacted by violence by creating an open space for learning, inspiration and collaboration among those working in brain injury and gender-based violence. Information about the task force, recordings of past calls, and links to press on group members

The numbers of women who have brain injury inflicted by a violent partner are estimated to be staggeringly high—higher than NFL players or those who injured in military service.

professionals who have been researching brain injury in women resulting from intentionally inflicted violence by their partners. Historically, it has been assumed by the medical community that symptoms observed in and reported by women who experienced domestic violence were solely the result of psychological trauma; however, now the experts in this field are discovering the signs and symptoms to be more associated with TBI. Brain injury had not been considered by survivors and professionals working with survivors as a possible impact of the violence; and the “life difficulties” these women faced were chalked up to either a mental health issue or the result of trauma and the experience of DV.

Bridging the Gap

As brain injury researchers in academia began to raise concerns regarding the brain injuries that could be caused by domestic violence, practitioners in the DV/IPV field began to wonder if brain injury was part of the trauma experienced by their clients. While it seems logical there should be a place for these two groups of researchers to connect and compare

can be found at on the PINK Concussions website at <https://www.pinkconcussions.com/violence>.

Leading the Task Force

In 2018, six professional women across three U.S. states and from Canada came together to form the leadership of this new task force with their combined body of research that has examined domestic violence-related brain injury in civilian and military populations.

Katherine Snedaker, LCSW, is the Founder and Executive Director of PINK Concussions. She is an international keynote speaker, advocate, clinician, researcher, and change agent raising awareness for sex and gender differences in brain injury since 2012, when she created the *PINKconcussions.com* website. Snedaker has produced seven International Summits on female brain injury with hosts such as Georgetown University Medical Center, Palo Alto VA Healthcare System, International Brain Injury Association, the International Conference on Paediatric Acquired Brain Injury,

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Case Law Summaries

by Anne L. Perry

Ohio: Guilty Plea to Domestic Violence, Attempted Murder Was Knowing and Voluntary, Request for Withdrawal Denied

Background. Defendant Ronald Magby and his girlfriend were present in his home when a fire broke out. Only Magby sustained injuries; he was taken to the hospital. Upon his release, he was arrested for intentionally causing the fire with his girlfriend in the house. Magby was ultimately charged with seven counts, including aggravated arson, kidnapping, attempted murder, assault, and domestic violence. He initially entered a not guilty plea, then reached a plea agreement, pleading guilty to five of the charges with two others dropped. The State agreed to sentence Magby to eight years. He was required to register as an arson offender.

At his plea hearing, when the trial court asked if Magby understood he was admitting to committing the charged crimes, Magby replied, “No, I didn’t commit none of them crimes.” The court conversed further with Magby and his counsel, informing him that the potential cumulative sentence if he was found guilty on all seven counts was 64 and one-half years of incarceration. Eventually, Magby accepted the plea agreement.

Subsequently, prior to his sentencing date, Magby filed a *pro se* motion to withdraw his guilty plea. A week later at the sentencing hearing, Magby and his counsel both confirmed that he was withdrawing his motion to withdraw his guilty plea. The trial court merged several convictions and ordered concurrent sentences for others, for a total of eight years in prison.

Two weeks later, Magby filed another *pro se* motion to withdraw his guilty plea and appealed the trial court judgment. The trial court denied the motion, which became part of the appeal.

The Appeal. The Court of Appeals of Ohio first considered Magby’s argument that the trial court erred in providing inaccurate information as to his potential maximum sentence, rendering

his plea involuntary. He argued that the advisement of 64 and one-half years was incorrect because the many of the counts would have merged for sentencing, as evidenced by his own sentencing. He further argued that the trial court failed to fully advise him of the lifetime arson registration. The court reviewed the trial court’s advisements for “substantial compliance” with the mandate to ensure that the defendant understands the implications of his plea and the rights that he is waiving. Here, both the State and Magby’s counsel agreed that the potential maximum sentence faced by Magby, with no merger and no concurrent sentences, was 64 and one-half years. The court determined that the “maximum penalty” referred to the “sentence for each charge rather than the cumulative total of all sentences for all charges to which the defendant is pleading.” Nor was the court convinced that the trial court failed to advise him about the arson offender registration requirement, as Magby specifically acknowledged his understanding.

Moreover, even if the court had not reviewed this requirement, it was the duty of prison officials to provide this notification to Magby, not the court. Here, the trial court properly informed Magby and “substantially complied” with the advisements.

Finally, the court noted that the standard for withdrawal of a guilty plea after a judgment of conviction and sentencing is “fairly stringent” and only granted to correct “manifest injustice.” Magby argued that the victim, his girlfriend, lied about material facts relating to the case and that he was informed by his counsel that in order to get medical treatment for his burns, he had to plead guilty. The court found that Magby’s motion to withdraw his plea had no evidentiary documents attached to it, so he did not satisfy his burden in his motion to withdraw his guilty plea. As the trial court’s ruling were correct, the judgment was affirmed. **State v. Magby**, 2018 WL 7625584 (Ohio Ct. App. 2018).

Editors’ Note: Ohio news reports about this November 2015 incident include terrifying details. Magby was said to have beaten his girlfriend with a baseball bat; tied her to a chair with plastic zip ties to prevent her escape; and doused the bedroom with kerosene before attempting to cut the gas lines to the home. He sustained severe burns through his actions to eliminate her. Litigation continued in 2019 as inmate Magby sued the prison system for negligent medical care for “pre-incarceration injuries.”

Nevada: Court Properly Admitted Prior Acts of Domestic Violence; Attempted Murder and Domestic Violence Convictions Upheld

Background. Defendant Eric Ryan Scott was convicted by jury of attempted murder with the use of a deadly weapon and battery with the use of a deadly weapon resulting in substantial bodily harm against one victim, and of battery constituting domestic violence against a second victim, his girlfriend. The girlfriend testified at trial that Scott did not batter her. The State presented a witness who testified to seeing bruising on the girlfriend and that the girlfriend attributed it to Scott’s abuse. The district court ruled that this testimony was not inadmissible hearsay because it was admitted as a prior inconsistent statement to the girlfriend’s trial testimony. The court also immediately gave a limiting instruction. Scott appealed, arguing that the district court improperly admitted evidence that he previously committed domestic violence against his girlfriend. He further contended that the State presented insufficient evidence to support his convictions. Finally, he argued that the State committed prosecutorial misconduct during its closing argument.

The Appeal. The Supreme Court of Nevada first reviewed the prior bad acts evidence, admissible when the evidence is relevant to the charged crime “for a non-propensity purpose” and the danger of unfair prejudice does not substantially outweigh the probative

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Boston Children's Hospital, and Mount Sinai. Snedaker has published in peer reviewed journals, presented a number of international keynotes, and also moderated online support groups for over 5,000 women, caregivers, and medical professionals.

Dr. Eve Valera is an Associate Professor in Psychiatry at Harvard Medical School, and a Research Scientist at Massachusetts General Hospital. She has been working in the field of domestic violence for nearly 25 years. Her current work uses a range of methodologies to understand the neural, neuropsychological, and psychological consequences of traumatic brain injuries (TBIs) resulting from intimate partner-violence (IPV). She published one of the first studies examining the prevalence of IPV-related TBI and its relationship to cognitive and psychological functioning, and has more recently provided the first neural mechanistic evidence of IPV-related TBI. Her work is ongoing and expanding to address other potential neural consequences of TBIs from partner violence.

Dr. Angela Colantonio is the Director of the Rehabilitation Sciences Institute at the University of Toronto where she held a Canadian Institutes for Health Research Chair in Gender, Work and Health. She is also a Senior Research Scientist at the Toronto Rehabilitation Institute-UHN. Dr. Colantonio leads a broad, internationally recognized program of research on acquired brain injury (ABI) that includes a major focus on women and sex/gender analyses. She has authored over 200 publications and has presented to over 400 research, clinical, and lay audiences. Dr. Colantonio co-leads an international task force on Girls/Women with TBI and serves on the Board of Brain Injury Canada. She is a Fellow of the American College of Epidemiology, the American Congress of Rehabilitation Medicine, and the Canadian Academy of Health Sciences. In 2015, she was awarded the Robert I. Moody Prize for Distinguished Initiatives in Brain Injury Research and Rehabilitation.

Halina (Lin) Haag, MSW, RSW, is a Ph.D. candidate at Wilfrid Laurier

University's Faculty of Social Work and member of the research team at the University of Toronto's Acquired Brain Injury Research Lab. Her work focuses on women survivors of intimate partner violence with resultant brain injury, exploring factors influencing mental health, return to work, and social inclusion. As part of an interdisciplinary research team, she recently completed a project exploring brain injury awareness in intimate partner violence service agencies and developed an educational tool kit to be used in this arena. She is committed to improving outcomes through direct practice, innovative research, and professional education, believing that increased knowledge and understanding in the community is key. As someone with lived experience of TBI, she has been a guest speaker addressing issues of disability, brain injury, and marginalization for a variety of international academic, professional, and community-based organizations. Her work is generously funded by the Ontario Women's Health Scholar Award.

Rachel Ramirez, LISW-S, RA, is the Founder and Director of The Center on Partner-Inflicted Brain Injury, a project of the Ohio Domestic Violence Network. The Center provides statewide, national, and international leadership to raise awareness on the emerging area of brain injury caused by domestic violence. The Center increases collaboration among systems, and provides training, technical assistance, consultation, research, and resource development for researchers and direct service providers. For the past 13 years at ODNV, Ramirez has led multiple initiatives on trauma-informed approaches, mental health and substance use, with a recent national focus on partner inflicted brain injury. She co-authored *Trauma-Informed Approaches: Promising Practices and Protocols for Ohio's Domestic Violence Programs*, which was originally published in 2010 and revised in 2019, and has published peer-reviewed articles in the *Family Violence* and in the *Journal of Aggression, Maltreatment & Trauma*.

