



The comprehensive resource on domestic violence

The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care

Developed by the Ohio Domestic Violence Network and the
National Health Care Standards Campaign Committee
Ohio Chapter (2003)



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Introduction

The Ohio Domestic Violence Network (ODVN) is a statewide coalition of domestic violence programs, support agencies and concerned individuals organizing to ensure the elimination of domestic violence by providing technical assistance, resources, information and training to all who address or are affected by domestic violence; and promoting social and systems change through public policy, public awareness and education initiatives. Through our public policy efforts around health care we began actively working with the Family Violence Prevention Fund.

The National Health Care Standards Campaign (NSC) is an initiative created by the FVPF in 2000 that brought together fourteen states to create innovative public health campaigns against domestic violence. The National Standards Campaign-Ohio branch was developed to identify the efficacy of the current medical response to victims of domestic violence in the state of Ohio and to identify what areas needed improvement. The NSC-Ohio is made up of individuals from a variety of fields, such as physicians, nurses, social workers and domestic violence advocates, who have a deep concern about the lack of education health care providers receive related to working with victims of domestic violence.

The experience of many committee members is that most health care providers feel uncomfortable discussing domestic violence with their patients or are unsure how to handle disclosures about this issue. That is why the NSC developed the Ohio Domestic Violence Network *Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care*. This protocol has been endorsed by the Ohio Chapter of the International Association of Forensic Nurses (IAFN), the Ohio Emergency Nurses Association (ENA), the Ohio Department of Health (ODH), the Ohio Public Health Association (OPHA), and the Ohio Chapter of the National Association of Social Workers (NASW). ODVN and the National Standards Campaign Committee wish to extend thanks to the Ohio Hospital Association (OHA) for the printing and assistance with distribution of this protocol.

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To obtain an electronic copy go to the ODH website at

<http://www.odh.state.oh.us/ODHPrograms/SADV/sadv1.htm>

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Ohio Domestic Violence Network Domestic Violence Protocol Summary

Purpose

The purpose of the Ohio Domestic Violence Network's DV protocol is to provide standards of care for health care providers and agencies to address the needs of patient's seeking health care who are victims of domestic violence. The essential components of the protocol include:

Prepare

- Understand the physical, emotional, and financial impact of domestic violence.
- Be familiar with documenting and reporting guidelines for abuse in the Ohio Revised Code 2321.22 (Appendix 2)
- Set the stage – Use environmental prompts that indicate your interest in domestic violence. Wear pins that say “You can talk to me about family violence.” Put posters in your office and in women's bathrooms about domestic violence and local resources. Leave safety cards with resource information and phone numbers in examination rooms and in women's bathrooms.

Screen

- Patients frequently do not present with obvious signs of domestic violence, therefore universal screening should be implemented. Specific guidelines for screening are included in detail in the protocol. Patients should be screened at every emergency room visit, during initial visits and annual physicals, each hospital admission or screening and once each trimester during pregnancy.
- Ask privately – Do not ask when anyone else is in the room, including parents, partners, children over the age of 2, friends, or family members.
- Be honest – Describe why you are asking about domestic violence and what you will be doing with the information. Inform patients about state laws regarding reporting domestic violence and child abuse. Patients need to know what you will and will not report.
- Ask general non-threatening questions to introduce the screen: “Do you feel safe in your relationship? How does your partner treat you?”
- Ask about physical abuse “Have you been hit, slapped, kicked, or otherwise physically hurt by anyone?” “Who?” Remember to ask about additional perpetrators with teens – “Who else?” Ask about emotional abuse “Are you afraid of anyone?” or “Has anyone put you down or humiliated you? Ask about forced sex. “Has anyone forced you into having sex with them or becoming intimate with them against your will?” Remember that the perpetrator might be heterosexual or homosexual.

Assess

- If you receive a positive response ask more questions about their domestic violence history and their health status.

- Ask how they cope or keep safe from violence. Listen for instances of use of substances, unsafe coping measures, and isolating strategies. Are there children in the household at risk for harm?
- Evaluate the victim's safety: fear of the abuser, use of alcohol /drugs, threats with weapons, increasing threats of severity of abuse, harm to children or pets, threats of suicide or homicide. If any of these are positive, then discuss your concern about patients' safety and encourage them to seek help.

Intervene

- Tell the patient that no one deserves to be hurt or put down.
- Affirm that it is hard to talk about abuse.
- Tell patients that they are not alone and that help is available.
- Reassure patients about confidentiality issues. Tell them that you will not reveal information about their violence experiences with their families or perpetrators. Keep the chart and abuse documentation in a secure area isolated from visitors. Tell patients that you will treat their perpetrators like any other family member so that you will not jeopardize their safety.
- Help patients to identify trusted individuals that they can approach for assistance.
- Discuss the importance of a safety plan. Help them to develop a plan or have them call the domestic violence crisis or hot line number from your agency to assist them with this.
- Provide information about community agencies.
- Ask them if they need additional help in any way to complete their safety plan
- Tell them that they can contact the hospital, clinic, or doctor's office for assistance between visits. Schedule a follow-up appointment.

Document

- Include information in the medical record with as many direct quotes as possible from the patient. Use a body map and photographs if there are bruises or scars present. Describe specific information about suggested resources and safety planning discussed during the interaction. Record the safety plan and referrals given to the woman.

Evaluate

- Ask about how things are going with the relationship at follow-up visits.
- Patients may choose to never leave or live with the abuse for awhile before choosing to leave the relationship. Continue to show the patient how the stress of the abusive relationship affects health.
- Celebrate each step taken as a step toward keeping safe.

Adapted from the ODVN Domestic Violence Protocol (2003) and Renker PR, (2003).
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Background

Philosophy

The Ohio Domestic Violence Network believes that all people are entitled to the right to live free from violence or threat of violence from current or former partners. Because violence against women poses an epidemic public health problem causing serious physical, psychological and social consequences, the following protocol has been developed to provide direction to caregivers. Men and children can be victims of family violence and should also be screened. In order to differentiate men who are abused from perpetrators of violence, providers should have appropriate training on domestic violence before screening this population.

