National Consensus Guidelines

ON IDENTIFYING AND RESPONDING TO DOMESTIC VIOLENCE VICTIMIZATION IN HEALTH CARE SETTINGS

Produced by
THE FAMILY VIOLENCE PREVENTION FUND

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endabuse
FAMILY VIOLENCE PREVENTION FUND

For more than two decades, the Family Violence Prevention Fund (FVPF) has worked to end violence against women and children around the world. Instrumental in developing the landmark Violence Against Women Act passed by Congress in 1994, the FVPF has continued to break new ground by reaching new audiences including men and youth, promoting leadership within communities to ensure that violence prevention efforts become self-sustaining, and transforming the way health care providers, police, judges, employers and others address violence.

The FVPF is a national non-profit organization committed to mobilizing concerned individuals, allied professionals, women's rights, civil rights, other social justice organizations and children's groups through public education/prevention campaigns, public policy reform, model training, advocacy programs and organizing.

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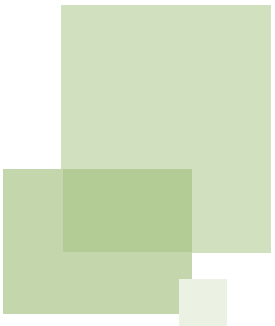

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The Family Violence Prevention Fund's
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NATIONAL CONSENSUS GUIDELINES

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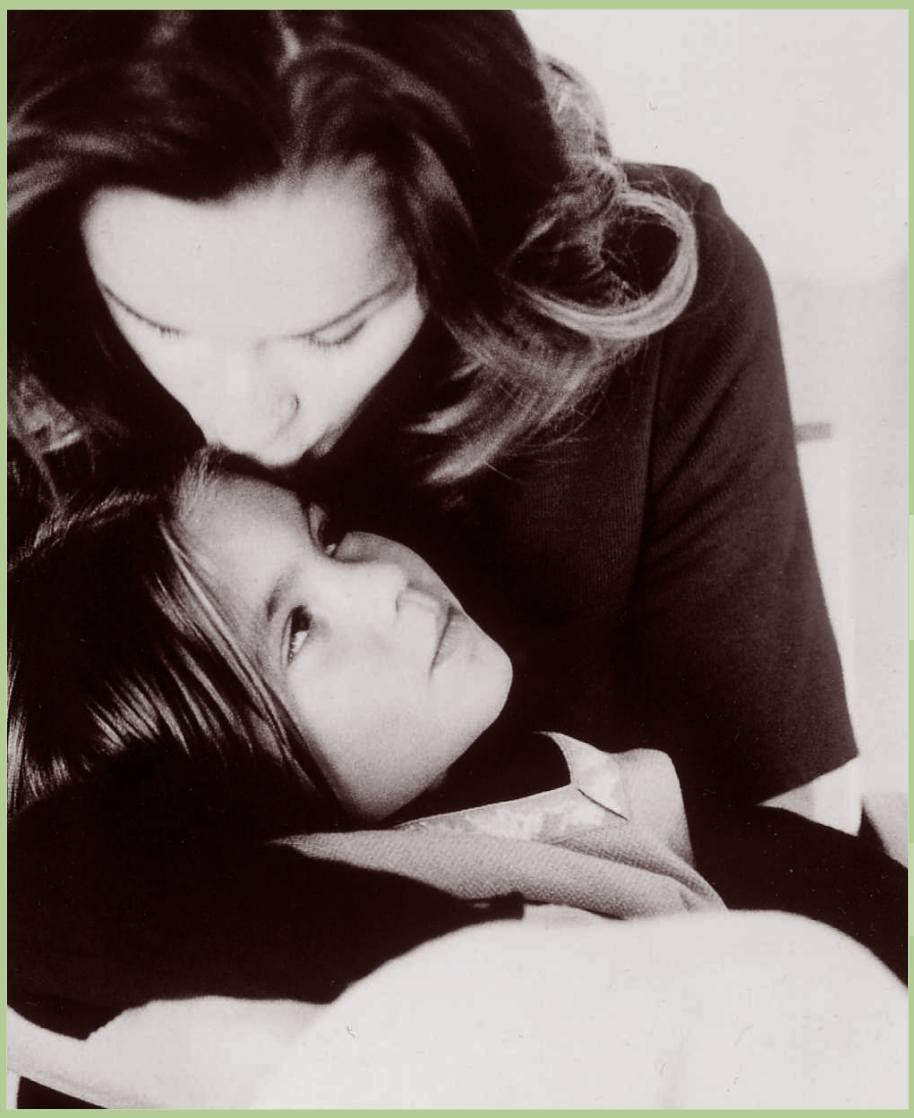

Family Violence Prevention Fund

Special Thanks to the

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The Family Violence Prevention Fund (FVPF) wishes to thank the National Advisory Committee members for the National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization for their time and rigorous attention to the development of these guidelines. Building consensus can be complicated and the expertise, experience and guidance of Advisory Committee members were invaluable. These individuals include members from the advisory committee for the FVPF's original Preventing Domestic Violence: Clinical Guidelines on Routine Screening as well as representatives from fourteen states participating in the FVPF's National Health Care Standards Campaign on Domestic Violence.

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CONTENTS

INTRODUCTION

PART I | INTRODUCTION

For over a decade, the Family Violence Prevention Fund (FVPF) through its publications, practices, educational programs, and outreach efforts, has promoted routine assessment for domestic violence and effective responses to victims in health care settings. Other health professional organizations including the American Medical Association, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Psychological Association, American Nurses Association, American Academy of Pediatrics, the Joint Commission on the Accreditation of Health Care Organizations, and the Institute of Medicine, have promulgated policy statements, position papers, guidelines and monographs about this important health issue.

In 1999, in collaboration with an expert advisory committee, the FVPF published *Preventing Domestic Violence: Clinical Guidelines on Routine Screening*. This document endorsed a set of national guidelines on screening for abuse and offered recommendations on whom to screen, how often and in what settings. As inquiry for domestic violence becomes more widespread, the need to expand these guidelines to include guidance regarding assessment and response has become apparent. It is critical that providers understand how to respond to domestic violence victims once they are identified, including providing appropriate health and safety assessment, intervention, documentation and referral.

Research indicates that the vast majority of victims of abuse in intimate relationships are women whose partners are men. Emerging research has not only confirmed earlier findings, but also has indicated that men in same-sex relationships experience domestic violence at rates at least equal to that of women in heterosexual relationships, and that lesbians and some men in heterosexual couples also experience abuse. Therefore, these Guidelines have been expanded to recommend assessment of all female and male adolescent and adult patients for domestic violence victimization.

The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization present recommendations on how inquiry for domestic violence victimization, assessment, documentation, intervention and referrals should occur in multiple settings, and in various professional disciplines. They do not however, address inquiry for perpetration. Part I of the Guidelines reviews current findings regarding the prevalence and health impact of domestic violence, presents a rationale for regular and routine inquiry and response, and underscores the importance of culturally competent practice in addressing domestic violence. Part II outlines the recommendations for identification and response. Part III offers continuous quality improvement goals to help monitor the impact and implementation of abuse identification and response protocols. The appendices contain additional recommendations and resources for providers including bibliographies, websites, and telephone numbers of organizations that can provide assistance.

INTRODUCTION

To develop these Guidelines, the FVPF partnered with advisors from the National Health Care Standards Campaign on Domestic Violence: a coalition of health care providers, public health and policy leaders, and domestic violence advocates from 15 states working to promote improved health care responses to victims of abuse. The FVPF also invited the Advisory Committee from the 1999 *Preventing Domestice Violence: Clinical Guidelines on Routine Screening* to be reviewers. Advisory Committee members worked assiduously to develop and revise the Guidelines. These recommendations reflect the combined decades of their experience in the field as well as results from current research.

Definitions and Rationale

During the past fifteen years, there has been a growing recognition among health care professionals that domestic violence (DV), also known as intimate partner violence (IPV) is a highly prevalent public health problem with devastating effects on individuals, families and communities. Most Americans are seen at some point by a health care provider, and the health care setting offers a critical opportunity for early identification and even the primary prevention of abuse. Studies show that assessing for IPV in medical settings has been effective in identifying women who are victims[1] and that patients are not offended when asked about current or past IPV.[2] A host of professional health care associations have issued position statements to their members describing the impact of IPV on patients and suggesting strategies for assessment and identification of abuse. These statements represent important steps in raising awareness about IPV in health care settings. Generally, however, they offer neither specific guidelines for intervening and responding, nor criteria that promote the utilization and evaluation of recommended practice. These guidelines offer specific recommendations for assessing for and responding to IPV that may be applied to multiple health settings.

The term "family violence" has been used to describe acts of violence between family members, including adult and adolescent partners; between a parent and a child (including adult children); between caretakers or partners against elders; and between siblings. While sometimes used interchangeably, the term "domestic violence" is generally seen as a subset of family violence between intimates. While all forms of family violence are harmful, these Guidelines focus only on IPV and use the following definition:

> ***Intimate partner violence*** *is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.*[3]

DEFINITIONS

Legal definitions of IPV reference state or federal laws and generally refer specifically to threats or acts of physical or sexual violence including forced rape, stalking, harassment, certain types of psychological abuse and other crimes where civil or criminal justice remedies apply. Laws vary from state to state. Since non-physical forms of IPV can have many medical, psychological, behavioral and developmental effects, the definition used in these Guidelines is better suited for the identification and treatment of IPV in the health care setting.

> ***Child exposure to IPV*** *is a term encompassing a wide range of experiences for children whose caregivers are being abused physically, sexually, or emotionally by an intimate partner. This term includes the child who observes a parent being harmed, threatened, or murdered, who overhears these behaviors from another part of the home, or who is exposed to the short- or long-term physical or emotional aftermath of a caregiver's abuse without hearing or seeing a specific aggressive act. Children exposed to IPV may see their parents' bruises or other visible injuries, or witness the emotional consequences of violence such as fear or intimidation, without having directly witnessed violent acts.*[4]

This term also includes children who are used by the perpetrator to intimidate and abuse the adult victim, as well as those who are forced by the perpetrator to participate in the abuse of an adult victim. The impact of IPV on children varies greatly depending on the nature and frequency of the perpetrator's abusive tactics, the development stage and gender of the child, and the presence of protective factors.

The vast majority of victims of IPV are women. The latest United States Bureau of Justice Statistics report on intimate violence found that 85 percent of victims are female.[5] Most of the research that has been conducted to date has measured the prevalence and impact of abuse on women and children; the references in these guidelines are reflective of that body of research. However, it is important to note that IPV also occurs in same-sex relationships, and that some victims of IPV are men in heterosexual relationships.

RATIONALE

Prevalence of Intimate Partner Violence

IPV is a health problem of enormous proportions. It is estimated that between 20 and 30% of women and 7.5% of men in the United States have been physically and/or sexually abused by an intimate partner at some point in their adult lives.[6, 7, 8] Heterosexual women are five to eight times more likely than heterosexual men to be victimized by an intimate partner.[9] From 1993 to 1998, victimization by an intimate accounted for 22% of the violent crime experienced by females and 3% of the violent crime sustained by males.[10] Women aged 16-24 experience the highest per capita rate of IPV.[11] For adolescents, the rates of experiencing some form of dating violence vary from 25-60%.[12, 13, 14] While studies indicate that boys and girls may accept physical and sexual aggression as normative in dating and intimate partner relationships, adolescent females are more likely to receive significant physical injuries than boys and are more likely to be sexually victimized by their partners.[15]

No one is immune from the risk of abuse. The National Center on Elder Abuse estimates that 818,000 elderly Americans were victims of domestic abuse in 1994.[16, 17] There are far fewer data on lesbian, gay, transgender, and bisexual (LGTB) victimization. However, the available literature suggests similarly high rates for LGTB adolescent and adult populations[18, 19] with higher rates in male same-sex relationships than female.[20] IPV occurs in every urban, suburban, rural and remote community; in all social classes, and in all ethnic and religious groups including immigrant and refugee populations. Consequently, all health care settings and professionals providing care to patients are treating patients affected by IPV and are in a position to identify and intervene on behalf of victims.

The estimates of children exposed to IPV vary from 3.3 million to ten million per year, depending on the specific definition of witnessing violence, the source of interview, and the age of child included in the survey.[21] In the Adverse Childhood Experiences (ACE) Study, conducted on a large sample of members (30,000 adults) of the Kaiser Health Plan in California, 12.5% of respondents indicated childhood exposure to IPV and 10.8% indicated a personal history of child abuse including physical, sexual and emotional abuse.[22] This research and other studies indicate that children who witness IPV are seen with both frequency and regularity in the health care system as children and as adults.

Health Effects of Intimate Partner Violence

In addition to injuries sustained by women during violent episodes, physical and psychological abuse are linked to a number of adverse medical health effects including arthritis, chronic neck or back pain, migraine or other types of headache, sexually transmitted infections (including HIV/AIDS), chronic pelvic pain, peptic ulcers, chronic irritable bowel syndrome, and frequent indigestion, diarrhea, or constipation.[23] Six percent of all pregnant women are battered and pregnancy complications, including low weight gain, anemia, infections, and first and second trimester bleeding, are significantly higher for abused women, as are maternal rates of depression, suicide attempts, and substance abuse.[24]

RATIONALE

Optimal management of other chronic illnesses such as asthma, HIV/AIDS, seizures, diabetes, gastrointestinal disorders, and hypertension can be problematic in women who are being abused or have been abused in the past. Often times the perpetrator controls the victim's access to and compliance with health protocols. Emerging research shows that women who are abused are less likely to engage in important preventive health care behaviors such as regular mammography and are more likely to participate in injurious health behaviors including smoking, alcohol abuse, and substance abuse.[25] In many controlled studies, IPV significantly increases the risk for serious mental health consequences for victims including depression, traumatic and posttraumatic stress disorder, anxiety, and suicidal ideation.[26, 27, 28, 29, 30] The health consequences of abuse can continue for years after the abuse has ended. IPV can also result in homicide; in 1996, 1,800 murders were attributed to intimates.[31]

Adolescents also suffer devastating and often lifelong effects from dating violence. In one study, female adolescents who reported experiencing sexual or physical dating violence were 2.5 times as likely to report smoking, 8.6 times more likely to attempt suicide, and 3.4 times more likely to use cocaine than their non-abused peers. In addition, abused teens were 3.7 times more likely to use unhealthy weight control behaviors such as using laxatives or vomiting.[32] The experience of interpersonal violence is also correlated with repeated pregnancy and higher rates of miscarriage among low-income adolescents.[33]

More than 100 studies have explored the short and long-term effects of IPV on children.[34] In 30 to 60% of families affected by IPV, children are also directly abused.[35] Children exposed to IPV, particularly chronic abuse, often show symptoms associated with posttraumatic stress disorder. One study found that a child's exposure to IPV (without being directly assaulted) was sufficiently traumatic to precipitate moderate to severe symptoms of posttraumatic stress in 85% of the children surveyed.[36] Although physical health problems have seldom been measured in children exposed to IPV, one study found that they are more likely to exhibit physical health problems including chronic somatic complaints, and behavioral problems such as depression, anxiety, and violence towards peers.[37] Another study found that children exposed were also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution, and commit sexual assault crimes.[38] There is a growing body of research regarding the impact of violence on early brain development that could have implications for children growing up in violent homes.[39]

There is an urgent need to address family violence over the lifespan because the health effects of victimization often persist for years after the abuse has ended.[40] Adults who were abused as children, witnessed IPV, had a parent with a mental illness, or parental substance abuse are at significantly high risk for obesity, heart disease, hepatitis, diabetes, depression, and suicide.[41] These adverse childhood experiences frequently cluster in

households and have a cumulative effect—the more adverse exposures in a household, the higher the likelihood of long-term health problems as an adult.

Identifying and Responding to Abuse Can Make a Difference

The health care system plays an important role in identifying and preventing public health problems. Models developed to identify other chronic health problems can effectively be applied to IPV. Routine inquiry, with a focus on early identification of all victims of IPV whether or not symptoms are immediately apparent, is a primary starting point for this improved approach to medical practice for IPV.[42]

Regular, face-to-face screening of women by skilled health care providers, markedly increases the identification of victims of IPV, as well as those who are at risk for verbal, physical, and sexual abuse.[43, 44] Routine inquiry of all patients, as opposed to indicator-based assessment increases opportunities for both identification and effective interventions, validates IPV as a central and legitimate health care issue and enables providers to assist both victims and their children. When victims or children exposed to IPV are identified early, providers may be able to break the isolation and coordinate with DV advocates to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Expert opinion suggests that such interventions in adult health settings may lead to reduced morbidity and mortality.[45] Talking with patients about IPV provides a valuable opportunity for providers to learn about their experiences with abuse. Battered women report that one of the most important aspects of their interactions with a physician was being listened to about the abuse.[46] Even if a patient chooses not to disclose being abused, the provider's inquiry can often communicate support and increase the likelihood of future discussion of the issue.

Assessment for exposure to lifetime abuse has major implications for primary prevention and early intervention to end the cycle of violence. Victims are often unaware of the co-occurrence of incest in homes with IPV. Assessing for IPV provides an opportunity to educate victims about the increased risk of child abuse and the health effects of childhood exposure to violence. Adolescents who grow up in violent households are more likely to engage in fighting, carry a weapon, attempt suicide, and become part of an escalating epidemic of dating violence.[47,48,49] Adolescent males who witnessed IPV are more likely to become teen fathers.[50] Adolescent girls who witness IPV are more likely have unintended and rapid, repeat pregnancies, have sex with a partner who have multiple partners, and use alcohol or drugs before having sex.[51,52,53] Routine assessment for lifetime abuse is part of a larger trend to meet the psychosocial needs of patients while moving towards prevention.

Asking about IPV and having resource and referral materials in health settings also sends a prevention message that IPV is unacceptable, has serious health consequences, and provides

the patient with important community referral information and resources. In most counties, programs serving victims of IPV include hotlines, walk-in services and shelters. These programs typically provide safety planning, confidential emergency housing, short time focused counseling, legal advocacy, housing support and help identifying financial support.

Working Cross Culturally

IPV affects people regardless of race, ethnicity, class, sexual and gender identity, religious affiliation, age, immigration status and ability. The term culture is used in this context to refer to those axes of identification and other shared experiences. Because of the sensitive nature of abuse, providing culturally relevant care is critical when working with victims of abuse. In order to provide care that is accessible and tailored to each patient, providers must consider the multiple issues that victims may deal with simultaneously (including language barriers, limited resources, homophobia, acculturation, accessibility issues and racism) and recognize that each patient who is a victim of IPV will experience both the abuse and the health system in culturally specific ways. Disparities in access to and quality of health care may also impact providers abilities to help abused patients. For example, women who are members of racial and ethnic minority groups are more likely than white women to experience difficulty communicating with their doctors, and often feel they are treated disrespectfully in the health care setting.[54] English-speaking Latinos, Asians and Blacks report not fully understanding their doctors and feeling like their doctors were not listening to them.[55] People with cognitive or communication disabilities may be dependent on an abusive intimate partner and thus at especially high risk. In addition, some patients may experience abuse from the health care system itself and this may impact their approach to and utilization of the health care system.[56]

Providers also enter patient encounters with their own cultural experiences and perspectives unique from those of the victim. In a successful health care interaction within a diverse client population, the provider effectively communicates with the patient, is aware of personal assumptions, asks questions in a culturally sensitive way and provides relevant interventions. Eliciting specific information about the patient's beliefs and experience with abuse, sharing general information about IPV relevant to that experience and providing culturally accessible resources in the community, improves the quality of care for victims of violence. In addition, having skilled interpreters who are trained to understand IPV (and who are not family members, caregivers or children) is crucial when helping non-English speaking patients. Culturally sensitive questions for all patients can also facilitate discussion and help providers offer appropriate and effective interventions.

