MISSISSIPPI'S DOMESTIC VIOLENCE

PROTOCOL FOR HEALTH CARE PROVIDERS:

PROCEDURES OF CARE

PREPARED BY THE:
MISSISSIPPI COALITION AGAINST DOMESTIC VIOLENCE
ADOPTED FROM:
OHIO DOMESTIC VIOLENCE NETWORK

MISSISSIPPI
COALITION AGAINST
DOMESTIC VIOLENCE
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INTRODUCTION

The Mississippi Coalition Against Domestic Violence was founded in 1980 by domestic violence shelter programs and advocates for battered women to help all victims of domestic violence. The coalition is comprised of persons working directly, indirectly or who have expressed interest in the issues and concerns of victims of family violence. The coalition provides technical assistance to domestic violence shelters, community and professional education and other related assistance to victims of domestic violence across the state. During the last thirty years, there has been a movement to end domestic violence and to help those who are victims of this crime. The Mississippi Coalition Against Domestic Violence is committed to this movement. The overall goal of the Coalition is to provide an end to domestic violence in the home and in our state.

MCADV provides support for member shelter programs though training, technical assistance and capacity building; advocates for public policy that supports victims; and seeks to change societal attitudes and beliefs through awareness and prevention activities in communities throughout Mississippi. MCADV does not provide direct services for victims of domestic violence but supports the twelve-member shelter programs that offer services throughout Mississippi. We can help victims to find the support they need in their local communities.

MCADV has worked to ensure the following:

- **Education:** Provides training sessions, special events and resource materials to all sectors of the community, including law enforcement; professional, civic groups, and faith-based organizations; schools and universities; and direct service providers

- **Public Awareness:** Conducts ongoing statewide media campaigns aimed at specific target audiences including action-oriented communications to victims and the public, as well as building public awareness about domestic violence in various entities within the community at-large

- **Referral Service:** Assists victims of domestic violence and other service providers by providing referrals to domestic violence shelter programs and other available services

- **Technical Assistance:** Provides training, support, resources, and capacity building to member shelter programs and coordinates efforts between programs and other community service agencies to enhance the strategies and programs for victim service provision

- **Resource Distribution:** Maintains information on domestic violence programs and services such as statistics, books, videos, training materials, and other resources on domestic violence, including stalking, teen dating violence and victims' rights

- **Legal Services:** Provides legal services to victims of interpersonal violence associated with shelter programs, such as family law matters and other non-tort legal services in a civil context.

State coalitions have played a unique role in the nation's response to domestic violence. Our history is rooted in the battered women's movement and the values that define this movement, including working towards social justice, self-determination and ending the oppression of women. The vision of early leaders from state domestic violence coalitions was to assist in the effort to end violence against women.

Traditionally, intimate partner violence, or domestic violence, has been looked at as a women's issue because of how disproportionately the abuse affects women. About 96% of females experiencing nonfatal intimate partner violence were victimized by a male; and about 16% of males experiencing nonfatal intimate partner violence reported that the offender was another male.[1] Since the majority of the violence is perpetrated by males, prevention efforts should focus on men. Not just to make men aware that they should not hit their partners, but also to encourage them to speak out against abuse and not tolerate family violence in their communities.

This medical protocol was originally developed in 1996 by a dedicated group of healthcare professionals, educators, shelter directors and advocates to provide information and guidelines to assist health care professionals in identifying, treating, and referring adult victims of domestic violence. After many years, the Medical Protocol Task Force was established to assist in the update of the manual. The support of the Mississippi Department of Health Office Against Interpersonal Violence, the Ohio Domestic Violence Network and Medical Protocol Task Force assisted in the update of the protocol.

This publication was made possible with funds from the U.S. Department of Health and Human Services, Administration for Children and Families, Family Violence Prevention and Services.

[1]http://www.ojp.usdoj.gov/bjs/intimate/ipv.htm#contents

DOMESTIC VIOLENCE PROTOCOL SUMMARY

PURPOSE

The purpose of the Mississippi Coalition Against Domestic Violence DV protocol is to provide standards of care for health care providers and agencies and to address the needs of patients seeking health care who are victims of domestic violence. The essential components of the protocol include:

PREPARE

- Understand the physical, emotional, financial and health impact of domestic violence.
- Be familiar with documenting and reporting guidelines for abuse in the Mississippi Code 43-21-353 (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." Place posters and safety cards in your office and in all bathrooms throughout the facility (men's, women's and staff) about domestic violence, the impact of violence on reproductive health, and local resources.

SCREEN

- Implement universal and routine screening.
- Patients should be screened at every point of contact within the health care system, including, but not limited to: emergency room visits, hospital admission, initial visits, follow up, wellness checkups, family planning visits, physicals, prenatal visits, and throughout pregnancies.
- Screen patients ALONE– Do not ask when anyone else is in the room, including parents, partners, children over the age of 2, friends, or family members. ALONE means ALONE; no exceptions.
- 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.
- Normalize the conversation to introduce the screen: "Because domestic violence is so common in our patients' lives we have begun to talk to everyone about it."
- Begin the screen with general non-threatening questions: "Is your partner kind and respectful of your choices?"; "Does your partner give you space and time to spend alone or with friends?"
- Ask about physical abuse: Has anyone ever put his/her hands on you in ways that you didn't want? (push, pinch, restrain, wrestle when you didn't want to, etc.) Who?