Because healthcare providers may be the first non-family member to whom an abused individual turns for help, the provider has an opportunity and responsibility to provide appropriate and sensitive interventions. Consistent with current Joint Commission for the Accreditation of Health Care Organizations (JCAHO) accreditation requirements and good medical practice, the health care system is committed to developing and implementing policies and procedures for identifying, treating, and referring victims of domestic abuse.

Purpose

The purpose of the Ohio Domestic Violence Protocol is to provide standards of care for health care systems and providers to address the needs of individuals receiving care for domestic violence within their systems. The protocol describes in detail how to screen, intervene and document when caring for individuals who are experiencing domestic violence. The specific steps discussed include responses to patients who screen negative for abuse as well as those who acknowledge violence.

The protocol for those who screen positive for abuse includes a *danger assessment, a detailed assessment of the physical and psychological state of the client, a safety plan, discharge instructions, referrals, and documentation issues*. The protocol includes additional information from the Family Violence Prevention Fund and other sources on screening and intervention in domestic violence.

The forms that are included in the protocol are intended to be completed by both the caregiver and the patient. A reference list at the end of the protocol identifies the contributing sources for the documents.

Scope of the Problem

In 1998, the National Violence Against Women Survey reported that more than one in four women surveyed acknowledged a history of intimate partner violence. The prevalence of violence during pregnancy is especially significant, with 20% of women over the age of 20 and 30-35% of adolescents reporting physical abuse during the perinatal period. Past research has focused on identification of intimate partner physical

violence only. The prevalence would be much higher if emotional and sexual abuse were included.

Definition of Domestic Violence

Domestic Violence, also called intimate partner violence (IPV), is an ongoing, debilitating pattern of physical, emotional, and/or sexual abuse involving force or threat of force, associated with increased isolation from the outside world and limited personal freedom and accessibility to resources. A battered person is any person who has been physically injured or emotionally or sexually abused by a person from a current or past intimate relationship. Specific definitions used in this protocol reflect guidelines provided by a Centers for Disease Control and Injury Prevention sponsored panel of experts from the government, private sector, and education/research arenas and published in *Intimate Partner Violence Surveillance Uniform Definitions and Recommended Data Elements*. These include:

- ***Physical abuse or violence***: “The intentional use of physical force with the potential for causing death, disability, injury or harm” (p.11)
- ***Sexual violence or abuse***: “Use of physical force (and intimidation or pressure) to compel a person to engage in a sexual act against her or his will, whether or not the act is completed.” (p.12).
- ***Emotional or psychological abuse*** “...involving trauma to the victim caused by acts, or coercive tactics.” (p.62). Emotional abuse represents the psychological burden and consequences or trauma of physical and/or sexual assault as well as verbal and psychological abuse including humiliation, deprivation, and coercion. Other examples of emotional or psychological abuse are rooted in ***financial and social areas*** and include controlling money, use of the car, contact with friends and family and other extracurricular activities. For example: frequent calls on the cell phone, monitoring voice mail or caller id history on the phone, hiding the car keys or taking the battery out of the car so that they are late for work, setting limits on who the victim can see and what they can do in their spare time.

While the great majority of victims of domestic violence are female, it is important to remember that males can also experience domestic violence and that domestic violence occurs in both heterosexual and same sex relationships.

Other examples of abuse are identified in Appendix 1, “What is Abuse?” written by the Ohio Domestic Violence Network.

Patterns of Violence

Scope and breadth of violence varies in relationships. However, three aspects remain consistent: isolation, intimidation, and control. Domestic violence victims frequently find themselves trapped as the violence increases in frequency and severity over time and may demonstrate symptoms often seen in post-traumatic stress disorders. The goal of

intervention is to return control and decision making to patients which increases their ability to stay safe.

Legal Considerations

The Ohio Revised Code 2919.25 (Appendix 2) defines domestic violence as a criminal offense.

Reporting Requirements

The Ohio Revised Code (ORC section 2921.22) requires that health care providers who suspect or identify that a woman is abused must document or write that assessment in the patient's medical record. Patients who identify that they have been abused can use the information recorded in the medical record at a later time for civil or criminal remedies.

Only the abused patient can assess the danger and relative risk of reporting versus non-reporting. Health care providers are not required to report abuse to police or other legal authorities *unless* the patient presents with injuries related to gunshot wounds, stabbings, second degree burns, serious injury and child or elder abuse (see ORC definitions in Appendix 2). Ohio does not have an explicit law requiring healthcare providers to report suspected instances of domestic violence. If the presenting injuries do not mandate reporting according to the ORC, health care providers only need to contact law enforcement at the patient's request.

Confidentiality

Conduct all interviews regarding domestic violence issues in private. Health care providers should assure their patients that they will maintain confidentiality of the patient's disclosure and their medical records as permitted by law.

Essential Steps: Screening, Assessment, Intervention, Documentation

Screening for Domestic Violence

The patient responses to screening must be carefully documented in order to be effective. Recording of the patients words in quotation marks will most accurately convey her personal experiences. Each step of subsequent violence assessment and intervention needs to be documented. All three steps of screening, intervention, and documentation are essential to provide the necessary care for victims.

Who should be screened?

The National Consensus Guidelines developed by the Family Violence Prevention Fund (FVPF) include the following statement: "Patients should be screened for current and lifetime exposure to Intimate Partner Violence (IPV) and 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 screening for current and

lifetime exposure into routine care. However, we acknowledge there will be times (particularly in emergency/urgent care) when screening for lifetime exposure to abuse will not always be possible due to time constraints. Therefore the FVPF's recommendations for screening are that:

- all adolescent and adult patients, as well as the parents or caregivers of children in pediatric care should be screened;
- all patients, regardless of cultural background or language barriers, should be screened;
- the majority of IPV perpetrators are male, so screening all patients increases the likelihood of screening perpetrators. We recommend routinely screening men only if additional precautions can be taken to protect victims whose batterers claim to be abused. Training providers on perpetrator dynamics is essential;
- health care providers learn that their responses to lesbian, gay, transgender, bisexual, and heterosexual victims is critical, regardless of whether the policy is to screen all patients or women only.”