Recent Trends

These guidelines reflect an important shift in terminology. "Assessment" has replaced the word "screening" throughout this document. The concept of screening in the medical

model usually involves use of a standardized clinical test to detect disease in asymptomatic patients. Psychosocial health issues like IPV do not fit well into a disease-based approach, particularly when identification of the health concern relies primarily on the patient's response to questions. The U.S. Preventive Services Task Force (USPSTF) uses the term "assessment" in their recommendations for many psychosocial issues such as tobacco use and alcohol consumption. The USPSTF and other prominent medical organizations have identified problems with fitting IPV into a traditional screening paradigm. The FVPF believes that using the term "assessment" will lead to a more appropriate evaluation of the importance of routine inquiry for IPV in the health care setting.

With growing recognition of the connection between IPV and other risk factors, there is a trend to integrate routine inquiry for IPV into assessment tools addressing a wide range of psychosocial issues associated with current or past victimization such as tobacco use, weight control, and access to preventive health care. This has led to innovative strategies for more comprehensive assessment and integrated service delivery. The Maternal and Child Health Bureau has funded several perinatal demonstration projects to develop an assessment tool for IPV, depression, and substance abuse. Another exciting initiative through the Substance Abuse and Mental Health Services Administration (SAMHSA) promotes coordinated services for women who experience violence, mental health problems, and have substance abuse issues.

Future Considerations

The FVPF believes that broader recommendations for assessment for perpetration in the health care setting may eventually be demonstrated to be appropriate. However, experience in this area is still in its infancy and there is little on which to draw conclusions. Before making recommendations on how assessment for perpetration and response should be conducted, the FVPF recommends:

- The collection and analysis of research and practice data on the efficacy of programs to assess for perpetration in health care settings.
- That interested providers consider adopting assessment for perpetration in their practice, especially if this can be tied to research and data collection to demonstrate efficacy.

RATIONALE

Notes

GUIDELINES

PART II GUIDELINES FOR RESPONDING TO INTIMATE PARTNER VIOLENCE VICTIMIZATION IN HEALTH SETTINGS

WHICH PROVIDERS DO THE GUIDELINES ADDRESS?

Providers who should be trained on IPV include (but are not limited to):

- physicians
- dentists, hygienists & assistants
- nurse practitioners
- physician assistants
- nurses and nursing assistants
- social workers
- medical interpreters
- medical assistants
- pre-hospital & emergency responders
- public health professionals
- midwives
- substance abuse counselors
- mental health professionals
- rehabilitation therapists
- same day surgery providers
- other allied health workers

Where should identification and response to IPV victims occur?

THESE GUIDELINES ADDRESS, (BUT ARE NOT LIMITED TO) THE FOLLOWING SETTINGS:

- Adult Primary Care
- Pediatric Primary Care
- Family Practice
- Geriatrics
- Urgent and Emergency Care
- Ob/Gyn & Women's Health
- Mental Health
- Family Planning and Pre-Natal Care
- Public health settings
- Dental care settings
- Orthopedic Surgery
- Inpatient
- Substance abuse treatment
- School health settings
- STI clinics
- Rehabilitation/occupational settings

(General guidelines for assessment and response to victims in all settings follow. A quick reference guide for setting-specific recommendations is located in Appendix A).

Inquiry and initial response should be conducted by a health care provider who:

- Has been educated about the dynamics of IPV, the safety and autonomy of abused patients, and elements of culturally competent care
- Has been trained how to ask about abuse, to provide information about IPV and local community resources and to intervene with identified victims
- Is authorized to record in the patient's medical record
- Has established a relationship or some trust with the patient in a primary care setting
- Has a clearly defined role in a specialty, urgent care or emergency setting

Assessment and intervention can be provided by:

- Any of the providers above and/or a DV advocate or trained volunteer

Responses to intimate partner victims are most efficient and effective when coordinated in a multi-disciplinary manner and in collaboration with DV advocates so that no single provider is responsible for the entire intervention. All providers in the settings listed above should be trained and achieve basic competence regarding how to identify and respond to IPV. Site-specific policies should be developed that clarify each provider's role in implementing specific elements of the protocol.

INQUIRY

What should providers ask?

Ask patients about current and lifetime* exposure to IPV victimization, including direct questions about physical, emotional and sexual abuse

> **Because of the long-term impact of abuse on a patient's health, we recommend integrating assessment for current and lifetime exposure into routine care. However, we acknowledge there will be times (particularly in emergency/urgent care) when assessment for lifetime exposure to abuse will not always be possible due to time constraints.*

Who should be routinely asked about current and past IPV victimization?

- All adolescent and adult patients* regardless of cultural background
- Parents or caregivers of children in pediatric care

*(Please see **Appendix A** for setting-specific recommendations and **Appendix B** for recommendations in child health settings).*

> **The majority of IPV perpetrators are male, so assessing all patients increases the likelihood of identifying perpetrators for victimization. We recommend routinely assessing men only if additional precautions can be taken to protect victims whose batterers claim to be abused. Training providers on perpetrator dynamics and the responses to lesbian, gay, transgender, bisexual and heterosexual victims is critical, regardless of policies to assess all patients or women only.*

*(See **Appendix C** for recommendations on assessing all patients for IPV).*

How should inquiry for present and past IPV victimization occur?

ASSESSMENT SHOULD BE:

- Conducted routinely, regardless of the presence or absence of indicators of abuse
- Conducted orally as part of a face-to-face health care encounter
- Included in written or computer based health questionnaires
- Direct and nonjudgmental using language that is culturally/linguistically appropriate
- Conducted in private: no friends, relatives (except children under 3) or caregivers should be present
- Confidential: prior to inquiry, patients should be informed of any reporting requirements or other limits to provider/patient confidentiality
- Assisted, if needed, by interpreters who have been trained to ask about abuse and who do not know the patient or the patient's partner, caregiver, friends or family socially

When should inquiry for past and present IPV victimization occur?

- As part of the routine health history (e.g. social history/review of systems)
- As part of the standard health assessment (or at every encounter in urgent care)
- During every new patient encounter
- During periodic comprehensive health visits (assess for current IPV victimization only)
- During a visit for a new chief complaint (assess for current IPV victimization only)
- At every new intimate relationship (assess for current IPV victimization only)
- When signs and symptoms raise concerns or at other times at the provider's discretion

(Please see Appendix D for suggested assessment questions and strategies).

When should inquiry not occur?

- If provider can not secure a private space in which to conduct inquiry
- If there are concerns that assessing the patient is unsafe for either patient or provider
- If provider is unable to secure an appropriate interpreter

If inquiry does not occur:

- Note in chart that inquiry was not completed and schedule a follow-up appointment (or if in an urgent care setting, refer patient to a primary care provider)
- Have posters, safety cards and patient education materials about IPV available in exam or waiting rooms, bathrooms or on discharge instructions

HEALTH AND SAFETY ASSESSMENT

The goals of the assessment are to a) create a supportive environment in which the patient can discuss the abuse and b) enable the provider to gather information about health problems associated with the abuse and c) assess the immediate and long-term health and safety needs for the patient in order to develop and implement a response.

When should assessment occur?

- Initial assessment should occur immediately after disclosure
- Repeat and/or expanded assessments should occur during follow-up appointments
- At least one follow-up appointment (or referral) should be offered after disclosure of current or past abuse with health care provider, social worker or DV advocate.

What should assessment include?

For the patient who discloses current abuse, assessment should include at a minimum:

ASSESSMENT OF IMMEDIATE SAFETY

- "Are you in immediate danger?"
- "Is your partner at the health facility now?"
- "Do you want to (or have to) go home with your partner?"
- "Do you have somewhere safe to go?"
- "Have there been threats or direct abuse of the children (if s/he has children)?"
- "Are you afraid your life may be in danger?"
- "Has the violence gotten worse or is it getting scarier? Is it happening more often?"
- "Has your partner used weapons, alcohol or drugs?"
- "Has your partner ever held you or your children against your will?"
- "Does your partner ever watch you closely, follow you or stalk you?"
- "Has your partner ever threatened to kill you, him/herself or your children?"

If the patient states that there has been an escalation in the frequency and/or severity of violence, that weapons have been used, or that there has been hostage taking, stalking, homicide or suicide threats, providers should conduct a homicide/suicide assessment.

(See Appendix E for danger assessment and other assessment tools).

Assess the impact of the IPV (past or present) on the patient's health:

There are common health problems associated with current or past IPV victimization. Disclosure should prompt providers to consider these health care risks and assess:

- How the (current or past) IPV victimization affects the presenting health issue
- "Does your partner control you access to health care or how you care for yourself?"
- How the (current or past) IPV victimization relates to other associated health issues

(See Appendix F for expanded assessment areas).

Assessment of the pattern and history of current abuse:

- "How long has the violence been going on?"
- "Have you ever been hospitalized because of the abuse?"
- "Can you tell me about your most serious event?"
- "Has your partner forced you to have sex, hurt you sexually, or forced you into sexual acts that made you uncomfortable?"
- "Have other family members, children or pets been hurt by your partner?"
- "Does your partner control your activities, money or children?"

For the patient that discloses past history of IPV victimization:

- "When did the abuse occur?"
- "Do you feel you are still at risk?"
- "Are you in contact with your ex-partner?" "Do you share children or custody?"
- "How do you think the abuse has affected you emotionally and physically?"

What to do if a patient says "no":

- Respect her/his response
- Let the patient know that you are available should the situation ever change
- Assess again at previously recommended intervals
- If patient says "no" but you believe s/he may be at risk, discuss the specific risk factors and offer information and resources in exam and waiting rooms, or bathrooms

(See Appendix G for indicators of abuse that should prompt follow-up questions).

INTERVENTIONS WITH VICTIMS OF IPV

Interventions will vary based on the severity of the abuse, the patient's decisions about what s/he wants for assistance at that time and if the abuse is happening currently. It is important to let the patient know that you will help regardless of whether s/he decides to stay in or leave the abusive relationship. For all patients who disclose current abuse providers should:

Provide validation:

- Listen non-judgmentally
- "I am concerned for your safety (and the safety of your children)"
- "You are not alone and help is available"
- "You don't deserve the abuse and it is not your fault"
- "Stopping the abuse is the responsibility of your partner not you"

Provide information:

- "Domestic violence is common and happens in all kinds of relationships"
- "Violence tends to continue and often becomes more frequent and severe"
- "Abuse can impact your health in many ways"
- "You are not to blame, but exposure to violence in the home can emotionally and physically hurt your children or other dependent loved ones"

Respond to safety issues:

Offer the patient a brochure about safety planning and go over it with her/him

(Please see Appendix H for a sample safety plan).

- Review ideas about keeping information private and safe from the abuser
- Offer the patient immediate and private access to an advocate in person or via phone
- Offer to have a provider or advocate discuss safety then or at a later appointment
- If the patient wants immediate police assistance, offer to place the call
- Reinforce the patient's autonomy in making decisions regarding her/his safety
- If there is significant risk of suicide, the patient should be kept safe in the health setting until emergency psychiatric evaluation can be obtained

Make referrals to local resources:

- Describe any advocacy and support systems within the health care setting
- Refer patient to advocacy and support services within the community
- Refer patients to organizations that address their unique needs such as organizations with multiple language capacities, or those that specialize in working with specific populations (i.e. teen, elderly, disabled, deaf or hard of hearing, particular ethnic or cultural communities or lesbian, gay, transgender or bisexual clients)
- Offer a choice of available referrals including on-site advocates, social workers, local DV resources or the National DV Hotline (800) 799-SAFE, TTY (800) 787-3224

For the patient who discloses past but not current IPV victimization:

- "Domestic violence is common and happens in all kinds of relationships"
- "Abuse can impact your health in many ways"
- "What happened to you may be related to health problems now"
- "How do you feel about this now? Is there anything I can do for you now?"
- If the patient feels the issue is still affecting them physically or emotionally, offer to set up an appointment to discuss it further with a primary care provider, mental health provider, social worker or DV advocate, depending on the patient's needs

(Please see Appendix I for more detailed recommendations on interventions for patients with current and/or past experience with IPV).

Reporting IPV to law enforcement or social service agencies:

Some states have requirements to report current victimization to law enforcement, or social services. Providers should:

- Learn applicable statutes in your state *(See Appendix J for a summary of state laws).*
- If you practice in a state with a mandated reporting law, inform patients about any limits of confidentiality prior to conducting assessment

(See Appendix B for a discussion of reporting requirements for child exposure to IPV).

Confidentiality procedures:

Inappropriate disclosure of health information may violate patient/provider confidentiality and threaten patient safety. Perpetrators who discover that a victim has sought care may retaliate with further violence. Employers, insurers, law enforcement agencies, and community members who discover abuse may discriminate against a victim or alert the perpetrator. It is imperative that policy, protocol, and practice surrounding the use and disclosure of health information regarding victims of IPV should respect patient confidentiality and autonomy and serve to improve the safety and health status of victims of IPV. The federal medical records privacy regulations issued in August 2002 (in effect April 14, 2003) have specific implications for victims of violence.

PRIOR TO IMPLEMENTING A DOMESTIC VIOLENCE PROGRAM:

- Review relevant state privacy laws
- Follow the federal regulations and privacy principles for victims of IPV

(For a summary of new federal regulations, see Appendix L).

DOCUMENTATION

Documentation should be conducted by a health care provider who is authorized to record in the patient's medical record. Providers should document the patient's statements and avoid pejorative or judgmental documentation (e.g. write "patient declines services" rather than "patient refuses services," "patients states" rather than "patient alleges").
(See Appendix B for recommendations on documentation in child health settings).

Document relevant history:

- Chief complaint or history of present illness
- Record details of the abuse and its relationship to the presenting problem
- Document any concurrent medical problems that may be related to the abuse
- For current IPV victims, document a summary of past and current abuse including:
  - Social history, including relationship to abuser and abusers name if possible
  - Patient's statement about what happened, not what lead up to the abuse (e.g."boyfriend John Smith hit me in the face" not "patient arguing over money")
  - Include the date, time, and location of incidents where possible
  - Patients appearance and demeanor (e.g. "tearful, shirt ripped" not "distraught")
  - Any objects or weapons used in an assault (e.g. knife, iron, closed or open fist)
  - Patients accounts of any threats made or other psychological abuse
  - Names or descriptions of any witnesses to the abuse

Document results of physical examination:

- Findings related to IPV, neurological, gynecological, mental status exam if indicated
- If there are injuries, (present or past) describe type, color, texture, size, and location
- Use a body map and/or photographs to supplement written description
- Obtain a consent form prior to photographing patient. Include a label and date.

(See Appendix K for more on photo documentation and forensic evidence collection).

Document laboratory and other diagnostic procedures:

- Record the results of any lab tests, x-rays, or other diagnostic procedures and their relationship to the current or past abuse

Document results of assessment, intervention and referral:

- Record information pertaining to the patient's health and safety assessment including your assessment of potential for serious harm, suicide and health impact of IPV
- Document referrals made and options discussed
- Document follow-up arrangements

If patient does not disclose IPV victimization:

- Document that assessment was conducted and that the patient did not disclose abuse
- If you supect abuse, document your reasons for concerns: i.e. "physical findings are not congruent with history or description," "patient presents with indications of abuse"

FOLLOW-UP AND CONTINUITY OF CARE FOR VICTIMS

At least one follow-up appointment (or referral) with a health care provider, social worker or DV advocate should be offered after disclosure of current or past abuse:

- "If you like, we can set up a follow-up appointment (or referral) to discuss this further"
- "Is there a number or address that is safe to use to contact you?"
- "Are there days/hours when we can reach you alone?"
- "Is it safe for us to make an appointment reminder call?"

At every follow up visit with patients currently in abusive relationships:

- Review the medical record and ask about current and past episodes of IPV
- Communicate concern and assess both safety and coping or survival strategies:
  - "I am still concerned for your health and safety"
  - "Have you sought counseling, a support group or other assistance?"
  - "Has there been any escalation in the severity or frequency of the abuse?"
  - "Have you developed or used a safety plan?"
  - "Told any family or friends about the abuse?"
  - "Have you talked with your children about the abuse and what to do to stay safe?"
- Reiterate options to the patient (individual safety planning, talking with friends or family, advocacy services and support groups, transitional/temporary housing, etc.)

For current and previous victims of IPV:

- Ensure that patient has a connection to a primary care provider
- Coordinate and monitor an integrated care plan with community based experts as needed, or other health care specialists, trained social workers or mental health care providers as needed.

(For more information on addressing short and long term mental health effects of IPV victims see the AMA's Diagnostic and Treatment Guidelines on Mental Health Effects of Family Violence referenced in Appendix N).

If patient does not disclose current or past IPV victimization:

- Document that assessment was conducted and that the patient did not disclose abuse
- If you suspect abuse, document your reasons for concern: i.e. "physical findings are not congruent w/ history or description,""patient presents with indicators of violence"

QUALITY & IMPROVEMENT IMPLEMENTATION

PART III | QUALITY IMPROVEMENT GOALS AND IMPLEMENTATION MEASURES

Systems should be in place that help providers implement the clinical recommendations above, such as ensuring that educational materials for patients are always available, providers have training and tools they need, and that site specific quality improvement goals for the IPV program are developed. *(See Appendix M for recommendations on preparing your practice)*. Site specific goals assist providers in evaluating the quality of their IPV protocol. These goals can be set for compliance with the assessment and response protocols or for the number of patients providers expect to identify and assist in their practice. Both provider compliance and identification rates will vary depending on patient population, availability of resources in the health care setting and community, as well as other issues.