Katherine Iverson, Ph.D., is a clinical psychologist and Investigator in the Women's Health Sciences Division of the National Center for PTSD at the VA Boston Healthcare System

and Associate Professor of Psychiatry at Boston University School of Medicine. Dr. Iverson specializes in developing, implementing, and evaluating healthcare-based interventions for intimate partner violence (IPV), particularly screening and counseling services for which she received the Presidential Early Career Award for Scientists and Engineers. She collaborates on implementation of trauma-informed services with the Veterans Health Administration's IPV Assistance Program and VHA's Office of Women's Health Services. Her research has highlighted TBIs from IPV among women veterans as well as TBIs and mental health symptoms resulting from military experiences (*i.e.*, deployment-related TBIs). Overall, she aims to translate research into clinical practice in order to enhance detection and treatment of posttraumatic stress disorder, TBI, and other mental health comorbidities that are common among women who experience IPV. Her work is funded by VHA's Health Services Research and Development Services.

Naming of the Task Force

When first established, the task force was called the Domestic Violence/IPV and Traumatic Brain Injury TBI Brain Task Force. Over the first few months, the group struggled to find more concise language to include both domestic violence and intimate partner violence. Also the group changed from using the term "TBI" to the term "brain injury" to be inclusive of brain injury from strangulation. They continued the search for the best terminology to use for the name of the task force to describe the type of brain injury and how it was caused.

While presenting at the Ohio University State Conference on Brain Health, Snedaker heard a presentation by Clare Edwards, MPH, CPH, who had coined the term "partner-inflicted brain injury" as a part of her MPH thesis work for the University of Pittsburgh's Graduate School of Public Health. Edwards had been involved in women's rights activism for several years with an academic background in neurotrauma and her thesis work focused on brain injury among

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survivors of domestic violence. Ramirez had been supportive of using this term since she heard it in early 2017, so Snedaker and Ramirez brought Edwards's term back to the leadership of the task force. Thus the task force decided to update their name to PINK Concussions Partner-Inflicted Brain Injury Task Force.

The Origins of the Task Force

The origins of this task force can be traced to December 2017, when NIH hosted a two day workshop: Understanding Brain Injury in Women Workshop. This event was conceptualized

to discuss the gestalt of their work and the need to collaborate more on this under-researched, under-funded area of TBI. Many of the participants in the audience had not considered the relationship between domestic violence and brain injury and there were a number of questions from the floor expressing a desire to learn more.

PINK Concussions sponsored a lunch symposium on Day One which included women sharing their experience of brain injury from sport, work-related injury, and violence. One of the most moving accounts that day was a woman sharing her personal story of the violence she suffered 23 years ago from her then-husband and

Colantonio, Haag, and Ramirez to launch a task force as a next step in their work together; and in January 2019, the PINK Concussions Partner-Inflicted Brain Injury Task Force launched their first call with 20 members. During the following 11 months, the Task Force has held nine conference calls and has grown to 130 members from 28 U.S. States, four Canadian Provinces, and five countries.

The initial goal of the task force was to create an open space for learning, inspiration, and collaboration among those working in brain injury and gender-based violence. After the first two calls where members introduced themselves and shared their interests, the leadership team decided the call provided an excellent opportunity to offer continuing education to its members and added one or two expert speaker presentations to each call to broaden the knowledge of task force members. The guest speakers on the task force have included some of the top researchers and cutting edge projects in the domestic violence/TBI fields in both civilian and military populations.

Past calls were recorded and include leadership updates, the presentations by world experts and time for members to ask questions or share resources. Recorded calls are linked on the PINK Concussions website and anyone (not just members) can play back the calls. A number of reporters have already used these calls when gathering information for articles. Here is a sample of some of the past calls and these calls are available for playback.

On the June call, Dr. Hirsch Handmaker, the Chairman and CEO of The CACTIS Foundation, and Carrie Borgen presented on the Sojourner MC3DV Collaboration in Arizona, which addresses the issue of concussions in survivors of intimate partner violence. The program includes all of the systems with which women exposed to domestic violence may be in contact; beginning with law enforcement, facilitating contact with forensic nursing, advocates, social workers, and opportunities for immediate shelter and neurological/neurocognitive assessments. The project hopes to better understand both the short- and long-term implications of concussions for survivors of domestic violence.

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There is a strong need for additional resources used to investigate IPV-related TBI and that, in order to move this new field forward, it is essential to have more opportunities to bring together like-minded individuals, researchers, and practitioners from the brain injury and the domestic violence fields, together on a regular basis.

through multiple discussions of shared interest among PINK Concussions, TBI researchers, and NINDS Program staff to put a focus on sex and gender differences in traumatic brain injury. PINK Concussions participated as a member of the agenda development working group for the workshop that was sponsored by multiple NIH ICs¹, the VA, and DVBIC (Defense and Veterans Brain Injury Center). A summary of the meeting can be found on the NINDS website and the entirety of the meeting can be viewed via NIH VideoCast.

On Day One of the NIH workshop, Snedaker moderated the session on "TBI as a Consequence of Intimate Partner Violence" where some of the top researchers in the field of Domestic Violence presented their data: Jacquelyn Campbell, Ph.D., RN, Johns Hopkins University; Eve Valera, Ph.D., Harvard Medical School; Jessica Gill, Ph.D., RN, NIH National Institute of Nursing Research; and Katherine Iverson, Ph.D., Boston University. Then the group sat on a panel

her subsequent week long hospitalization from her injuries. Again, the audience was surprised to hear about brain injury in domestic violence as it has not been a common topic at most brain injury conferences.

On Day Two of the NIH workshop, Snedaker moderated the work session, "TBI as a Consequence of Intimate Partner Violence," which drew a large crowd of over 50 researchers as well as practitioners interested in finding more resources, data, and funding for DV-TBI research. One of the conclusions of the workshop was that there is a strong need for additional resources used to investigate IPV-related TBI and that, in order to move this new field forward, it is essential to have more opportunities to bring like-minded individuals, researchers, and practitioners from the brain injury and the domestic violence fields together on a regular basis.

Creating the Task Force

After continuing to present together at several conferences in 2018, Snedaker approached Valera, Iverson,

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On the July call, Dr. Jacquelyn Campbell (Johns Hopkins University) presented on Strangulation and Brain Injury. Dr. Campbell is a national leader in research and advocacy in the field of domestic violence or intimate partner violence (IPV). She has authored or co-authored more than 230 publications and seven books on violence and health outcomes. Her studies paved the way for a growing body of interdisciplinary investigations by researchers in the disciplines of nursing, medicine, and public health. Her expertise is frequently sought by national and international policy makers in exploring IPV and its health effects on families and communities.

In the August call, Dr. Hirsch Handmaker and Dr. Jonny Lifshitz presented on traumatic brain injury and domestic violence victimization. Their presentation was based on their publications on these topics in the *Journal of Aggression, Maltreatment & Trauma*, Vol. 28, Nos. 6 and 7 (2019).

In the September call, Halina (Lin) Haag, MSW, RSW, presented the Abused and Brain Injured Toolkit, available on the Canadian website at abitookit.ca. Lin Haag is one of the team members who created the website. The purpose of the website is to increase awareness and education and to share resources about the intersection of traumatic brain injury and intimate partner violence. Intended for direct service providers, it is an easy-to-use site to quickly find basic information, while also providing access for a deep dive into all the latest research and science. For women survivors and the general public, the site uses clear, simple language with personal stories to create a sense of shared experience and understanding.

In October, Tara E. Galovski, Ph.D., the Director of Women's Health Sciences Division, National Center for PTSD and Associate Professor of Department of Psychiatry, Boston University School of Medicine, VA Boston Healthcare System, presented her work examining the impact of head injury on the effectiveness of Cognitive Processing Therapy (CPT) in treating PTSD, depression, and related factors in women (civilian) survivors of IPV with and without a history of TBI/HI.

Dr. LeAnn Bruce also presented on the October call. She is the National Program Manager for the Intimate Partner Violence (IPV) Assistance Program under the National Care Management and Social Work Office, Department of Veterans Affairs. Dr. Bruce presented research on the Veteran prevalence of IPV and Co-morbid issues and risk factors. She also presented on the VA's Intimate Partner Violence Assistance Program and its guiding principles and model for service delivery. For over 25 years, Dr. Bruce has been involved in the prevention and intervention of Domestic Violence and Intimate Partner Violence across a variety of

tight deadlines to write articles and may not have the time or the access to contact top experts. To help increase the number and quality of articles on partner-inflicted brain injury, members of the PINK Task Force have been very active in helping reporters obtain interviews with those people with lived experience as well as facilitating easy access to top experts in the field.

In addition to bringing together this strong network of experts, the PINK Concussions Task Force has helped promote many subsequent news articles on the topic of partner-inflicted brain injury. As PINK Concussions has almost 8,000 social media followers in over

PINK Concussions has almost 8,000 social media followers in over 80 countries, and excellent connections with reporters.

settings throughout her social work career serving active duty military, Veterans and their families.

In November, Peggy Reisher, MSW, the executive director of the Brain Injury Alliance of Nebraska (BIA-NE), shared the results of The Nebraska 2019 Report. BIA-NE and its partners have increased brain injury recognition, assessment, and management in programs serving survivors of domestic violence. Reisher has 25 years of experience working with and advocating for individuals with brain injury and their families across the state of Nebraska.

Ann Hayne also presented on the November call. She is the Gender-Based Violence Manager at NHS Lanarkshire in Scotland. She is a qualified social worker with over 15 years of experience in the violence against women sector in Scotland. Hayne presented on the training purpose and use for the NHS Lanarkshire's Trauma and the Brain video, an eight-minute animation.