While the ODVN supports the National Consensus Guidelines for screening, the purpose of this protocol is to address the needs of women and men over the age of 18. Additional protocols are necessary to address specific needs and concerns of minors, those with guardians, and the elderly population. Other concerns that need additional exploration and policy formation include violence in the lives of adolescents and screening of parents who present with pediatric patients.

Violence Indicators

The following information developed by the Family Violence Prevention Fund represents findings that may suggest abuse. This list suggests some, but not all, of the indicators of abuse. Any person seen in a health care setting may be a victim of abuse and should be screened.

Common Complaints

- Indication of having been hurt physically, sexually, and/or emotionally
- Unexplained injuries or injuries inconsistent with the history given
- Assaulted by alleged stranger
- Chronic pain syndrome, headaches
- Overdose/suicide attempts
- Anxiety, depression, insomnia, multiple somatic complaints
- Miscarriage, sexually transmitted diseases, and non-specific gynecologic complaints (e.g. pelvic pain, painful intercourse), as well as rapid repeat pregnancies and (unwanted) abortions
- Multiple motor vehicle and single vehicle accidents

Red Flags in Medical History

Review patient's past medical history:

- Any old unexplained injuries
- Delay in seeking care
- “Accident prone” patient
- Documented history of family violence
- High stress in family
- Pregnancy
- Frequent Emergency Department, urgent care, or office visits
- Drug/alcohol addiction (partner and/or patient)
- Request for medication for anxiety, sleep, or “nerves”

Red Flags of Patient Presentation

- Patient is evasive/guarded
- Patient appears embarrassed and/or exhibits poor eye contact
- Patient presents with injuries and appears depressed
- Patient has financial concerns
- Patient experienced a recent separation with partner
- Patient has a recent loss of job, close family member or intimate relationship
- Patient seems upset by recent unemployment
- Patient denies abuse too strongly
- Patient minimizes injury or demonstrates unexpected responses (e.g. cries, laughs)
- Patient has intense and/or fearful behavior with partner
- Patient appears angry and defensive “Last straw phenomena”
- Patient defers to partner
- Partner answers questions and/or refuses to leave patient alone

Physical Findings

- Injuries to areas not prone to injury by falls
- Injuries to multiple sites
- Symmetrical injuries
- Wounds in varying stages of healing
- Mid arm injuries (defensive)
- Strangulation marks: petechiae, ligature marks, and subconjunctival hemorrhage
- Weapon injuries or marks
- Bites/burns (scald and cigarette)
- Black eyes
- Dental injuries
- Mid-face injuries
- Breast/abdomen (particularly during pregnancy)
- Neck injury
- Injuries to hidden sites (covered by clothes)
- Internal injuries
- Other commonly seen domestic violence injuries

Screening must be done in a private area with no one other than the patient present. Ask any visitors to wait for a few minutes in the lobby or waiting area before starting the abuse assessment. Let visitors know that this is standard practice. Check to ensure that the visitor/s are not standing outside the door.

Suggestions for private interviewing of patient include:

- a. Interview patient in private area, bathroom, X-ray or treatment room.
- b. Excuse visitor/s while you do a physical exam.
- c. Ask social worker, patient liaison, registration, reception etc. to ask family to step out for several minutes in order to attain privacy (eg. have second party request to speak with visitor outside of exam room).

Listed below are some suggested screening questions and strategies developed by the Family Violence Prevention Fund.

Framing questions:

- “Because family violence is so common in 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 routinely ask about it.”

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?”
- “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?”
- “Is it safe for you to go home?”

Cross Cultural Screening Strategies

It is important to adapt your screening 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 screening questions. For example: for coastal Inuit groups, “acting funny” describes IPV, while in some Latino communities, “disrespects you” indicates IPV. Focusing on actions and behaviors as opposed to culturally specific terminology can also help. Be aware of verbal and non-verbal cultural

cues (eye contact or not, patterns of silence, spacing, and active listening during the interview).

- Use your patient’s language: “Does your boyfriend disrespect you?”
- Be culturally specific: “Abuse is widespread and can happen even in lesbian relationships. Does your partner ever try to hurt you?”
- Focus on behaviors: “Has your 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?”

Two versions of domestic violence assessment forms for both female and male patients were adapted by the Ohio Domestic Violence Network from forms developed by The Family Violence Prevention Fund and the Nursing Network on Violence Against Women International (Appendix 3 and Appendix 4). These forms provide basic directions for caring for patients from assessment to documentation.

The Abuse Assessment Screen (AAS) (Appendix 5) is also a good way to begin the assessment process because it asks direct and uncomplicated questions about domestic violence. While the forms in Appendix 3 and 4 address screening, basic assessment, intervention, and documentation of abuse, the AAS is only used to identify abuse. Individuals who acknowledge abuse during the AAS are then provided with follow up individualized assessment and safety planning with documentation included in the narrative of the medical record or on a specific documentation form.

Assessment and Intervention

If Abuse is Denied

If abuse is denied and no indicators of abuse are present, document the findings in the medical record and offer referral information for future reference.

Advise patient who CONTINUES TO DENY ABUSE but in whom you still suspect abuse:

1. “Even though you have said that you have not experienced any type of violence, you seem (describe patient’s affect that increases the index of suspicion). Is there anything else that you can tell me that might explain your being uncomfortable with these questions?”
2. Contact social worker or individuals designated by individual agency protocol to further assess the patient.
3. “If you are ever abused, please come back to the office or contact the local domestic violence program at (insert telephone number).”
4. Let patient know that experts and help are available. Offer a crisis card/safety card. Tell them that even if they don’t need it that they can give it to a friend or family member who might use it.
5. Discuss possible repercussions if their partner finds the card.