GOALS FOR COMPLIANCE WITH IPV PROTOCOLS

Research shows that provider compliance with IPV protocols increases significantly with administrative support, including adequate staffing and training time and by offering provider tools. Over time, systems see significant improvements in provider compliance with the IPV protocols. Based on research and practical clinical experience, reasonable goals for provider compliance are:

- Thirty percent of providers comply with protocol (with minimal administrative support and monitoring) in the first year of the program.
- Seventy percent of providers comply with protocol (with strong administrative support and monitoring after the program is in place.)[57]

QUALITY IMPROVEMENT GOALS FOR IDENTIFICATION BASED ON SETTING-SPECIFIC PREVALENCE DATA

Understanding local IPV data or other available setting-specific prevalence data can help providers establish goals to reach as many victims as possible. Providers or administrators are encouraged to compare their identification rates with the research on prevalence of IPV to work towards these improved identification goals. When a comprehensive and well designed assessment and response program is in place, identification rates can reflect national prevalence data fairly closely.[58] Measuring provider skills, knowledge level and satisfaction with the program will also provide valuable information that can be used to continually improve identification rates and response to victims. **Success should not be based on disclosure alone and there are many reasons why a patient may or may not disclose abuse. Evaluating patient satisfaction and improved health and safety behaviors in addition to measuring identification rates is strongly recommended.**

However, the results from the following studies can provide a basis from which to develop goals for identifying and assisting patients experiencing abuse in individual settings:*

EMERGENCY DEPARTMENTS

- Studies in emergency departments find an 11.7-14% annual prevalence of abuse among women.[59] An effective assessment strategy could identify:
  - 12% female patient population experiencing abuse within last year

PRIMARY CARE

- Studies in primary care settings find that 3.4-5.5% of patients have experienced violence within the last year and 21.4-37% lifetime prevalence.[60] An effective assessment strategy could identify:
  - 4% of the female patient population experiencing abuse within last year
  - Between 21-37% of the female population experiences abuse at some point in her life

INTERNAL MEDICINE

- Studies in internal medicine practices have shown a 14% annual and 28% lifetime prevalence.[61] An effective assessment strategy could identify:
  - 14% of the female patient population experiencing abuse within last year
  - 28% of the female patient population experiencing abuse at some point in her life

OB/GYN

- Estimated IPV prevalence rates for pregnant women range from 0.9-20.1% with the majority of studies between 3.9 and 8.3% annual prevalence rates.[62] An effective assessment strategy could identify:
  - 6% of the female patient population experiencing abuse within last year

Most of the research that is setting-specific focuses on women. We have only included information for settings where setting-specific prevalence rates were located.

** The Family Violence Prevention Fund thanks Dr. Connie Mitchell of the California Medical Training Center at the University of California, Davis, for her work which significantly informed this section on site-specific quality improvement goals.*

IMPLEMENTATION MEASURES

Random sample medical record reviews, whether done just for the purpose of improving IPV assessment performance or whether folded into other quality documentation activities such as HEDIS reporting, can provide valuable information about provider compliance with the IPV protocol. If the sample size is large enough it is also possible that information from chart review can be used to estimate the number of patients being identified and referred at the level of a medical group (this is not applicable to individual physicians because of small sample size). Reviewing a random selection of medical records of each provider is recommended to evaluate documentation of assessment, intervention and follow-up as outlined in the consensus guidelines.

Records should provide information on assessment including:

- Percent of patients seen who were assessed for IPV during the last year
- Percent of patients assessed who disclosed that they were victims of abuse
- Percent of providers who complied with assessment protocols

For patients who assessed positive for current or past IPV, records should indicate that the following was conducted:

- Immediate safety and initial danger
- Abuse history (severity and extent)
- Impact of abuse on health issues & presence of related health care issues
- For those who answered yes to initial danger assessment questions, a suicide and homicide assessment was conducted

For patients disclosing abuse, records should indicate that intervention and treatment plans were offered including:

- Verbal and/or written information about safety planning (current victims only)
- An option to talk with an advocate in person or on the phone (current victims only)
- Verbal and/or written information about abuse and its impact on health
- Referrals to culturally and linguistically appropriate services
- A review of discharge instructions and a scheduled follow-up appointment or care plan with mental health, social worker or community-based service provider

If patient did not disclose abuse but provider is concerned, records should indicate:

- Verbal and written information about IPV and referrals were offered
- Prompts for specific follow-up questions to occur at the patient's next visit

(See Appendix M for how to Prepare Your Practice to Implement an IPV program).

APPENDICES

APPENDIX A | SETTING SPECIFIC CLINICAL RESPONSE TO VICTIMS OF DOMESTIC VIOLENCE QUICK REFERENCE GUIDE FOR HEALTH CARE PROVIDERS

ENTRY POINT	INQUIRY	ASSESSMENT	INTERVENTION	DOCUMENTATION	REFERRAL & FOLLOW UP

• ED, Urgent Care
• Same Day & Episodic visits
• In-patient
• Orthopedic Surgery
	• Routinely ask at every visit
	• Ask about current abuse and if time allows, ask about past history of abuse
	• Privately (1 on 1) or with non-related, trained interpreter
	• 4 'W's: What happened?
	  • When did it happen?
	  • Where did it happen?
	  • Who did this?
	• Respect patient decision to disclose or not
	• Discuss any reporting requirements before inquiring
	• Include screening questions on intake forms
		• Assess immediate safety
		• Health impact of abuse
		• Assess pattern of abuse
		• Danger/Lethality assessment
		• If yes to danger assessment: assess for suicide/homicide
			• Careful listening and support
			• I'm concerned for your health & safety
			• You are not alone
			• Help is available
			• It is not your fault
			• You don't deserve it
			• What happened to you has an impact on your health
			• Provide DV info & materials
			• Ask: "What can I do for you?"
			• Provide a safety plan
			• Offer services: to DV advocate, social work, police, shelter, etc.
				• Legible, full signature, maintain confidentiality of records
				• Abuse History: Subjective info: (patient states " ") Objective info: detailed description of patient's appearance, behavioral indicators, injuries and health cc's
				• Use of rape kits where appropriate
				• Results of physical exam
				• Use body maps (blue ink)
				• Photography (w/patient consent)
				• Radiology, lab findings, collection of forensic evidence- clothes, debris, etc.
				• Any materials and referrals offered
				• Results of health, safety assessment
					• Check if patient has a pcp to follow up with or refer to pcp, mental health provider, social work or DV advocate
					• Obtain permission to notify provider
					• Know phone numbers for:
					  • DV programs
					  • Legal services
					  • Children's programs
					  • Mental health services
					  • Law enforcement
					  • Substance abuse
					  • Transportation
					  • Local clergy or other community organizations

• Adult/Teen Primary Care
• Family Practice
• Public Health
• School Health Settings
	• Routinely sk about current and lifetime history of abuse
	• Ask at initial visit
	• Annually or during periodic health assessments
	• w/ new relationships and if signs/symptoms are present
	• Privately (1 on 1) or with non-related trained interpreter
	• Add questions on forms
	• Respect patient decision to disclose or not
	• Discuss any reporting requirements before inquiring
		• Conduct assessment immediately after disclosure
		• Assess immediate safety
		• Health impact of abuse
		• Assess pattern of abuse
		• Danger/lethality assessment
		• If yes to danger assessment: assess for suicide/homicide
		• Expanded assessment if time allows *(see Appendix F)*
		• If IPV is in the past, assess how the abuse affects patient now: physically/emotionally
		• Ask: "Are you still at risk?" "Are you still in contact with your partner?"
			• Careful listening and support
			• I'm concerned for your safety
			• You are not alone, help is available, it is not your fault, you don't deserve it
			• Provide DV info and material
			• Ask: "What can I do for you?"
			• Offer/Explain services: DV advocates, social work, police, shelter etc.
			• Offer to call DV advocate
			• Review (or have a DV advocate) review safety plan
			• If IPV is not current:
			  • What happened to you may have an impact on your health
			  • Ask "Is there anything I can do for you?" Offer referral if patient desires to DV advocate, pcp, mental health or other providers.
			  • Plan strategies to respond to difficult emotions after the visit
				• Legible, full signature, maintain confidentiality of medical records
				• Abuse History: Subjective info: (patient " " states) Objective info: detailed description of patient's appearance, behavioral indicators, injuries and health cc's.
				• If rape kit needed (<120 hours) know referral sites for exam
				• Results of physical exam
				• Use body map (blue ink)
				• Photography (w/patient consent)
				• Radiology, labs as indicated
				• Materials and referrals offered
				• Results of health, safety assessment
				• Plans for follow-up
					• Offer close follow-up visits as situation warrants
					• If needed, offer referral to mental health, DV advocate
					• Identify follow-up strategy w/patient: (next visit, safe contact number, address)
					• Know phone numbers for:
					  • DV programs
					  • Legal services
					  • Children's programs
					  • Mental health services
					  • Law enforcement
					  • Substance abuse
					  • Transportation
					  • Local clergy or other community organizations
					  • Ask about DV at follow-up

APPENDIX A | SETTING SPECIFIC CLINICAL RESPONSE TO VICTIMS OF DOMESTIC VIOLENCE QUICK REFERENCE GUIDE FOR HEALTH CARE PROVIDERS

ENTRY POINT	SCREENING	ASSESSMENT	INTERVENTION	DOCUMENTATION	REFERRAL & FOLLOW UP

Specialty Providers:
Ob-Gyn, family planning, pre-natal, women's health dental, geriatric, STI clinics
	• Routinely screen for current and lifetime history of abuse
	• Screen at initial visit or
	• annually or at periodic health assessments
	• if chart indicates abuse, w/ new relationship and/or when signs or symptoms are present
	• At pre-natal/post partum visits
	• Privately (1 on 1) or with non related trained interpreter
	• Screening questions on forms
	• Discuss any reporting requirements prior to screening
		• Assess immediate safety
		• Health impact of abuse
		• Assess abuse pattern/history
		• Danger/lethality assessment
		• If yes to danger assessment: assess for suicide/homicide
		• Conduct expanded assessment if time allows *(see Appendix F)* or offer referral to DV advocate, social worker or mental health provider for further assessment
		• If IPV is in the past, assess how the abuse affects patient now, physically & emotionally
		• Ask: "Are you still at risk?" "Are you in contact with your partner?"
			• Careful listening and support
			• I'm concerned for your health & safety
			• You are not alone
			• Help is available
			• It is not your fault, you don't deserve it
			• What happened might impact your health
			• Provide DV info and materials
			• Offer/explain services: DV advocacy, social services, police, shelter, etc.
			• Offer to call DV advocate on phone
			• Review (or have a DV advocate) develop safety plan with patient
			• If IPV is not current: ask "Is there anything I can do for you?" Offer referral to DV advocate, pcp, mental health or other providers
			• Plan strategies to respond to difficult emotions after the visit
				• Legible, full signature, maintain confidentiality of medical records
				• Abuse history: Subjective info: (patient states"") Objective info: detailed description of patient's appearance, behavioral indicators, injuries and cc's.
				• If rape kit needed (<120 hours) know referral sites for exam
				• Results of physical exam
				• Use body map (blue ink)
				• Photography (with patient consent)
				• Radiology, labs as indicated
				• Referrals and materials offered
				• Results of health, safety assessment
				• Plans for follow-up
					• Offer follow-up visits as situation warrants
					• Identify if patient has a pcp to follow up with or if needed offer referral to pcp, mental health or DV advocate
					• Obtain permission to notify provider
					• Know phone numbers for:
					  • DV programs
					  • Legal services
					  • Children's programs
					  • Mental health services
					  • Law enforcement
					  • Substance abuse
					  • Transportation
					  • Local clergy or other community organizations

Mental Health Substance Abuse Settings	• Routinely screen for current and lifetime history of abuse
	• Screen at initial visit
	• Annually, and/or during periodic health history
	• w/ new relationship
	• If chart indicates abuse and/or when symptoms are present
	• Privately (one on one) or with non related trained interpreter
	• Screening questions on forms
	• Discuss any reporting requirements prior to screening
		• Assess immediate safety
		• Mental health impact of abuse
		• Assess abuse pattern/history
		• Danger/Lethality Assessment
		• Suicide/homicide assessment
		• Ask about coping strategies and psycho-social history.
		• Ask: "What have you tried already? What helped?"
		• Conduct needs assessment
		• Substance Abuse Assessment
		• If IPV is in the past, assess how the abuse affects patient now: physically/emotionally
		• Ask: "Are you still at risk?" "Are you in contact with your partner?"
			• Careful listening and support
			• I'm concerned for your health/safety
			• You are not alone
			• Help is available
			• It is not your fault, you don't deserve it
			• What happened might impact your health
			• Provide info & materials re: DV
			• Ask: "What can I do for you?"
			• Offer/explain services: DV advocates, social services, police, shelter etc.
			• Offer to call DV advocate on phone
			• Review (or have a DV advocate) develop safety plan with patient
			• Treat related mental health or substance abuse problems
			• If abuse is in the past, ask "is there anything I can do for you now?"
			• Plan strategies to respond to difficult emotions after the visit
				• Legible, full signature, maintain confidentiality of medical records
				• Results of health, safety assessment
				• Abuse history: Subjective info: (patient states"") Objective info: detailed description of patient's appearance, behavioral indicators, injuries and cc's.
				• Referrals and materials offered
					• If patient desires, refer back to pcp or other provider
					• Offer close follow-up visits as situation warrants
					• Offer group or individual therapy
					• Identify follow-up strategy w/patient: (next visit, safe contact number, address)
					• Know phone numbers for
					  • Legal services
					  • Children's programs
					  • Law enforcement
					  • Transportation
					  • DV programs & shelter
					  • Local clergy or other community organizations

APPENDIX B | DILEMMAS FACED BY CHILD HEALTH PROVIDERS

A policy of universal and regular assessment for IPV in child health settings presents particular dilemmas to the providers who conduct the assessment that may not exist when assessing patients in an adult health setting. Perhaps the fundamental difference lies in the fact that the adult is not the primary patient during pediatric visits. This section reviews several major dilemmas and provides specific recommendations for responding. Because these dilemmas present challenging practice and ethical questions for the provider, it is strongly recommended that child health practices have access to legal consultation, as well as consultation from battered women's service providers, child protection and child mental health. These resources can be helpful in making decisions about how to intervene in ways that do not increase risk for the family or unnecessarily alienate the non-offending parent. More information can be found in the FVPF's *Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health*.

WHEN DOES CHILD EXPOSURE TO INTIMATE PARTNER VIOLENCE BECOME CHILD MALTREATMENT?

Because of the high rate of co-occurrence of IPV and child abuse, child health providers need to be concerned about the possibility of child abuse whenever IPV is disclosed. Whenever a child is abused, either intentionally or unintentionally, as a result of IPV, state law requires health care providers to report this abuse to child protection services. Mandated reporters would also report any high-risk situation of IPV in which children were at risk.

However, state laws may be less clear about whether exposure to IPV in the absence of injury or serious risk of injury to the child would require a report to children's protective services. In some states, there are stringent requirements for mandated reporters requiring them to notify child protective services whenever a child is in the home and has been exposed to a parent's abuse, whether or not the child has been directly abused. Proponents of this definition point to the ample documentation of the overlap between adult IPV and child abuse and the adverse physical and psychological effects on children who witness IPV. Opponents believe this policy penalizes women for abuse they have no control over and may discourage women from seeking help.

In other states, a child's exposure to IPV does not automatically require a mandatory child protection report. There is wider discretion left to the provider to assess whether a child has been directly involved and what other factors may exist to put the child at risk. In deciding whether to notify CPS in these states, a provider should take into account the existence of direct injury to a child, the potential danger of the situation, and the capacity of the mother to keep her children safe.

Many recommend having the mother place a phone call herself to CPS from the practitioner's office, thus protecting her from charges of "failure to protect" while simultaneously protecting the child and meeting statutory child abuse reporting laws.

Unless a child health care provider is legally required to report all incidences of IPV to CPS, it is preferable to make this decision based on the specifics of the case and the provider's clinical judgment. In some instances, the children are not in danger; the victim has planned for their safety; and is responding adequately to the child's needs or emotional reactions. In these cases, a provider should offer voluntary services and support instead of simply submitting a report to CPS, especially if not mandated.

A policy that automatically defines child exposure to IPV as neglect or maltreatment assumes that victims are neglectful parents solely because their children witnessed the abuse, implying that somehow the victim could have stopped the abuse. This approach implies that not only is the abused parent a victim of IPV, but they also bear the responsibility for child neglect, which may be inaccurate and unfair. This policy also makes the assumption that all children are uniformly affected by exposure to violence, no matter what the circumstances are. It ignores the fact that some children are more adversely affected than others and that some families and communities are more able to support children than others. Finally, opponents of this policy allege that mandatory reports would also increase the demands on protective services—a system that is already overburdened and under funded in most states.[63] In addition, the practice of routinely reporting IPV incidents that involve children to protective services discourages victims from seeking help with IPV. If a victim believes that children may be removed from her care, she will be less likely to seek help from medical professionals. A mandatory reporting policy may also discourage child health care providers from assessing for IPV because they do not want to involve protective services in their patient's life.

Recommendations

Know your state or county's child abuse reporting laws and its specific policies on defining child exposure to IPV as child maltreatment. In a state that requires mandated reporting in all cases of IPV, the provider should inform the non-offending parent of the obligation to file a report to CPS, assess the safety needs of the victim, and inform CPS about the specifics of the perpetrator, his anticipated response and the potential for danger. In states where there is more discretion left to the provider, the provider should assess the specifics of each situation as a means of making a decision about whether it is necessary to make a report. The assessment should include inquiries about injury or abuse to children, the current safety of the home, and whether the perpetrator has made threats to the children. Depending on the answers to these questions, the provider can make a decision about the imminent risk of harm to the child and victim. If the situation is not currently dangerous,

the provider can refer the victim to voluntary services: battered women's services, counseling (preferably with a provider who has worked with victims of IPV), or child-focused services. If the situation is currently dangerous to the child, a report needs to be filed. Consider involving the mother in filing the report and follow the recommendations above to maximize the protection afforded to the mother during the CPS investigation.

INTIMATE PARTNER VIOLENCE VICTIMIZATION REPORTING REQUIREMENTS FOR HEALTH CARE PROVIDERS

Most states have enacted mandatory reporting laws, which require the reporting of specified injuries and wounds, suspected abuse or IPV for individuals being treated by a health care professional. Mandatory reporting laws are distinct from elder abuse or vulnerable adult abuse reporting laws, in that the individuals to be protected are not limited to a specific class, but pertain to all individuals whom the health care professional provides treatment or medical care, or who come before the health care facility.

The laws vary from state to state, but generally fall into four categories: 1) states that require reporting of injuries caused by weapons; 2) states that mandate reporting for injuries caused in violation of criminal laws, as a result of violence, or through non-accidental means; 3) states that specifically address reporting in IPV cases; and 4) states that have no general mandatory reporting laws.

In the majority of states, neither statutory nor case law specifies if a health care provider must report a parent's injuries if they are observed or discovered during a health care visit with that parent's child. Therefore, under a strict reading of most laws, if a child's health care provider is not providing treatment or medical care to the abused parent during the child's visit, the health care provider would not be required to make a report. In family practice situations where the child and parent are the provider's patients, and the current visit appointment is for the child, the same reasoning could be applied, although it is less clear-cut. That is, the health care provider would not be required to report since he or she is not treating the parent for the specified injuries during the appointment. This issue merits further discussion among health care providers, advocates, licensing authorities, and other professionals, as it is uncharted territory. There has been much debate about the benefit of mandatory reporting of IPV by health care providers. A more extensive discussion of these laws, their risks and benefits, and their application to pediatric and family practice providers can be found in the FVPF's *Guidelines for Responding to IPV in Child Health Settings*.

Recommendations

Providers should know their state's IPV reporting law, including who is required to report, and under what conditions. *(Appendix J contains a chart listing state codes)*. In order to maximize patient input regarding law enforcement action, providers should also familiarize themselves with how their local law enforcement agency responds to such reports. Becoming familiar with such procedures will allow the provider to better assist the patient in safety planning, and in knowing what to expect. Mandated reporting responsibilities should be discussed with teens seeking primary care prior to assessing for dating violence or IPV in their homes. Additionally, recent federal privacy regulations require providers to inform patients of health information use and disclosure practices in writing, and whenever a specific report has been made. Health care facilities should ensure that their IPV protocols and training materials address their state reporting laws and federal regulations.

