COVER PAGE

EXECUTIVE SUMMARY (2 pages max)

- Key findings and recommendations (TBD)

REPORT (15-20 pages max)

1. FACTS AND PERSONAL STORIES

GENERAL

- Non-fatal strangulation: "reduced blood flow to or from the brain via the external compression of blood vessels in the neck" (Sorenson, Joshi, & Sivitz, 2014).
- Unconsciousness may occur within seconds and death within minutes. (Strangulation Institute, 2017)
- A person can be fatally strangled in less than 5 minutes and left with no visible injury (Strangulation Institute Webinar, 2017)
- Very little pressure on both the carotid arteries and/or veins for ten seconds is necessary to cause unconsciousness. However, if the pressure is immediately released, consciousness will be regained within ten seconds. To completely close off the trachea (windpipe), three times as much pressure (33 lbs.) is required. Brain death will occur in 4 to 5 minutes, if strangulation persists. (Strangulation Institute, 2017)
- victims, perpetrators, judges, juries, police officers and the public all minimize the crime (Strangulation Institute Webinar, 2017)
- Very severe health consequences including psychological intimidation, loss of consciousness, loss of sphincter and bladder control, short and long term raspy voice, petechiae on the face and eyes, and death (Joshi, Thomas, & Sorenson, 2012; Sorenson et al., 2014; Thomas, Joshi, & Sorenson, 2014).
- The long term effects of strangulation include stroke and mild brain injury (Sorenson et al., 2014).
- Often bruises do not appear until days afterward which impedes the likelihood that a law enforcement and other responders will believe the victim was strangled (Sorenson et al., 2014). Fatal strangulation can occur without any external evidence of violence on the human body – the best way to document a strangulation case is still by autopsy (Strangulation Institute Webinar, 2017)
- An individual with a history of non-fatal strangulation has seven times the odds of becoming an intimate partner homicide victim and many who experience strangulation experienced it multiple times within a relationship (Joshi et al., 2012; McClane, Strack, & Hawley, 2001).
- Often IPV and strangulation are a method for one partner to assert control over the partner (Thomas et al., 2014). Where the batterer can demonstrate control over the victim's next breath; having devastating psychological effects or a potentially fatal outcome (Strangulation Institute, 2017)

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- Individuals who are “structurally or socially vulnerable,” minority groups and disabled persons are more likely to report strangulation by an intimate partner (Sorenson et al., 2014).
- Women who have experienced intimate partner violence have correspondingly experienced sexual risk behavior and adverse sexual health outcomes (Laanpere, Ringmets, Part, & Karro, 2013).

NEW MEXICO

- Within New Mexico, domestic violence is a very serious public health issue with the second highest domestic violence rate in the United States (Armstrong, Roybal Caballero, & Thomson, 2017). One in four adults have been a victim of domestic violence in their lifetime (Miller, 2015).
- 89% of IPV victims that died due to IPV in 2013 had a history of victimization (Miller, 2015).
- High risk populations for IPV in New Mexico: females (93%), Hispanics (56%), African Americans (5% - higher than the state population: 2%), Native Americans (15% - higher than the state population: 9%), individuals with English as a second language (24%), a high school education level (84%), enrollment in Medicaid (39%), abuse as a child (29%), individuals who grew up with a parent with a mental illness (55%), individuals who have been told they have a substance abuse problem (69%) and individuals with a prior domestic violence experience as an adult (57%) (Caponera, 2016). Despite 93% of survivors reporting they were female, social acceptability bias may be operating with many men not wanting to report that they are experiencing IPV.
- Of the 89% of New Mexican survivors who reported the type of IPV, 12% reported strangulation (Caponera, 2016).
- However, there is no established statewide policy or procedure to document the number of IPV strangulation cases or even deaths due to strangulation.
- New Mexico is one of only six states that do not have a law penalizing strangulation and instead charges perpetrators with assault or battery, which can be either increased to a felony or dropped to a misdemeanor (Hayes, 2015). In the 2015 New Mexico Intimate Partner Violence Death Review Team Annual Report there is no mention of strangulation (Garcia, 2016).
- As a result the New Mexico Legislature established a task force to “create a statewide health plan to reduce the incidence of and address the long-term health implications of interpersonal violence strangulation” (Armstrong et al., 2017).