6. Do not write any domestic violence referral on discharge papers that will be taken home with the patient.
7. If patient has obvious or suspected abuse but cannot communicate to acknowledge abuse (i.e. unconscious or impaired), schedule a follow-up appointment or initiate appropriate social work consult to ensure follow up.

If Abuse Is Acknowledged But Patient Refuses Social Work Consultation or Further Intervention:

1. Encourage follow-up with local domestic violence program and offer crisis/safety card.
2. If in potential need of shelter, encourage patient to contact local domestic violence shelter.
3. Offer the use of your office phone for the patient to contact the local domestic violence program.
4. Advise patient to return to office, or make contact if further abuse occurs.
5. Do not write referral numbers on discharge form.
6. Confer with social worker and offer additional appropriate referral information and materials.

If Abuse is Identified

1. Validate patient's feelings. Let them know they are not responsible and that abuse occurs in many relationships. Tell them they are not alone and that help is available.
2. Express concern for their safety and complete a danger assessment. Review the Danger Assessment Screen (DAS) [Appendix 6] with them, explaining that the DAS assists victims in identifying the danger present in their life so that they can make informed decisions about their safety.
3. The DAS can be used without the calendar if time is limited. However, use of a calendar often helps those who are abused to identify a pattern of abuse and assists recall of past abuse.
4. After they have completed the Danger Assessment Screen ask them if it is safe to go home today. If they indicate that it is not safe offer to make a referral, such as a hospital social worker, battered woman's shelter or other community resource per the hospital protocol, upon completing your examination. If patient says they do not need to leave home today, emphasize that there are ways to increase their safety in all situations, i.e. whether they leaves or not.
5. Complete the expanded assessment provided by the Family Violence Prevention Fund in the next section according to agency protocol.

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. If the patient is uncomfortable speaking with the provider about the abuse, the provider should offer or suggest that the victim talk with someone else from the community who is a trained advocate. Expanded assessments can occur in primary care, obstetric/gynecology, 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

- Health issues related to IPV injuries, chronic pain (neck, back, pelvic, migraines) peptic ulcers, irritable bowel syndrome, sexually transmitted infections (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
- If attempted strangulation (choking) or head injury occurred and the patient was unconscious, conduct a neurological exam
- Ability to manage other illnesses (such as hypertension, diabetes, asthma, HIV/AIDS)
- Mental health problems such as depression, PTSD, anxiety, stress and 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 occurred, assess for gynecological problems including Sexually Transmitted Infections (STI), anal/vaginal tearing, sexual dysfunction, and ask about safe sex practices and family planning
- Assess for exposure to dating and sexual violence or forced use of drugs such as MDMA (Ecstasy), GHB (Gamma Hydroxybutyric acid) etc.
- Encourage and help facilitate preventive health behaviors, such as regular mammography, pap smears, early pre-natal care, etc.

Questions About the Batterer

- Does the batterer use illicit drugs and/or alcohol? How much? How often?
- Does the batterer increase his/her violent behavior when under the influence?
- Does the batterer have any mental health problems?
- Does the batterer's violent behavior extend outside of the home?

Additional questions about the batterer's behavior are located in the Danger Assessment (Appendix 6).

Suicide and Homicide Assessment Questions

In addition to the initial danger assessment the following questions assess the risk for victim's homicidal and suicidal ideation:

Risk of Suicide by 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 seriously harming your partner?
- Have you thought about how you would do it? Do you have a plan?
- Do you have access to a weapon?
- 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 an emergency psychiatric evaluation can be obtained. Immediate, explicit threats of homicide must be reported to local law enforcement.

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 how the victim's community responds to abuse, marriage, divorce, health and healing, and how the victim responds to cultural expectations
- Assessment of how the abuse has affected the children (physically, emotionally, etc.)
- Assessment of how abuse is affecting their life, work, school, and relationships

Safety Planning

The next critical step in the process is the development of the safety plan. Safety plans can be developed by health care providers or support staff, social workers, and/or advocates depending on agency/clinic protocol and resource availability. An example of a safety plan document is included in Appendix 7. The example provided is a very basic plan and may be helpful depending upon the individual and their specific circumstances. A patient should always be provided the opportunity to use a hospital/agency phone to contact the local domestic violence program for more intensive safety planning or shelter services.

Discharge Checklist for Health Care Providers

- Did you screen the patient for domestic violence?
- Did you screen the patient for sexual assault?
- Did the patient identify who assaulted them (husband, boyfriend, child, family member)?
- Did the patient describe in detail how they received their injuries?
- Did you document in detail, the patient’s words about how the injuries occurred and who did it?
- Did you document on a body map where the injury was observed?
- Did you take multiple photographs, including a full head and body shot and the injury from different angles?
- Did you get the patient’s consent to take the photographs?
- Did you offer the patient information about community resources, including the local domestic violence program?
- Did you ask the patient about safety concerns and plan accordingly?
- Did you document your suspicions about a patient’s injuries whether or not they disclosed the abuse?
- Did you talk to the patient about follow-up procedures?

Documentation

Written Documentation

Document findings objectively.

1. Document the results of initial screening.
2. If abuse is denied, but the health care provider suspects abuse, document the suspicions and validate with objective observations that the injuries are inconsistent with patient explanation.
3. Note patient’s general demeanor.
4. Include the completed Abuse Assessment Form, along with the body map indicating designated areas of injury documented and the Danger Assessment Screen.
5. Describe detailed positive and negative findings from physical assessment and interview.
6. Use as many patient quotes as possible. Use terms such as “stated” and “said.”
7. Follow agency protocol or practice guidelines for photographing injuries (see photo documentation section below).
8. Include documentation of safety plan, specific referrals and plans made.
9. Document contacts with social work, police, and other resources that were initiated during the patient care interaction.
10. Describe discharge plans (patient’s plans for safety after leaving health care site).