ASKING ABOUT INTIMATE PARTNER VIOLENCE WITH A CHILD IN THE ROOM

Providers differ in their practice of asking sensitive questions of the mother when the child is present. Generally, if the child is under age three, most providers assume that asking a mother about safety or other sensitive issues is appropriate with the child present. However, there is not consensus about whether to require that an older child not be present in the room when assessing the mother for IPV. Some providers are concerned about asking questions when older children are present. They assert that having the child in the room will be a barrier to disclosure because parents will avoid discussing it in front of their children. Some say that it would be upsetting for children to hear such conversation or that children may reveal the conversation to the batterer that may endanger the mother and child. Other providers believe that the assessment questions about IPV should be asked regardless of the age of the child. They assert that children generally are aware of the IPV and that mothers will indicate if they are uncomfortable with the subject, thus giving the provider the opportunity to schedule a more private conversation with the parent.

Recommendations

Assessment should occur regardless of the age of the child. It is best to conduct inquiry without children in the room. In some practices it is possible to have the child wait in a supervised waiting area or under the supervision of another staff member. In other practice settings, it is not possible to have children leave the exam room. In these situations, providers can ask general questions and should always be sensitive to the comfort level of the parent. If the parent seems uncomfortable, the provider can offer other options for talking more privately, either by telephone or in a follow-up visit. Providers should be aware of the impact of a disclosure on a child, and should ask follow-up questions about the child and family's safety.

DOCUMENTATION

There is no consensus over the procedure for documenting the presence of IPV in a child's chart. If the batterer is the biological or custodial parent, he may have access to the chart and the information about the victim is not confidential. Therefore, putting information about IPV disclosures in the child's chart may not be advisable. On the other hand, the information is important and other providers who work with the family should know about this risk factor if they read the child's chart. It can also be helpful to the victim should custody disputes arise.

Recommendations

A review of the literature and current practice reveals that recommendations for documentation are contradictory and inconsistent. One recommendation is for the provider to document all assessments for IPV in the child's chart. The suggested notation, perhaps in the section on anticipatory guidance is: "The parent was routinely asked about verbal abuse, threats, physical violence in the home and community. If so, the parent was offered information about community resources for safety planning and counseling."[64] This type of routine documentation is recommended for tracking and quality assurance. If possible, the documentation for the outcome of the inquiry (if positive for abuse) should be placed in the woman's health chart or in social work notes where there is more protection of confidentiality. Some practices use non-specific terms or a code word to indicate the presence of IPV in a child's chart: for example, "family problems", "difficult home situation" or "+wtv". Some practices maintain a section of the child's chart that is confidential and is not released when there is a request for medical records. A brief notation of IPV in this section is appropriate. IPV should not be listed as a discharge diagnosis or billing information that is sent home or can be viewed by the perpetrator.

If the provider is unsure about documenting IPV and keeping that from the battering parent, consultation from local medical records experts, billing personnel, risk management professionals or attorneys should be sought.

RESPONDING TO A CHILD'S DISCLOSURE OF INTIMATE PARTNER VIOLENCE IN THE HOME

Direct disclosures of IPV occur more frequently with older children or teenagers who see child health providers without their parents. If the parents are unaware of the disclosure, the provider must decide how to inform the parents in a way that protects the child and does not create an unsafe situation in the home. The provider may feel uncomfortable about how to handle this disclosure. Should the provider notify child protective services? What are the consequences for the child of telling someone outside the family about the violence? What are the issues and laws related to confidentiality?

Recommendations

Find out as much specific information as possible about the abuse and the extent of risk for the child and the adult victim. If the situation is dangerous, notify protective services. Inform the child of your concern about his/her safety and tell the child that you would like to speak to the non-offending parent about the situation. If possible, inform the non-offending parent of the child's concerns, taking care to stress that you are concerned and that you want to be helpful and supportive. Ask if the parent is safe and what types of supports would be helpful. If possible make a referral to IPV support services or to counseling/social services/mental health. Schedule a follow-up appointment for the next week.

APPENDIX C | DILEMMAS WHEN ASSESSING ALL PATIENTS FOR VICTIMIZATION

Routinely assessing all patients for IPV victimization raises additional policy and practice issues for providers and there is debate in the field about appropriate responses. Those opposed to these policies assert that the risks of alerting perpetrators to the practice of assessing for IPV outweigh the benefits. There are concerns that perpetrators may limit their partner's access to health care, may threaten victims who disclose, or may learn about safety planning materials, which could ultimately undermine victim safety. Proponents of policies to assess men and women assert that because men in same-sex relationships experience IPV in equal rates as women in heterosexual relationships, and some men in heterosexual couples experience abuse, it is critical to identify and assist as many victims as possible. Proponents also argue that determined perpetrators can already access safety planning materials and that assessing all patients offers unparalleled opportunities for abuse prevention. Still others maintain that because the majority of IPV victims are women, providers should begin by assessing all female patients and integrate assessing for men as a second step, after gaining more experience in assessment for victimization and developing policies to address some of the difficult practical concerns that are raised when assessing all patients. Providers and health facilities should consider the dilemmas and recommendations listed below as they develop site-specific protocols.

DILEMMAS

It may be difficult to assess who the victim is. The accounts of one or both parties may lead to confusion about the incident.

- Male perpetrators often claim victimization to avoid consequences or as a tactic to further control victims.[65] Because the majority of IPV perpetrators are male, assessing men increases the likelihood of assessing perpetrators who may claim they are victims. There is not sufficient experience with female perpetrators of violence to know if this is also true of them.
- Victims may take the blame for the abuse because they have been told repeatedly by their partners that the problems in the relationship are their fault or because they used violence or other tactics in self-defense.
- Both parties may use physical force in an incident.

Whether the patient is viewed as a victim or perpetrator will influence the health care provider's response and may lead to inappropriate treatment.

- A victim who takes the blame for the abuse might prevent providers from offering them support and information about IPV.
- Perpetrators who falsely claim they are victims might lead providers to share safety-planning strategies with them, inadvertently colluding and undermining victims' safety planning efforts.
- What is recorded in the medical record by the health care provider can have legal

ramifications for the victim particularly in divorce, custody or other legal cases. While it is not the role of the health care provider to determine if the patient is telling the truth, the provider should take care in evaluating the patient's information and in identifying whether or not they are victims of IPV, just as they take care in evaluating other patient's reports of health concerns. Understanding the definition of IPV and being skilled in behavioral inquiry assists providers in making accurate identification of victimization.

RECOMMENDATIONS FOR ASSESSMENT POLICY IMPLEMENTATION

We recommend that you implement policies to assess all patients for victimization only after you take precautions to protect victims whose perpetrators claim to be abused. Training providers on perpetrator dynamics and responses to lesbian, gay, transgender, bisexual and hetrosexual victims is critical for all IPV programs, including those that target women only. When implementing a policy to assess all patients, first:

- Contact local DV programs (and batterers intervention programs that they recommend) and explain that you are considering a plan to assess all patients for victimization. This will prepare them for referrals and will give them an opportunity to inform the development of your protocol.

- Inform all patients that you assess men and women for victimization and make safety planning materials available to both, so that victims who are concerned about perpetrators sabotaging their safety plan efforts can plan accordingly. Make information available about advocates on-site or in the community that can help the victim with these plans, regardless of whether the victim discloses abuse.

- Understand and conduct training on the IPV prevalence studies. Emerging research demonstrates that IPV occurs at similar rates in LGTB, adolescent and adult populations[66] with higher rates in male same-sex relationships than female.[67] Most studies indicate that about 5-15%[68] of all victims are men (an unknown percentage of whom are gay). Because of this, you should expect to see a fairly small percentage of heterosexual male victims in your practice, but should be prepared to respond to all victims.

- Understand and conduct training on the dynamics of IPV. IPV serves the purpose of establishing power and control through various tactics. This establishment of an abusive imbalance of power and control is fundamentally what distinguishes IPV perpetrators from victims. There are multiple indicators of abusive behavior (denying access to friends/family, intimidation, etc.) not just physical abuse, and victims' lives generally become more limited and controlled.

Recommendations for clinical practice:

- Do not blame patients or force them to prove their "victimhood."
- Assessments should be handled sensitively and without bias.
- Even if you are unsure of whether your patient is a victim, document that you assessed, the patient's response, and note the details of the abuse and health consequences. Offer the patient educational materials about IPV and referrals.

RESPONSES TO LESBIAN, GAY, TRANSGENDER, BISEXUAL AND HETEROSEXUAL MALE VICTIMS

Lesbian, gay, transgender and bisexual victims of abuse:

Emerging research demonstrates that IPV occurs at similar rates in LGTB adolescent and adult populations as in heterosexual populations with higher rates in male same sex relationships than female. However, it is important to realize that the statistics may be low because those in same sex relationships may not be comfortable stating their sexual preference. A policy to assess all patients should include specific recommendations for responding to LGTB and heterosexual victims. Specialized services may be limited in your area so when unavailable, refer patients to national organizations or the national domestic violence hotline.

PRIOR TO IMPLEMENTING A PROGRAM TO ASSESS ALL PATIENTS, IT IS IMPORTANT TO:

- Be aware of your own biases about who is a victim and/or homophobia
- Call your local IPV program and determine what resources are available for LGTB clients
- Call any local programs for LGTB communities and determine what resources they offer for victims of IPV
- In addition (or if no programs exist in your area) provide LGTB victims with the national DV hotline number for more information or materials
- Have educational and safety materials available that are appropriate for LGTB victims *(For clinic materials go to the FVPF website: www.endabuse.org)*
- Refer gay male victims of IPV to Anti-Violence Project (AVP), Community United Against Violence (CUAV), Gay Men's Domestic Violence Project or other organizations for information and support
- Refer lesbian victims to CUAV, the Network for Battered Lesbians and Bisexual Women, AVP and/or other local organizations for information and support

(Please see Appendix N for a listing of resources).

Heterosexual male victims:

There is limited research on male victims of IPV in heterosexual relationships. Most major studies on male victimization do not clarify if male victims are in gay or heterosexual relationships. However, a policy to assess all patients, should include specific recommendations for responding to heterosexual male victims. Services for male victims may be very limited in your area, so be prepared to refer patients to national or international programs and to the national domestic violence hotline. Prior to implementing a program it is important to:

- Be aware of your own bias regarding who might be a victim of abuse.
- Call your local DV program and learn about their policy on heterosexual male victims
- Refer patients to any local programs available, the national domestic violence hotline or other resources including those found in *Appendix N*.
- Have gender neutral educational materials available about abuse or refer patients to the websites listed in *Appendix N* for more educational materials for battered men.

TRAINING PROVIDERS TO ASSESS ALL PATIENTS FOR IPV VICTIMIZATION

Prior to implementing a protocol to assess all patients about abuse, providers should be trained on the dynamics of IPV and perpetrator issues including the context and intent of abuse and how the abuse affects both the perpetrator and the victim. Training should include but not be limited to what is known about perpetrator and victim dynamics:

Perpetrators:

- Often control access to money, property and other shared commodities
- Are often notably jealous of friends, family, co-workers, and others
- Are often scornful of their partner's perspective
- Can use various forms of status to claim authority, knowledge or power. (E.g., professions, citizenship, age, family background, education, etc.)
- Often minimize or explain their behavior, make excuses, or become defensive
- Are often vague about violent incidents
- May have a documented prior use of violence
- Often have offensive wounds (i.e. scratches or bite marks when injuries are present)
- Use physical force against people or property

Victims:

- Are often fearful of their partners
- Are often not allowed access to family, friends, or other support networks
- Often experience reduced autonomy and/or when they exercise autonomy, there are negative or abusive consequences
- Often feel guilty or wonder if they are to blame for their partner's violence.
- May experience problems sleeping, chronic pain, GI disorders, nervousness, depression, or signs of PTSD
- Are more likely to have more serious injuries (injuries to the head, neck and torso)
- Can often articulate what precipitated specific incidents or the progression of violence
- Have been told by others (family friends, etc.) about the concern for the patients safety

In addition, providers should be trained about the health impact of abuse, clinical responses to victims, culturally relevant resources and referral agencies. Training resources are available through the Health Resource Center on Domestic Violence, (888) RX-ABUSE, TTY (800) 595-4889, and at the FVPF's website: www.endabuse.org/health or other local or national DV agencies.

APPENDIX D | SUGGESTED ASSESSMENT QUESTIONS AND STRATEGIES

The following sample assessment questions can also be used to develop a strategy most comfortable for each individual.

Framing questions:

- "Because violence is so common in many people's lives, I've begun to ask all my patients about it"
- "I am concerned that your symptoms may have been caused by someone hurting you"
- "I don't know if this is (or ever has been) a problem for you, but many of the patients I see are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely"

Direct verbal questions:

- "Are you in a relationship with a person who physically hurts or threatens you?"
- "Did someone cause these injuries? Was it your partner/husband?"
- "Has your partner or ex-partner ever hit you or physically hurt you?"
- "Do you (or did you ever) feel controlled or isolated by your partner?"
- "Do you ever feel afraid of your partner? Do you feel you are in danger?"
- "Is it safe for you to go home?"
- "Has your partner ever forced you to have sex when you didn't want to? Has your partner ever refused to practice safe sex?"
- "Has any of this happened to you in previous relationships?"

Effective assessment strategies when working cross culturally:

It is important to adapt your assessment questions and approach in order to be culturally relevant to individual patients. Listen to patients, pay attention to words that are used in different cultural settings and integrate those into assessment questions. For example: for coastal Inuit groups, "acting funny" describes IPV, in some Latino communities, "disrespects you" indicates IPV. Focusing on actions and behaviors as opposed to culturally specific terminology can also help, or some groups may be more willing to discuss abuse if you use general questions. Be aware of verbal and non-verbal cultural cues (eye contact or not, patterns of silence, spacing and active listening during the interview).

SOME EXAMPLES INCLUDE:

- Use your patients language: "Does you boyfriend disrespect you?"
- Be culturally specific: "Abuse is widespread and can happen even in lesbian relationships. Does your partner every try to hurt you?"
- Focus on behaviors: "Has you partner ever hit, shoved, or threatened to kill you?"
- Begin by being indirect: "If a family member or friend was being hurt or threatened by a partner do you know of resources that could help them?"

APPENDIX E | VALIDATED ABUSE ASSESSMENT TOOLS

ABUSE ASSESSMENT SCREEN[69]

1) Have you ever been emotionally or physically abused by your partner or someone important to you?
   Yes ☐ No ☐
   If yes by whom? _____
   Total number of times _____

2) Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
   Yes ☐ No ☐
   If yes by whom? _____
   Total number of times _____

3) Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
   Yes ☐ No ☐
   If yes by whom? _____
   Total number of times _____

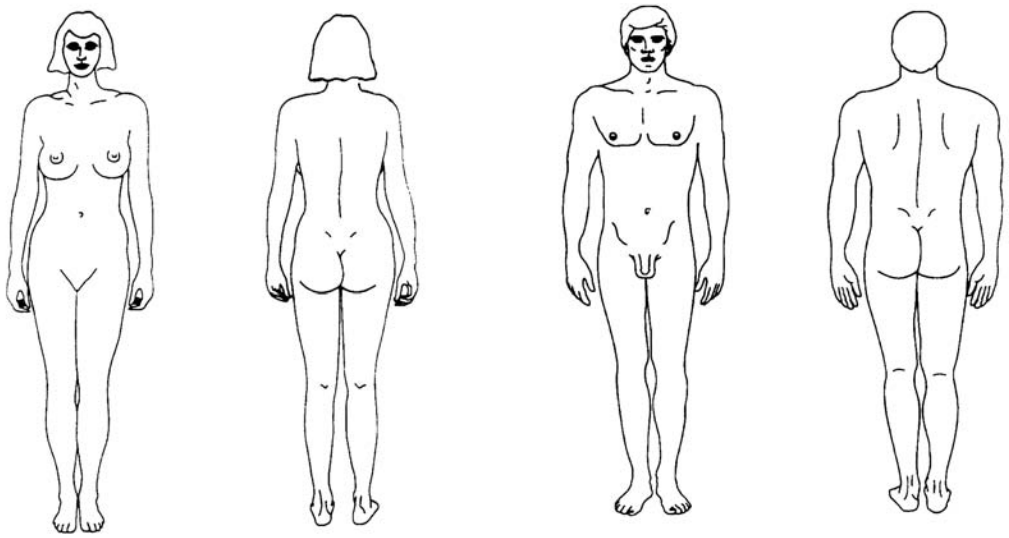
4. Within the last year, has anyone forced you to have sexual activities?
   Yes ☐ No ☐
   If yes by whom? _____
   Total number of times _____

5. Are you afraid of your partner or anyone you listed above?
   Yes ☐ No ☐

MARK THE AREA OF INJURY ON A BODY MAP AND SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:

If any of the descriptions for the higher number apply, use the higher number.

1 = Threats of abuse including use of a weapon
2 = Slapping, pushing; no injuries and/or lasting pain
3 = Punching, kicking, bruises, cuts, and/or continuing pain
4 = Beating up, severe contusions, burns, broken bones
5 = Head injury, internal injury, permanent injury
6 = Use of weapon; wound from weapon



DANGER ASSESSMENT TOOL

Several risk factors have been associated with homicides (murders) of both batterers and battered women in research conducted after the murders have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation.

USING THE CALENDAR, PLEASE MARK THE APPROXIMATE DATES DURING THE PAST YEAR WHEN YOU WERE BEATEN BY YOUR HUSBAND OR PARTNER. WRITE ON THAT DATE HOW BAD THE INCIDENT WAS ACCORDING TO THE FOLLOWING SCALE:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number).

MARK YES OR NO FOR EACH OF THE FOLLOWING. ("HE" REFERS TO YOUR HUSBAND, PARTNER, EX-HUSBAND, EX-PARTNER, OR WHOEVER IS CURRENTLY PHYSICALLY HURTING YOU.)

_____ 1. Has the physical violence increased in frequency over the past year?
_____ 2. Has the physical violence increased in severity over the past year and/or has a weapon or threat from a weapon ever been used?
_____ 3. Does he ever try to choke you?
_____ 4. Is there a gun in the house?
_____ 5. Has he ever forced you to have sex when you did not wish to do so?
_____ 6. Does he use drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
_____ 7. Does he threaten to kill you and/or do you believe he is capable of killing you?
_____ 8. Is he drunk every day or almost every day? (In terms of quantity of alcohol).
_____ 9. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him, check here): _____
_____ 10. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: _____)
_____ 11. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can").
_____ 12. Have you ever threatened or tried to commit suicide?
_____ 13. Has he ever threatened or tried to commit suicide?
_____ 14. Is he violent toward your children?
_____ 15. Is he violent outside of the home?

Total "Yes" Answers _____

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

APPENDIX F | EXPANDED ASSESSMENT

Assessment time will vary with the severity of the abuse, the readiness of the patient to discuss it and time available with the provider. Unless the patient is in crisis, the assessment can be conducted over time. Expanded health assessments can include assessment of associated health problems and/or expanded assessment of the abuse. Provide the victim an opportunity to talk with someone else from the community who is trained on IPV if they are uncomfortable speaking with the provider. These assessments can occur in primary care, ob/gyn, mental health settings or in any setting where a trained health care provider, social worker, or advocate can conduct the assessment in private.