Working With the Press and Social Media

For many years, advocates in the sports concussion world have complained about articles in the press where reporters lacked an understanding of brain injury or, in their efforts to get a story, included less than accurate safety information. Reporters have

80 countries, and excellent connections with reporters, the task force has also been able to provide experts for many recent articles. Links to all these articles can be found on the PINK Concussions website in the Task Force pages.

Joining the Task Force

The task force welcomes students, clinicians, and researchers at all levels to join the group and share their work and experiences with DV/IPV-related TBI. Along with international experts from all over the world, we also invite students to present their work. Recently, students for Spain and Colombia were guest speakers on our call. It is very important to the task force to provide opportunities for young investigators to network with more senior researchers and clinicians.

Membership on the PINK Concussions Partner-Inflicted Brain Injury Task Force is still open to any medical, research or clinical professional in the field. Anyone interested in joining the task force, can sign-up using the link <http://www.pinkconcussions.com/violence>.

End Note

1. The National Institutes of Health (NIH) has 27 separate institutes and centers (ICs) that carry out its mission in different areas of biomedical research. ■

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symptoms of TBI. Abused women who have been choked or strangled may never be identified as having incurred a strangulation because the symptoms are hidden and/or the Emergency Department (ED) staff failed to ask about choking/strangulation. In a sample of 225,727 female visits to the ED with an IPV diagnostic code from 2006-2014 in the largest ED sample (20% of U.S. EDs), only 1.2% received a strangulation code in addition to the IPV code.⁵ This is a far smaller proportion than one would expect of abused women in the ED (from 5%-69%) depending on the sample and study.⁶ Abused women who have had a blow to the head are similarly not usually assessed for a concussion because they are asked if they lost consciousness rather than for symptoms of alteration

more long-lasting difficulty in recalling the events. If a woman is asked about “strangulation” she may think that because the incident involved a choke hold or a forearm against the neck or because she lived through it, that it does not “count” as a strangulation. Another issue in these assessments is that many clinicians fail to understand the repeated nature of these abusive incidents. When a brain has incurred multiple injuries, the cumulative damage is greater as in the multiple concussions of athletes resulting in long-term cumulative brain damage.

The long-term damage from a TBI involves the immune system response to injury in the brain. Although a complicated response, the long-term consequences to the brain involve the “blood-brain barrier breakdown” that leads to an inflammatory response in

- Blows or being hit with an object resulting in broken facial bones (because of the force behind it);
 - Hitting one’s head on a wall or the floor other hard surface;
 - Repeated violent shaking as well as one or more of the above.
2. Choking/strangulation, both attempted and completed, including ever and how many times. Ask about any alteration in consciousness and ask her to describe.
 3. If positive for head or facial injury with alteration in consciousness and/or choking/strangulation then assess for: difficulty concentrating, memory loss, dizzy spells, seizures, vision problems, hearing problems.⁸
 4. If DV advocacy in other systems (*e.g.*, criminal justice, child welfare, housing, legal) the same brief assessments should be done).

DV Advocacy Program Intervention:

1. If head/facial injury or choking/strangulation with any alteration in consciousness within the prior 72-96 hours, send the survivor to ED or urgent care (send back if seen there) with specific directions as to what to say about having a loss of consciousness because of being “strangled” or being hit on the head or having had her head struck by something hard. Be sure she stresses the loss of consciousness.
2. If difficulty concentrating (having trouble organizing), memory loss (*e.g.*, missing appointments), dizzy spells, seizures, vision problems, hearing problems, help her with “work arounds,” including calendar reminders, cell phone apps, writing down injuries and symptoms (DA calendar with symptoms included) to show to health care or other relevant systems.
3. If being seen by a mental health professional have her tell that person about the head injuries and strangulation.
4. Check on availability of physical therapy and/or occupational therapy for women with their current health care insurance and help her consider how to have a discussion with primary care provider about possible need for those services.
5. See Nemeth and colleagues⁹ for wording of referrals and for materials to use and other suggestions.

Another issue in these incomplete assessments is that many clinicians fail to understand the repeated nature of these abusive incidents.

of consciousness such as feeling dizzy, “blacking out,” or feeling dazed. Often an abused woman is assessed for only the injuries she presents with at Urgent Care, such as a black eye. The clinician should find out all the facial/head injuries the woman may have experienced in one “beating up” incident. Often an abused woman may not fully disclose that her partner hit her or beat her up because of the stigma of domestic violence and/or a fear of the violence being reported to the authorities. To encourage disclosure, clinicians must be empathic, make eye contact, ask about abuse in private, and use an interpreter if language is a barrier. If an abused woman explains away a facial injury by saying, “I fell,” or something similar, the provider may fail to suspect other head injuries and treat the injury as relatively minor. In incidents involving a victim being “slammed” up against a wall or pushed to the floor, the woman’s anxiety or fear may lead her to forget all of the possible injuries. If she has been strangled, the anoxic brain injury can lead to temporary or

the brain that contributes to long-term dysfunction. Abused women have been found to have more circulating inflammatory cytokines because of long-term HPA axis (stress response) alteration. This ongoing inflammatory response in abused women may make them even more vulnerable to the effects of TBI from abuse.

Thus, there are multiple implications for both immediate assessment and care of TBIs from IPV and long-term interventions. Both DV Advocacy and the health care systems need to be aware of the need for complete assessment and interventions for abused women who may have experienced a TBI from abuse. These assessment and intervention implications are summarized below.

DV Advocacy Assessment (All Types of Advocacy Programs):

1. Immediate Assessment on Entry into Programs for:
 - Blows to the face or head—approximate frequency ever and in past year (The Calendar in the Danger Assessment very helpful)⁷;
 - Blows to the ear;

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Health Care Professionals:

1. In ED, the importance of routine inquiry for IPV that is trauma informed, private, and complete (e.g., if using the question “are you safe at home?” add the phrase “and I mean are you safe from the people in your home?”)
2. If she discloses IPV be sure to ask about prior head injuries or strangulations as well as this event.
3. Standardize processes to minimize missed injuries – asking about (allowing for memory difficulties from alteration in consciousness) and examining full body with close attention to the head.
4. Use alteration in consciousness language versus loss of consciousness.
5. Put in place post-strangulation evaluation and treatment protocols.¹⁰
6. Objective, detailed documentation.
7. Clearly communicate diagnoses/injuries and discharge instructions given possible post-injury and/or long-term and/or shock and fear cognition challenges. Make sure someone (not abusive partner) is helping her – warm referrals to Domestic Violence Advocacy.¹¹
8. In primary care, importance of routine assessment for IPV accompanied by a quick assessment of past severe head injury and/or choking/strangulation. If positive for either then a quick assessment for neurological symptoms (memory problems, dizzy spells, blacking out, trouble concentrating) and appropriate referral (consider PT, OT, neurological work-up).
9. Care continuity with other providers.

Looking Forward

In summary, we are only beginning to understand the complete picture of Traumatic Brain Injury in abused women both in terms of etiology and implications for assessment and interventions in all the systems that see abused women. Research is needed on all of these issues as well as strategies to avoid the unintended consequence of these long-term problems being documented and used against an abused woman. Before we have all the research and evaluation we need in our midst, however, we must attend to the abused

women who have TBIs and do the best we can to get them the help they need.

End Notes

1. Andrea Cimino, Gao, Y., Patch, M., Alter, Y. Campbell, J., Gundersen, K., Tang, J., Tsuyuki, K. & Jamila Stockman, (2019). The effect of intimate partner violence and probable Traumatic Brain Injury on mental health outcomes for Black Women. *Journal of Aggression, Maltreatment & Trauma*, 28(6), 714–731. Available at <https://doi.org/10.1080/10926771.2019.1587657>.
2. Definition of Mild Traumatic Brain Injury by the Committee on Mild Traumatic Brain Injury and American Congress of Rehabilitation Medicine (1993). Available at https://acrm.org/wp-content/uploads/pdf/TBIDef_English_10-10.pdf.
3. Jacquelyn Campbell (2002). Violence against women and health consequences. *The Lancet*, 359(9314), 1331–1336.
4. Jacquelyn Campbell, Anderson, J., McFadgion, A., Gill, Zink, E., Patch, M., Callwood, G. & Campbell, D.W. (2017). The effects of intimate partner violence and probable traumatic brain injury on central nervous system symptoms in women of African descent. *Journal of Women's Health* 27(6). Available at <http://online.liebertpub.com/doi/10.1089/jwh.2016.6311>; Lorraine Davies, Wuest, J., Willson, A.E., Varcoe, C., Scott-Storey, K., Campbell, J. & Ford-Gilboe, M. (2015). Patterns of cumulative abuse among female survivors of intimate partner violence: Links to women's health and socioeconomic status. *Violence Against Women*, 21(1), 30–48.
5. Michelle Patch (2019). Prevalence and associated characteristics of emergency department visits by women after non-fatal intimate partner strangulation and subsequent diagnostic and treatment experiences: A mixed methods study. Unpublished Dissertation. Available at <http://jhir.library.jhu.edu/handle/1774.2/61597>.
6. Colleen McQuown, Frey, J., Steer, S., Kinkopf, B., Fakler, M. & Prulhiere, V. (2016) Prevalence of strangulation in survivors of sexual assault and domestic violence. *American Journal of Emergency Medicine*, 34(7), 1281–5.
7. www.dangerassessment.org. Jacquelyn Campbell, Webster, D. & Glass, N. The Danger Assessment: Validation of a lethality risk assessment instrument for intimate partner femicide. *Journal of Interpersonal Violence*, 24(4), 653–674. (2009). doi: 10.1177/0886260508317180.
8. Can use the Miller Abuse Physical Symptom and Injury Scale (MAPSAIS) described in Jacquelyn Campbell et al., note 4 supra. Available at www.dangerassessment.org.
9. Julianna M. Nemeth, Mengo, C., Kulow, E., Brown, A. & Ramirez, R. (2019). Provider perceptions and domestic violence (DV) survivor experiences of traumatic and anoxic-hypoxic brain injury: Implications for DV advocacy service provision. *Journal of Aggression,*

Maltreatment & Trauma, 28(6), 744–763. doi: 10.1080/10926771.2019.1591562.