Photodocumentation

1. With the patient's permission, a physician, nurse, or other appropriate professional may take photos of any visible injury.
 - a. Consent for photos should be obtained according to hospital policy.
 - b. Instant photography (Polaroid), digital photography and 35mm photography can all be used. However, some jurisdictions have a preference for criminal justice purposes. Area prosecutors should be consulted as to which type of photography they prefer, if possible. Ultimately, any photo taken is preferable to an absence of photographs.
2. Each health care system should develop a protocol for storage and retrieval of photos in accordance with the Ohio Revised Code and after consultation with local prosecutors and hospital risk management.
 - a. The primary purpose of photos is to visually document assault injury for use in criminal and civil proceedings. Copies of the photos should be available to patients in the same way that their medical records are available. All others seeking copies of the photos should present a subpoena to the hospital system for said photos.
 - b. A permanent log of photos should be maintained. When releasing photos to a patient or individual presenting a subpoena, that person must sign for the photos. The signature of the person releasing the photos should also be obtained, along with the date and time of the release.
 - c. Photos should be stored in the hospital system for a minimum of three years. Hospitals should discuss length of storage with area prosecutors.
3. Photos should be taken noting the following on the back of the photo or attached document: date, location, patient name, patient record number, photographer's name, and part of body photographed.
4. Multiple photos should be taken of injuries to provide detail of the mechanism of injury and scope of the injury. A full facial photo must be taken for identification purposes.
 - a. If the patient requests copies of the photos, a second set can be taken. The patient should be advised to store the photos in a safe place (i.e. a relative's home). Otherwise, advise patients how they can obtain copies of their photos from the hospital system prior to discharge.

Conclusion

The protocol concludes with two additional appendices. Appendix 8 summarizes many of the key points made within the protocol. Appendix 9 is an algorithm for decision making when caring for patients who experience domestic violence.

Women, men, and children who live with the terror of domestic violence deserve nothing less than our informed interventions to help them not only to survive, but to remain physically safe and spiritually free.

Appendix 1

What is Abuse?

DEFINITION—Abuse is a pattern of physically and emotionally violent and coercive behaviors that one person uses to exercise power and control over another. Abusers may use verbal insults, emotional abuse, financial deprivation, threats, and/or sexual and physical violence as a way to dominate their partners and get their way. Here are some examples of abusive behaviors:

VERBAL ABUSE

- yelling
- name calling
- threatening to hurt or kill
- degrading women in general
- criticizing appearance
- belittling accomplishments
- constant blaming

EMOTIONAL MANIPULATION

- apologizing and making false promises to end the abuse; offering false hope
- isolating from others
- abusing pets
- ignoring, withholding affection
- neglecting physical or emotional needs
- ridiculing, criticizing, blaming
- accusing of affairs
- monitoring conversations
- making account for time
- criticizing friends, family
- constant phone calls/pages
- embarrassing in front of others
- undermining authority with children

FINANCIAL/RESOURCE ABUSE

- taking or breaking phone
- controlling money/bank accounts
- withholding financial information
- making account for expenditures
- withholding child support
- destroying property
- taking or disabling car
- taking keys/purse
- quitting or losing jobs

- running up debts
- sabotaging work or school

SEXUAL ABUSE

- constant sexual demands
- forcing unwanted sexual acts
- committing rape or incest
- forcing sadistic sexual acts
- treating others as sex objects
- calling fat, ugly, no good in bed
- wanting sex after abuse
- forcing to have sex with others
- forcing pregnancy or abortion
- making demeaning sexual remarks
- forcing family members to see
- pornographic materials
- insisting on unwanted and uncomfortable touching

PHYSICAL ABUSE

- holding down
- hair pulling
- poking, grabbing
- pushing, shoving
- locking in or out of house
- subjecting to reckless driving
- burning
- throwing or hitting with objects
- using a knife or gun
- kicking, biting
- hitting, slapping
- choking, strangling
- refusing to help when sick or injured

Appendix 2

Ohio Domestic Violence Law

Failure to Report a Crime: ORC 2921.22

- A) No person, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authorities.
- B) No physician, limited practitioner, nurse, or person giving aid to a sick or injured person, shall negligently fail to report to law enforcement authorities any gunshot or stab wound treated or observed by him, any serious harm to persons that he knows or has reasonable cause to believe resulted from an offense of violence, any second or third degree burn that was inflicted by an explosion or other incendiary device, or any burn that shows evidence of having been inflicted in a violent, malicious, or criminal manner.

E)(1) As used in this division, “burn injury” means any of the following:

- (a) Second or third degree burns;
- (b) Any burns to the upper respiratory tract or laryngeal edema due to the inhalation of superheated air;
- (c) Any burn injury or wound that may result in death;

(5) Anyone participating in the making of reports under division (E) of this section or anyone participating in a judicial proceeding resulting from the reports is immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of such actions. Notwithstanding, the physician-patient relationship is not a ground for excluding evidence regarding a section 4731.22 of the Revised Code person’s burn injury or the cause of the burn injury in any judicial proceeding resulting from a report submitted under division (E) of this section.

F)(1) Any doctor of medicine or osteopathic medicine, hospital intern or resident, registered or licensed practical nurse, psychologist, social worker, independent social worker, social work assistant, professional clinical counselor, or professional counselor who knows or has reasonable cause to believe that a patient or client has been the victim of domestic violence, as defined in section 3113.31 of the Revised Code, shall note that knowledge or belief and the basis for it in the patient’s or client’s records.

(2) Notwithstanding section 4731.22 of the Revised Code, the doctor-patient privilege shall not be a ground for excluding any information regarding the report containing the knowledge or belief noted under division (F)(1) of this section, and the information may be admitted as evidence in accordance with the Rules of Evidence.

Ohio Domestic Violence Law

Definition: ORC 2901.01

- A) “Serious physical harm to persons” means any of the following:
- (1) Any mental illness or condition of such gravity as would normally require hospitalization or prolonged psychiatric treatment;
 - (2) Any physical harm which carries a substantial risk of death;
 - (3) Any physical harm which involves some permanent incapacity, whether partial or total, or which involves some temporary, substantial incapacity;
 - (4) Any physical harm which involves some permanent disfigurement, or which involves some temporary, serious disfigurement;
 - (5) Any physical harm which involves acute pain of such duration as to result in substantial suffering, or which involves any degree of prolonged or intractable pain.

