Chapter 4

Establishing an Appropriate Response to Domestic Violence in Your Practice, Institution And Community

By Carole Warshaw, M.D.

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Introduction

In order for clinicians to develop and sustain an appropriate response to domestic violence, they must have the support of the institutions in which they practice. As health care professionals attempt to incorporate routine inquiry about abuse into the standard of care for all women patients, the need for a coordinated institutional response to domestic violence becomes increasingly evident. This chapter addresses strategies for changing institutions and practice settings to support and encourage health care providers to meet the needs of victims of domestic violence.

Providers acting alone simply cannot meet all of the needs of domestic violence victims and their children. The optimal response to domestic violence requires the coordinated efforts of all members of the community, including health care providers, community-based domestic violence advocacy groups, child welfare and protective service agencies, and the civil and criminal justice systems. This chapter will describe how to work within clinical practice settings, health care institutions, and communities to develop such a coordinated response. It will also describe strategies to assure that battered women receive appropriate care within individual practice settings. The following issues will be addressed:

- Creating a practice environment that enhances rather than discourages identification of abuse.
- Educating health care staff about domestic violence intervention.
- Developing an integrated response to

domestic violence within the health care setting, whether in an HMO, hospital, clinic or group practice.

- Developing appropriate contacts and written resource materials for referral of battered women and their children to domestic violence programs, legal advocacy programs, and other services.
- Creating practice and training environments which model and support mutually respectful behavior among staff, faculty and trainees, and clinicians and patients.
- Developing site and community specific intervention strategies for battered women and their children.
- Integrating ongoing evaluation of provider response to domestic violence into continuous quality improvement programs and developing evaluation measures of outcomes for victims of domestic violence.
- Becoming part of a coordinated response within the community.

I. THE NEED FOR INSTITUTIONAL CHANGE

Despite the well-documented prevalence of partner abuse among women seeking medical services in health care settings, clinicians continue to have difficulty incorporating routine inquiry about domestic violence into their practices and responding appropriately to women who have been battered by their partners. Even institutions with established domestic violence protocols and training often fail to provide the support necessary for a sustained provider response. There are several reasons for this.

Unlike traditional "medical problems," domestic violence often raises complex issues and challenges both for individual providers and for the institutions that shape the practice of medicine. Some of these issues involve individual experiences and responses to abuse, as well as biases and cultural assumptions about gender, power, and partner abuse. Addressing these issues requires more than simply adding new diagnostic categories to differential diagnoses or new technical skills to clinical repertoires. Instead, it entails asking clinicians to behave in ways that may conflict with their personal needs and cultural values. The development of effective responses to domestic violence then requires changes in knowledge, attitudes, and skills that push the limits of a traditional medical framework.

Other structural obstacles can also interfere with a clinician's ability to provide an appropriate standard of care for battered women. For example, when medical training programs foster an atmosphere in which students and residents learn to survive at the expense of their own feelings, it can be difficult for them to respond appropriately to the feelings of others. If addressing complex psychosocial issues is devalued at an institutional level, clinicians' survival within the health care system may be placed in conflict with the needs of their patients. To improve an institution's response to domestic violence, these barriers must be addressed systemically.

In addition, traditional training strategies must be expanded to change attitudes and behaviors in order to more effectively respond to patients who are battered. Standard didactic training formats alone have not proven sufficient to help providers incorporate identification and intervention

strategies into their clinical work. While initial trainings may raise awareness and help clinicians develop skills, systematic feedback and support are necessary for sustaining provider response. Ongoing discussions are needed to help clinicians develop interviewing skills, address their assumptions and concerns, model the respect needed for true collaborative working relationships, and invest participants in the process of making individual and institutional change.

Thus addressing the issue of domestic violence requires changes in the approach to medical training and in the institutional culture of medicine and healthcare delivery. It means

1) prioritizing issues that (while perhaps not alien to nursing or social work) have traditionally been considered outside the purview of medical practice;

2) utilizing models that recognize the social context in which symptoms develop;

3) valuing the quality as well as the content of clinical interactions and fostering interactions that facilitate rather than direct change;

4) creating training environments that encourage clinicians to be able to address complex issues with skill and compassion;

5) developing interdisciplinary teams within the health care setting that

THE DOMESTIC VIOLENCE EMERGENCY DEPARTMENT PILOT-TEST PROGRAM

A 1993 survey of California and Pennsylvania hospitals' emergency departments conducted by the FUND and the PCADV asked respondents to identify their institution's willingness to serve as "test-sites" to evaluate the "useability" of the domestic violence resource manual, to assess the implemantation strategies suggested in the manual and examine the manual's adaptability to various settings (e.g., rual, urban, HMO, private institution.) Nearly 250 hospitals volunteered to be test sites in recognition of the need to develop a coordinated institutional response to domestic violence. Competition was fierce but six hospitals from each state were chosen representing a diversity of characteristics:

- size
- location (urban, ultra-urban, rural, suburban)
- type of ownership
- type of facility (trauma center, teaching hospital, HMO, general)
- diversity of patient population

While the pilot test focused on the emergency department response to domestic violence, it is easily replicable in other health care settings.

The test hospitals received two days of training and six months of technical assistance free of charge but received no funding for implementing and creating a comprehensive response to domestic violence.

model mutual respect and support, and

6) creating collaborative partnerships between the domestic violence advocacy community and the health care system in conjunction with the legal system and other community agencies that serve battered women and their children. This type of collaboration is important, not just to provide referral sources for patients but to develop intervention strategies that are effective, appropriate, innovative and coordinated with existing community resources.

There are also specific skills health care providers can learn from working closely with battered women and domestic violence advocates. These include: knowledge about what is and is not helpful to battered women, recognition of the differences between a directive diagnosis and treatment model and an equality-based advocacy model, and experience in developing strategies for social change.

This shifting of priorities is particularly important in the rapidly changing health care climate. It is important that administrators, insurers and those who influence health care policy recognize that the costs of nonintervention far exceed the costs of investing in appropriate prevention and intervention. Screening, assessment and advocacy interventions are essential components of preventing the long-term health as well as social consequences of domestic violence. Whether they are provided by a nurse, a social worker, a physician or an advocate, they must be accepted as significant aspects of providing quality health care.