10. Strangulation institute protocols are available at <https://www.strangulationtraininginstitute.com/>. Nonfatal strangulation toolkit IAFN is available at <https://www.forensicnurses.org/page/STOverview>.

11. Futures Without Violence. Available at <https://www.futureswithoutviolence.com/>; <https://www.futureswithoutviolence.org/health-materials-index/>.

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Health at The Ohio State University, pursued Institutional Review Board (IRB) approval from the Ohio State University (OSU) to oversee the research and evaluation of this grant. This allows ODNV to share these findings from the field that has the potential to transform crime victim services.

Brain Injury, Mental Health, and DV

It is critically important that all domestic violence survivors, including those with disabilities, be able to access and benefit from program

this goal, ODNV created a Community of Practice made up of diverse organizations and individuals who work with mental health, brain injury, and/or domestic violence.

While most domestic violence advocates have some knowledge or training on mental illness, translating that knowledge into effectively accommodating needs in service provision has been elusive and difficult. In regard to partner-inflicted brain injury (defined as disrupted brain function caused by a traumatic brain injury or strangulation inflicted by a partner), this project has uncovered a serious public health crisis that has yet to receive the

injury in the lives of domestic violence victims, ODNV's project provides the tools to improve advocacy and service provision, better meet the needs of survivors, and address the invisible injuries that can last a lifetime.

A critically important contribution of this project was the development of specific resources and tools created for survivors of abuse who might have experienced a head injury. All resources are available for free download at www.odvn.org and are described below:

The *Has Your Head Been Hurt?* educational card is a connection tool around issues of traumatic brain injury and strangulation. It provides information on how those working with domestic violence survivors can:

- Provide education on possible head injuries related to traumatic brain injury and/or strangulation;
- Identify current and past head injuries and possible physical, emotional and cognitive symptoms; and
- Highlight warning signs of a dangerous or life-threatening injury, with special guidance related to strangulation.

The Invisible Injuries Booklet is a companion tool for the *Has Your Head Been Hurt?* card to assist domestic violence programs in accommodating the needs of survivors who have experienced head injuries and identifying possible follow-up care or evaluation. It provides additional and more in-depth information on:

- What is a head injury and what can happen after a head injury;
- A chart to track symptoms of head trauma, including warning signs that could signify the need for medical care;
- A focus on strangulation, its risks, and its role as a red flag for danger;
- Tips for healing and possible ways to address common challenges related to head injuries, and
- Worksheets related to safety planning and organizing daily life tasks.

Just Breathe: A Guide to Wellness is a present-focused resource that helps survivors attain mastery and safety from trauma (including symptoms of PTSD) and emotional distress by

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In regard to partner-inflicted brain injury (defined as disrupted brain function caused by a traumatic brain injury or strangulation inflicted by a partner), this project has uncovered a serious public health crisis that has yet to receive the attention it deserves.

services. In recognition of the importance of addressing mental health and brain injury disabilities, the Office on Victims of Crime Vision 21 Initiative selected ODNV as one of two coalitions in the United States to implement this work through OVC FY 2016 Enhancing Access and Attitudinal Changes in Domestic Violence Shelters for Individuals With Disabilities (2016-XV-GX-K012).

The program was designed to help DV programs improve services by accommodating the needs of survivors who may have a brain injury or struggle with their mental health by:

1. Equipping local program staff through training, program support, development of resources and materials, policies and procedures, and best practices. To meet this goal, ODNV partnered with five diverse domestic violence member agencies as funded partners in this grant to pilot strategies developed in this project.
2. Building collaboration with agencies and organizations that work with mental health and brain injury to increase access to services. To meet

attention it deserves. This project has identified the critical need for survivor and advocate education on brain injury, mental illness, and its intersection with domestic violence.

The lack of knowledge on brain injury and lack of access to trauma-informed mental health services often leads advocates to misunderstand the physical, emotional, and cognitive challenges caused by brain injury and mental illness. When domestic violence program staff do not recognize or accommodate for these functional limitations caused by brain injury or mental illness, it hinders a survivor's ability to access, effectively engage in, remain connected to, and benefit from services. This leaves the most vulnerable survivors without the life-saving shelter, safety, and supports provided by domestic violence programs.

Head injuries, like all injuries, are better addressed, treated, and accommodated when they are identified and acknowledged. By developing practical and accessible education, training, resources, and best practice responses to address the often interrelated struggles of mental health and brain

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emphasizing coping skills, grounding techniques, and education. It was designed for anyone who has experienced trauma, and for advocates to use with survivors. This highly usable, research-based resource has several key objectives including:

- Helping survivors of trauma develop safety in thinking, emotions, behaviors, and relationships;
- Providing survivors information regarding traumatic stress and its triggers; and
- Counteracting loss of ideals and self-efficacy experienced as a result of trauma.

The findings from this groundbreaking project are significant and many. These lessons learned can help statewide organizations implement capacity building projects, and/or guide local programs in a variety of professions interested in better addressing mental health and brain injury in their services. Findings are grouped into two categories:

1. Lessons learned about the intersection of domestic violence, brain injury, and mental health.
2. Findings on effectively addressing brain injury and mental health in domestic violence services.

As the stark data discussed above highlights, domestic violence victims are likely to struggle with mental health challenges and have been hurt in ways that could cause a brain injury. This could be a traumatic brain injury due to blows to the head, neck or face and/or an anoxic-hypoxic brain injury as a result of strangulation. The impact of the functional limitations and possible disabilities caused by these assaults creates additional difficulty for victims when trying to access and effectively use life-saving domestic violence and other crime victim services.

Lessons Learned About Brain Injury and Mental Health

1. Almost all domestic violence survivors experience violence that could cause brain injuries and struggle with mental health.
2. Domestic violence causes and exacerbates brain injury and mental

health struggles, and is connected to suicidality and substance use.

3. Ignorance is common in the field as to the incidence of brain injuries among domestic violence victims. While domestic violence victims report incredibly high levels of head trauma, brain injury is largely unidentified, rarely addressed, and not well understood by domestic violence programs.
4. Partner-inflicted brain injury is markedly different from other commonly studied brain injuries, including brain injuries caused by accidents, sports, and combat.

contribution to this area of work through research conducted as a part of this grant. It has provided some of the earliest glimpses into the prevalence, frequency, and experience of partner-inflicted brain injury (including traumatic brain injury and strangulation) experienced by survivors. In terms of hits or blows to the head, 85% of domestic violence victims accessing domestic violence program services at five local domestic violence partner agencies have been hit in the head, with almost 50% of survivors reporting that their head was hurt too many times for them to count. Close

When talking with domestic violence survivors participating in domestic violence services, over 90% of survivors agreed or strongly agreed with the statement:

“It is common for someone accessing this agency to struggle with mental health.”

Lesson 1: Almost all domestic violence survivors experience violence that could cause brain injuries and many struggle with mental health. DV programs should assume that victims accessing services are struggling with their mental health and have been hurt in ways that could cause brain injury until proven otherwise.

Through research conducted as a part of this project, ODVN learned that domestic violence victims have lived through extensive violence directed at the head, neck, and face and through strangulation. They have also experienced emotional abuse and mental health coercion, and they may live in traumatic environments. The alarming and disturbing statistics speak for themselves. When talking with domestic violence survivors participating in domestic violence services, over 90% of survivors agreed or strongly agreed with the statement: “It is common for someone accessing this agency to struggle with mental health.” The research on domestic violence and traumatic brain injury is scarce, and ODVN is making a major

to 83% of survivors interviewed have been strangled, and 71% of them said it happened a few times or too many times to count. (Nemeth et al., 2019).

Lesson 2: Domestic violence causes and exacerbates brain injury and mental health struggles, and also is connected to suicidality and substance use. These public health problems, on both an individual and population level, are intertwined and very much related to the traumatic impact of abuse.

Brain injury, mental health, suicide, and substance use are unique public health challenges with their own characteristics, responses, and approaches. But due to their significant overlap, domestic violence programs must use a holistic framework and understanding of how these issues are integrated. While brain injury is a newer topic for domestic violence advocates, ODVN intentionally resisted separating these issues and addressing them in isolation. A very stark example is how an experience of strangulation—that could cause a brain injury—can also cause

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PTSD or trauma reactions such as flashbacks, avoidance reactions, or withdrawal. It can also exacerbate any existing mental health challenges.

Research funded by this project, conducted by ODVN in collaboration with The Ohio State University, suggests often co-occurring health conditions (such as disruptions in mental health, traumatic brain injury, and the impact of strangulation, as well as substance use) often caused by abuse and resulting in disability are prevalent among almost all domestic violence survivors accessing DV program services (including shelter, community-based advocacy, and criminal justice advocacy) as well as other crime victim services. Our findings suggest the vast majority of survivors who access advocacy services have had experiences that clearly impact the brain and cause the symptoms listed in Figure 1.

Most service providers assume that people accessing services can remember appointments, understand conversations, concentrate and focus, set goals and follow case plans, stay motivated, and figure out next steps. Psychological and physical trauma hinder the brain's ability to do almost all these complicated brain functions. The data we are uncovering through this research challenges programs to find ways to adjust services and accommodate the physical, emotional, and cognitive functional limitations caused by trauma, mental illness, brain injury, and substance use.