Expanded Assessment of Related Health Problems

A positive identification for lifetime or current exposure to IPV should trigger expanded health assessment (either by the provider who identified the patient or a specialist to whom the patient is referred). Consider and address the following areas:

- Health issues related to IPV: injuries, chronic pain (neck, back, pelvic migraines) peptic ulcers, irritable bowel syndrome, STI's (including HIV/AIDS), insomnia, vaginal and urinary tract infections, multiple pregnancies, miscarriages and abortions
- Substance abuse by the patient: (such as tobacco, alcohol, or others)
- Ability to manage other illnesses (such as hypertension, diabetes, asthma, HIV/AIDS)
- Mental health problems: depression, PTSD, anxiety, stress, suicide risk
- If pregnant: pregnancy complications such as miscarriages, low weight gain, anemia, infections, first and second trimester bleeding, and low birth weight babies
- If forced sex occured: assess for gynecological problems including STI's, anal/vaginal tearing, sexual dysfunction, and ask about safe sex practices and family planning
- If choking/head injury and the patient was unconscious: conduct a neurological exam
- Particularly for teens: Assessment of exposure to dating violence or forced use of drugs such as Rohypnol (RH) "rophies", GHB (Gama Hydroxybutyric acid) etc.
- Preventive health behaviors: encourage and help facilitate preventive health behaviors: such as regular mammography, pap smears, early pre-natal care, etc.

Expanded assessment of the history and extent of the abuse

- Discussion of childhood history of abuse in family of origin
- Discussion about whether abuser is limiting access to friends, family or co-workers
- Assessment of supports in place including friends, family, community, church, etc.
- Discussion of separation, divorce, or seeking shelter
- Assessment of the victim's community's response to abuse, marriage, divorce, health and healing, and find out how the victim responds to cultural expectations
- Assessment of how the abuse has affected the children (physically, emotionally, etc.)
- Assessment of how abuse affected her/his life, work, school, and relationships
- Assessment of whether threats have been made, or violence has been carried out against the family pet(s).

Questions about the batterer

- Does the batterer use illicit drugs and/or alcohol? How much? How often?
- Does batterer increase his/her violent behavior when under the influence?
- Does the batterer have any mental health problems?
- Is the batterer taking medications, if so what?
- Does the batterer have a criminal record?

Suicide and Homicide Assessment Questions

In addition to the initial danger assessment questions included on *Appendix E* other questions to assess the risk for victim's homicidal and suicidal ideation follow:

RISK OF SUICIDE BY THE VICTIM

- Have you ever felt so bad that you didn't want to go on living?
- Have you ever attempted or thought about suicide in the past?
- Are you thinking about killing yourself? Do you have a plan?
- Do you feel this way now?

RISK OF HOMICIDAL THOUGHT BY THE VICTIM

- How do you perceive your options for safety?
- Have you ever attempted or thought about homicide in the past?
- Have you thought about how you would do it? Do you have a homicide plan?
- Assess if the patient is expressing anger or a genuine intent to kill.

If there is significant risk of suicide or homicidal ideation the patient should be kept safe until emergency psychiatric evaluation can be obtained.

APPENDIX G | INDICATORS OF ABUSE

Many victims of IPV will talk about their experiences if asked to do so in a sensitive and empathetic way. However, other victims may be reluctant to disclose. They may be embarrassed, ashamed, or afraid that if they tell anyone they may be at risk for more severe abuse. There may be financial issues and/or concerns about immigration status, or they may lack trust in people because trust was violated in their intimate relationship. Below are some of the reasons one might suspect IPV and might ask follow-up questions.

For Adults

- Failure to keep medical appointments, or comply with medical protocols
- Secrecy or obvious discomfort when interviewed about relationship
- The presence of a partner who comes into the examining room with the patient and controls or dominates the interview, is overly solicitous and will not leave the patient alone with her/his provider
- The patient returns repeatedly with vague complaints
- A patient who presents with health problems associated with abuse
- Unexplained injuries or injuries inconsistent with the history given
- Somatic complaints
- Delay between an injury and seeking medical treatment
- Injury to the head, neck, chest, breasts, abdomen, or genitals
- Bilateral or multiple injuries, especially if in different stages of healing
- Physical injury during pregnancy, especially on the breasts and abdomen
- Chronic pain without apparent etiology
- An unusually high number of visits to health care providers
- High number of STI's, pregnancies, miscarriages, and abortions
- Repeat vaginal and urinary tract infections.

(See Appendix F for others)

For Children and Adolescents

All of the applicable health problems listed above as well as:

- Age inappropriate injuries, burns, injuries to the genital areas
- Developmental & behavioral problems
- Psychological distress such as depression, suicidal ideation or attempts, attachment problems, anxiety, sleeping and/or eating disorders, panic attacks, symptoms of PTSD, and substance use/abuse problems

If you see any of these indicators, or if you suspect abuse, yet the patient remains reluctant to discuss or disclose, provide the patient with a hotline number and other resources in case they need them in the future. Let the patient know that should s/he ever need it, you are available as a resource. Bring the issue up during the next visit. The goal is not to force the victim to admit to a problem, but to try and anticipate his/her concerns about disclosure and to let her/him know that you can be a resource should this ever be a problem. Encourage her/him to return and schedule a follow-up visit within a short time.

APPENDIX H | SAFETY PLAN AND DISCHARGE INSTRUCTIONS

SAFETY PLAN

Step 1: Safety during a violent incident. I can use some or all of the following strategies:

A. If I have/decide to leave my home, I will go _____.

B. I can tell _____ (neighbors) about the violence and request they call the police if they hear suspicious noises coming from my house.

C. I can teach my children how to use the telephone to contact the police.

D. I will use _____ as my code word so someone can call for help.

E. I can keep my purse/car keys ready at (place)_____, in order to leave quickly.

F. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.

Step 2: Safety when preparing to leave. I can use some or all of the following safety strategies:

A. I will keep copies important documents, keys, clothes and money at _____.

B. I will open a savings account by_____ , to increase my independence.

C. Other things I can do to increase my independence include: _____.

D. I can keep change for my phone calls on me at all times. I understand that if I use my telephone credit card, the telephone bill will show my partner those numbers that I called after I left.

E. I will check with _____ and my advocate to see who would be able to let me stay with them or lend me some money.

F. If I plan to leave, I won't tell my abuser in advance face-to-face, but I will call or leave a note from a safe place.

Step 3: Safety in my own residence. Safety measures I can use include:

A. I can change the locks on my doors and windows as soon as possible.

B. I can replace wooden doors with steel/metal doors.

C. I can install additional locks, window bars, poles to wedge against doors, and electronic systems etc.

D. I can install motion lights outside.

E. I will teach my children how to make a collect call to_____ if my partner takes the children.

F. I will tell people who take care of my children that my partner is not permitted to pick up my children.

G. I can inform_____ (neighbor) that my partner no longer resides with me and they should call the police if he is observed near my residence.

Step 4. Safety with a protection order. The following are steps that help the enforcement of my protection order.

A. Always carry a certified copy with me and keep a photocopy.

B. I will give my protection order to police departments in the community where I work and live.

C. I can get my protection order to specify and describe all guns my partner may own and authorize a search for removal.

DISCHARGE INSTRUCTIONS

If you are currently being abused…

Are you here as a result of someone hitting or threatening you—a spouse, boyfriend, lover, relative or someone you know? Have you been sexually abused by someone you know? As you read this, you may be feeling confused, frightened, sad, angry or ashamed. **You are not alone!** Unfortunately, what happened to you is very common. Domestic violence does not go away on its own. It tends to get worse and more frequent with time. There are people who can help you. If you want to begin talking about the problem, need a safe place to stay or want legal advice—call one of the agencies listed on the back of this instruction sheet today.

While still at the clinic…

- Think about whether it is safe to return home. If not, call one of the resources listed on the back of this instruction sheet or stay with a friend or relative.
- You have received instructions on caring for your injuries and taking medications prescribed. Remember, if you have received tranquilizers they may help you rest but they won't solve the problem of battering.
- Battering is a crime and you have the right to legal intervention. You should consider calling the police for assistance (see information on back of this sheet). You may also obtain a court order prohibiting your partner from contacting you in any way (including in person or by phone). Contact a local DV program or an attorney for more information.
- Ask the doctor or nurse to take photos of your injuries to become part of your medical record.

When you get home…

- Develop an "exit plan" in advance for you and your children. Know exactly where you could go even in the middle of the night—and how to get there.
- Pack an "overnight bag" in case you have to leave home in a hurry. Either hide it yourself or give it to a friend to keep for you.
- Pack toilet articles, medications, an extra set of keys to the house and car, an extra set of clothing for you and your children, and a toy for each child.
- Have extra cash, loose change for phone calls, checkbook, or savings account book hidden or with a friend.
- Pack important papers and financial records (the originals or copies), such as social security cards, birth certificates, green cards, passports, work authorization and any other immigration documents, voter registration cards, medical cards and records, drivers license, rent receipts, title to the car and proof of insurance, etc.
- Notify your neighbors if you think it is safe

CALLING THE POLICE*

When someone has injured you or violated a restraining order, criminal stay-away order or emergency protective order, do the following:

1. Call the police at 911, if it is an emergency. Tell them you are in danger and you need help immediately. Let them know if you have a court order. If the police do not come quickly, call again and say "This is my second call." Note the time and date of your call(s).

2. When the police arrive, tell them only what the attacker did. Describe your injuries, how you were injured or how he violated a restraining order, and if the attacker used weapons. If he has violated a restraining order, show the police your order and any proof of service. Ask that the police file a report and give you a report number.

3. If the police refuse to make an arrest, you may ask to make a private person's arrest. Tell the officers that the attacker will come back and beat you unless they make an arrest or allow you to make a private person's arrest. If the police make an arrest and take the attacker into custody, you should be aware that the attacker could be released within a few hours. You can use those hours to get to a safer place.

4. If you don't have a restraining order or an injunction for protection, ask the officer for an Emergency Protective Order. This is an order that may protect you until you obtain a criminal stay-away order or restraining order.

5. Always get the police officers' names and badge numbers. If you have trouble with a police officer, you can complain directly to the Chief of Police or to the officer's supervisor.

6. If the attacker or violator is arrested and taken to the police station, this is what may happen: he may be charged and he will probably be released on bail or, in certain circumstances, without bail until the hearing. Ask that a condition of his release be that he should not come near you. This process may take from 2 to 48 hours.

7. If the attacker is not arrested you should call the prosecutor or police department about how to follow-up with your complaint.

8. Keep a journal documenting what happened.

*** NOTE: The above instructions are specific to the State of California; instructions regarding calling the police should be specific to your state.**

APPENDIX I | INTERVENTIONS WITH CURRENT OR PAST VICTIMS OF DOMESTIC VIOLENCE

If time and trained staff are available, patients should be offered more in-depth interventions after disclosing abuse. This can be provided at the initial visit or during a follow-up appointment. This intervention can include:

For patients experiencing current abuse:

- In-depth safety planning by a health care provider, social worker, or DV advocate
- Identification of family, friends, peers, clergy and social support systems in the community that may be able to assist the patient
- Help accessing a wide range of services including but not limited to:
  - Emergency shelter/housing
  - Transportation
  - Other basic needs: food, clothing
  - Counseling or support groups for victims and their children
  - Child care/welfare assistance
  - Legal Assistance
  - Substance abuse treatment
- Assisting the patient in contacting the police if she/he wants to file a report
- Helping the patient secure orders of protection if she/he wants
- Encourage patients to utilize advocacy services in conjunction with mental health services.
- Do not refer patients who are being physically or sexually abused by their partner to couples counseling
- If the woman request couples counseling, after discussing potential risks, refer to a clinician experienced in IPV who will also address issues of safety and control

For patients with a past history of abuse:

- Give supportive messages and recognize that this may be the first time the patient has disclosed the abuse
- Validate the importance of disclosure and the significance of abuse whenever it occurred in her/his lifetime
- Explain to the patient that the effects of abuse can continue for years after the abuse has ended
- Conduct an in-depth assessment for health problems and risk behaviors listed in *Appendix F* that are commonly associated with IPV
- Help the patient to understand how a history of victimization may be related to current or past health problems and risk behaviors
- Ask the patient how she/he feels that the abuse has affected their health, lifestyle, and family members
- Prepare the patient for unanticipated or suppressed emotions and feelings that may surface after disclosure
- Ask the patient if she/he has anyone safe to talk to about the past abuse
- Educate the patient that survivors can benefit from advocacy and counseling services

even if the abuse was many years or decades earlier

- Ask the patient if she/he would like a referral to a support group or domestic violence advocate to talk about the past abuse
- Ask the patient if she/he would like a referral to a mental health provider or other clinician to help process the trauma they experienced and emphasize that mental health symptoms are a common response to trauma
- Consider referral to a case manager or provider who can develop a comprehensive treatment plan for medical, mental health, and community-based services
- Consider the implications of a disclosure of past abuse on current health problems that the patient is experiencing
- Help the patient to develop an action plan to address concerns related to past abuse and consider a follow-up visit when appropriate

The specific health care required, if any, will vary depending on each patient's experience with abuse, community supports and other factors. Mental health care providers should refer to the AMA's Diagnostic and Treatment Guidelines on Mental Health Effects of Family Violence[70] *for guidance on how to work with current and past victims of abuse.*

APPENDIX J

STATE CODES ON INTIMATE PARTNER VIOLENCE VICTIMIZATION REPORTING REQUIREMENTS FOR HEALTH CARE PROVIDERS* *Current through March 8, 2002*

			IF ANY OF THE FOLLOWING TYPES OF INJURIES ARE PRESENT, PRACTITIONERS IN THE STATE MUST MAKE A REPORT:								
	Code Number	States with General Mandatory Reporting Laws	Injuries Resulting from Domestic Violence or Abuse	Injuries Resulting from Criminal Activity	Injuries Resulting from General Violence	Intentionally Inflicted Injuries	Injuries Inflicted by Gun or Firearm	Injuries Inflicted by Knife or Other Sharp Object	Burn Injuries	Injuries Likely to Cause Death	Treatment of Specified Injuries Requires Practitioners to Report**
AL											
AK	Alaska Stat. §08.64.369	X				X	X	X	X	X	X
AZ	A.R.S. §13-3806	X		X			X	X			X
AR	A.C.A. §12-12-602	X				X	X	X			X
CA	Cal. Pen. Code §11160	X	X	X			X				X
CO	C.R.S. §12-36-135	X	X	X		X	X	X			X
CT	Conn. Gen. Stat §19a-490f	X					X				X
DC	D.C. Code §7-2601	X		X			X				X
DE	24 Del. C. §1762	X				X	X	X			X
FL	Fla. Stat. §790.24	X			X		X			X	X
GA	O.C.G.A. §31-7-9	X				X					
HA	HRS §453-14	X			X		X	X		X	X
ID	Idaho Code §39-1390	X		X			X				X
IL	20 ILCS 2630/3.2	X		X			X				X
IN	Ind. Code Ann. §35-47-7-1	X					X	X		X	X
IA	Iowa Code §147.111	X		X			X	X			X
KS	K.S.A. §21 – 4213	X					X	X		X	X
KY	KRS §209.030	X	X								
LA	La. R.S. §14:403.4 to 3.5	X					X		X	X	X
ME	17-A M.R.S. §512	X					X				X
MD	Md. Ann. Code art. 27, §336A	X					X				X
MA	Ma. Ann. Laws ch. 112, §12A	X		X			X	X	X		X
MI	MCLS §750.411	X			X		X	X			X
MN	Minn. Stat. §626.52	X		X			X		X	X	X
MS	Miss. Code Ann. §45-9-31	X					X	X			X
MO	§578.350 R.S.Mo.	X					X				X
MT	Mont. Code Anno. §37-2-302	X					X	X			X

* This document is intended to provide a cursory overview of mandatory reporting laws. Please be sure to consult the complete set of mandatory reporting laws in your state for further information. If you note any changes or errors on this document, please contact the FVPF at 415-252-8900.

** Under a strict reading of these laws, practitioners must be providing treatment or medical care to the person with specified injuries in order to trigger the reporting requirement. Therefore, in a pediatric or family practice setting, if an attending parent with injuries is bringing her child in for a health care appointment, the attending parent is not actually receiving treatment or medical care from the practitioner, and thus the practitioner in the state would not be required to report. Further discussion is merited, given the lack of statutory or case law that have been developed around this area.

*** The law provides an exception to reporting if the patient is over the age of 18, did not suffer a gunshot wound, and does not consent to reporting.

**** Report is made for medical data collection purposes only, and does not contain identification information.

Prepared by Josephine Yeh, J.D., for the Family Violence Prevention Fund

APPENDIX J

STATE CODES ON INTIMATE PARTNER VIOLENCE VICTIMIZATION REPORTING REQUIREMENTS FOR HEALTH CARE PROVIDERS* *Current through March 8, 20*

	Code Number	States with General Mandatory Reporting Laws	IF ANY OF THE FOLLOWING TYPES OF INJURIES ARE PRESENT, PRACTITIONERS IN THE STATE MUST MAKE A REPORT: Injuries Resulting from Domestic Violence or Abuse	Injuries Resulting from Criminal Activity	Injuries Resulting from General Violence	Intentionally Inflicted Injuries	Injuries Inflicted by Gun or Firearm	Injuries Inflicted by Knife or Other Sharp Object	Burn Injuries	Injuries Likely to Cause Death.	Treatment of Specified Injuries Requires Practitioners to Report**
NE	R.R.S. Neb. §28-902	X		X	X						X
NV	Nev. Rev. Stat. Ann. §629.041, §629.045	X				X	X	X	X	X	X
NH	RSA §631:6	X	X***	X			X				X
NJ	N.J. Stat. §2C:58-8	X					X		X		X
NM											
NY	NY CLS Penal §265.25 to .26	X	X				X	X	X	X	X
NC	N.C. Gen. Stat. §90-21.20	X		X	X		X	X			X
ND	N.D. Cent. Code, §43-17-41	X		X			X	X			X
OH	ORC Ann. 2921.22	X		X	X		X	X	X		
OK	10 Okl. St. §7104	X		X							X
OR	ORS §146.750	X				X	X	X			X
PA	18 P.A.C.S. §5106	X		X			X				X
RI	R.I. Gen. Laws §11-47-48, §12-29-9	X	X****				X				X
SC	S.C. Code Ann. §16-3-1072	X					X				X
SD	S.D. Codified Laws §23-13-10	X					X				X
TN	Tenn. Code Ann. §38-1-101	X			X		X	X			X
TX	Texas Health & Safety Code §161.041	X					X				X
UT	Utah Code Ann. §26-23a-2	X		X			X	X			X
VT	13 V.S.A. §4012	X					X				X
VA	Va. Code Ann. §54.1-2967	X					X	X			X
WA											
WV	W. Va. Code §61-2-27	X		X			X	X			X
WI	Wis. Stat. §146.995	X		X			X		X		X
WY											

* This document is intended to provide a cursory overview of mandatory reporting laws. Please be sure to consult the complete set of mandatory reporting laws in your state for further information. If you note any changes or errors on this document, please contact the FVPF at 415-252-8900.