II. THE NEED TO WORK COLLABORATIVELY: EXPLORING MODEL INTERVENTION STRATEGIES

Before health care providers routinely inquire about domestic violence, intervention strategies must be in place. This means working with a multidisciplinary team of clinicians and the domestic violence advocacy community to assess needs, identify resources, and develop protocols for providing services and creating change. While the primary provider's focus may be on diagnosis and treatment, an optimal response to domestic violence necessitates that clinical interventions become part of a coordinated community response. It means creating a safe place within a practice setting for women to discuss the violence in their lives. It means knowing what resources are available in the community and coordinating new initiatives with those who already have extensive commitment and expertise in this area, the domestic violence advocacy community and the many women who have survived abusive relationships. The availability of institutional support, community coordination, designated staff, and incentives for implementation greatly increases the likelihood that screening and intervention will become routine.

At a minimum, every institution or practice should support individual clinicians in their efforts to incorporate routine screening and intervention into ongoing practice. Conducting a training, adapting a protocol, and working with the domestic violence advocacy community to create a referral network is one way to start. When there are no battered womens' services available in the community, it may be necessary to develop domestic violence advocacy projects on site. This could mean training staff within the institution to provide advocacy as part of their ongoing clinical work.

In some communities, groups of

DOMESTIC VIOLENCE EMERGENCY DEPARTMENT PILOT TEST PROGRAM

Each of the twelve hospitals selected as pilot-test sites recruited a multi-disciplinary team made up of an emergency department physician, nurse, social worker and administrator and a domestic violence advocate from the local domestic violence program in the community. Each team member attended the two day training and received a draft copy of this manual.

In addition to providing training on clinical skills in identifying and assisting victims of domestic violence and addressing issues related to institutionalizing a comprehensive response, it is important to note that time was allotted during the training for team members to:

- identify obstacles, strengths and solutions in organizing their hospital's response to domestic violence;
- identify ways for practitioners to begin working together across disciplines;
- identify their disciplines' roles within the team in bringing about institutional change;
- develop an action plan and assign specific responsibilities; and
- identify additional staff recruits to the team from within the hospital (hospitals expanded their teams; some include drug and alcohol, ob/gyn, security, pediatrics, clergy, mental health, hospital board of directors and others)

In addition, many of the hospitals and the domestic violence programs in attendance made plans to visit and spend some time in each other's facilities to better understand each other's work, constraints and strengths.

advocates and health care providers have established training and intervention programs on a community-wide basis in city, county, state and federally funded clinics, and are currently establishing community-based programs that link the health and legal systems with domestic violence advocacy services. In some states, medical and nursing societies are taking a leading role in these efforts. It is important to obtain technical assistance and training from groups experienced in working with battered women. The small but growing number of successful hospital-based domestic violence intervention programs have involved coordination in the planning and implementation stages between health care providers/institutions and domestic violence advocacy groups from the outset. Whether the goal is to improve individual provider response or to develop a more comprehensive institutional-based training and advocacy program, this type of collaboration is the best way to assure appropriate care for battered women and their children.

III. DEVELOPING AN IMPROVED RESPONSE

The elements necessary to develop an institutional response to domestic violence are outlined in the box below. These key programmatic tasks do not need to occur in this particular order. How they are implemented will depend on individual practitioners, the institutions they work in, and the community resources available to them. (See Figure 4-1).

A. Getting Started

1. ESTABLISHING A COLLABORATIVE WORKING GROUP

A key aspect of developing an appropriate response to battered women is the initial collaboration between health care providers and the domestic violence

FIGURE 4-1

KEY ELEMENTS FOR ESTABLISHING A HEALTHCARE SYSTEM RESPONSE TO DOMESTIC VIOLENCE

1. **Getting Started**
   - Establishing a Collaborative Working Group: healthcare providers and domestic violence experts
   - Assessing Needs and Resources within institution and community
   - Building Institutional Support and Involvement
   - Generating Administrative Commitment
   - Establishing a Broad Base: Multidisciplinary and Multidepartmental Support
2. **Development of Interventions**
   - Site- and Community-Specific Intervention Strategies
   - Referral Network
   - Written Resource Material
   - Protocols
3. **Implementation**
   - Preparing Practice Environment
   - Training Strategies and Programs
4. **Sustaining the Response**
   - Structural Support and Incentives
   - Monitoring and Evaluation procedures
5. **Community Linkages**
   - Ongoing Community Involvement

advocacy community. This could mean working with a local group, a state domestic violence coalition, a domestic violence health care program from another area or the Family Violence Prevention Fund's Health Resource Center on Domestic Violence. At present, a wide range of resources are available for collaboration and technical support. In order to sustain individual efforts, it may be helpful to network with other colleagues who are concerned about domestic violence, whether in your own institution or outside. It is also critical to collaborate with domestic violence advocates and survivors who know firsthand the experience of battered women and are knowledgeable about available resources.

The individuals initially involved in establishing a collaborative working group will vary according to the setting and size of the practice. In smaller practices, everyone may be able to work together to establish a coordinated response. In larger institutions, it is often critical to establish a core group that prioritizes addressing domestic violence within the institution. There may be others interested in the issue, but without the time or initiative to create or sustain active involvement in the initial group. Identify these people and keep them involved in the process, even if they can't participate in the core group. Early involvement of deans and faculty in charge of training and education will help facilitate the eventual integration of domestic violence into medical, nursing, social work, dental and continuing medical education curricula. Keep in mind that integrating a coordinated response to domestic violence on an institution-wide basis can be a very slow process. Think long term, be patient and persistent, and find other people who are supportive. This will help to sustain the initial working group.

2. Building Institutional Support and Involvement

a. Administrative Commitment

Convincing key people in health care institutions that addressing domestic violence is a necessary standard of care can be facilitated by obtaining domestic violence prevalence data on your target population. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements that health care institutions have policies and procedures for the identification, intervention and referral of victims of violence provide a vehicle for approaching administrators with a plan to meet those standards. In addition, presenting documents such as the American Medical Association (AMA) Diagnostic and Treatment Guidelines for Domestic Violence, manuals or guidelines from state and local medical and nursing societies, the American College of Obstetricians and Gynecologists (ACOG) and American College of Physicians (ACP) recommendations on domestic violence, the American Nurses Association's Resolutions and Guidelines on Domestic Violence, as well as key articles listed in Appendix P of this manual, can help demonstrate the need for an institutional response.

Although data comparing costs of intervention vs. nonintervention are not currently available and outcomes of health care setting interventions for battered women and their children are just being studied, preliminary data should be available within the next few years. It is clear, however, that the health care costs of nonintervention are exceedingly high, as are the indirect costs of lost productivity, diminished quality of life, and the social impact of domestic violence on others.[1] We do know that with a range of interven-

1 Koss, M.P. (1993). The impact of crime victimization on women's medical use. Journal of Women's Health, 2, 67-71.

tions, millions of women are able to leave abusive relationships and go on to lead lives free from violence.