Lesson 3: While domestic violence victims report incredibly high levels of head trauma, brain injury is largely unidentified, rarely addressed, and not well understood by domestic violence programs.

In ODVN's initial needs assessment, domestic violence program staff reported they felt unequipped to address partner-inflicted brain injury (defined as disruptions to brain function caused by blows to the head or strangulation by a partner). None of the domestic violence agencies had any of the following in place and needed:

- Policies or procedures on identifying, acknowledging and responding to head injuries;
- Advocate tools or guidance to assist with providing accommodations in services;
- Educational materials designed for domestic violence victims on these topics;
- Screening questions and guidance on how to ask and respond;
- Training on traumatic brain injury and strangulation that becomes a routine part of any agency's initial or continuing education; and
- More knowledge and tools to feel more confident and comfortable addressing these topics.

Staff were hesitant to address brain injury directly, as they felt like they did not know enough about the topic, lacked the tools to properly intervene, and did not want to do additional harm. In contrast to mental health findings that expressed knowledge of available services but frustration with

the inability to access services, staff had little awareness of or connection to even what types of services might be helpful for someone with a possible brain injury.

Survivors accessing services also shared that they were not regularly asked about traumatic brain injury and strangulation, did not get education and information about the impact of head injury, were not aware of symptoms or problems that could be connected to their head injuries, and were not provided accommodations or referrals to possible follow up care.

The implementation of the CARE framework (see Implementation of Best Practices, below) with agency programs and the development of tools for advocates to address brain injury has fundamentally altered this reality. In an evaluation after the implementation of CARE, staff reported a marked increase in knowledge of the interrelations between DV, mental health, and brain injury, and a significant increase in comfort and confidence in addressing hits to the head, strangulation, mental health, and suicide with survivors.

Domestic violence programs must become proficient in identifying, acknowledging, and responding to brain injury. Partner-inflicted brain injury must become a standard training for professionals and volunteers working with survivors of domestic violence.

Lesson 4: Partner-inflicted brain injury is markedly different from other commonly studied brain injuries, including brain injuries caused by accidents, sports, and combat.

Partner-inflicted brain injuries are intentional assaults by a loved one. Existing research in the brain injury field has centered on injuries related to automobile accidents, sport, and traumatic brain injuries in military combat situations. A brain injury caused by domestic violence is very different and changes the way we identify, intervene, and promote recovery and healing. The brain injury field has depended on strategies for identification that include educating others

Figure 1. Common Signs and Symptoms of Possible Exposure to Partner-Inflicted Brain Injury Can Mean Troubles With These Items

PHYSICAL	EMOTIONAL	THINKING PROBLEMS
Headaches	Worries and fears	Remembering things
Sleeping problems	Panic Attacks	Understanding things
Sensitive to light or noise	Flashbacks	Paying attention or focusing
Dizziness	Sadness	Following directions
Balance problems	Depression	Getting things started
Fatigue	Hopelessness	Figuring out what to do next
Seizures	Anger or rage	Organizing things
Vision problems	Irritability	Controlling emotions or reactions

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(including coaches, parents, teachers, bystanders, etc.) to recognize possible concussions. The recovery recommendations, such as return to play and return to learn protocols, often mandate rest or reduced activity, avoidance of stress, and a gradual return to activities as tolerated.

Due to the context in which they occur, current approaches to identify, treat, and heal from concussions or other more severe brain injuries related to sports and other situations are not effective or feasible when a brain injury is caused by domestic violence. Survivors, themselves, often do not recognize that hits to the head and/or strangulation can cause brain injury. There are no coaches or witnesses to train on identifying and intervening. Survivors face very real barriers and safety risks to accessing medical care or evaluation after an event. A victim is attempting to heal from the almost universally unidentified brain injury in a traumatic and unsafe environment.

ODVN has taken a national lead on developing and advocating for a new conceptualization of brain injury in this context that addresses the complexities, named partner-inflicted brain injury, which is when a person's brain is hurt by strangulation and/or blows to the head while experiencing domestic violence. Correctly understanding and defining the problem will lead to the development of approaches that can help shape effective interventions and responses.

Implementation of Best Practices

Domestic violence programs work in a trauma-based, crisis-oriented field with high turnover. Implementing strategies on a local and statewide level to change attitudes and increase access to services is a challenging proposition. Transforming programs and agencies to change how they are doing things requires unique strategies that increase local program buy-in.

1. The CARE framework is a critically important tool for acknowledging, identifying, and responding to these often unrecognized, invisible disabilities.
2. When programs are provided with tools and training developed by

CARE and supported in using them, it can transform their services and make advocacy more accessible to all survivors.

3. Organizations can adapt CARE as a successful framework for implementing statewide and/or multi-agency collaboration projects.

Lesson 1: The CARE framework is a critically important tool for effectively identifying, acknowledging, and responding to these often unrecognized invisible injuries that can result in disability.

ODVN developed the CARE (Connect, Acknowledge, Respond and Evaluate) framework (explained below), a relationship-based, holistic framework

- **EVALUATE** accommodations and referrals and touch base regularly to see if adjustments need to be made.

Increasing access to program services for those with unidentified, invisible possible disabilities (like brain injury and mental health) as opposed to recognized, visible disabilities (such as a physical disability) requires a different approach. Mental health and brain injury disabilities are unique in a number of ways. Survivors are often unaware of a possible brain injury, and do not know that some of their emotional or cognitive struggles could be connected to it. Survivors who struggle with their mental health have often had this used against them, by

The CARE framework is a critically important tool for effectively responding to these often unrecognized invisible injuries that can result in disability.

of providing services that better meets the needs of program participants and intentionally and purposefully addresses head injuries and mental health. CARE is a framework that focuses on developing connections and forming alliances with survivors to better identify, understand, and accommodate the unique needs of each survivor. While the CARE framework can be used to address a wide variety of issues and challenges, it was developed as a part of this project to address mental health and brain injury. The CARE framework encompasses the following:

- **CONNECT** with survivors by forming genuine and healthy relationships with them.
- **ACKNOWLEDGE** that head trauma and mental health challenges are common, provide information and education to survivors, and identify short- and long-term physical, cognitive, and emotional consequences.
- **RESPOND** by accommodating needs related to traumatic brain injury, strangulation, and mental health challenges, and provide effective, accessible referrals and advocacy for individuals who need additional care.

abusers and others, and there is still enormous stigma surrounding mental health, with many survivors trying to hide or mask symptoms or struggles.

Many programs have made enormous improvements in making their programs physically accessible. We are now challenged to identify physical, cognitive, and emotional challenges related to mental health or a brain injury. Then we must develop strategies to make programs emotionally and cognitively accessible. The CARE framework and the tools developed as a part of this project, as well as the accommodations provided, can effectively increase access to effective services.

The CARE framework helps local programs identify possible accommodations to account for the physical, emotional, and cognitive impact of mental health, brain injury, and other issues. Examples of accommodations developed as a part of this project include:

- Providing earplugs, headphones, sunglasses, or adjust lighting if necessary;
- Helping to identify conditions that facilitate sleep (music, darkness, quiet, etc.);

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- Slowing down information, planning for additional time;
- Repeating things frequently and having the individual repeat back to you, in his or her own words, what you talked about;
- Providing written information and documenting conversations as much as possible, for recall;
- Providing calendars, notebooks, and checklists to help with memory;
- Checking in with each survivor often, particularly in the beginning of his or her stay;
- Having staff wear nametags for memory or processing challenges.

Administrative staff at a local domestic violence partner agency explained:

It's easy to become frustrated with a client or to not understand why [we are seeing] the behavior that we are seeing, and this gives us, "oh, well this makes perfect sense." [With CARE] here are some ways we can help them with that.

Lesson 2: When programs are provided with tools and training developed by CARE and there is support in using them, it can transform their services and make advocacy more accessible to all survivors.

Domestic violence program staff provide excellent, important services. Survivors reported great satisfaction with domestic violence services offered, and advocates at program staff were enthusiastic and eager to provide the best services possible. They were very interested in training and strategies to help them better meet the needs of survivors.

DV program staff also work in very challenging trauma-based environments. Domestic violence survivors often come to services at an incredibly vulnerable time of their lives with extensive needs. The project's success hinged on a couple of strategies: in response to the needs assessment, ODVN developed simple advocacy tools and basic accessible training that made addressing brain injury and mental health doable for advocates. ODVN empowered agencies and advocates to figure out what CARE looked like in

their respective settings, and provided support that was helpful to them. Agencies that had a staff member who really believed in CARE and the importance of discussing and accommodating for needs related to brain injury and mental health reported more shifts in attitudes and increased access. That staff member did not need to be an administrator or agency leader—he or she just needed to have influence with other staff members and access to tools and training. That leads to the second component, which was designing an approach that made sense for agencies with high turnover and limited funds and time for training. Staff must have direct access to tools and training, and the training needs to focus on building connections to effectively use the tools with DV survivors. This drove the development of online training that was simple and to the point.

The following comments are illustrative of the responses:

- "The advocacy tools are incredibly helpful and extremely informative for both clients and myself." Staff, Post CARE online survey.
- "Not just us saying it, but our survivors being actually able to see [the printed CARE advocacy tools] and that we are educated." DV Staff, CARE process evaluation focus group.
- "[The CARE tools] helps them have validation. It gives them power." DV Staff, CARE process evaluation focus group.
- "A lot of this resource material, we can hand it to them and it gives them a validation. What I feel and what this has done to me is valid." DV Staff, CARE process evaluation focus group.
- "I had a client who was frustrated with the way she was feeling. She was sexually assaulted and...that was what stuck out in her mind about the assault, not the fact that she had been hit in the head during the assault. So giving her [the CARE resources] and kind of talking to her about this helped her to realize maybe some of my frustrated feelings and emotions may be because of a concussion or something else that happened during that, and that kind of helped her to feel a little bit better about how she was feeling...maybe this is the result of my injury as well." DV Program

Administrator, CARE process evaluation focus group.