** Under a strict reading of these laws, practitioners must be providing treatment or medical care to the person with specified injuries in order to trigger the reporting requirement. Therefore, in a pediatric or family practice setting, if an attending parent with injuries is bringing her child in for a health care appointment, the attending parent is not actually receiving treatment or medical care from the practitioner, and thus the practitioner in the state would not be required to report. Further discussion is merited, given the lack of statutory or case law that have been developed around this area.

*** The law provides an exception to reporting if the patient is over the age of 18, did not suffer a gunshot wound, and does not consent to reporting.

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Prepared by Josephine Yeh, J.D., for the Family Violence Prevention Fund

APPENDIX K | PHOTO DOCUMENTATION AND FORENSIC EVIDENCE COLLECTION

PHOTO-DOCUMENTATION

Equipment Needed:

- Camera: 35 mm, digital (with security software), instant
- Macro lens (focal length 100-105 mm) and/or colposcope
- Ring Flash (to avoid "white-outs")
- Color Bar
- Ruler
- Blue sheet for background behind extremity images
- Modesty drape for patient

Procedure:

- Explain the importance of photographic documentation and obtain consent to obtain photographs
- Use a color bar in the first picture of each roll of 35 mm film or on one image of digital or instant films
- The first 3 images should be a) a full body image of the clothed patient, b) a close-up facial view and c) a close-up view of patient's identification card or plate
- Remove all clothing and use an examination gown or other drapes appropriately
- Each injury should have a medium distance body part image and then at least 2 close-ups with one at a 90 degree angle and one tangential to the injury and one that tries to duplicate patient and perpetrator positions
- Use color film and a measuring standard (such as a ruler) to assess the size of each individual injury, ideally taking one image with the standard and one without so as to avoid suspicion so something was hidden behind the standard
- Use security measures and software to assure that the photographs can not be altered
- When photographing bite marks, use the American Board of Forensic Odontology (ABFO) #2 standard
- Offer the patient a visit for follow-up photographs at a later visit (2-4 days) to document the duration and progression of injuries
- Obtain photographs of areas of permanent residual injury (as permanent injuries can increase penalties if a case is prosecuted)
- Use a colposcope if available for documenting small findings or injuries to mouth or ear canals
- If using instant images, take one set of pictures for the record and one set of pictures for the patient
- Include a label on each hard copy photograph that includes the date, patient's name, record number and photographer's name
- Adhere to the highest standards for privacy and confidentiality regarding developing, storage, retrieval and review of photos

Evidence Collection:

- Collect, describe or photograph: torn, stained or bloody clothing according to local protocols. Clothing should be dried and sealed in paper bags only
- Collect corroborating evidentiary materials such as fingernail scrapings, hair, fiber, soil, debris or other foreign materials
- Swab areas suspicious for blood, saliva or semen. Collect a reference sample of blood from victim if blood swabs are collected
- Swab bite marks with saline soaked cotton swabs for saliva analysis
- Use a sexual assault evidence collection protocols (rape kit) if sexual assault occurred
- Consider further imaging or laryngoscopy evaluation when strangulation is involved
- Consider voice recording in strangulation cases where patient reports a voice change
- Collect, store and transfer evidence with strict adherence to "chain of evidence" protocols
- Determine evidence collection procedures with local crime lab professionals
- Document any other laboratory results, diagnostic imaging studies or consultations

APPENDIX L | CONFIDENTIALITY PROCEDURES

As the health care system identifies and supports victims of IPV in a more systematic fashion, patients may become vulnerable to inappropriate disclosure of their health information. For victims of IPV this is a critical safety issue as well as an issue of confidentiality. Perpetrators who discover that a victim has sought care for injuries and disclosed the abuse may retaliate with further violence. Employers, insurers, law enforcement agencies, and even members of a victim's community who discover abuse in health records may discriminate against a victim. Health information is shared to process claims, for public health purposes, for quality review and oversight, research, to investigate fraud and abuse, to secure advice or a second opinion, to inform family members of a patient's condition, or to evaluate the care delivered by a provider. To ensure that the benefits of health care intervention are achieved, medical records privacy concerns must be adequately addressed. All providers and health systems should assess for and document IPV and establish strong policies that ensure that medical records are kept as confidential as possible. The federal medical records privacy regulation that will take effect in April 2003 has provisions that specifically impact victims of violence. Work with your administration, billing personnel, medical information systems, and risk management department to develop and monitor those policies based on the federal regulations and the general privacy principles listed below.

A. De-Identified information

- Federal Regulations: Encourages but does not require use or disclosure or de-identified information.
- General Privacy Principles: Personal identifiers should be removed, to the fullest extent possible, before the information is used or disclosed. (Personal identifiers include but are not limited to, information that could be used to identify an individual – such as name, address, telephone number, birth date and social security number).

B. Safeguards

- Federal Regulations: Covered entities are generally required to take steps to limit disclosure of protected health information to those who most need the information. The regulation requires use and disclosure of the minimum amount of information but this requirement has numerous exceptions.
- General Privacy Principles: Limit access to personally identifiable health information on a need-to-know basis. Limit disclosures to the minimum necessary. If possible, the entire record/chart should not be released to process a claim, only the information that is necessary to secure payment should be disclosed.

C. Patient access and notice

Federal Regulations:

- An individual has the right to inspect, copy and amend their medical records.
- Individuals must receive written notice of how health information is used and disclosed.
- General Privacy Principles: When a patient is a victim of abuse, a health staff person should review this information with the patient verbally, in a language they understand or with the assistance of an interpreter.

D. Patient authorization

1. HEALTH CARE DIRECTORY INFORMATION:

- Federal Regulation: A patient has the right to restrict or object to the use of information in a health care facility directory.
- General Privacy Principles: Individuals who are capable of opting out or limiting the amount of information to be included in the directory should be given the opportunity to exercise their right to do so upon admittance. Directory use should be explained to patients so they can make informed decisions about whether to opt out. If individuals opt out of directory information, health care staff should also use care when making comments or using names on emergency department boards.

2. NEXT OF KIN:

- Federal Regulation: Providers may refuse to disclose information to a person involved in the patient's care, who, for example, could also be the perpetrator.
- General Privacy Principles: Access to information by next of kin should be granted only with the explicit and informed consent of the patient. Providers should verify who is requesting information as next of kin.

3. MINORS:

- Federal Regulation: Health care providers may disclose a minor's medical records to her/his parents, unless state law explicitly states that they cannot do so.
- General Privacy Principles: Those states that do not have laws to prevent the release of minor's records to parents should warn patients who are minors about the limits of confidentiality.

E. Provider discretion

- Federal Regulations: Health care providers may refuse to release information to a patient's personal representative if the provider believes that the representative has or may subject the patient to abuse or neglect.
- General Privacy Principles: Individual intent and consent to release information should be controlled even when providers are given discretion. Health care professionals should have broad discretion to withhold information from third parties when disclosure could harm the patient who is the subject of the information.

F. Alternate address

- Federal Regulations: Patients have the right to request that health care communication including bills, explanation of benefits, routine calls and other communication be sent to an alternative contact and be conducted through an alternative means (such as a closed envelope rather than a postcard, or a sent to a P.O. box instead of to their home).
- General Privacy Principles: Ideally, all victims should be notified in person of this option and offered assistance in securing safe alternatives. If insurance information is sent to the abuser, make other billing arrangements according to the situation.

G. Disclosures to government authorities

- Federal Regulations: In most instances (even in states where reporting IPV is required) health care providers must promptly inform a victim of abuse that abuse has been or will be reported to government authorities. This requirement does not apply to child abuse. Providers are not required to inform the victim if the information is disclosed pursuant to a court order, other process or administrative request.
- General Privacy Principles: Victims of abuse should be informed of any disclosure of information that could put them at risk of harm.

H. Disclosures in civil judicial and administrative proceedings

- Federal Regulation: Information may be disclosed pursuant to an order of a court or administrative tribunal. Information may also be disclosed in response to a subpoena or discover request if the party seeking the information has made reasonable efforts to notify the victim or has secured a protective order regarding disclosure of the information.
- General Privacy Principles: In all circumstances, individuals whose information has been requested should have reasonable notice and reasonable opportunity to object to the disclosure on the basis that the individual's privacy interest outweighs the interest of the person seeking the information. In cases where disclosure must occur, proper notice should provide time for the victim to plan for her/his own safety.

I. Chain of trust and privacy protections

- Regulations: Entities must generally limit use and disclosure of information to carry out treatment, payment and health care operations. Under some circumstances, entities must enter into contracts with non-covered entities to protect from inappropriate use or disclosure of information.
- General Privacy Principles: Protections should follow the information. Data holders should have an ethical responsibility to maintain public trust by treating health information in a confidential manner and should be accountable for the ways in which they use, maintain, and disclose personally identifiable health information.

J. Penalties

The Health Insurance Portability and Accountability Act provides for penalties for knowing and willful violations of federal privacy regulations.

For more information see the FVPF's policy paper: Health Privacy Principles for Protecting Victims of Domestic Violence and look for an analysis of the 2002 federal regulations and their impact on victims of IPV online at: @www.endabuse.org/health).

APPENDIX M | PREPARING YOUR PRACTICE

There are a number of important steps to take to prepare your practice to identify and respond to victims of IPV. It is essential that the clinical setting be designed to support the staff to respond effectively and efficiently. In preparing your practice to begin routine inquiry for and response to IPV, it is advisable to obtain support from the leadership and administration at your setting as well as staff input. Finally, as the Joint Commission on the Accreditation of Health Care organization requires, and the Institute of Medicine recommends, staff should receive initial and on-going training.

Physical environment should:

- Allow for confidential interviewing, ideally establishing a policy that requires a portion of the interview be conducted in private
- Have posters on IPV that are multicultural and multilingual; that present available resources; and that include information about victims, perpetrators, and/or other family and community members affected by abuse
- Have brochures/pocket cards for victims and perpetrators and resources that describe the impact of IPV on children
- Have brochures placed in exam rooms and private places such as bathrooms

(See Appendix N for resources or www.endabuse.org for materials).

Training for staff should include:

- Survivors' perspectives
- Cultural competency
- Dynamics of victimization and perpetration
- Physical and mental health consequences of IPV on victims and children exposed
- How to assess, intervene, support and document appropriately
- Interactive role playing and modeling of assessment and response techniques
- Information on where employees in abusive relationships can access assistance
- Boundary setting and self-care

Training should be part of staff orientation; ongoing, repeated and institutionalized; and mandatory for all employees. Providers who will be assessing and documenting in the medical record should receive training on dynamics and clinical response as well as other staff and allied health professionals. Receptionists and security, which can play an essential role in identifying victims, should receive general awareness training on IPV. Interpreters in particular should be trained in advance about the dynamics of IPV and the importance of confidentiality and non-judgmental interpretation and appropriate word choices for translation of routine assessment questions.

Protocols should include:

- Definitions, guiding principles, routine assessment, intervention, and documentation strategies, reporting policies and confidentiality rules
- Roles and responsibilities of staff

All staff should receive an orientation on the protocol. It should also be updated regularly and informed by new knowledge, laws, and policies regarding IPV. It should be accessible to all staff.

Adequate staffing includes:

- On-site trained advocates available and/or
- Relationships with DV programs in the community and/or
- Hiring and/or designating specific health care staff to conduct IPV assessment and response
- Hiring and/or designating specific staff to oversee the IPV program

Continuous quality improvement (CQI) program:

- Regular discussions during staff meetings regarding functioning of IPV program
- Patient satisfaction surveys
- Links to other quality improvement efforts
- Scheduled audits of select medical records to review compliance with the protocol
- Links to any medical information system developments
- CQI goals shared with providers

Provider resources should include:

- Chart prompts in the medical record
- Documentation and assessment forms
- Posters and practitioner pocket cards
- Materials that are easily accessible to providers and regularly updated
- Consultation with on-site or off-site DV advocates, legal and forensic experts, counselors with expertise in trauma treatment, and community experts from diverse (LGTB, disability, elder, teen, ethnic specific and immigrant) communities
- Feedback mechanisms for providers

Patient/client resources:

- Materials should be easily accessible to patients (in bathrooms and waiting rooms); regularly updated; culturally appropriate and representative of patient population; multilingual; and at appropriate reading level)
- Patient materials include: brochures, discharge instructions, safety planning handouts and referral information on services for on-site or off-site advocacy, counseling, and legal and other community-based services for victims, perpetrators, and others affected by IPV
- IPV information could be included in member or patient newsletters

Employee assistance or human resources programs should:

- Address IPV victimization and perpetration
- Be confidential (within legal limits)
- Easily accessible and specific IPV services should be well publicized
- Incorporate IPV information into managerial training
- Include IPV information in employee publications and alerts

APPENDIX N | RESOURCES AND REFERRALS

HOTLINES FOR PATIENTS

National Domestic Violence Hotline 24 hours, 1-800-799-SAFE (7233), 1-800-787-3224 (TTY). Links individuals to help in their area using a nationwide database that includes detailed information on DV shelters, other emergency shelters, legal advocacy and assistance programs, and social service programs. website: *www.ndvh.org*

Rape Abuse & Incest National Network (RAINN) 24 hours, 1-800-656-HOPE Will automatically transfer the caller to the nearest rape crisis center, anywhere in the nation. It can be used as a last resort if people cannot find a DV shelter. 635-B Pennsylvania Ave SE, Washington, DC 20003 phone: (800) 656-HOPE (4673) ext. 3 fax: (202) 544-3556 e-mail: *rainnmail@aol.com* website: *www.rainn.org*

Local Domestic Violence Hotlines
Numbers are listed in the front of your telephone book.
For the list of State Domestic Violence or Sexual Assault Coalitions visit:
www.ojp.usdoj.gov/vawo/state.htm

DOMESTIC VIOLENCE ORGANIZATIONS

Family Violence Prevention Fund (FVPF) is a national non-profit organization that focuses on domestic violence education, prevention and public policy reform. 383 Rhode Island St., Suite 304, San Francisco, CA 94103-5133 phone: (415) 252-8900 TTY: (800) 595-4889 fax: (415) 252-8991 e-mail: *fund@endabuse.org* website: *www.endabuse.org*

National Coalition Against Domestic Violence (NCADV) is dedicated to the empowerment of battered women and their children and is committed to the elimination of personal and societal violence in the lives of battered women and their children. PO Box 18749, Denver, CO 80218 phone: (303) 839-1852 fax: (303) 831-9251
website: *www.ncadv.org*

Pennsylvania Coalition Against Domestic Violence and National Resource Center (PCADV) is a private, nonprofit membership organization and is dedicated to ending domestic violence and helping battered women and their children re-establish physical, social, and economic dignity. 6400 Flank Drive, Suite 1300, Harrisburg, PA 17112 phone: (800) 932-4632 fax: (717) 671-8149 website: *www.pcadv.org*

The National Network to End Domestic Violence (NNEDV) is a membership and advocacy organization of state domestic violence coalitions, allied organizations and supportive individuals and is a leading voice among domestic violence advocates in public policy. 660 Pennsylvania Ave., SE, Suite 303, Washington D.C. phone: (202) 543-5566 email: *nnedv@bellatlantic.net* website: *www.nnedv.org*

Sacred Circle: The National Resource Center to End Violence Against Native Women is dedicated to the actions that promote the sovereignty and safety of native women. 722 St. Joseph St., Rapid City, SD 57701 phone: (605) 341-2050 (877) RED ROAD (733-7623)

Asian & Pacific Islander Institute on Domestic Violence strives to eliminate domestic violence in Asian and Pacific Islander communities by increasing awareness about the extent and depth of the problem making culturally specific issues visible; strengthening community models of prevention and intervention; identifying and expanding resources; informing and promoting research and policy; and deepening understanding and analysis of the issues surrounding violence against women. 942 Market Street, Suite 200, San Francisco, CA 94102 phone: (415) 954-9964 fax: (415) 954-9999 website: *www.apiahf.org*

Institute on Domestic Violence in the African American Community provides an interdisciplinary vehicle and forum by which scholars, practitioners, and observers of family violence within the African American community will have the continual opportunity to articulate their perspectives on family violence through research findings, the examination of service delivery and intervention mechanisms, and the identification of appropriate and effective responses to prevent/reduce family violence in the African American community. 290 Peters Hall 1404 Gortner Avenue, St. Paul, MN 55108-6142 phone: (877) NIDVAAC (643-8222) fax: (612) 624-9201 website: *www.dvinstitute.org*

National Latino Alliance for the Elimination of Domestic Violence is a network of nationally recognized Latina and Latino advocates, community activists, practitioners, researchers, and survivors of domestic violence working together to promote understand, sustain dialogue, and generate solutions to move toward the elimination of domestic violence in Latino communities, with an understanding of the sacredness of all relations and communities. P.O. Box 322086, Fort Washington, New York, NY 10032 phone: (800) 342-9903 fax: (800) 216-2404 website: *www.dvalianza.org*

CLINICAL MATERIALS FOR THE HEALTH CARE SETTING

The National Health Resource Center on Domestic Violence a project of the FVPF, provides support to thousands of health care professionals, policy makers and domestic violence advocates through its four main program areas: model training strategies, practical tools, technical assistance, and public policy. 383 Rhode Island St., Suite 304, San Francisco, CA 94103-5133 phone: (888) Rx-ABUSE TTY: (800) 595-4889 fax: (415) 252-8991 e-mail: *health@endabuse.org* website: *www.endabuse.org/health*

Physicians for a Violence-free Society (PVS) is a national non-profit organization that helps physicians and other health professionals improve their response to victims of violence, particularly IPV through educational programs, written materials and web-based resources. 160 14th Street, San Francisco, CA 94103 phone: (415) 621-3584 fax: (415) 621-3438 e-mail: *pvs@pvs.org* website: *www.pvs.org*

Alaska Family Violence Prevention Project specializes in training for health care and service providers, provides articles and curricula in PowerPoint that can be downloaded, acts as a clearinghouse of education materials
website: *http://www.hss.state.ak.us/dph/chems/injury_prevention/akfvpp/*

California Medical Training Center trains medical professionals to effectively identify, evaluate and treat victims of child abuse and neglect, sexual assault, domestic violence, and elder and dependent adult abuse and offers comprehensive domestic violence curriculum targeted for a continuum of learners. 3300 Stockton Boulevard, Sacramento, CA 95820 e-mail: *mtc@ucdmc.ucdavis.edu* website: *www.calmtc.org*

WEBSITES OF INTEREST FOR ADOLESCENTS

The Empower Program works with youth to end the culture of violence. 1312 8th Street, Washington, DC 20001 phone: (202) 882-2800 fax: (202) 234-1901
e-mail: *empower@empowered.org* website: *www.empowered.org*

Girls Incorporated National Resource Center is a national youth organization dedicated to inspiring all girls to be strong, smart and bold. 441 West Michigan Street, Indianapolis, IN 46202 phone: (317) 634-7546 fax: (317) 634-3024
e-mail: *girlsinc@girls-inc.org* website: *www.girlsinc.org*

Liz Claiborne Inc. produces "A Teen's Handbook" and web pages to help teens learn about dating violence by providing facts, guidance and resources. To order a free handbook, phone: (800) 449-STOP (7867)
website: *www.lizclaiborne.com/lizinc/lizworks/women/handbook.asp#teen*