As health care providers and institutions become increasingly competitive for patients, strategies that provide visibility and generate community awareness about domestic violence can also help spark administrative interest. Include information about domestic violence services in newsletters and brochures, offer public lectures, generate newspaper articles, television and radio spots to bring positive publicity to a given practice setting. Targeting information to employers and insurance purchasing groups and to individuals will help link domestic violence awareness and services to a particular health care institution. In addition, seeking legal counsel to discuss potential liability to the institution for failure to respond appropriately to victims of domestic violence may be another way to gain administrative support for this issue.

Clear administrative messages that routine inquiry, intervention and referral are institutional priorities will increase the effectiveness of the intervention strategies that are established. Committing staff time and providing on-site space for advocates to work with clinicians and patients are important for initial program development. Thus, staff should not be

FIGURE 4-2

STRATEGIES FOR BUILDING INSTITUTIONAL AND ADMINISTRATIVE SUPPORT

1. Pilot data from your institution showing prevalence and current level of response to domestic violence
2. Data from other health care institutions in the same or similar communities or from studies done in other locations.
3. Data from other institutions in the community such as the police, the courts, state attorney general's offices, local shelters and state domestic violence coalitions
4. Clinical and public health literature indicating need for routine identification, assessment and intervention
5. Policy statements from AMA, ANA, ENA, ACOG, ACEP, ACP and Surgeon General on standards of care
6. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements on domestic violence
7. Cost savings
8. Visibility for institution
9. Potential liability for nonintervention
10. Meetings with formerly battered women and domestic violence advocates to hear about importance of generating a health care response to domestic violence

penalized for spending "too much time" talking to patients or not given sufficient time to attend trainings on domestic violence. (See Figure 4-2).

b. Multidisciplinary Involvement

Patients often see a range of clinicians and staff members, increasing the opportunity for identification and intervention if all staff are trained to recognize domestic violence and offer appropriate responses. Initial intake may provide the best opportunity to inquire about partner abuse. In some settings, the non-triage nurse, nurse practitioner, physician assistant or doctor may be in the best position to ask patients about domestic violence. A triage nurse or receptionist who sees a hovering spouse and suspects abuse can remind the primary provider to ask directly. Women have been referred to domestic violence advocates by security guards, newspaper vendors in the hospital, by supervisors who recognize that a staff member is being abused, and through the Employee Assistance Program, self-referred after trainings. The wider the range of staff awareness, the more battered women will have access to the resources they need.

Clinicians have begun to recognize the ways that domestic violence impacts on a wide range of medical and psychiatric problems and the need for a multidisciplinary approach to address the complexity of issues women face. For example, domestic violence may be one of the greatest single risk factors for HIV infection in women. When HIV risk is addressed solely through a biomedical framework, i.e., the physical route of transmission, without addressing the coercion and control many women experience in their sexual relationships, "safer" sex counseling becomes ineffectual. Addressing the problem of substance abuse without recognizing the relationship to, and impact of, battering denies women access to necessary resources and services. Working as part of a team permits expansion beyond traditional boundaries set by disciplines and specialties and the limits of an often fragmented problem-oriented medical framework.

c. Multi-departmental Involvement

It is essential to involve as many departments as possible in domestic violence intervention programs. To do so, however, may be a gradual process. By beginning where members of the initial working group have support and influence, a domestic violence project can develop experience and demonstrate success, and ultimately integrate and expand the program. This process of expansion may be uneven as awareness spreads through a variety of routes and strategies. While trainings, posters, brochures, newsletters, in-house and community-based media events can increase general awareness of the issue, much of the educational work is done through informal discussions among colleagues.

d. Collaborating with Domestic Violence Programs

Mobilizing the resources necessary to address domestic violence rather than just treating its physical manifestations requires the development of working relationships with a range of other agencies and disciplines. Working collaboratively with domestic violence programs can help break the isolation health care providers may experience and deepen their understanding of the complex issues that often arise when working with battered women. An advocacy approach, which involves helping patients recognize and utilize their own resources, is based on models different from traditional biomedical intervention. Recognizing the limitations of a directive, provider-centered treatment approach allows providers to develop interventions that assist patients in formulating their own assessments and making their own decisions.

THE DOMESTIC VIOLENCE EMERGENCY DEPARTMENT PILOT-TEST PROGRAM

Prior to receiving training, emergency department staff of each of the participating hospitals were asked to fill out pre-test evaluation surveys to collect baseline data on attitudes and behaviors toward battered patients. Participating hospitals were also surveyed to determine existing policies, procedures and structural practices in place within their emergency departments. Highlights of the findings included:

1. 67% reported treating one to five victims of domestic violence each month;
2. Over one-half reported that they did not know if JCAHO domestic violence standards had been implemented in their emergency department; 27% responded that the standards had not been implemented;
3. 42% were not certain they could identify a battered patient; one third felt uncertain about asking about domestic violence with substance abusers, bay men, lesbians, Asian/Pacific Islanders, Chicano/Latina/Hispanic or African American patients;
4. over one-half perceived patient barriers (lack of disclosure, fear of repercussion and denial) to be the greatest barriers to the identification of battered patients;
5. only 5% take photographs of a battered patient's injuries; 43% record injuries on a body map; and 46% conduct safety planning;
6. over 90% know or have known, or have been the victim of domestic violence;
7. surprisingly! 100% report that they write legibly in the medical record.

Each of the hospitals have been asked to conduct pre-training surveys of all staff that receive domestic violence training.

3. ASSESSING NEEDS AND RESOURCES

a. Establishing Baseline Data

Baseline data can be established both for assessing the prevalence and needs of battered women in a particular practice setting, and for assessing provider knowledge, attitudes and behavior regarding standards of care for battered women. The prevalence of domestic violence in the lives of women seen in a wide range of clinical settings is well documented. (See Introduction for prevalence data and fact sheet in Appendix B.)

However, it may be helpful to document the prevalence in a practitioner's own clinical setting. This can be done through record review or prospective interviews or surveys. Collecting data with patient demographics and a range of other information can serve a number of functions. It can be utilized in garnering administrative support, incorporated into trainings, used to dispel myths about "types" of abused women and about

"typical" clinical presentations, and used to assess the particular needs of women in a given community or practice setting.