Domestic Violence: 2919.25

- A) No person shall knowingly cause or attempt to cause physical harm to a family or household member.
- B) No person shall recklessly cause serious physical harm to a family or household member.
- C) No person, by threat of force, shall knowingly cause a family or household member to believe that the offender will cause imminent physical harm to the family or household member.

Domestic Violence Training & Protocol Requirements: 3727.08

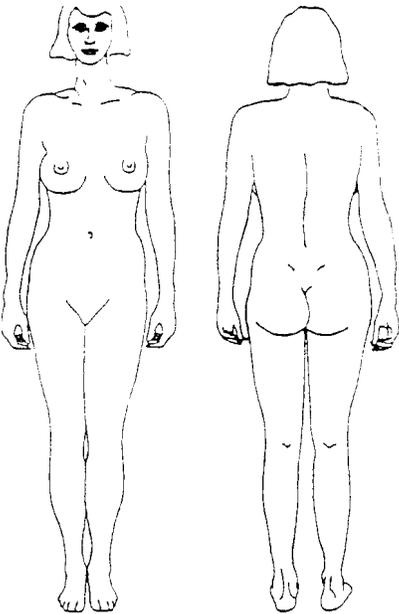
- Health care professionals who have reasonable grounds to believe a patient has been a victim of domestic violence shall note that in the patient’s record.
- Requires every hospital to adopt protocols for conducting interviews and creating a photographic record of injuries-when there is reasonable cause to believe domestic violence has occurred.
- Conforms Ohio definition of family members to include domestic violence committed by a person with whom the victim shares a child in common.

APPENDIX 3

DOMESTIC VIOLENCE SCREENING/DOCUMENTATION FORM FEMALE

DV Screen <input type="checkbox"/> DV+ (Positive) <input type="checkbox"/> DV? (Suspected)

Date _____ Patient ID # _____
 Patient Name _____
 Provider Name _____
 Patient Pregnant? Yes No



ABUSE ASSESSMENT

- Have you ever been hit, slapped, kicked or physically hurt by anyone?
Who?
- Have you been physically hurt by someone in the past month?
- Have you ever been forced into unwanted sexual activities?
Who?
- Have you been forced into unwanted sexual activities in the last month?
Who?
- Are you afraid of anyone?
Who?
- Does anyone criticize you, make you feel bad about yourself, or try to control you?
Who?

ASSESS PATIENT SAFETY

- Yes No Is abuser here now?
- Yes No Is patient afraid of their partner?
- Yes No Is patient afraid to go home?
- Yes No Has physical violence increased in severity?
- Yes No Has partner physically abused children?
- Yes No Have children witnessed violence in the home?
- Yes No Threats of homicide?
By whom: _____
- Yes No Threats of suicide?
By whom: _____
- Yes No Is there a gun in the home?
- Yes No Alcohol or substance abuse?

INTERVENTION

- Yes No Was safety plan discussed?

REFERRALS

- Hotline number given
- Legal referral made
- Shelter number given
- In-house referral made
- Describe: _____
- Other referral made
- Describe: _____

REPORTING

- Law enforcement report made
- Child Protective Services report made
- Adult Protective Services report made

PHOTOGRAPHS

- Yes No Consent to be photographed?
 - Yes No Photographs taken?
- Attach photographs and consent form*

Developed by the Family Violence Prevention Fund and Educational Programs Associates, Inc. Modified by the Ohio Domestic Violence Network.

APPENDIX 4

DOMESTIC VIOLENCE

SCREENING/DOCUMENTATION FORM MALE

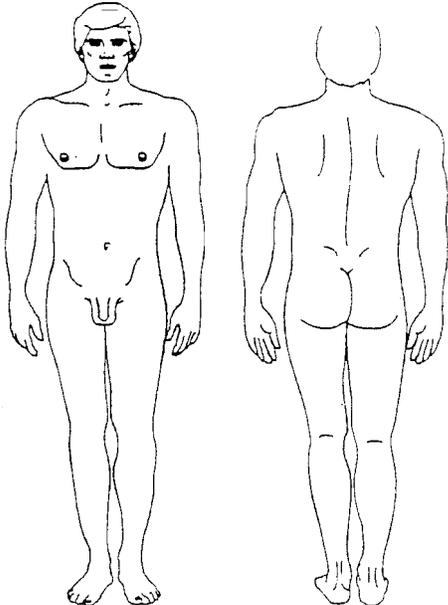
DV Screen
 DV+ (Positive)
 DV? (Suspected)

Date _____ Patient ID # _____
Patient Name _____

Provider Name _____

ABUSE ASSESSMENT

- Have you ever been hit, slapped, kicked or physically hurt by anyone?
Who? _____
- Have you been physically hurt by someone in the past month?
Who? _____
- Have you ever been forced into unwanted sexual activities?
Who? _____
- Have you been forced into unwanted sexual activities in the last month?
Who? _____
- Are you afraid of anyone?
Who? _____
- Does anyone criticize you, make you feel bad about yourself, or try to control you?
Who? _____



ASSESS PATIENT SAFETY

- Yes No Is abuser here now?
- Yes No Is patient afraid to go home?
- Yes No Has physical violence increased in severity?
- Yes No Has partner physically abused children?
- Yes No Have children witnessed violence in the home?
- Yes No Threats of homicide?
By whom: _____
- Yes No Threats of suicide?
By whom: _____
- Yes No Is there a gun in the home?
- Yes No Alcohol or substance abuse?

REFERRALS

- Hotline number given
- Legal referral made
- Shelter number given
- In-house referral made

Describe: _____
 Other referral made
Describe: _____

REPORTING

- Law enforcement report made
- Child Protective Services report made
- Adult Protective Services report made

PHOTOGRAPHS

- Yes No Consent to be photographed?
 - Yes No Photographs taken?
- Attach photographs and consent form*

INTERVENTION

- Yes No Was safety plan discussed?