STORIES

- Requested from Task Force members who work closely with clients
- Currently we have one from Josh Lopez (EMS) and David Adams (Parnall Adams Law Firm)

Commented [MC2]: I requested stories from Task Force members who work closely with clients (either from clients or themselves)

2. INFORMATION/HISTORY OF THE TASK FORCE

The Domestic Violence partners have previously worked towards reducing the incidence of strangulation within relationships through promotion of legislation penalizing strangulation. Since 2011, five bills outlawing strangulation have been introduced, including HB 145 Strangulation as 3rd Degree Battery (2012), SB 262 Crimes of Strangulation & Suffocation (2013) and SB 513 Domestic Violence Suffocation and Strangulation (2015), all five have failed. In 2017, the House Joint Memorial Bill establishing a Domestic Violence Task Force was enacted with the mandate to create a statewide health plan to reduce the incidence of and address the long-term health implications of interpersonal violence strangulation. The Task Force is committed to taking a public health approach to this devastating state-wide problem, working towards awareness and health promotion to provide for the safety of the population over further penalization of marginalized communities.

The primary goals of the task force are twofold. During Phase 1, the Task Force identified data sources, researched and evaluated the current policies and protocols for various key institutions including law enforcement, hospitals, medical providers and other public health agencies in New Mexico and in other states, and finally developed the most appropriate recommendations for a plan to address intimate partner strangulation within the state, with a special focus on the unique populations within our state. During Phase 2, the Task Force will work to implement these recommendations statewide.

The Task Force is comprised of key stakeholders and members from key institutions throughout New Mexico. Members of the task force include the following organizations and individuals: New Mexico Coalition Against Domestic Violence, New Mexico Coalition of Sexual Assault Programs; Coalition to Stop Violence Against Native Women; Parnall Adams Law; Strong Families Forward Together; Young Women United; Southwest Women's Law Center; Salude; Children, Youth and Families Department; New Mexico Department of Health; Planned Parenthood; the New Mexico Crime Victims Reparation Commission; the Santa Fe Coordinated Community Response Council; the University of New Mexico Health Sciences Center; Valencia Shelter Services; Jemez Pueblo; Christus St. Vincent Medical Center; the Indian Health Service; Department of Health Injury Prevention Program and Epidemiology and Response Division; a former prosecutor; a medical first responder agency; as well as a sexual assault nurse examiner, a law enforcement officer with expertise in domestic violence, and a

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medical professional with expertise in the area of anoxic brain injury caused by strangulation. There were advisors from the Interpersonal Violence Data Central Repository; Center on Law and Poverty; Homeland; the Santa Fe Police Department; and the Eddy County Sheriff's Office.

3. SPECIFIC INSTITUTION INFORMAITON AND RECOMMENDATIONS

The findings of this report are consistent with the LFC in that it was determined that a coordinated community response is the best way to implement and institutionalize change in the State's response to strangulation.

Data Collection around Non-Fatal Strangulation in New Mexico:

Currently, the majority of data around non-fatal strangulation is collected by statewide SANE programs who see sexual assault victims for medical exams and/or forensic evidence collection following a rape. Between 2010 and 2014, an average of 1,103 rape victims were seen each year by statewide SANE programs. An average of 12% of SANE patients experienced strangulation each year from 2010-2014. When analyzed by age from 2010-2014, an average of 1% child SANE patients, 7% of adolescent SANE patients, and 16% of adult SANE patients experienced strangulation each year (Caponera email, 2017). A preliminary analysis of a more detailed study of patients visiting the Albuquerque SANE Collaborative (ABQ SANE), servicing Bernalillo County, from 2010 to the present revealed that 36% of domestic violence victims seen at ABQ SANE were observed to have strangulation injury (Caponera email, 2017).

Commented [MC7]: I am not sure if Dr. Caponera would like this information included in the report, as her report is not officially out until the beginning of next year.

The New Mexico Interpersonal Violence Data Central Repository does not collect statewide non-fatal strangulation data from law enforcement or domestic violence service provider agencies, nor do these institutions include any question about strangulation in their forms. In order to obtain information from statewide service providers and law enforcement, the legislature would need to enact a law requiring the collection of this data. Additionally, as data is collected in aggregate, little could be learn about relationships between strangulation and other variables of interest. However, frequency counts could be obtained through these avenues in order to determine a baseline statewide rate of non-fatal strangulation.

It has been recommended that the task force focus recommendations on adding any data collection questions on SANE program and ER or medical provider forms as they have personnel who are specifically trained to observe and document injury as opposed to self-reported data in aggregate police incident or service provider reports.

Other Potential Sources previously identified by the Task Force:

IPVDRT Data?

EMS database?