Baseline assessments of provider knowledge, attitudes, and behavior about domestic violence can also be useful in targeting training and intervention strategies, convincing administrators of the need to improve their response, and in measuring gains made. In addition, this type of assessment can be used for continuous quality improvement programs within the institution or practice setting and as the baseline for evaluating training and implementation strategies. (See Appendix N.)

b. Assessing Resources

Assessing the resources available within the health care setting and the community is essential to developing an optimal intervention strategy. Relevant questions to be considered are outlined in Figure 4-3.

B. Development of Interventions

1. Developing Site-Specific Intervention Strategies

Once the initial working group is established and an assessment completed, it is necessary to decide what kind of response is best suited to a particular institution and community. Deciding what

FIGURE 4-3

ASSESSING RESOURCES

1. Are there staff members with an interest or experience in addressing domestic violence who are willing to help improve their institution's response to this issue?
2. Are there providers who are already addressing this issue in their own practice or teaching activities?
3. Are there administrators or department chairs who are willing to allocate time for interested staff to work on this issue/project?
4. How can the health care response be developed and implemented in collaboration with local community-based domestic violence programs?
5. What domestic violence advocacy services are available for battered women and children in the community?
6. Are there domestic violence advocates willing to collaborate with and train health care providers?
7. Are there other groups of health care providers in the community attempting to address this issue?
8. Is there a state domestic violence coalition or national resource center that can help provide technical assistance, support, and connections to other domestic violence resources?

Continued...

FIGURE 4-3 *Continued...*

9. Is there access to other hospital-based projects or community-based health initiatives?
10. Are there appropriate services for batterers available in the community?
11. Is there funding available to establish on-site advocacy services? If not, can existing health care staff be trained by the domestic violence advocacy community to provide those services themselves?
12. Is there someone in the development or research department who can assist in obtaining funds to support and expand this work?
13. Are there mental health and substance abuse services in a given institution or community that are sensitive to issues faced by victims of domestic violence and their children?
14. Are local shelters able to accommodate women with mental health or substance abuse problems?

clinical settings or hospital departments should be targeted will depend on motivation and availability of resources.

There are a number of factors that will influence the nature of intervention strategies within an institution or practice. (See Figure 4-4).

FIGURE 4-4

FACTORS AFFECTING INTERVENTION STRATEGIES

1. Type of clinical: inpatient vs. outpatient; acute vs. ongoing care; specialty vs. primary care.
2. Clinician availability: nurses, nurse practitioners, physicians, physician assistants, house staff, social workers, domestic violence advocates, chaplains
3. Physical layout affects safety and confidentiality
4. Usual intake procedures: questionnaire vs. interview; nurse vs. physician; waiting room vs. home vs. exam room
5. Resources available within practice setting
6. Time, reimbursement, and legal constraints
7. Availability and accessibility of community resources

a. Routine Inquiry

(1). WHEN AND WHERE WILL SCREENING TAKE PLACE?

How routine inquiry is incorporated will depend on staff availability and interest, and on the physical layout of the clinical setting. Privacy is essential for providing both physical and emotional safety (see Chapter Two). While a reception or triage desk may seem the logical place to ask about abuse, it may in fact be the least safe. An examining room with a closed door or a private clinician's office is more appropriate. Trends to involve partners and family in health care decisions, while increasing support and advocacy in many situations, are obviously problematic in dealing with domestic violence. In Emergency Departments or clinics, signs to indicate that only patients will be allowed beyond a certain point make it clear that it is general policy for patients to be seen alone. Current policies may have to be modified to ensure that all patients are seen alone until abuse has been ruled out. In larger institutions, security departments should be involved in developing safety measures and in providing sensitive and timely interventions.

(2). WHO WILL ASK?

Ideally, every health care professional should ask about abuse during their part of the medical encounter. Overworked staff, while concerned about domestic violence, may initially want to shift the responsibility of inquiring to someone from another discipline. If all staff are prepared to inquire, fewer patients will be overlooked. Many patients will become more comfortable after the initial inquiry or feel more at ease with another practitioner. For clinicians who do overcome their initial resistance and become comfortable incorporating inquiry into their routine histories or intakes, "asking" is no longer an issue. Whoever does the initial intake, history, or psychosocial assessment must be skilled at asking about abuse and violence. Asking during each visit when there is concern about abuse is also important. (See Example 1)

(3). FACILITATING ROUTINE INQUIRY

As health care institutions have grappled with incorporating routine screening into their standard of care, a number of screening methods have emerged. Since even concerned providers state that when busy they often forget to ask about abuse, utilizing reminder forms, stamps, or stickers on charts can help facilitate inquiry. Questions about abuse can also be added to intake forms with a checkbox indicating whether or not domestic violence was identified, screening questions to check, or information about whom to call for advocacy and referrals. Some institutions have developed patient information forms and include domestic violence services within a list of others, such as HIV counseling, smoking cessation, and substance abuse programs. Indicating on the form that patients should let their

EXAMPLE 1

One woman, admitted to a trauma unit for serious injuries that resulted from battering, told a domestic violence advocate that it was only after her physician had asked her about abuse every day for six days that she felt safe enough to tell him what had happened. It took his repeated inquiry to convince her that he must really care and that she could trust him. She said that if he hadn't asked that last time, she probably would never have told him.

THE DOMESTIC VIOLENCE EMERGENCY DEPARTMENT PILOT-TEST PROGRAM

Over a six-month period following the training program, hospitals designed programs that were tailored to their staffing patterns and available resources. Their plans incorporated the following elements.

- Routine screening to detect battered patients;
- development of domestic violence protocols;
- documentation in the medical record;
- conducting training for all emergency department staff and institutionalizing an ongoing training program (training in many of the hospitals was extended to other health disciplines as well as administrators, quality assurance personnel and security staff);
- creating quality assurance mechanisms to monitor ongoing response; and
- expanding and connecting the response institution-and communitywide.

doctors know if they are interested not only encourages self-referral but also serves as a reminder for clinicians to ask about abuse. (See Appendix D and F for samples.)

b. Assessment and intervention models

There are a number of different models for providing assessment and intervention which can be adapted to a particular setting, institution, or community. The primary provider must be able to meet the minimal identification, assessment, documentation, intervention, referral and follow-up requirements described in Chapter Two. Full assessment, counseling, and referral can be provided by one or two designated health care providers or advocates, or the tasks can be split between one or more staff. Regardless of which model is utilized, when a social worker or domestic violence advocate is not available, physicians and nurses should be expected to conduct an initial safety assessment, help develop a safety plan, and provide access to community resources before a woman is discharged from the clinical setting.