Lesson 3: Organizations can adapt CARE as a successful framework for implementing statewide and/or multi-agency collaboration projects.

Without intentionally doing so, ODVN adapted CARE from an individual level intervention framework to a statewide level strategy for this initiative. ODVN's approach to engagement with local domestic violence programs and an increase in cross-system and issue collaboration followed a system advocacy care process:

1. CONNECT and build relationships with project partners by bringing partners together to explain the goals of the project, people's roles, and learn about what partners needed from the collaboration, and visiting the projects several times to learn about their programs.
2. ACKNOWLEDGE the complexities, challenges, and opportunities when tasked with addressing brain injury and mental health in domestic violence programs. Domestic violence programs already are extremely underfunded and crisis oriented, and we needed to learn from them how to develop a project that would be realistic and doable in these environments.
3. RESPOND by integrating all feedback into thoughtful and intentional design of training, materials, technical assistance, and resources developed for programs to use.
4. EVALUATE by adjusting and changing next steps or phases of the project, and improving future programming based on lessons learned, as well as changing strategies for training and support to meet the needs of programs.

Results

The results of this project provide users with the opportunity to change the victim services advocacy landscape and create crime victim programming that effectively meets victims of crime where they are, and provides services in a manner that acknowledges and responds to the impact of domestic violence, trauma, mental health and brain injury. These include:

1. A new trauma-informed advocacy framework for crime victims called

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- CARE, focusing on building positive relationships with DV survivors and acknowledging and responding to the individualized needs of each person accessing services.
2. A shift in attitude of DV program staff that increased access to DV program services. This also includes a marked increase in staff knowledge of the interrelationships between DV, mental health, and brain injury, and a significant increase in comfort and confidence in addressing hits to the head, strangulation, mental health, and suicide with survivors.
 3. Accessible, easy to use advocacy and educational materials for programs and survivors in English and Spanish, available for free download at www.odvn.org and designed for widespread use. ODVN created these versatile, user-friendly tools on mental health and brain injury in the context of domestic violence for domestic violence partners, health care, criminal justice services, and other crime victim service providers. Free online learning courses are in development and will be available shortly.
 4. A multidisciplinary community of practice with representatives from brain injury, mental health, suicide prevention, health care, statewide coalitions, and advocacy organizations resulting in increased collaboration between domestic violence, mental health, and brain injury organizations. This group continues to break down silos and facilitates a more comprehensive response to domestic violence survivors.
 5. The identification of a previously unidentified public health crisis named partner in partner-inflicted brain injury and the provision of national and international leadership to better understand and respond to this issue. This has resulted in increasing national collaboration and outreach in the research and practice arenas on addressing strangulation and traumatic brain injury in the context of domestic violence. ODVN, as an advocacy organization with an extensive and sophisticated understanding of domestic violence, has played a critical role in this collaboration.

6. A practice-based research partnership, furthering our understanding of these overlapping issues that need to inform best practice responses. ODVN and OSU (the Ohio State University) are leading the nation with a community based partnership research agenda to better understand translational research and on the ground strategies.

Next Steps

This project provided the support necessary to better equip domestic violence programs to respond to mental health concerns of survivors, a reality that DV programs have been struggling with since the creation of this field. There is still much work to

The CARE model will be widely disseminated related to mental health and brain injury, and also will be used with other issues, such as substance use and suicide.

be done, but the needle has moved in the right direction.

In addition, ODVN identified a significant unmet need in the domestic violence services field related to acknowledging and responding to traumatic brain injury and strangulation, a need that many of us doing this work did not know existed before this grant. This grant has put this issue on the map and prompted a conversation that will continue for years and decades to come.

This grant also shaped ODVN's thinking around access to program services, and what it looks like to be physically, emotionally, and cognitively accessible to all survivors of domestic violence. To create meaningful access to services for survivors with disabilities requires us to respond to the unique needs of survivors by providing services in a different way that works for them through accommodations, support, and effective linkages to other resources, systems, and people.

This grant helped develop the foundation and framework of the CARE model, which now will be widely disseminated related to mental health and brain injury and will be used with other issues (such as substance use and suicide). ODVN staff funded by this project will be directing and implementing

two new statewide initiatives for domestic violence programs and other crime victim services in Ohio. ODVN is applying for federal, statewide, and foundation funding to support the next steps of the project, which include:

1. The establishment of the Center on Partner-Inflicted Brain Injury, a systems advocacy initiative providing statewide, national, and international leadership on research and practice initiatives related to the emerging issue of brain injury caused by domestic violence. The Center will focus on building collaboration between health care, victim services, and the criminal justice system and offer training, technical assistance, consultation, and resource development

for service providers and researchers working at the intersection of abuse and brain injury.

2. The Development of a Meaningful Access Project, which will assist programs in implementing meaningful access policies and procedures into their agencies. Meaningful access plans outline the assistance that will be provided by organizations receiving federal funding that documents compliance and provides a framework for the provision of timely and reasonable, nondiscriminatory assistance. This project will help programs provide accessible services to all survivors of domestic violence, including survivors of marginalized populations, LGBTQ individuals, individuals with Limited English Proficiency, and survivors with varying disabilities and cognitive challenges (including survivors who struggle with their mental health, and survivors with possible head injuries).

Conclusion

Domestic violence services save lives, and do it in a way that empowers, respects, and supports survivors. Domestic violence advocates care

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party, can easily be overlooked by both the concussed individual as well as the people around her. With no recognition of the mTBI, there is no management of it, increasing the likelihood for poor recovery and consequently more frustration and difficulties.

If we take this scenario one step further, we can see how sustaining that mTBI could possibly have even more detrimental effects down the road. For example, if the couple ends up in front of a judge at some point, police records will show her to be off-balance and irritable with no external injuries, whereas the abuser was cooperative at the scene. In front of the judge, her story has gaps in it, but his is clear. If there is no indication that a TBI has occurred, her behavior is likely to be interpreted in a negative light. Furthermore, if she tried to leave her partner and goes to a women's shelter, she may struggle with the new routine, new rules, tasks that need to get done, and the general commotion of the shelter. Suffering from a TBI or a history of repetitive TBIs may make all of these things much more challenging to manage than if no TBI has been experienced. In short, TBIs that go unrecognized can have a range of short- and long-term effects that make everyday life—as well as possibly leaving the abuser—significantly more difficult.

Because so little research has been conducted thus far on the intersection of IPV and TBI, we are largely left to guess about the true impact of “hidden TBIs” for the possibly millions of women who have been abused by their partners. This scenario provides just a few ways in which such TBIs can have extremely detrimental effects on the lives of women who are abused and sustain unacknowledged mTBIs. For this reason (among others), it is imperative that we determine whether TBIs have occurred when interacting with a woman who has experienced IPV.

How Can We Try to Determine Whether an mTBI Has Occurred?

First, it is important to recognize that this is not a recommendation to “diagnose” TBI in women who have experienced IPV. Rather this is a recommendation to always at least *entertain the idea that an mTBI may have occurred*—especially if there are no witnesses. The

first step in doing this is to verify whether the right questions have been asked. A woman will not necessarily know that she has sustained an mTBI and one cannot expect that she will offer up this information. Even if she thinks she may have taken a “dinger” to the head, she may not recognize the relevance of reporting that she sustained a TBI—especially if there are no externally visible marks. Unfortunately for these women, partners will also hit to the back or side of the head because those hits will “not leave any marks” that could be identified by police, medical, or legal personnel. Although it may seem obvious that a trip to the hospital is necessary for a broken arm or ruptured and bleeding eardrum, in contrast, a brief moment of confusion or memory loss after a forceful blow to the head may not register as something important for which medical attention should be sought.

What Questions Should Be Asked?

To ascertain whether a woman sustained an mTBI it is important to determine whether an “alteration in consciousness (AIC)” occurred after a strong force or blow to the head. An AIC may be represented as a: loss of consciousness (even if only seconds long), memory loss for part of the event, or a period of confusion or disorientation surrounding the incident. If a woman reports any of these experiences, follow-up questions should be asked to determine whether these represent a TBI or something else (*i.e.*, intoxication). For example, suppose one asks, “After anything your partner did to you tonight, did you ever lose consciousness or black out?” If she says, “Yes, when he smashed my head against the wall”: That is a TBI. If she says, “Yes, after he forced me to drink a pint of vodka”: That is not a TBI. If one asks, “After anything your partner did to you tonight did you feel really confused or disoriented?” If she says, “Yes, after he punched me really hard in the face I did not know where I was or what was going on”: That is a TBI. If she says, “Yes, I was not sure why we were arguing”: That is not necessarily a TBI unless she also mentions something indicating an AIC. So in short, all that is required to know whether a TBI has occurred is an external force or blow to the head, followed by an alteration in consciousness or brain function as defined above. It is important

to note that a loss of consciousness is *not* required for a TBI and, in fact, is more typically not the case. Likewise, a negative brain scan does *not* mean that there is no TBI, as most concussions are not identifiable on standard computed tomography (CT) scans.

In sum, there is an abundance of evidence that women who are experiencing IPV, are sustaining concussions/mTBIs from their partners. My research has shown high rates of IPV-related TBI and has also shown associations between IPV-related TBI and women's cognitive and psychological functioning as well as structural and functional connectivity within the brain (Valera and Kucyi, 2016; Valera, et al. 2018). What we know even less about is the degree to which these brain injuries are being identified as such and the degree to which these “hidden injuries” are negatively impacting these women's abilities to succeed in judicial and shelter settings and possibly escape their abusive situations. This commentary is a plea for all relevant stakeholders to *entertain the possibility* that an IPV-related TBI may have occurred for every woman seen. It is imperative that we work toward determining whether one or more TBIs have occurred and how they may be impacting a woman's ability to survive in a potentially dangerous and abusive situation.