Victim Services/Prevention and Advocacy

Aging and Long-term Services:

- What we know:
  - NM specific information around elder abuse and strangulation is limited
  - Strangulation is under researched, specifically true for special populations
  - Elders are more frail – it takes less pressure for serious injury
  - We have mandatory reporting for elder abuse in NM
  - CYFD doesn't include anything in their screening for elder abuse, and it is not being prosecuted unless there is a sexual assault
- Information we still need:
  - To find out how serious is problem?
    - This is one of least reported groups and was ranked as the #1 underserved population for the last 2 funding cycles across all types of victimization in NM
- Recommendations:
  - Train everyone that even slight pressure is very serious for elders
  - Should be part of all reporting EMT, ER, etc.
  - Request that the NM Office of Aging include questions in their screenings for elder abuse
  - Include information in the benchbook training for judges
  - Recommend all senior centers have informational signs/pamphlets

CYFD (DV, BIPs)

DOH (RCCs, SANE)

CYFD/Protective Services/Advocacy/MDT

- What we know:
  - Statewide CYFD doesn't screen for/track strangulation.
    - CYFD identifies DV through a screening tool, refers to a shelter for a risk assessment. Follow-up varies (confidentiality).
    - There is a new project at CYFD for state level training for DV – this is an opening to include strangulation in this
    - Could possibly get information from lethality assessments
- Information we still need:
  - Data around children – will follow up with CYFD
  - Work with Advocacy services to ask questions and collect data about strangulation (the offender program has begun this work)
- Recommendations:
  - DV and RCC programs should collect data around strangulation
  - Implement training for these institutions and maybe for educators/schools

- Conduct a survivor/offender survey
- Advocacy for CYFD should be CYFD specific, DV agencies should not be tied to CYFD funding

Law Enforcement

Law Enforcement:

- What we know:
  - Statewide reports do not ask for strangulation
- Information we still need:
  - Should we recommend training everyone or specialized officers?
    - Give everyone a basic EMS level so they know where to divert cases
  - Local vs State Police – who gets the training/experiences these cases more often
- Recommendations:
  - Extrapolation of data and training
  - Change law or recommend to change statewide form to include a check box -
    - help with data, we know how many are responding to strangulation and prosecution rates for strangulation
  - Institute an MDT type setting for training/participation
    - won't get all officers, but possibly recommend legislation around mandatory training
    - pilot DV instructor training (maybe with SFPD, but that wouldn't include all officers)
    - think about most applicable to be trained not blanket requirement
  - Develop ~3 questions all officers need to know – rather than curriculum and educate all officers that "choking" = strangulation and this is lethal.

Pre-Court Legal

Prosecutors:

- What we know:
  - 1 case management system for all prosecuting attorneys though not everyone is using it
  - No check box for strangulation,
    - don't know actual strangulation #, dedicated prosecutors,
  - Barrier to legislation because of idea of spectrum length of time = misdemeanor/felony
  - No uniform reporting from law enforcement or mechanism for follow up
  - No mandatory training, uniform protocol for DA
  - Conviction rates poor
  - Have many resources that work – National Association of DAs, etc.
- Recommendations:
  - Check box must be approved by AODA
  - Need prosecutors who want to train

Civil Legal Services

Judicial

Healthcare Services

Pre-Hospital Dispatch: EMS/First Responders

- What we know:
  - There are no current specific trainings/protocols but good foundations in place
    - An existing overarching protocol system throughout NM: EMS are given guidelines follow, contacts and resources, dispatch has a script
    - existing protocols/guidelines from other states (San Diego, Strangulation Training Institute, EMS, dispatch, forms, event questions)
  - There is data that could be collected
    - EMS agencies charting systems and NMEMSTARS (huge database)
- Information we still need:
  - What do we want EMS to do for victims?
    - More knowledge about dangers of strangulation (stroke), assessment card (give to patients to monitor symptoms), describe danger in medical terms– goal not to get to end relationship but to get information for the safety of the victim
- Recommendations:
  - EMD and EMS specific strangulation protocol
    - Add a question about strangulation (be careful because 911 tapes are admissible, can be included in a case)
    - Mandatory dispatch of EMS/police if caller indicates strangulation (statewide)
      - currently based on medical logic tree (varies rural, urban, tribal) and may not get first responder
      - protocols are updated every 4 months by the Emergency Medical Consortium
    - Include pre-arrival instructions from dispatcher to victim and prompts for dispatcher to include MDT
    - Don't allow victim to send away EMS/not engage in medical care (advise of potential harm) – this can be enforced/encouraged through EMS training
  - Develop trainings for EMS

Physical and Mental Healthcare:

- What we know:
  - It is difficult to code for strangulation
    - Maybe we can go through data entry clerks for data, pilot with St Vincent
    - Many ICD10 codes around strangulation