1. MODELS

(1). INDIVIDUAL PROVIDER/INDIVIDUAL PRACTICE SETTINGS

Within a given practice site, providers can begin by asking their own patients about abuse and developing connections with local domestic violence programs. Sharing these experiences with colleagues and raising the issue of domestic violence can generate interest in developing a practice-wide response. Guest speakers, videos, reading material, ongoing training for staff, and, in larger practices, task forces or working groups can also begin to effect change.

(2). INTERVENTION AND ADVOCACY BY PRIMARY PROVIDER

Physicians and nurses can also offer crisis intervention, safety assessment and

planning, referral and follow-up as part of routine care for patients. Training involving the development of interactional and counseling skills and knowledge of a range of issues specific to domestic violence is necessary to provide this level of care for battered women. In addition, some health care facilities may be able to provide follow-up counseling and support groups for battered women and their children in conjunction with domestic violence advocates.

(3). TRAINING EXISTING STAFF TO PROVIDE ADVOCACY

Another model of responding to domestic violence involves developing a sufficient number of designated hospital or practice staff (e.g., patient advocates, case managers, social workers, nurse clinicians) specifically trained to provide crisis intervention, safety assessment and planning, counseling, referral and follow-up as part of their clinical duties.

(4). EMPLOYEE ASSISTANCE PROGRAMS (EAP)

Developing a response to domestic violence within the health care setting not only improves care to women seen as patients but functions as a work-site program as well. For many battered women, workplace services may be the only ones they can access freely. Guaranteeing that staff will not be penalized by supervisors for utilizing services during work time and insuring that advocacy and counseling files are not accessible to workplace staff are imperative. Indeed, developing specific EAP procedures for working with battered women employees should be a part of any intervention strategy. Policies should address counseling, referral needs, time off and on-the-job safety. For example, EAPs can work with their institutions to arrange leave time for court appearances, child care, counseling, support groups, finding new housing, or when a woman needs to be in hiding. Working with security and supervisors to deny access or information to an abuser who is stalking a partner or harassing a partner on the job and to institute protective measures increases safety for victims and for other employees.

Many health care providers are battered women who will contact identified resource people if they are assured of confidentiality within the health care institution. Strict confidentiality is essential in protecting staff from repercussions from supervisors, colleagues and from batterers who may have access to their partner's work site. (See Appendix L for the Poloroid Corporation's Model EAP policies.)

(5). ON-SITE ADVOCACY PROGRAM

Health care providers can routinely inquire about abuse and refer battered women to an on-site domestic violence advocacy program for further assessment and intervention. While the primary provider offers initial assessment, documentation and referral, a domestic violence advocate can provide much more extensive services as needed. If an advocate is not available on-site, providing access to initial crisis intervention and advocacy over the telephone is another alternative. (See Appendix F for Womankind's hospital-based, domestic violence advocacy program sample intake.)

2. DEVELOPING A REFERRAL NETWORK

a. Battered women's shelters

There are approximately 1,200 shelters in this country. Although many women identified in health care settings may not want or be ready to utilize a shelter, there are still insufficient beds for the women who need them. (See Appendix M to contact your state domestic violence coalition to find out about the shelters in your

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See also Hadley, S. Working with battered women in the emergency department: A model program. *Journal of Emergency Nursing, 18*(1), 18-23; and Sheridan, D., & Taylor, W. (1993). Developing hospital-based domestic violence programs, protocals, policies, and procedures. *AWHONN's Clinical Issues, 4* (3).

community.) Having a series of back-up plans in place will help provide safety for women and decrease the frustration of health care providers who are trying to protect their patients. For example, some domestic violence advocacy projects are funded to provide hotel beds for battered women in danger until shelter space becomes available. Providers can also talk to staff of local shelters to identify special services in the community for battered lesbians and gay men. Thus, health care providers must know what other options are available, including utilizing hospitalization as a final back-up plan when all else fails. Social work departments are often knowledgeable about other sources of housing. Law enforcement, social service departments, and domestic violence and homeless shelters may also have access to hotel vouchers for short stays.

b. Legal assistance

Health care providers should be knowledgeable about reporting requirements in their states, legal protections and options available to battered women in their state, and what patients may encounter when they call the police or have further contact with the criminal justice system. Local and state domestic violence programs can provide this information.

c. Counseling and support groups

Counseling and support groups can assist patients in making the difficult and often frightening transition toward ending an abusive relationship. Most domestic violence programs offer counseling and support groups to women living in the community as well as those residing in shelters.

d. Mental health and substance abuse treatment

At a programmatic level, it is important to identify and develop appropriate resources for battered women with substance abuse and/or mental health problems. Substance abuse and psychiatric symptoms may begin or increase when women become trapped in abusive relationships. While psychiatric treatment is not the primary way to address abuse, for some women it may be an important adjunct to advocacy services; for others it is an essential part of helping them to access the kinds of services that can lead to safety. For many women, once they are out of danger, their "psychiatric" symptoms disappear. For others, treatment for post-traumatic stress-related symptoms can only begin once the trauma is "post."

Efforts can be made to assure that mental health providers within the institution or the community are trained and sensitive to the wide variety of issues faced by battered women before making referrals to them. Keep in mind that marital and family counseling are almost always contraindicated. Working in collaboration with domestic violence advocates, the mental health system and psychological and psychiatric professional organizations in the community can help facilitate this process. In some communities, advocates and mental health professionals have mobilized to provide pro bono services for battered women. In other areas, mental health providers and advocates have established ongoing case conferences to help clinicians address complex clinical and advocacy issues that arise during the course of treatment. Working to provide mental health services to shelters to meet the needs of battered women with psychiatric illnesses and having advocacy services available on substance abuse and psychiatric units will also help assure a broader spectrum of care.

e. Childcare

Providing even limited childcare within a practice setting increases access to care for all women patients, not just women living in abusive relationships. Sometimes

children will be the first to reveal that their mother is being abused. Developing a multidisciplinary team that can work with children as well as their mothers will increase the sensitivity of care.

f. Addressing barriers of language, culture, and disability

Make sure that written materials are culturally sensitive and in appropriate languages (including braille) for your practice setting. Arrange to have suitable translators, signers, and equipment for the hearing impaired available. Work with disability advocacy groups to ensure that services, including shelters, are accessible to women with a range of visible and non-visible disabilities. In addition, involve members of the cultural groups served by your practice to help address culturally specific barriers to accessing health care. Forming links with community groups working with specific ethnic communities or other special populations concerned about domestic violence can aid in developing services that are inclusive of all victims of battering. For example, utilizing or creating new resources for battered gay men, knowing which shelters are wheelchair accessible and working to expand accessibility, and working with members of American Indian communities to combine traditional healing methods and community sanctions with advocacy and intervention are all ways to make domestic violence services more accessible to populations otherwise not served.