End Note

1. A range of cognitive, emotional, behavioral or physical symptoms that are commonly observed after someone sustains a concussion.

References

- Arosarena, O.A., et al. (2009) Maxillofacial injuries and violence against women. *Arch Facial Plastic Surgery*, 11(1), 48–52.
- Valera, E.M. & H. Berenbaum (2003). Brain injury in battered women. *J Consult. Clin. Psychol.*, 71(4), 797–804.
- Valera, E. & A. Kucyi (2016). Brain injury in women experiencing intimate partner-violence: Neural mechanistic evidence of an “invisible” trauma. *Brain Imaging Behavior*, 11(6), 1664–1667.
- Valera, E.M., et al., (2018). White Matter correlates of mild traumatic brain injuries in women subjected to intimate-partner violence: A preliminary Study. *J. of Neurotrauma*, 36(5), 661–668.
- Wu, V., Huff, H. & M. Bhandari (2010). Pattern of physical injury associated with intimate partner violence in women presenting to the emergency department: A systematic review and meta-analysis. *Trauma Violence Abuse*, 11(2), 71–82. ■

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domestic violence victims have suffered some type of TBI and 83% have been strangled.¹³ Despite the prevalence of a TBI, most professionals who handle domestic violence cases are not trained to identify the symptoms of a TBI or what to do if TBI is even suspected.¹⁴ Unless professionals are specifically trained to look for these injuries, TBI can easily go undetected, as can a fractured hyoid bone or a carotid dissection which often do not have visible injury or significant symptoms. Victims of domestic violence deserve more and we can do better. Family Justice Centers can play an important role and partner in addressing early detection of internal injuries. With early detection, there is hope for early diagnosis, treatment, and recovery.

As the healthcare industry prioritizes “whole person care,” it is essentially funding and focusing on the very heart of a Family Justice Center framework—health, behavioral health, and social services all provided in a coordinated manner.¹⁵ This creates potential funding to expand health services in Family Justice Centers across the United States by focusing on a multi-sector, co-located services approach in order to meet the health, behavioral health, and social service needs of both adult and child survivors of violence and abuse.

End Notes

1. See Lyndsay Winkley, “Focusing on Strangulation—A Deadly Form of Domestic Violence” (2017). Accessed 12/1/2019 at <https://www.strangulationtraininginstitute.com/focusing-strangulation-deadly-form-domestic-violence/>.

2. To access the Institute’s Radiographic Imaging Guidelines, go to <https://www.strangulationtraininginstitute.com/wp-content/uploads/2015/07/Recommendations-for-Medical-Radiological-Eval-of-Non-Fatal-Strangulation-v17.9.pdf>.

3. Zuberi, O., Dixon, T., Richardson, A., Ganche, A., Hadi, M. & Joshi, J. (2019). CT angiograms of the neck in strangulation victims: Incidence of positive findings at a level one trauma center over a 7-year period. *Emergency Radiology*, 26(5), 485–492. Available at: https://www.researchgate.net/publication/332880314_CT_angiograms_of_the_neck_in_strangulation_victims_incidence_of_positive_findings_at_a_level_one_trauma_center_over_a_7-year_period.

4. Davis, J., Holbrook, T., Hoyt, D., Mackersie, R., Field, T. & Shackford, S. (1990). Blunt carotid artery dissection: Incidence, associated injuries, screening and treatment. *J. Trauma*, 30(12), 1514–7. Available at <https://reference.medscape.com/medline/abstract/2258964>.

5. See Patch, M., Anderson, J. & Campbell, J. (2018). Injuries of women surviving intimate partner strangulation and subsequent emergency health care seeking: An integrative evidence review. *J. Emerg. Nurs.* 44(4), 384–393.

6. *Id.*

7. For more information, go to <https://nofjc.org/medical-forensics-details>.

8. In Erie County, NY, for example, doctors and nurses provide forensic assessments but they are part of the University of Buffalo Family Medicine Clinic, allowing for streamlined referrals for services after the initial examination. See <https://www.fjcsafe.org/about/partners/>.

9. Family Justice Center (2013). Health survey report: Addressing health needs of intimate partner violence survivors in family justice centers. Accessed 12/1/2019 at <https://www.familyjusticecenter.org/wp-content/uploads/2017/10/Health-Survey-Report-Addressing->

[the-Health-Needs-of-Intimate-Partner-Survivors-in-Family-Justice-Centers.pdf](https://www.familyjusticecenter.org/wp-content/uploads/2017/10/Health-Survey-Report-Addressing-the-Health-Needs-of-Intimate-Partner-Survivors-in-Family-Justice-Centers.pdf).

10. Menon, D., Schwab, K., Wright, D. & Maas, A. (2010). Position statement: Definition of traumatic brain injury. *Archives of Physical Medicine & Rehabilitation*, 91(11), 1637-1640. Available at <https://www.ncbi.nlm.nih.gov/pubmed/21044706>.

11. Valera E. (2018). Increasing our understanding of an overlooked public health epidemic: traumatic brain injuries in women subjected to intimate partner violence. *Journal of Women’s Health*, 27(6), 735–736. Available at <https://www.liebertpub.com/doi/10.1089/jwh.2017.6838>.

12. Campbell, J., Anderson, J., McFadgion, A., Gill, J., Zink, E., Patch, M., Callwod, G. & Campbell, D. (2018). The effects of intimate partner violence and probable traumatic brain injury on central nervous system symptoms. *Journal of Women’s Health* 27(6), 761–767. Available at <https://www.ncbi.nlm.nih.gov/pubmed/29083256>.

13. See *Science News* (July 2, 2019). Brain injury common in domestic violence. Available at <https://www.sciencedaily.com/releases/2019/07/190702152756.htm>.

14. Smirl, J., Jones, K., Copeland, P., Khatra, O., Taylor, E. & Van Donkelaar, P. (2019). Characterizing symptoms of traumatic brain injury in survivors of intimate partner violence. *Brain Injury* 33(12), 1529–1538. Available at <https://www.ncbi.nlm.nih.gov/pubmed/31442093>.

15. California is one of numerous states now pushing forward with a focus on whole person care. See, e.g., Cal. Dept. of Health Care Services, \$20 Million One-Time Funds for Counties to Initiate Future Whole Person Care Pilots Oct. 18, 2019. Available at https://www.dhcs.ca.gov/services/Documents/MCQMD/WPC_Documents/20M-One-Time-Funding-10-18-19.pdf. ■

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deeply about their work and want to provide the best services possible.

What ODNV learned from this project—about traumatic brain injury, strangulation, and mental health and their intersection with other common struggles domestic violence survivors experience—has transformed the work of the organization. ODNV has developed new, groundbreaking projects on meaningful access to services and

deepening our understanding of partner-inflicted brain injury. Our findings highlight the important opportunity domestic violence programs have to adjust their current services, processes, and design to be accessible and effective for survivors of abuse, so survivors can move forward on their journey towards safety and healing.

References

Nemeth J.M., Mengo, C., Ramirez, R., Kulow, E. & Brown, A. (2019). Provider perceptions

and domestic violence (DV) survivor experiences of traumatic and anoxic-hypoxic brain injury: Implications for DV advocacy service provision. *Journal of Aggression, Maltreatment & Trauma*, 28(6),744–763.

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value of the evidence. The court emphasized that evidence of prior acts of domestic violence can be relevant and admissible “when, during trial, a victim recants pretrial accusations.” Here, the girlfriend testified at trial that Scott did not batter her, in contradiction to what she told others at the time of the incident. The district court thus properly allowed the State to present a witness who testified that the girlfriend had ascribed previous bruising to Scott’s abuse. The court found that the danger of unfair prejudice did not substantially outweigh the probative value of the evidence, where “that there was sufficient evidence

the criminal process, and such scrutiny is constitutionally necessary to ensure a fair trial. Here, the appeals court was correct that prosecutors must not tell a jury “how victims typically act.” There is no typical victim, and each person affected by violence experiences the criminal process uniquely. It is the province of expert witnesses to educate juries.

Georgia: Convictions for Murder of Wife and Son Affirmed Over Claim That Custodial Interview Testimony Was Prejudicial

The Facts. Defendant Robert Maurice Davis was convicted of the murders of his wife and son, as well as possession of a firearm during the commission of a felony. Davis called his

to testify about the delay in his custodial interview. At the outset of his interview, the investigator read the **Miranda** warnings to Davis, and Davis agreed to submit to an interview. But after signing the waiver, Davis asked the investigator if he needed a lawyer and suggested he needed someone to advise him. The investigator explained that, if he wanted a lawyer, the interview would have to stop. Davis then said he wanted to continue with the interview. The investigator nonetheless discontinued the interview for 22 minutes while he consulted with the district attorney about how to proceed. He then returned to the interview room and read the **Miranda** warnings again. Davis confirmed that he wanted to go forward with the interview and the investigator proceeded to question him. The investigator made a video recording of the interview and the prosecution offered the recording as evidence at trial. The prosecutor asked the investigator to explain the 22-minute gap in the recording that coincided with the investigator consulting with the district attorney. The investigator testified that, in light of Davis’s statement about wanting a lawyer, he had stopped to consult with the district attorney “to make sure that it was good to go back in and interview Davis” after he said he wanted to continue. On appeal, Davis claimed that the testimony to explain the 22-minute gap was inadmissible hearsay and unduly prejudicial, as it implied that the district attorney thought his submission to an interview was voluntary.