Youth Resource website created for GLBTQ youth to promote sexual health
website: *www.youthresource.com*

LESBIAN, GAY, TRANSGENDERED, BISEXUAL, QUEER (LGBTQ)

Community United Against Violence (CUAV) is a 20-year old multicultural organization working to end violence against and within lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) communities. The Love & Justice Project aims to lead the discussion on positive communication skills, consensual sexuality, partnership decision making and naming abusive behavior in LGBTQ youth relationships by building bridges and

community resources between LGBTQ youth and elders. 973 Market St., #500, San Francisco, CA 94103 phone: (415) 777-5500 fax: (415) 777-5565
24 Hr. Support Line: (415) 333-HELP (4357) e-mail: *cuav@aol.com*
website: *www.cuav.org*

Parents, Families, and Friends of Lesbians and Gays (PFLAG) is a national organization that promotes the health and well-being of gay, lesbian, bisexual and transgendered persons, their families and friends. Their web site provides users with information on local chapters, advocacy and support information and other resources that support the family and friends of gays and lesbians. 1726 M Street, NW, Suite 400, Washington, DC 20036 phone: (202) 467-8180 fax: (202) 467-8194
e-mail: *info@pflag.org* website: *www.pflag.org*

Gay Men's Domestic Violence Project is a grassroots, non-profit organization in Boston providing community education and direct services for clients. GMDVP offers shelter, guidance, and resources to allow gay, bisexual, and transgender men in crisis to remove themselves from violent situations and relationships GMDVP, PMB 131, 955 Mass Ave. Cambridge, MA 02139 fax: (617) 354-6072 phone: (617) 354-6056
crisis: (800) 832-1901 toll-free: (800) 832-1901 website: *www.gmdvp.org*

Network for Battered Lesbians and Bisexual Women was formed to address battering in lesbian, bisexual women's, and transgender communities. POB 6011 Boston, MA 02114 phone/TTY: (617) 695-0877
hotline/TTY: (617) 423-7233 website: *www.thenetworklared.org*

The Northwest Network provides support and advocacy for bisexual, transgender, lesbian and gay survivors of abuse and dating violence. P.O. Box 20398, Seattle, Washington 98102 phone: (206) 568-7777 TTY: (206) 517-9670 website: *www.nwnetwork.org*

The Survivor Project expanding access to sex/gender variant survivors of domestic violence. P.O. Box 40664, Portland, Oregon 97240 phone: (503) 288-3191
email: *info@survivorproject.org* website: *www.survivorproject.org*

Anti-Violence Project serves LGTB & HIV-positive and others affected by violence. 240 West 35th St., Suite 200, New York, NY 10001
24-hour bi-lingual Hotline: (212) 714-1141 TTY: (212) 714-1134 website: *www.avp.org*

LAMBDA GLBT community services. P.O. Box 31321, El Paso, TX 79931
phone: (208) 246-2292 fax: (208) 246-2292 email: *info@lambda.org*
website: *www.lambda.org/dv97.htm*

WEBSITES OF INTEREST FOR MALE VICTIMS OF DOMESTIC AND SEXUAL VIOLENCE

Menweb information for battered men on how to cope and the steps they should take, as well as other resources. website: *http://www.batteredmen.com/*

National Organization on Male Sexual Victimization commited to prevention, treatment & elimination of all forms of sexual vicitmization of boys and men
website: *www.nomsu.org*

For Men Only information for male survivors of sexual assault
website: *www.utexas.edu/student/cmhc/booklet/menassault.html*

TEEN PREGNANCY

American College of Obstetricians and Gynecologists (ACOG) has a membership of 40,000 physicians and is the nation's leading group of professionals providing health care for women. ACOG's website provides adolescent sexual assault assessment tools as well as other teen pregnancy materials. To request free copies of their educational bulletins, call: (202) 638-5577 or e-mail: *violence@acog.org* ACOG, 409 12th Street, SW, PO Box 96920 Washington, DC 20024 phone: (202) 863-2487
fax: (202) 484-3917 e-mail: *adolhlth@acog.org* website: *www.acog.org*

SEXUAL ASSAULT

Center for the Prevention of Sexual and Domestic Violence is an interreligious educational resource addressing issues of sexual and domestic violence whose goal is to engage religious leaders in the task of ending abuse, and to serve as a bridge between religious and secular communities. 936 North 34th St., Suite 200, Seattle, WA 98103 phone: (206) 634-1903 fax: (206) 634-0115 e-mail: *cpsdv@cpsdv.org*
website: *www.cpsdv.org*

Rape Abuse & Incest National Network (RAINN) (see "Hotlines")

Sexual Assault Resource Service (SARS) is designed for nursing professionals involved in providing evaluations of sexually abused victims. SARS' website provides information and technical assistance to individuals and institutions interested in developing new SANE-SART programs or improving existing ones. website: *www.sane-sart.com*

ANIMAL CRUELTY AND FAMILY VIOLENCE

The Humane Society of the United States, through its First Strike campaign, is dedicated to raising public and professional awareness about the connection between animal cruelty and family violence. 2100 L Street, NW, Washington, DC 20037 phone: (301) 258-3076; toll-free (888) 213-0956 fax (301) 258-3074 e-mail: firststrike@hsus.org
website: www.hsus.org/firststrike

OTHER WEBSITES OF INTEREST

RESOURCES AND REFERRALS

American Academy of Pediatrics: *www.aap.org*

American College of Emergency Physicians: *www.acep.org*

American College of Nurse Midwives: *www.acnm.org*

American College of Obstetricians and Gynecologists: *www.acog.org*

American Medical Association: *www.ama-assn.org*

American Medical Women's Association: *www.amwa-doc.org*

American Psychological Association: *www.apa.org*

Association of Traumatic Stress Specialists: *http://www.atss-hq.com*

Battered Women and Their Children: *http://hosting.uaa.alaska.edu/afrhm1/wacan*

Child Witness to Violence Project at Boston Medical Center: *www.childwitnesstoviolence.org*

Family Violence and Sexual Assault Institute: *www.fvsai.org/*

International Association of Forensic Nurses: *www.forensicnurse.org*

Johns Hopkins University School of Nursing: *www.son.jhmi.edu*

Massachusetts Medical Society: *www.massmed.org*

Men Stopping Violence: *www.menstopping.violence.org*

Nursing Network to End Violence Against Women International: *www.nnvawi.org*

National Sexual Violence Resource Center: *www.nsvor.org*

Physicians for a Violence-Free Society: *www.nnvawi.org*

Society of Academic Emergency Medicine: *www.saem.org*

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TRAINING & EDUCATION MATERIALS CATALOG

Produced by the Family Violence Prevention Fund's National Health Resource Center on Domestic Violence

For more than two decades, **The Family Violence Prevention Fund** (FVPF) has worked to end violence against women and children around the world, because everyone has the right to a life free of violence. Instrumental in developing the landmark Violence Against Women Act passed by Congress in 1994, the FVPF has continued to break new ground by reaching new audiences including men and youth, promoting leadership within communities to ensure that violence prevention efforts become self-sustaining, and transforming the way health care providers, police, judges, employers and others respond to violence. For more information, visit www.endabuse.org.

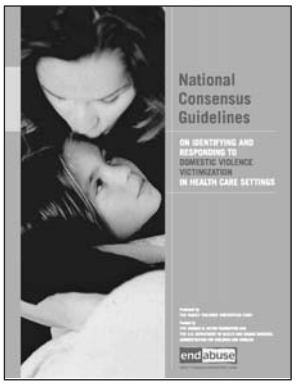
In addition to the public health education materials included in this catalog, the FVPF also produces training and education materials designed for community advocates and organizers, children's advocates, the judiciary and other legal service providers, employers, and providers of support and services to immigrant women. For further information or to receive catalogs of these products, call 415-252-8089 or check the box on the enclosed order form.

The FVPF's **National Health Resource Center on Domestic Violence** was developed to strengthen the health care response to domestic violence by providing both free and low-cost resources, training materials, and technical assistance to health care professionals and to other providers serving victims of domestic violence. Information, materials and program specialists are available through our toll-free numbers 1-888-Rx-ABUSE (1-888-792-2873), TTY: 1-800-594-4889, on the web at www.endabuse.org/health or by e-mailing health@endabuse.org

If you are a victim of domestic violence, call the National Domestic Violence Hotline at 1-800-799-SAFE, TDD: 1-800-594-4889 24 hours a day for supportive counseling and referrals to a domestic violence program near you.

If you are a victim of sexual assault, call the National Sexual Assault Hotline 24 hours a day at 1-800-656-HOPE.

To order complete the enclosed order form and fax to (415) 252-8991 or mail to the Family Violence Prevention Fund, 383 Rhode Island St., Ste. 304, San Francisco, CA 94103-5133 or visit www.endabuse.org/store to place your order online. Prices listed are good as of December 2003 and are subject to change. Thank you!



The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings

Developed to assist health care providers in addressing domestic violence victimization, screening, assessment, intervention, referral and documentation. These consensus-developed guidelines were developed with over 35 experts in the field. They also cover screening for lifetime exposure, as well as current abuse and make recommendations on how to prepare your practice to screen both women and men for victimization.

Quantity	Item #	Price	Savings
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Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health

These Consensus Recommendations were developed by the Family Violence Prevention Fund's National Health Resource Center on Domestic Violence in partnership with the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, *Child Witness to Violence Project* (Boston Medical Center) and the National Association of Pediatric Nurse Practitioners.

Designed to assist health care providers from the pediatric and family physician settings in addressing adult and childhood domestic violence victimization. Includes screening, assessment, documentation, intervention and referrals.

These recommendations are the first of their kind to address how to screen children and youth for domestic violence, and specifically offer recommendations on screening adults for victimization with children present.

Consensus Recommendations for Child and Adolescent Health are an invaluable tool for anyone working with children or youth in a health care setting!

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100	010303.100	$525.00	save $75 + an additional 10% off order

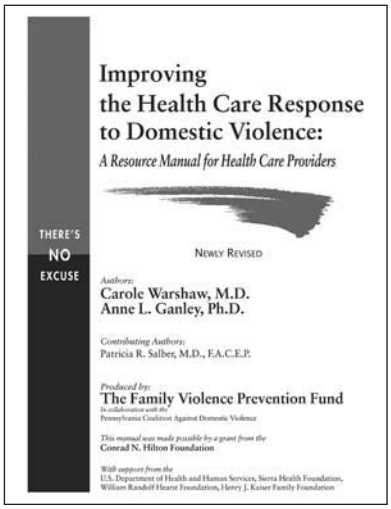
The Family Violence Prevention Fund's Resource Manual and Trainer's Manual give health care providers in all settings the information, tools and ideas they need to provide victims of domestic violence with the care they need to get well and stay safe.

Set of Manuals:
$100.00
Item #010503.SET

Also available with additional health education materials through our Health Resource Kit for $160.00 (see page 13)

"Improving the Health Care Response to Domestic Violence is the bible for the field"

– Robert McAffee, M.D., Former President, American Medical Association



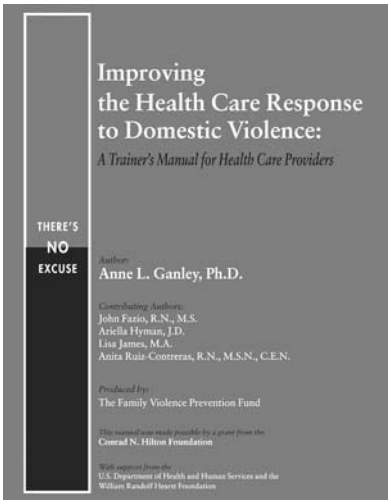
Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers
Authors: Anne L. Ganley, Ph.D. and Carol Warshaw, M.D.
$65.00 Item #010501

Health care practitioners and domestic violence experts who want to implement a comprehensive response to domestic violence now have this powerful tool which includes:

Information on the dynamics of domestic violence, how to screen, assess and intervene with victims of domestic violence, and intervene with batterers.

Practical tools such as protocols, sample screening questions, sample charting and documentation forms, abuse assessment tools, safety planning and discharge sheets, state and national resources.

Ideas on how to prepare your practice and support clinicians in a variety of health care practices and settings.



Improving the Health Care Response to Domestic Violence: A Trainer's Manual for Health Care Providers
Author: Anne Ganley, Ph.D.
$45.00 Item #010502

To help health care providers and domestic violence advocates to meet the challenge of training clinicians and other staff within the busy clinic or hospital setting, we developed this comprehensive Trainer's Manual. The Manual provides step-by-step instructions for teaching each section of the Resource Manual; including the basic dynamics of domestic violence, clinical skills, legal issues and community resources and role play scenarios. It also includes a special module on cultural diversity. Each training module is roughly one hour long, – ideal for workshops, inservice trainings and grand rounds.

Safe Haven Decal
10 decals $5.00
Item #040815.10

Every community needs safe havens for victims of domestic violence. This 3.25"x 5.5" decal has been successfully used in local businesses and health care facilities to advertise the location as a safe place for victims of domestic violence to access help. The sticker also provides the toll-free number of the National Domestic Violence Hotline. Within the health care setting, the decal may be used on a facility's front and internal doors, on exam room chart holders, at the reception desk, in the bathrooms, and inside lavatory stalls.


Send Important Messages to Patient (avoid victim blaming):
- You are not alone
- You are not to blame
- There is help available
- You do not deserve to be treated this way

Assess Safety:
- Are you afraid to go home?
- Have there been threats of homicide or suicide?
- Are there weapons present?
- Can you stay with family or friends?
- Do you need access to a shelter?
- Do you want police intervention?

Make Referrals:
- Involve social worker if available
- Provide list of shelters, resources, and hotline numbers
- **National Domestic Violence Hotline: (800) 799-SAFE**
- Schedule follow-up appointment

Document Findings:
- Use the patient's own words regarding injury and abuse
- Legibly document all injuries; use a body map
- Take instant photographs of injuries

Sponsoring organizations

American College of Emergency Physicians, American College of Nurse-Midwives, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Nurses Association, Emergency Nurses Association, Nursing Network on Violence Against Women International, Physicians for a Violence-free Society, Society for Social Work Administrators in Health Care, San Francisco General Hospital

Practitioner Reference Card: Domestic Violence Guide

This laminated 3"x 5" pocket reference card outlines the steps providers can take to help battered patients, including actual questions that can help identify abuse. Two versions are available: National and California. The California version includes information on how to comply with California's mandatory reporting law. The card is lined by a 5" ruler for measuring and documenting injuries that result from domestic violence.

Quantity	5 Cards	50 Cards	100 Cards
Price	$5.00	$45.00	$85.00
National	010201.5	010201.50	010201.100
California	010202.5	010202.50	010202.100

Many of these materials can be viewed in more detail on our website: www.endabuse.org.

Some of these materials are also downloadable.

Reach Out to Battered Immigrant Women

The FVPF's Battered Immigrant Women's Rights Project seeks to improve the lives of battered immigrant women through public policy and strengthening direct services. Our multilingual educational resources are essential for providers of social services and health care to battered immigrant women.

You Have the Right to Be Free From Violence in Your Home:
Questions and Answers for Immigrant and Refugee Women
50 brochures $12.50
English Item #020101.50
Spanish Item #020102.50

Contains questions that battered immigrant and refugee women most commonly ask about domestic violence as it relates to immigration and family law. The brochures address the following issues: specific suggestions for immigrant and refugee women facing domestic violence, legal issues around immigration status and domestic violence, and national resources for help.

Is someone hurting you? You can talk to me about it.
10 buttons $6.00
English Item #010801.10
Spanish Item #010802.10

All clinic or hospital staff can wear this button to send the message to patients that the staff is available to help. Button shown in English. Please see www.endabuse.org/store for Russian, Vietnamese and Chinese versions.

Screen to End Abuse Video

VHS version $10.00
Item #010603
CD version $10.00
Item #010604
Loop $15.00
Item #010605

The award-winning *Screen to End Abuse* video offers health care providers crucial information and step-by-step guidance in five different clinical settings demonstrating screening and simple techniques on helping patients that disclose abuse. As one of the most comprehensive training videos on screening for domestic violence, providers will learn how to:

- Understand the critical role all health care providers play in preventing abuse. Take time in a busy medical practice to ask patients about violence and get them the information and assistance they need.
- Create a welcoming atmosphere that lets patients know they are safe disclosing abuse to their provider.
- Institutionalize policies and procedures around identifying and assessing for abuse in all health care settings.

Film is 32 minutes and is available on VHS, CD and looped (for continuous play)

Voices of Survivors VHS Video

$10.00 Item #010602

Written and directed by a physician for health care providers, *Voices of Survivors* addresses the dynamics and prevalence of domestic violence, and the need for providers to routinely screen their patients. It offers specific step-by-step instructions on how to screen, support victims, assess safety and give effective referrals. The video also describes the hidden costs and hidden physical and mental health issues that could be addressed sooner if screening were to occur. Dr. Christina Nicolaids' video is strengthened by interviews she conducted with survivors of domestic violence who retell their personal experiences and offer suggestions for health care providers to improve their response.

Put up these posters in the reception area, exam rooms or hallways and let patients know that they can talk to their health care provider about domestic violence.

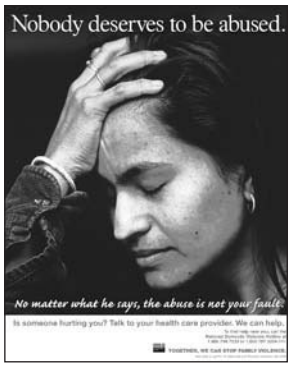
Posters are also available as camera-ready art at our website: www.endabuse.org/store. On all versions, space is available for your clinic/hospital to add in your own logo, local hotline number or information about awareness activities.

Poster Sampler
(5 posters) $15
Item #010701.SEL
Includes *Feeling Alone..., Nobody Deserves..., Are You Tired..., Violence Doesn't Have to..., and Violence Destroys.*

All posters on this page are $3.50 each.

Are You Tired of Making Excuses for Him? Why Should There be a Next Time?
20"x 16"

English	Item #010712
Spanish	Item #010713
Russian	Item #010714
Chinese	Item #010715
Vietnamese	Item #010716



Nobody Deserves to be Abused. No Matter What He Says, the Abuse is Not Your Fault
16"x 20"

English	Item #010707
Spanish	Item #010708
Russian	Item #010709
Chinese	Item #010710
Vietnamese	Item #010711

Violence Doesn't Have to be Part of Your Life. You and Your Children Deserve to be Safe and Happy
20"x 16"

English	Item #010717
Chinese	Item #010718
Vietnamese	Item #010719

Feeling Alone? Don't Know Who to Talk to?
20"x 16"

English	Item #010702
Spanish	Item #010703
Russian	Item #010704
Chinese	Item #010705
Vietnamese	Item #010706

Nobody Deserves to be Abused. No Matter What He Says, the Abuse is Not Your Fault
16"x 20"

African-American/English only	Item #010724

Violence Destroys. Keep Our Families Sacred
16"x 20"

English	Item #010720
Spanish	Item #010725

All posters on this page are $3.00 each.