3. PROTOCOLS

Once intervention strategies are developed, protocols can be written and adapted to each clinical area. Gathering existing protocols (see Appendix C for model protocols) and tailoring them to the particular setting is an effective way to proceed. The process of protocol development can provide a vehicle for establishing collaborative efforts within the institution. A team that involves key administrators and staff in delineating roles, allocating time, preparing materials, developing and revising intervention and training strategies and assuring that patients will be seen in a safe and timely manner can begin to establish official policy. Working together to determine who will do what, when, where, and how, will help establish a multidisciplinary process for ongoing work and can generate creative solutions as obstacles arise. Protocols should also be seen as working documents, subject to adaptation and change as they are tested. It is imperative that protocols on domestic violence become part of official policy and procedures so as to assure their adoption into practice. (See Figure 4-5)

FIGURE 4-5

MINIMAL ELEMENTS OF A PROTOCOL

1. **DEFINITIONS.** Include the various manifestations and types (physical, sexual, psychological) of abuse and who (adult, adolescent, elderly, lesbian/gay) is covered by the policies.
2. **SCREENING PROCEDURES.** Information should be available to clinicians either within the protocol or as an addendum addressing how to ask about abuse directly, including sample questions. Specify who is to do the screening. Specify precautions for ensuring safety and confidentiality.

Continued...

FIGURE 4-5 *Continued...*

3. **INTERVENTION PROCEDURES.** Include interviewing strategies, safety assessment and planning, and discharge instructions. Information should be available to clinicians either within the protocol or as an addendum to the protocol on assessment (sample questions and techniques) and intervention (supportive information to convey, referrals, patient education materials, etc.).
4. **STATE REPORTING REQUIREMENTS.** Clarify the law(s), if any. Include procedures for the release of information to the proper authorities as required by law.
5. **COLLECTION OF EVIDENCE AND PHOTOGRAPHS.** Include procedures for the collection, retention and release of evidentiary materials; hospital procedures for taking in-house photographs and securing release forms.
6. **MEDICAL RECORD DOCUMENTATION.** Clearly delineate what is to be included in the medical record (e.g., a description of the injuries, coloration, size, use of a body map to indicate location of injuries, stated or suspected cause of injury, action taken by clinician, etc.).
7. **REFERRALS.** Include instructions regarding available resources, and how to make referrals to in-house staff, domestic violence programs, legal advocacy, children's services or other appropriate community agencies. Keep phone numbers updated on a regular basis.
8. **PLAN FOR STAFF EDUCATION.** All health care personnel should receive training, including hospital security. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) requires a staff education plan.

Formal adaptation of the protocol is one aspect of implementing an overall intervention strategy. Incorporating protocol review into formal domestic violence training sessions is one way to assure initial awareness and understanding of newly established policies and procedures. Including protocol review in all orientations for new staff will help maintain awareness. Post-implementation in-service trainings and meetings to review protocols and discuss problems that may indicate a need for revision can help to increase involvement in developing and maintaining an institution-wide response to domestic violence. (See Figure 4-6)

C. Implementation

1. PREPARING THE ENVIRONMENT: MATERIALS FOR PATIENTS AND PRACTITIONERS

Creating an atmosphere that lets women know it is safe to discuss domestic violence increases the likelihood that they will be able to reveal the abuse in their lives. Place brochures or referral cards in bathrooms to allow patients to obtain information anonymously and safely. Post

FIGURE 4-6

IMPLEMENTATION OF PROTOCOLS

1. Define target areas.
2. Review a variety of existing protocols relevant to your institution or practice.
3. Address issues specific to your state, institution and setting such as documentation, confidentiality, liability and reporting.
4. Determine site specific interventions: Decide who does what, when and where regarding identification, assessment, documentation, intervention, referrals and follow-up.
5. Formulate clinician roles in collaboration with each provider group involved and with domestic violence advocates.
6. Develop community specific referral networks.
7. Make sure protocol is easily accessible: in a readable format and posted in clinical settings.

phone numbers of domestic violence advocacy or referral services to allow women to seek help when they are ready. Incorporate discussions of domestic violence into ongoing patient education activities and materials. Provide brochures about services or wallet-sized cards with phone numbers of resources within the health care and domestic violence communities. Display posters in waiting areas and exam rooms to indicate concern about abuse and encourage discussion. Provide reading materials in a safe area for women who cannot bring information about domestic violence home. Participate in community health fairs. These are all ways to inform the community that health care providers are concerned, that services are available and that domestic violence is a crime.

Many resource materials have already been generated by health care providers and the domestic violence advocacy community. Reviewing what has already been developed and adapting it to a particular health care setting saves time and may spark new ideas. (See Appendix G and H

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One test site hospital developed informational patient pocket cards that remained virtually untouched by patients when placed in the waiting room, examination areas and large public bathrooms. When the hospital tried placing the cards in a single bathroom area they reported that they, disappeared so quickly they couldn't be kept in stock.

for model materials, many of which can be copied or adapted for use in your facility. (See Figure 4-7)

In addition, having written and audio-visual materials available for staff can serve a number of functions. Until routine inquiry is fully integrated into history taking, clinicians may need visual reminders to encourage them to ask about abuse. Posters or pocket cards describing what to ask, how to document, how to assess safety and numbers to call can simplify and facilitate intervention. Protocols that detail procedures for less familiar tasks such as evidence collection and photography can be used for reference to insure proper documentation. (See Figure 4-8)

2. TRAINING

Implementation of an institutional or practice setting response to domestic violence begins with education. Traditional didactic training formats alone, such as grand rounds, are not as effective for changing clinician attitudes and behavior as the more adult-learner-centered techniques. Training techniques which create the emotional safety to explore personal responses to asking about abuse and the opportunity to identify and address individual, professional and institutional obstacles to care can double as a form of organizing within the health care community. Seeing the process of ongoing training as a form of community organizing within the institution can expand your repertoire of training techniques and strategies. For example, informally talking with students or colleagues about the importance of addressing domestic violence in the health care setting can generate interest among faculty, staff, and trainees.

All hospital/practice staff, as well as clerks, administrators, translators, EMTs, receptionists, transporters, medical records staff, security, and others should receive, at a minimum, initial training about domestic

FIGURE 4-7

RESOURCE MATERIALS FOR PATIENTS

1. Posters to let victims of domestic violence know that they are not alone, the violence is not their fault, the health care professional is concerned, and they can discuss their abuse, and that list available resources and phone numbers.