The Appeal. The Supreme Court of Georgia first concluded that the evidence at trial was “sufficient to authorize a rational trier of fact to find beyond a reasonable doubt” that Davis was “guilty of the crimes for which he was convicted.” The court then determined that the testimony of the investigator was “not hearsay because it was admitted not for the truth of the matter allegedly asserted—that the statement he gave in his interview was voluntary (at least in the eyes of the district attorney)—but rather for the purpose of explaining the gap in the recording.” Moreover, the court held that Davis failed to show that the testimony was unduly

The testimony of reluctant victims will be met with scrutiny in the criminal process, and such scrutiny is constitutionally necessary to ensure a fair trial.

to convict Scott absent the prior bad acts, the district court gave the jury an immediate limiting instruction, and Scott’s cross-examination opened the door to the prior bad acts.” The district court “therefore did not abuse its discretion in admitting the challenged evidence.” The court next examined the sufficiency of the evidence, finding that the “battery domestic violence charge was supported by physical evidence, witnesses’ testimony regarding the girlfriend’s injuries and their knowledge of her relationship with Scott, as well as admissions by Scott that he held and grabbed the girlfriend.” The court reasoned that the “fact that Scott presented contradictory evidence does not change this conclusion.” Lastly, the court agreed with Scott that “the State telling the jury during its closing how domestic violence victims typically act was impermissible expert opinion and outside the evidence.” However, Scott did not demonstrate that this error affected his substantial rights or the jury’s verdict, “especially in light of the strong evidence supporting the verdict.” The convictions were affirmed. **Scott v. State**, 448 P.3d 565 (Nev. 2019).

Editors’ Note: The testimony of reluctant victims will be met with scrutiny in

boss and reported that he had shot his wife and son; both Davis and his boss contacted law enforcement. Officers responded to the Davis family home, where they found the body of his wife upstairs with a gunshot wound to her forehead and the body of his son in the garage with a gunshot wound to his back. Davis told investigators that during a verbal and physical altercation with his wife, she threatened to kill him, and their son intervened and attacked him in an upstairs bedroom. Davis claimed that he grabbed a handgun which accidentally discharged as he was trying scare his wife, and that he turned and shot his son as he ran through the kitchen into the garage. Further investigation contradicted this account, as Davis had no visible injuries, there was no evidence of an altercation in the bedroom, and the son had been shot in the spinal cord which would have caused immediate paralysis, leaving him unable to run to the garage. Evidence also showed a history of domestic violence by Davis toward his wife and son, including a prior domestic violence arrest.

The Miranda Warnings. Following his convictions, Davis appealed, arguing that the trial court erred when it allowed the lead investigator

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prejudicial. The court reasoned that the testimony was relevant to explain the gap and did not reveal exactly what the district attorney said. The court concluded that, “[a]t best, the testimony merely implied that the district attorney had determined that the investigator could proceed with the interview.” The court did not find evidence that the testimony tainted the jury’s consideration of the voluntariness of the statement. Finally, even if Davis could show the testimony was inadmissible, he failed to demonstrate that its admission affected the outcome of the proceedings. “Even without the testimony about the investigator consulting with the district attorney, ample evidence—including the video recording of the interview—was presented to show that the statement [Davis] gave in his interview was voluntary.” The judgment was affirmed. **Davis v. State**, 827 S.E. 265 (Ga. 2019).

Editors’ Note: The protections of a proper Miranda warning are substantial for criminal defendants. A defendant who was not properly Mirandized can argue the court must exclude all statements made in a custodial interview. Davis unsuccessfully attempted to exploit the court’s decision to allow testimony explaining the 22-minute gap in the interview process.

Ohio: Conviction for Domestic Violence Affirmed Where Self-Defense Claim Not Established

The Facts. Defendant Duane Barlow went to the home he had shared with his estranged wife, R.H., to deliver money to help support their young children. While he was on the property, an argument escalated into physical violence. Their testimony about the fight diverged. R.H. testified that when she stepped outside, Barlow swung and pushed her, then struck her twice, so she fled into his car for safety. He then pulled her hair and removed her from the car. She grabbed his cell phone to call the police and he pursued her back into the house. He banged her head against the counter and as he was physically on top of her, R.H. stabbed him once with a knife that she obtained from a kitchen drawer. Barlow then fled the house and she called 911. Barlow’s testimony differed, as he claimed that R.H. initiated

the verbal confrontation and lunged at him, so he grabbed her wrist and swung her to the ground. Barlow testified that after R.H. got in his car and grabbed his phone, he then grabbed R.H. by the back of her clothing and threw her from the front seat of his car. He pursued her into the house to get his phone, then pushed her to prevent her from getting the knife from the drawer. Police briefly detained R.H., but she was not charged as a result of the incident. Barlow received treatment for his injuries, but was later charged with domestic violence and burglary. He waived his right to trial by jury and the trial court found him guilty of domestic violence but not guilty of burglary. Barlow appealed, arguing that his conviction was based on insufficient evidence and against the manifest weight of the evidence because he acted in self-defense.

The Appeal. The Court of Appeal of Ohio first addressed the sufficiency of the evidence, noting that self-defense is an affirmative defense that must be proved by the defendant in a criminal case. “Consequently, a challenge to the sufficiency of the evidence ‘is not an appropriate vehicle to review self-defense.’” On the manifest weight of the evidence argument, the court reviewed the entire record, including Barlow’s evidence that he acted in self-defense. A defendant who seeks to establish that he acted in self-defense must demonstrate three elements: “(1) the defendant was not at fault in creating the violent situation, (2) the defendant had a bona fide belief that [he] was in imminent danger of death or great bodily harm and that [his] only means of escape was the use of force, and (3) that the defendant did not violate any duty to retreat or avoid the danger.” Here, the court concluded that Barlow’s argument that he acted in self-defense failed “because regardless of whether he was initially at fault in creating the violent situation that unfolded, he did not establish that his only means of escape from imminent danger or death or great bodily harm was the use of force or that he did not violate a duty to escape.” The testimony at trial, including Barlow’s, established that the altercation met the elements of domestic violence, as Barlow pursued R.H. at multiple points, grabbed, wrestled,

and threw her, and tried to wrestle his phone away from her. “Based on this testimony, a rational trier of fact could conclude that rather than facing a threat of imminent bodily harm that could only be escaped by use of force, Mr. Barlow pursued R.H. and repeatedly reengaged in the conflict with her.” The court concluded that the weight of the evidence failed to support the conclusion that Barlow acted in self-defense. The judgment was affirmed. **State v. Barlow**, 2019 WL 691582 (Ohio Ct. App. 2019).

Editors’ Note: Self-defense is an explanation that perpetrators of domestic violence often employ. It can be difficult for law enforcement to ascertain if there is a dominant aggressor or if the situation is one of mutual combat between two persons. This case makes clear that the burden to establish self-defense rests on the defendant, and Barlow failed to meet his burden.

Georgia: Motion to Suppress Evidence After Police Entry Into Home Properly Denied Where Husband Gave Consent to Enter

Background. Defendant Miranda D.L. Smith was charged with unlawfully opposing or resisting a government employee in the performance of their official duty by forcibly resisting lawful detention by a military police officer. Police officers responded to a domestic violence call at Smith’s home. Upon arriving, officers observed Patrick Rush, who identified himself as Smith’s husband, bleeding significantly from his nose in front of the house. He informed the officers that Smith had struck him in the face and that she was inside the marital home. According to the testimony of one officer, Rush said that officers could “go get her.” Officers considered the scene “active” and were told by neighbors that Smith was seen hitting her husband. When officers approached the home, Smith refused to answer the door and turned on loud music. Officers then went to the rear door and Smith answered. She told the officers to leave and when she was asked to come with them, she withdrew into the home and forcibly resisted apprehension. Prior to trial, Smith filed a motion to suppress evidence, alleging she was arrested in her home without

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a warrant, her consent, or exigent circumstances to authorize the warrantless entry. The government responded that Smith’s husband, a co-occupant of the house, gave his consent to enter the home and that sufficient exigent circumstances existed to authorize the officers’ entrance of the home without a warrant to arrest Smith.

The Decision. The U.S. District Court for the Middle District of Georgia reviewed the five-factor exigent circumstances test to determine whether the home invasion was justified to make an arrest. The court concluded that the factors were all “clearly met” here where the officers were confronted with a bleeding victim who made an excited utterance about his injuries as a result of a domestic assault. The victim identified Smith as the assailant and confirmed she was in the house. “Delay to obtain a warrant risked further assault on the victim or [Smith] absconding, a conclusion reinforced by her resistance to detention ad arrest.” Therefore, the court concluded that the facts known to the responding officers “would lead a reasonable and experienced officer

to believe that exigent circumstances existed.” Moreover, the court concluded that the officers had the “affirmative consent” of Smith’s husband to enter the marital residence that they shared. The officers’ “sole purpose in entering the home was to secure an active crime scene of domestic violence and detain [Smith], who Rush identified as his assailant.” The court was also satisfied that the officers did not search the home and that nothing was taken from the home other than Smith herself. Given that the officers were faced with exigent circumstances and had the valid consent of the victim, Smith’s motion to suppress was denied. **U.S. v. Smith**, 2019 WL 2267305 (MD Ga. 2019).

*Editors’ Note: The **Smith** court stated, “It is a basic principle of Fourth Amendment law that searches and seizures inside a home without a warrant are presumptively unreasonable.” *Payton v. New York*, 445 U.S. 573, 586 (1980). Indeed, unwarranted entry into the home is the “chief evil” which the Fourth Amendment is directed at combatting.” Crossing this constitutional line and forcibly removing a person from his or her home requires exigent circumstances or consent—both of which were demonstrated here.* ■

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