While You're Trying to Find the Right Words, Your Friend May Be Trying to Stay Alive.
African-American Item #040712
Caucasian Item #040711

It's Hard to Confront a Friend Who Abuses His Wife, But Not Nearly As Hard As Being His Wife
English only Item #040713

Contrary To Popular Belief, Straight People Do Not Have a Monopoly on Abusive Relationships
(Lesbian, Gay, Transgender & Bisexual)
English Item #010721
Spanish Item #010722

Some Men Break More Than Their Girlfriends' Hearts
English only Item #040707

He Said He'd Never Hit You Again
African-American Item #040701
Asian Item #040702
Latina Item #040703
Spanish Language Item #040704
Russian Language Item #040705

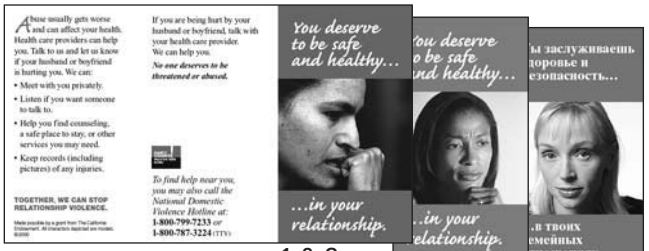
He Wouldn't Hurt a Flea, But He Put His Wife In a Coma
English Item #040706
Russian Item #040710

Safety Cards
A card small enough to fit in your pocket can save lives. The safety cards, now available in seven languages, outline potentially life-saving steps women can take to protect themselves and their children from domestic violence.

Safety Card Holder
Make your safety cards easy to access! Cardboard boxes can be attached to posters where space is available to hold up to 25 safety cards.
$1.00 each
Item #010299

Safety cards may also be displayed with a standard business card holder available at most office supply stores.

At Einstein Hospital in Philadelphia, small safety cards with phone numbers of local domestic violence programs were placed in the emergency department waiting room. No one picked them up. But, after a staff member took the cards and placed them in the restrooms, where women could take them anonymously, they disappeared as fast as they were stocked.



General (2"x 3.5") *"You deserve to be safe and healthy in your relationship."*

Quantity	50 Cards	100 Cards	500 Cards	1000 Cards
Price	$6.00	$11.00	$52.00	$95.00
1. English	010203.50	010203.100	010203.500	010203.1000
2. Spanish	010204.50	010204.100	010204.500	010204.1000
3. African-American/English	010225.50	010225.100	010225.500	010225.1000
4. Russian Image/English	010205.50	010205.100	010205.500	010205.1000
5. Russian Image/Russian	010226.50	010226.100	010226.500	010226.1000

Native American (2"x 3.5") *"Violence destroys. Keep our families sacred."*

Quantity	50 Cards	100 Cards	500 Cards	1000 Cards
Price	$6.00	$11.00	$52.00	$95.00
6. English	010206.50	010206.100	010206.500	010206.1000
7. Spanish	010227.50	010227.100	010227.500	010227.1000

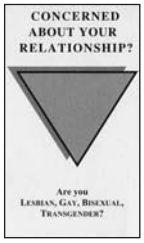
Asian (2"x 3.5") *"Is there abuse in your family? You are not alone."*

Quantity	50 Cards	100 Cards	500 Cards	1000 Cards
Price	$6.00	$11.00	$52.00	$95.00
8. English	010207.50	010207.100	010207.500	010207.1000
9. Chinese	010208.50	010208.100	010208.500	010208.1000
10. Vietnamese	010209.50	010209.100	010209.500	010209.1000

Teens (2"x 3.5") *"You deserve to be healthy and safe in your relationship."*

Quantity	50 Cards	100 Cards	500 Cards	1000 Cards
Price	$6.00	$11.00	$52.00	$95.00
11. English	010210.50	010210.100	010210.500	010210.1000
12. Spanish	010211.50	010211.100	010211.500	010211.1000
13. Russian	010212.50	010212.100	010212.500	010212.1000
14. Chinese	010213.50	010213.100	010213.500	010213.1000
15. Vietnamese	010214.50	010214.100	010214.500	010214.1000

16 17 18 19 & 20 Abuser



21 LGTB

Abuser (2"x 3.5") *"Are you hurting your wife or girlfriend? You can get help."*

Quantity	50 Cards	100 Cards	500 Cards	1000 Cards
Price	$6.00	$11.00	$52.00	$95.00
16. English	010215.50	010215.100	010215.500	010215.1000
17. Spanish	010216.50	010216.100	010216.500	010216.1000
18. Russian	010217.50	010217.100	010217.500	010217.1000
19. Chinese	010218.50	010218.100	010218.500	010218.1000
20. Vietnamese	010219.50	010219.100	010219.500	010219.1000

Lesbian, Gay, Transgender, Bisexual (2"x 3.5") *"Are you concerned about your relationship..."*

Quantity	50 Cards	100 Cards	500 Cards	1000 Cards
Price	$6.00	$11.00	$52.00	$95.00
21. English	040208.50	040208.100	040208.500	040208.1000

22 - 26 LGTB

27 & 28 Safety Cards

29, 30 & 31 Educational Brochures

LGTB (2"x 3.5") *"You deserve to be healthy and safe in your relationship."*

Quantity	50 Cards	100 Cards	500 Cards	1000 Cards
Price	$6.00	$11.00	$52.00	$95.00
22. English	010220.50	010220.100	010220.500	010220.1000
23. Spanish	010221.50	010221.100	010221.500	010221.1000
24. Russian	010222.50	010222.100	010222.500	010222.1000
25. Chinese	010223.50	010223.100	010223.500	010223.1000
26. Vietnamese	010224.50	010224.100	010224.500	010224.1000

Safety Cards (2"x 3.5") *"If you are being abused at home...you are not alone."*

Quantity	50 Cards	100 Cards	500 Cards	1000 Cards
Price	$6.00	$11.00	$52.00	$95.00
27. Lao	040203.50	040203.100	040203.500	040203.1000
28. Tagalog	040206.50	040206.100	040206.500	040206.1000

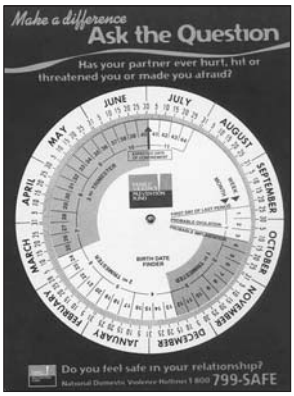
LGTB
Lesbian, Gay Transgender & Bisexual item

Educational Brochures
Camera-ready copies available for creating your own brochure with local resource numbers (8.5"x 14" foldout) are available at our website: www.endabuse.org.

Educational Brochures
Concerned About Your Relationship? Your Partner May Be Abusive.
(4.5"x 8.5")
This is a great basic educational brochure for health care providers to give to patients or have available in waiting rooms, exam rooms or bathrooms. The brochure addresses: the warning signs of abuse, how abuse affects your health, what actions you can take if you are being abused, and how your health care providers can help you.

50 brochures
$12.50
29. English
Item #010101.50
30. Spanish
Item #010102.50
31. LGTB
Item #010104.50

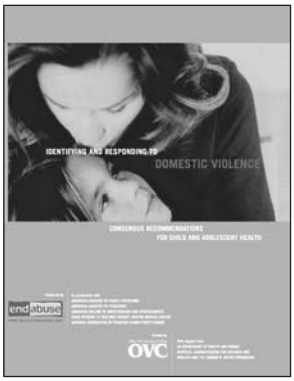
See page 8 for teen-specific Safety Cards.



Pregnancy Wheel

A pregnancy wheel printed with routine screening questions for domestic violence has been newly developed for use in Obstetrics and Gynecology departments. The card reminds staff every time they calculate anything related to birth control or pregnancy to ask about domestic violence, posing simple questions like: "Are you being hurt, hit, or threatened...Do you feel safe in your relationship?" The back of the wheel provides information related to assessing safety, documentation, follow-up, and referrals.

Quantity	Item #	Price
1	010229	$2.50
5	010229.5	$12.00
25	010229.25	$60.00
50	010229.50	$120.00
100	010229100	$240.00



Identifying and Responding to Domestic Violence: Consensus Recommendation for Child and Adolescent Health

These Consensus Recommendations were developed by the Family Violence Prevention Fund's National Health Resource Center on Domestic Violence in partnership with the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, *Child Witness to Violence Project* (Boston Medical Center) and the National Association of Pediatric Nurse Practitioners.

Designed to assist health care providers from the pediatric and family physician settings in addressing adult and childhood domestic violence victimization. Includes screening, assessment, documentation, intervention and referrals.

These recommendations are the first of their kind to address how to screen children and youth for domestic violence, and specifically offers recommendations on screening adults for victimization with children present.

Consensus Recommendations for Child and Adolescent Health are an invaluable tool for anyone working with children or youth in a health care setting!

Quantity	Item #	Price	Savings
1	010303	$6.00	
2	010303.2	$10.00	save $2
10	010303.10	$55.00	save $5
25	010303.25	$135.00	save $15
50	010303.50	$265.00	save $35
100	010303.100	$525.00	save $75 + an additional 10% off order

When You Bring Your New Baby Home
17″x 11″
$3.00
English Item #010726
Spanish Item #010727

When Mom Gets Abused, Her Children Suffer Too
11″x 17″
$3.00
English Item #010728
Spanish Item #010729

New! Posters for the Pediatric Setting
These posters were developed to increase pregnant and parenting women's awareness about the effects of domestic violence on their children, and the potential for escalating violence during pregnancy and the postpartum period. The target population for these posters include prenatal programs, family planning, WIC, Head Start, Child Health and Adolescent Settings and Ob/GYN programs.

How can we engage public health leaders to respond to family violence? The FVPF has developed a tool (on CD with an accompanying guidebook) that makes the connection between family violence and leading public health concerns and presents effective strategies for responding. This evidence-based tool offers the most relevant research on family violence, implications for select public health programs, recommended clinical and policy strategies, promising practices and resources from around the country.

This PowerPoint Presentation and accompanying guidebook helps presenters by providing evidence and "speaker's notes" for each slide to make the case for violence prevention to public health leaders. A presenter may opt to present on any of the following areas and may mix and match sections depending on their audience:

- *Overview & Epidemiology Women's Health*
- *Mental Health & Substance Abuse*
- *Family Planning*
- *Sexually Transmitted Infections & HIV, Perinatal Programs*
- *Breastfeeding and Nutritional Supplements*
- *Child and Adolescent Health*
- *Injury and Violence Prevention and*
- *Regional and Local Data on Domestic Violence*

Making the Connection: Domestic Violence and Public Health
Author: Linda Chamberlain, PhD, MPH

The CD is formatted for PC computers

Quantity	Item #	Price	Savings
1	010606	$16.00	
10	010606.10	$155.00	save $5
50	010606.50	$750.00	save $50 + an additional 10% off order

Work to End Domestic Violence Kit
Standard Price: $35.00
English Item #050801.KIT
Advocate Price: $20.00
English Item #050802.KIT

The *Work to End Domestic Violence Organizer's Kit* gives you everything you need to organize your workplace response to domestic violence. With easy-to-use tools, you can help your co-workers who may be facing domestic violence. The Kit includes:

- *Employee communications*, including a sample newsletter article, e-mail scripts and paycheck insert copy.
- *Special tips* for managers, supervisors and human resources personnel.
- *A reproducible brochure* on developing a personal and workplace safety plan.
- *A model workplace policy* including security measures.
- *Public relations tools*, including a sample press release.

...and much more!

Health Resource Kit
Standard Kit: $60.00
English Item #010812.KIT
Spanish Item #010815.KIT
Kit + Resource Manual and Trainer's Manual: $160.00
English Item #010811.KIT
Spanish Item #010814.KIT

Everything you need to organize your office, clinic, HMO or hospital to respond to domestic violence. The Kit includes:

- *National Consensus Guidelines on Identifying and Responding to Domestic Violence in Health Care Settings (see page 1)*
- *Practitioner Reference Cards: Domestic Violence Guide* (5 cards) *see page 5*
- *Safety Cards* (120 cards) *see pages 13–16* Includes one of each language/version, the remaining General cards in English.
- *Safe Haven Decal* (3) *(see page 5)*
- *Pregnancy Wheel* (5) *(see page 17)*
- *Buttons (Is Someone Hurting You?) see page 6*
  English (10)
  Spanish (2)
- *Posters* (5) *see page 9*
  - *Feeling alone? Don't know who to talk to?*
  - *Nobody deserves to be abused*
  - *Are you tired of making excuses for him?*
  - *Violence doesn't have to be a part of your life*
  - *Violence destroys. Keep our families sacred.*

* Health Resource Kits are available in Spanish and English versions. Spanish kits include patient materials in Spanish, provider materials are English only.

Please note: Safety Cards are also available separately in Spanish, Russian, Tagalog, Vietnamese, Chinese and Lao (*see pages 8–9*).

Educational brochures are also available in Spanish and Tagalog (*see page 9*).

Some posters available in Spanish, Russian, Chinese and Vietnamese language versions, as well as in versions targeting African Americans, Asians and Latinas (*see pages 6–7*).

All are available in LGTB relationship versions.

Help raise awareness of domestic violence with these items from the *There's No Excuse for Domestic Violence* campaign.

Backpack with Water Bottle
$15 Item #010808

Make a statement with an EndAbuse Backpack. This signature backpack includes two front zipper pockets, a cell phone sized side velcro pocket, and water bottle holder. Available in black with EndAbuse water bottle included.

"There's No Excuse for Domestic Violence" T-Shirts
$12.00 each
Size L Item #040804
Size XL Item #040805

These white cotton t-shirts display the campaign's powerful message: *There's No Excuse for Domestic Violence*. Let everyone know you don't condone violence against women with this colorful t-shirt. Available in L and XL.

Coffee Mugs
$6.50 each
Item #040806

Send a message to your officemates about domestic violence by drinking your morning coffee from a *There's No Excuse for Domestic Violence* mug.

Bumper Stickers
10 bumper stickers $5.00
English Item #040801.10
Spanish Item #040802.10

Black and blue vinyl bumper stickers drive home the message: *There's No Excuse for Domestic Violence*. Bumper stickers available in English and Spanish. Minimum order of 10 - distribute them to your co-workers and friends!

Item #	Description	Qty	Price	Total

1	Subtotal (add "total" column)	
2	Bulk discount (if applicable; see chart)	
3	Total order (subtract line 2 from line 1)	
4	CA residents add 8.5% sales tax	
5	Shipping and handling (see chart; based on subtotal)	
6	Tax-deductible contribution to FVPF	
7	TOTAL amount enclosed (add lines 3-6) US funds only	

Shipping and Handling Charges

Subtotal Amount	Regular	Rush
$5.00 - $19.99	$5.00	$15.00
$20.00 - $49.99	$8.00	$20.00
$50.00 - $99.99	$12.00	$30.00
$100 - over	15%	30%

Bulk Discount

Subtotal Amount	Discount
$300 - $999	10%
$1000 - over	20%

Note: pre-payment is required for all orders.

Please select method of payment:

☐ *Check enclosed* payable to the Family Violence Prevention Fund
Check # _____
Returned checks are subject to a $20 service charge.

☐ *Bill my credit card*:
- ☐ Visa
- ☐ Mastercard

Card # _____
Expiration date _____
Signature _____
Name on card _____

Please select shipping method

☐ *Regular* (shipped via US Mail; allow 3-5 weeks for delivery)

☐ *Rush* (shipped via UPS; street address required; allow 5-7 business days for delivery

For international orders, please call (415) 252-8900.

bill to:

organization
attention to
street address
city/state/zip
phone fax
e-mail

ship to:

organization
attention to
street address
city/state/zip
phone fax
e-mail

Information Requests:

☐ Send me information about the following:
- ☐ Public education & awareness materials
- ☐ Domestic Violence Awareness Month
- ☐ National Health Initiative
- ☐ Battered Immigrant Women
- ☐ Media Advocacy
- ☐ Judicial Education
- ☐ Workplace Education
- ☐ Membership

For more information about our programs, or to sign up for e-mail updates about domestic violence, please visit www.endabuse.org.

For orders by fax:
415-252-8991

For orders by phone:
415-252-8089

For orders by mail:
The Family Violence Prevention Fund
383 Rhode Island Street
Suite 304
San Francisco, CA
94103-5133

For orders online:
www.endabuse.org/store
e-mail:
ordering@endabuse.com

The Family Violence Prevention Fund does not profit from the sale of these products. If you are an individual or organization in financial need, please let us know.

Item #	Description	Qty	Price	Total

1	Subtotal (add "total" column)	
2	Bulk discount (if applicable; see chart)	
3	Total order (subtract line 2 from line 1)	
4	CA residents add 8.5% sales tax	
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Shipping and Handling Charges

Subtotal Amount	Regular	Rush
$5.00 - $19.99	$5.00	$15.00
$20.00 - $49.99	$8.00	$20.00
$50.00 - $99.99	$12.00	$30.00
$100 - over	15%	30%

Bulk Discount

Subtotal Amount	Discount
$300 - $999	10%
$1000 - over	20%

Note: pre-payment is required for all orders.

Please select method of payment:

☐ *Check enclosed* payable to the Family Violence Prevention Fund
Check # _____
Returned checks are subject to a $20 service charge.

☐ *Bill my credit card*:
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Card # _____
Expiration date _____
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Please select shipping method

☐ *Regular* (shipped via US Mail; allow 3-5 weeks for delivery)

☐ *Rush* (shipped via UPS; street address required; allow 5-7 business days for delivery

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bill to:

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attention to
street address
city/state/zip
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Information Requests:

☐ Send me information about the following:
- ☐ Public education & awareness materials
- ☐ Domestic Violence Awareness Month
- ☐ National Health Initiative
- ☐ Battered Immigrant Women
- ☐ Media Advocacy
- ☐ Judicial Education
- ☐ Workplace Education
- ☐ Membership

For more information about our programs, or to sign up for e-mail updates about domestic violence, please visit www.endabuse.org.

For orders by fax:
415-252-8991

For orders by phone:
415-252-8089

For orders by mail:
The Family Violence Prevention Fund
383 Rhode Island Street
Suite 304
San Francisco, CA
94103-5133

For orders online:
www.endabuse.org/store
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ordering@endabuse.com

The Family Violence Prevention Fund does not profit from the sale of these products. If you are an individual or organization in financial need, please let us know.

Item #	Description	Qty	Price	Total

1	Subtotal (add "total" column)	
2	Bulk discount (if applicable; see chart)	
3	Total order (subtract line 2 from line 1)	
4	CA residents add 8.5% sales tax	
5	Shipping and handling (see chart; based on subtotal)	
6	Tax-deductible contribution to FVPF	
7	TOTAL amount enclosed (add lines 3-6) US funds only	

Shipping and Handling Charges

Subtotal Amount	Regular	Rush
$5.00 - $19.99	$5.00	$15.00
$20.00 - $49.99	$8.00	$20.00
$50.00 - $99.99	$12.00	$30.00
$100 - over	15%	30%

Bulk Discount

Subtotal Amount	Discount
$300 - $999	10%
$1000 - over	20%

Note: pre-payment is required for all orders.

Please select method of payment:

☐ *Check enclosed* payable to the Family Violence Prevention Fund
Check # _____
Returned checks are subject to a $20 service charge.

☐ *Bill my credit card*:
- ☐ Visa
- ☐ Mastercard

Card # _____
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(415) 252-8900
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