2. Brochures describing abusive relationships, abusive and controlling behaviors, common myths and available resources.

3. Booklets describing dynamics of abuse, the impact of domestic violence on women and their children, characteristics of batterers, legal options, shelters, counseling services, and resources.

4. Resource lists or pocket-sized cards with telephone numbers of both emergency and non-emergency domestic violence services in both the health care setting and the community. Having material available with phone numbers printed in disguised form (i.e., “for next appointment or in case of emergency, call ______”) will be helpful for women whose partners go through their wallets.

FIGURE 4-8

RESOURCE MATERIALS FOR PROVIDERS

1. Reminder forms, stickers or stamps to encourage routine inquiry
2. Protocols or algorithms clearly describing appropriate identification, assessment, documentation, intervention, referrals and designated roles within a setting
3. Referral lists in all clinical sites
4. Pocket cards with distilled protocols and referral numbers
5. Articles, manuals, and booklets with more in-depth information about domestic violence
6. Videos to increase understanding of women's abuse experiences
7. Posters in clinical areas that remind clinicians what to ask and what to do

violence. Not only does this increase safety for battered women seen as patients (i.e., knowing not to reveal that a woman has been sent to x-ray in an attempt to be helpful to an inquiring spouse), it also raises general awareness of domestic violence and provides a link to services for staff who are being abused.

a. Key Tenets of Training

(1). INSTITUTIONAL COMMITMENT

Institutions must offer and require training and in-service programs and provide continuing education credits to ensure provider awareness. It is also essential to set aside time for follow-up trainings to identify and address attitudes and assumptions, barriers to care, clinician experiences, anticipated difficulties, and complex clinical situations.

(2). CONTENT GROUNDED IN THE EXPERIENCE OF BATTERED WOMEN

The participation of domestic violence advocates and survivors as faculty helps ground providers in the experience of former victims who know what is and is not helpful. Working with domestic violence advocates and survivors as faculty increases the likelihood that responses and interventions will be appropriate and respectful. Most domestic violence programs have information on current laws and legislation, resources available within the community, teaching materials and videotapes that can be used in trainings, and considerable expertise in training service providers from a variety of disciplines.

(3). UTILIZE ADULT LEARNER-CENTERED TECHNIQUES

Having participants take a more active role in learning about abuse, recognizing and addressing barriers, practicing new skills, talking with formerly battered

women and advocates and strategizing for change will be far more effective in changing attitudes and behaviors than passive learning techniques.

(4). ONGOING FACULTY REINFORCEMENT AND ROLE MODELING OF NEW ATTITUDES AND BEHAVIOR

Ongoing faculty reinforcement through role modeling and feedback is an essential aspect of helping clinicians to improve their responses to domestic violence. Developing alternatives to controlling or judgmental clinical interaction styles is important not only in asking about abuse, but also in being able to address the need to rescue or "fix" a woman's situation. No matter what trainees learn in a seminar or workshop, it is their ongoing daily experience that ultimately shapes their clinical attitudes and behaviors.

(5). INTEGRATION OF DOMESTIC VIOLENCE INTO MEDICAL, NURSING AND DENTAL TRAINING PROGRAMS

Comprehensive guidelines have been developed for nursing and physician education. Some of these include descriptions of course content and training methods, comprehensive case discussions, simulated patient scripts and extensive bibliographies. In addition, the Robert Wood Johnson Foundation has funded a report detailing guidelines for nursing, dental and medical education in family violence, and the American Association of Medical Colleges is preparing a report on the current status of family violence teaching in medical schools with recommendations for integration into standard curriculum.

b. Training Elements

The following are some of the key elements of a training program:

(1). UNDERSTANDING THE DYNAMICS OF DOMESTIC VIOLENCE

Trainings should develop providers' awareness and understanding of the dynamics of abuse and its impact on victims and their children.

(2). DEVELOPMENT AND ENHANCEMENT OF SKILLS

Training should also be designed to help clinicians feel comfortable asking about domestic violence, assessing danger, planning for safety, and giving messages of support and referral to appropriate agencies. Use of role plays and videotaped examples of clinical encounters can illustrate the difference between helpful and counterproductive interactions with battered women.

(3). ADDRESSING CLINICAL BARRIERS

Providers must have the opportunity to examine and address their own biases, attitudes, assumptions and feelings that may interfere with their ability to respond appropriately to patients who are battered. This means setting aside time for discussions with faculty/advocates and creating an environment that is conducive to open discussion.

(4). DISCUSSION OF SOCIAL, CULTURAL AND LEGAL ISSUES AFFECTING THE PROVISION OF CARE

Trainings should address a variety of different social, cultural and legal aspects of domestic violence, including, for example: the impact of religion, culture, class, race, sexual orientation, and immigration status; local community/legal responses; the experiences of battered lesbians and gay men; prostitution and battering; victims with disabilities, mental illnesses and/or substance addiction; and victims who are police officers.

It is always helpful hearing from formerly battered women. Allowing providers to listen empathetically without feeling they have to "do something," can help clinicians increase their sensitivity, reflect on their ability to respond appropriately to battered women and deepen their understanding of the complexities of domestic violence. It is also important for providers to see that victims can leave abusive partners and maintain healthy relationships free of violence. Using videos

where women are talking about their experience of being abused can also provide a better understanding of what it is like to deal with domestic violence. (See Appendix B for training materials and a list of videos.)

D. Evaluating And Sustaining The Response

1. Structural Supports and Incentives

Since one-time trainings do not create sustained change in clinical practice, structural supports and strategies are needed to help clinicians sustain their response to domestic violence. Sustaining change requires ongoing reinforcement to expand awareness, deepen understanding, refine skills, work collaboratively and develop comfort and expertise. The structural factors that mitigate against this change are strongly entrenched, and need to be identified and countered.

Sustaining an effective response to victims of domestic violence entails the following:

- Provide periodic follow-up training for all clinicians and staff.
- Ensure that domestic violence becomes fully embedded in the educational structure of the institution.
- Conduct ongoing discussions with colleagues focusing on obstacles to an effective response.
- Review and adopt protocols to improve and expand the institutional response.
- Provide feedback to staff from quality assurance reviews regarding changes in practices to maintain standards of care.
- Ask about abuse in all case presentations and clinical conferences.
- Set up monthly lunchtime discussions, video showings, or discussions with advocates.
- Provide technical assistance to departments developing responses to domestic violence.
- Initiate a public awareness campaign within the institution.
- Hold violence prevention forums for the community.
- Incorporate services available in the practice or institution into brochures on women's health.