Developed by the Family Violence Prevention Fund and Educational Programs Associates, Inc. Modified by the Ohio Domestic Violence Network.

APPENDIX 5

Abuse Assessment Screen

APPENDIX E | VALIDATED ABUSE ASSESSMENT TOOLS

ABUSE ASSESSMENT SCREEN⁶¹

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 _____

4. Within the last year, has anyone forced you to have sexual activities?
 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 _____

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

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 _____

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



APPENDIX 6

DANGER ASSESSMENT

Jacquelyn C. Campbell, Ph.D., R.N.
Copyright 1985, 1988, 2001

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 severity or frequency over the past year?
- ___ 2. Has he ever used a weapon against you or threatened you with a weapon?
- ___ 3. Does he ever try to choke you?
- ___ 4. Does he own a gun?
- ___ 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, when you can see your family, how much money you can use, 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. Does he threaten to harm your children?
- ___ 15. Do you have a child that is not his?
- ___ 16. Is he unemployed?
- ___ 17. Have you left him during the past year (If you have *never* lived with him, check here ___)
- ___ 18. Do you currently have another (different) intimate partner?
- ___ 19. Does he follow or spy on you, leave threatening notes, destroy your property, or call you when you don't want him to?

___ Total "Yes" Answers

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

APPENDIX 7

SAFETY PLAN

The victim is the expert for her own safety. The following plan is very basic, but it supplies the beginning steps in helping victims to keep safe. Victims should be encouraged to contact trained advocates at their local domestic violence programs to develop a personalized safety plan that will answer their needs and concerns. Victims should not be encouraged to take the safety plan home unless they are sure that their perpetrator will not find it.

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.

Appendix 8

Setting Specific Clinical Response to Victims of Domestic Violence Quick Reference Guide for Health Care Providers

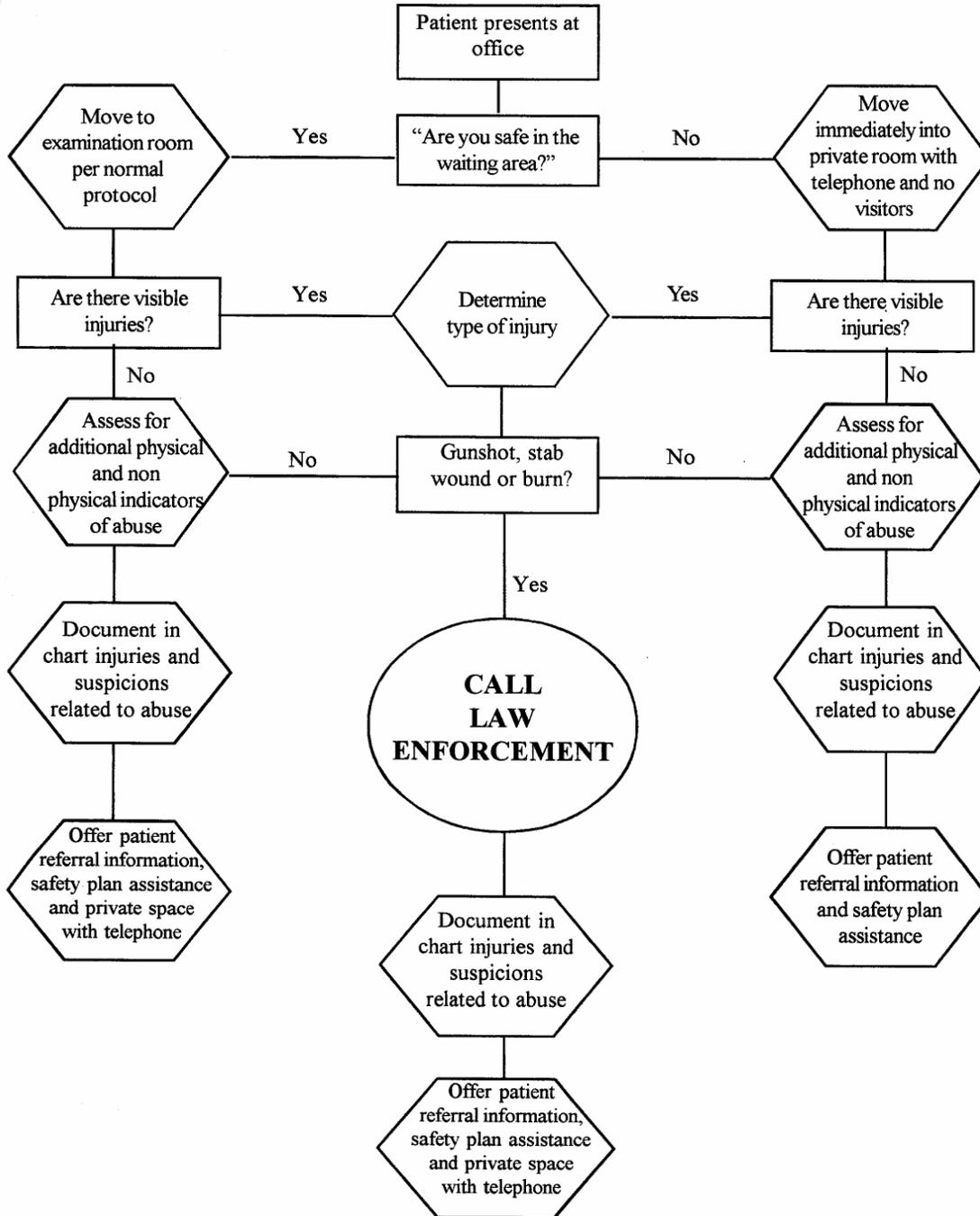
Entry Point	Screening	Assessment	Intervention	Documentation	Referral & Follow Up
<ul style="list-style-type: none"> • ED, Urgent Care • Same Day & Episodic visits • In-patient • Orthopedic Surgery 	<ul style="list-style-type: none"> • Routinely screen at every visit • Screen for current abuse and if time allows, screen for past history of abuse • Privately (1on 1) or with non-related, trained interpreter • 4 ‘W’s’: <ul style="list-style-type: none"> • 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 screening • Include screening questions on intake forms 	<ul style="list-style-type: none"> • Assess immediate safety • Health impact of abuse • Assess pattern of abuse • Danger/Lethality assessment • If yes to danger assessment: assess for suicide/homicide 	<ul style="list-style-type: none"> • Careful listening and support • I’m concerned with 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?” 	<ul style="list-style-type: none"> • 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 • Photography (w/patient consent) • Radiology, lab findings, collection of forensic evidence-clothes, debris, etc. • Materials and referrals offered • Results of health, safety assessment 	<ul style="list-style-type: none"> • Check if patient has a health care provider (HCP) to follow up with or refer to HCP, mental health provider, social work or DV advocate • Obtain permission to notify provider • Know phone numbers for: <ul style="list-style-type: none"> • DV program • Legal Services • Children’s programs • Mental health services • Law enforcement • Substance abuse • Transportation • Local clergy or other community organization
<ul style="list-style-type: none"> • Adult/Teen Primary Care • Family Practice • Public Health • School Health Settings 	<ul style="list-style-type: none"> • Routinely screen for current and lifetime history of abuse • Screen at initial visit • Annually or during periodic health assessments • With new relationships and if signs/symptoms are present • Privately (1 on 1) or with non-related trained interpreter • Screening questions on forms • Respect patient decision to disclose or not • Discuss any reporting requirements before screening 	<ul style="list-style-type: none"> • 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 • If IPV occurred in past, assess how the abuse affects patient now: physically/emotionally • Ask: “Are you still at risk?” “Are you still in contact with your partner?” 	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 DV advocate, pcp, mental health or other providers • Plan strategies to respond to difficult emotions after the visit 	<ul style="list-style-type: none"> • 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 • Photography (w/patient consent) • Radiology, labs as indicated • Materials and referrals offered • Results of health, safety assessment • Plans for follow-up 	<ul style="list-style-type: none"> • Offer close follow-up visits as situation warrants • If needed, offer referral to mental health, DV advocate • Identify follow-up strategy with patient: (next visit, safe contact number, address) • Know phone numbers for: <ul style="list-style-type: none"> • DV program • Legal Services • Children’s programs • Mental health services • Law enforcement • Substance abuse • Transportation • Local clergy or other community organizations • Ask about DV follow-up