        - If there is a diagnosis, individuals may not want this on the record – can be used in child custody cases, as a pre-existing condition, etc.
        - Maybe we can develop a system for anonymous reporting?
    - The ER departments are not taking strangulation seriously or not aware that symptoms may be hidden
    - We don't know much, it is difficult to get info
    - most personnel are not trained
    - Rape Crisis Centers: ABQ SANE collects information
    - Data is important to get buy – need to find a way to collect NM medical data
        - healthcare provider data and police data more credible
        - We have national data and from EMS and police
    - A Georgia coalition conducted a less than 2 months anonymous survivor survey with shelters/ER – could imitate for medical data in NM
- <u>Information we still need:</u>
    - how other states are gathering data – can use for enhancement for penalties
    - policies, protocol, training
    - Access to EMS repository information, SANE data, hospital discharge information (required to collect by state)
        - how collect info without manually charting
    - Work with the NM Brain Injury Alliance (currently working on insurance coverage)
    - How other states are collecting data – given coding issue
    - Ask Cameron how track data
- <u>Recommendations:</u>
    - make recommendations simple and easy as possible to implement
    - Could say we looked into collecting data and found a variety reasons that collecting Med data is difficult or inappropriate and determined we could not collect data

Managed Care Organizations:

- <u>What we know:</u>
    - operate with codes for reimbursement,
    - no package for care instructions, (DV as whole but not strangulation specifically)
        - have brochures (problematic)
        - ask the question – do you feel safe at home
- <u>Information we still need:</u>
    - Bring insurance providers in the room
- <u>Recommendations:</u>
    - Update screening process – ensure there is a safety net/protocol in place
    - Include a specific packet/information about strangulation not just DV
    - Consider reimbursement to get providers on board (Medicaid)
    - Use as entry points for prevention with primary care providers, while signing up for insurance

Education

PED

Sex Educators

Higher Education
Media

Tribal

IHS/Native Services/BIA

- <u>What we know:</u>
  - Law Enforcement:
    - Indian Police Academy trains all Native Police across nation, there is language in the training guide but we do not know if there is interaction/retention of the information
  - Medical:
    - Native victims will often go to ER before the police for medical needs
    - There is a danger and lethality risk section in IHS handbook, each IHS facility will create own policies and procedures,
      - each team and special agent in charge for procedures was emailed (15 different facilities)
      - Northern Navajo Medical Center and the Gallup Indian Medical Center have questions about strangulation (likely because they have SANE unit)
- <u>Recommendations:</u>
  - add more questions that the IHS facilities can use

SUMMARY

APPENDICIES

1. TASK FORCE MEMBERSHIP

   MEMBERS

   David Adams, Parnall Adams Law - prosecutor/trainer
   Adriann Barboa, Strong Families Forward together - organizing/ advocacy
   Denicia Cadena,Young Women United - organizing/advocacy
   Donald Clark, Sexual Assault Services of Northwest NM, MDT member - medical
   Sarah Coffe, Southwest Womens Law Center - policy/ legislation
   Cameron Crandall, Salude - medical

Rebecca Edwards, CYFD - funding
Heather Frankland, NM Department of Health - prevention/ education
MaryEllen Garcia, NM Crime Victims Reparation Commission –funding
Naomie Germain, Young Women United - policy
Julianna Koob, NM Coalition of SA Programs - co-convenor NMCSAP
Sheila Lewis, Santa Fe Safe (CCRC) - policy /legislation
Joshua Lopez, UNM EMS Academy - EMS training
Emily Martin, NM CYFD - funding
Marshal Martinez, Planned Parenthood - organizing/advocacy
Deleana Otherbull, Coalition to Stop Violence Native Women - co-convener CSVNW
Angelia Parent, Carlsbad SANE nurse - MDT Member
William Perdue, Santa Fe Police Department – domestic violence law enforcement
Edna Sprague, MDT member - former prosecutor
Gail Starr, Albuquerque SANE nurse - MDT Member
Alexandria Taylor, Valencia Shelter Services - advocate
Yolanda Toya, Jemez Pueblo - advocate
Andrea Verswijver, Christus St. Vincent Medical Center - advocate
Lisa Weisenfeld, NM Coalition Against Domestic Violence - co-convener NMCADV
Michele Williams, Santa Fe Police Department - law enforcement
Judy Wolf, Indian Health Service- medical

ADVISORS

Betty Caponera, NM Coalition of Sexual Assault Programs, Inc - Interpersonal Violence Data Central Repository - data
Abuko Estrada, Center on Law and Poverty - policy
Lily Love, Ear Nose and Throat - medical
Quintin McShan, Homeland - law enforcement
Eric Threlkeld, Eddy County Sherrif's Office - rural law enforcement

Mary Carmody, UNM Public Health Masters Candidate - Project Assistant

2. Longer Provider Testimonials
3. SAMPLE REPORT FORMS, etc.
4. BIBILIOGRAPHY OF RESOURCES