2. Evaluation and Monitoring

Making appropriate responses to victims of domestic violence the target of quality assurance reviews notifies providers this is now a standard of care and no longer left to their "discretion." If a baseline needs assessment has been done, ongoing quality review can be utilized to engage clinicians in setting goals and addressing obstacles.

3. Research Projects to Evaluate Interventions

Collaborative research models with community domestic violence advocacy groups and experts can help create more effective and useful outcomes and address essential considerations such as: what are outcome priorities for battered women, what safety issues are involved in follow-up and how can research be used to enhance services, improve outcomes, and ultimately increase the safety and well-being of victims of domestic violence? Research

projects can be designed to measure both provider and patient outcomes. It is also critical to involve domestic violence experts, including battered women, in discussing any plans for surveillance, monitoring, or follow-up outside the institution to be sure plans do not endanger abused women and their children. Potential areas of research and research tools are outlined in Figure 4-9.

FIGURE 4-9

RESEARCH TOOLS

Have provider knowledge, attitudes and behavior improved?

TOOLS: Use pre-and post-training questionnaires, individual interviews, group discussions, and observation of interactions, presentations and attitudes.

Has the number of women being asked, identified, and receiving interventions increased?

TOOLS: Use chart reviews, patient questionnaires/interviews, number of referrals as measures.

Does intervention improve the health and safety of battered women?

TOOLS: Measure health impact, health care utilization, safety, impact on children using health status questionnaires, record review, ongoing follow-up assessment.

IV. PARTICIPATING IN THE COLLABORATIVE COMMUNITY RESPONSE

Strategies for linking the health care system with the larger community and ultimately developing a coordinated community response to domestic violence include:

- LOCAL DOMESTIC VIOLENCE PROGRAMS AND SHELTERS: Volunteer with the domestic violence shelter or program in your community (e.g., provide health care to clients, become a board member, volunteer for their speaker's bureau, help raise funds).

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One rural hospital has joined the local community's domestic violence task force. A pilot test hospital team member of another hospital became a board member of the local shelter. The shelter and hospital held a picnic, as a kick-off celebration for the hospital domestic violence project.

- CHILD ABUSE AND DOMESTIC VIOLENCE: Help coordinate the domestic violence, child abuse and child protective services response to domestic violence.

- DIVERSE COMMUNITIES: Work with community organizations with expertise and understanding of issues particular to people with disabilities, prostitutes, immigrants, gay men and lesbians, the homeless and diverse cultural groups to develop sensitive services and improve access to care.

- MENTAL HEALTH, SUBSTANCE ABUSE AND DOMESTIC VIOLENCE: Help coordinate domestic violence services and training with local, county, and/or state mental health and substance abuse departments, associations or task forces.

- SCHOOL HEALTH PROGRAMS: Participate in or help develop programs for children and teens around issues of violence and forming healthy relationships.

- DOMESTIC VIOLENCE AND THE LEGAL SYSTEM: Work with the legal community to educate judges, court evaluators and attorneys about the medical and psychological impact of abuse, and about not using psychiatric diagnoses inappropriately in custody evaluations.

- INSURANCE ABUSE: Monitor the activities of insurance companies around the denial of insurance policies or claims for domestic violence victims. Work proactively with your local or state domestic violence coalitions to introduce state legislation and to support federal legislation to prevent revictimization by insurance companies.

- HEALTH CARE SYSTEM REFORM: Create or support a plan that will comprehensively and appropriately meet the health care needs of victims of battering and their children. This includes addressing the way managed care may interfere with meeting the mental health and substance abuse needs of victims of trauma and insuring universal coverage so that battered women do not lose their health insurance if they leave their husbands. (Contact the Family Violence Prevention Fund for working paper on domestic violence and health care reform and join the efforts of the Campaign for Women's Health and the American Medical Women's Association on this issue.)

- LEGISLATIVE EFFORTS: Work with the domestic violence advocacy community to help set state and national funding priorities for services and to develop and influence legislation on domestic violence.

- PROFESSIONAL ORGANIZATIONS: Work within your own professional medical organization as well as other health care organizations to make domestic violence a national priority and to share experiences as we begin to learn more about what is needed to stop the violence in our society. Organizations which have developed guidelines, curriculum materials, task forces and/or policy statements regarding domestic violence include the American Medical Association, the American College of Obstetrics and Gynecology, the American College of

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The Polaroid Company generously donated camera wound documentation kits to all of the twelve test hospitals. One of the hospitals arranged to buy the same camera kit for the local domestic violence program to document injuries that did not require treatment or to follow up on photographs taken by the hospital.

Emergency Physicians, the American Medical Women's Association, the American Nurses Association, the Emergency Nurses Association, the National Nursing Network on Violence Against Women, the March of Dimes, and Physicians for a Violent Free Society.

- COMMUNITY EDUCATION AND MEDIA CAMPAIGNS: Participate in community education efforts through domestic violence awareness programs at religious institutions, community groups, and local medical societies and through public forums generated by individual practices or health care institutions. Work with domestic violence experts to help promote media awareness and become a spokesperson on domestic violence. (Contact the Family Violence Prevention Fund, which has launched a national prevention campaign with the Ad Council.)

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One inner city hospital has reached out to the local school district to see if they can collaborate on prevention programs.

- HEALTH DEPARTMENTS: Help local, state and federal health departments to recognize domestic violence as a priority issue that affects all other aspects of women's health.

CONCLUSION

As providers become involved in working with their communities, new ideas and creative responses will emerge to help providers become more effective in serving the needs of all victims of domestic violence. By working together, we can begin the social change necessary to prevent domestic abuse and to make it possible for us all to live free of violence.

AUTHOR'S NOTE: The author would like to express her appreciation to the following individuals and programs whose collective experience has inspired and contributed to this chapter: Susan Hadley (Womankind, Minneapolis, MN), Amanda Cosgrove, Kevin Fullin and Patty Fullin, (Domestic Violence Project Inc. in Kenosha, WI), Wendy Taylor (former Family Violence Program at Rush Presbyterian St. Luke's Hospital, Chicago, IL), Courtney Esposito, Nancy Durborow (hospital based advocacy projects of PCADV), Anne Flitcraft, Kate Parenteau and Evan Stark (Project Safe-Domestic Violence Training Project in New Haven, CT) and especially Vickie Coffey and Hospital Crisis Intervention Project (Cook County Hospital in collaboration with the Chicago Abused Women Coalition, Chicago, IL) possible.