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
<p>Specialty Providers: Ob-Gyn, family planning, pre-natal women’s health, dental, geriatric, STI clinics</p>	<ul style="list-style-type: none"> • Routinely screen for current and lifetime history of abuse • Screen at initial visit or annually or at periodic health assessments • If chart indicates abuse, with 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 	<ul style="list-style-type: none"> • Assess immediate safety • Health impact of abuse • Assess pattern of abuse • Danger/Lethality assessment • If yes to danger assessment: assess for suicide/homicide • Conduct expanded assessment if time allows or refer to DV advocate, social worker or mental health provider for further assessment • If IPV occurred in past, assess how the abuse affects patient now, physically and emotionally • Ask: “Are you still at risk?” “Are you in contact with your partner?” 	<ul style="list-style-type: none"> • Careful listening and support • I’m concerned with 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 • Offer/explain services: DV advocacy, social services, police, shelter, etc. • Offer to call DV advocate on phone • Review (or have an DV advocate) and/or develop safety plan with patient • If IPV is not current: ask “Is there anything I can do for you?” Offer referral to DV advocate, health care provider, mental health or other providers • Plan strategies to respond to difficult emotions after the visit 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Offer follow-up visits as situation warrants • Identify if patient has a health care provider (HCP) to follow up with or if needed offer referral to HCP, mental health or DV advocate • Obtain permission to notify provider • Know phone numbers for: <ul style="list-style-type: none"> • DV program • Legal Services • Children’s programs • Mental health services • Law enforcement • Substance abuse • Transportation • Local clergy or other community organizations
<p>Mental Health Substance Abuse Settings</p>	<ul style="list-style-type: none"> • Routinely screen for current and lifetime history of abuse • Screen at initial visit, annually or at periodic treatment conference • If chart indicates abuse, with new relationship and/or when signs or symptoms are present • Privately (1 on 1) or with non related trained interpreter • Screening questions on forms • Discuss any reporting requirements prior to screening 	<ul style="list-style-type: none"> • Assess immediate safety • Mental health impact of abuse • Assess pattern of abuse • Danger/Lethality Assessment • If yes to danger assessment: assess for suicide/homicide • Ask about coping strategies and psycho-social history • Ask: “What have you tried already? What helped?” • Conduct needs assessment • Conduct 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?” 	<ul style="list-style-type: none"> • Careful listening and support • I’m concerned with 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 • Offer/explain services: DV advocacy, social services, police, shelter, etc. • Offer to call DV advocate on phone • Review (or have an DV advocate) and/or 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 know?” • Plan strategies to respond to difficult emotions after the visit 	<ul style="list-style-type: none"> • Legible, full signature, Maintain confidentiality of medical records • Results of health, safety assessment • Abuse history: Subjective info: (patient states “”) Objective info: detailed descriptions of patient’s appearance, behavioral indicators, injuries and cc’s. • Referrals and materials offered 	<ul style="list-style-type: none"> • If patient desires, refer back to health care provider or other provider • Offer close follow-up visits as situation warrants • Offer group or individual therapy • Identify follow-up strategy with patient: (next visit, safe contact number, address) • Know phone numbers for: <ul style="list-style-type: none"> • DV program • Legal Services • Children’s programs • Law enforcement • Transportation • Local clergy or other community organizations

APPENDIX 9

INTERVIEW AND SCREENING FLOW CHART (General Adult Population)



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