Protocol Summary

Prepare: Schedule training on domestic violence, get to know advocates at the local domestic violence program, and prepare your office setting with posters, screening cards and patient literature.

Screen: Routinely, universally, confidentially, and non-judgmentally. Normalize the conversation and ask about non-physical forms of abuse.

Assess: If indicated, ask additional questions about their immediate safety, their coping strategies, and their day-to-day safety.

Intervene: Validate the survivor's experience, assure survivor's confidentially, provide referral for a safety plan to the local program, offer a phone or offer to make the call for the survivor.

Documentation: Document physical findings of abuse, use patient's words and do not "clean up" their story. Do not use legal terms unless used by the patient.

- Ask about other forms of coercion and abuse:
  - ☐ Verbal/Emotional Abuse: "Does your partner ever degrade or humiliate you?"; "Does your partner ever undermine your authority or criticize your parenting?"
  - ☐ Sexual Coercion/Abuse: "Has anyone ever forced you to do something sexually you did not want to do?"; "Does your partner ever beg or demand sex or tell you it is your duty?"
  - ☐ When appropriate, ask about reproductive coercion: "Are you afraid to ask your partner to use condoms?"; "Has your partner ever messed with your birth control?"

ASSESS

- If a patient discloses that they are currently being abused, at a minimum their immediate safety should be assessed. This could include asking:
  - ☐ Are you in immediate danger?
  - ☐ Is your partner in the facility now?
  - ☐ Has the violence escalated or gotten worse over the past year?
  - ☐ Has your partner threatened to kill you or your children?
  - ☐ Does your partner have access to guns or other lethal weapons?
  - ☐ Ask how they cope or keep safe from violence. Listen for instances of using substances, unsafe coping measures, and isolating strategies.
  - ☐ Are there children in the house that may be 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 patient's safety and encourage them to seek help.

INTERVENE

- 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 locked, secure area isolated from visitors.
- Assure patients that you will treat their perpetrators no differently so as not to jeopardize their safety.
- Explain limits of confidentiality and your legal obligation to report felonious assaults as well as child abuse.
- Tell the patient that no one deserves to be hurt by their partner.
- Affirm that it takes a lot of courage to talk about what is happening in their relationship.
- Tell patients that they are not alone and that help is available.
- Help patients to identify trusted individuals who they can approach for assistance.

- Discuss the importance of a safety plan. Discuss safety planning options with them or encourage them to call a local advocate to discuss their options. Offer to make the call for them if they are afraid or hesitant to place such a call.
- 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.
- Let them know about invisible birth control options.

DOCUMENTATION

- Document any physical indicators or reports of abuse.
- Documentation should be completed by a healthcare provider who is authorized to document in the patient's file. Allowing anyone other than a healthcare practitioner to document in the patient's file may violate HIPAA regulations.
- Providers should document the patient's statements and avoid negative or judgmental documentation. (i.e., write "patient declines services" rather than "patient refuses services," "patient states" rather than "patient alleges")
- Providers should not use legal terms in their documentation unless it is used by the patient. (i.e., "patient states she was raped" rather than "patient was raped")

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 a while before leaving 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.

BACKGROUND

PHILOSOPHY

The Mississippi Coalition Against Domestic Violence is comprised of people dealing with concerns of victims of family violence. We represent both rural and urban areas. Our programs support and serve victims of all racial, social, ethnic, religious, and economic groups, regardless of age, sex or lifestyle. We oppose the use of violence as a means of control over others and support respect and equality in relationships. We encourage and support survivors in assuming responsibility over their lives in the community.

PURPOSE

The purpose of the Mississippi Coalition Against Domestic Violence is to provide standards of care for health care providers to address the needs of individuals receiving care for domestic violence. 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 negatively for abuse as well as those who acknowledge violence.

The protocol for those who screen positively for abuse includes a detailed assessment of the physical and psychological state of the client (hereinafter known as patient), a safety plan, discharge instructions, referrals, and documentation issues. The protocol includes additional information from *Futures Without Violence* 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 healthcare provider and the patient. A reference list at the end of the protocol identifies the contributing sources for the documents.

SCOPE OF THE PROBLEM

In 2010, the National Intimate Partner and Sexual Violence Survey reported that:

- More than 1 in 3 women and more than 1 in 4 men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner at some time during their lives;
- Approximately 1 in 4 women and 1 in 7 men surveyed reported having experienced severe physical intimate partner violence;
- 1 in 5 women and 1 in 71 men had been raped;
- 1 in 6 women and 1 in 19 men experienced stalking in their lifetime;
- Rates of intimate partner violence in LGBT relationships are equivalent; and
- Women who had experienced rape or stalking by any perpetrator or physical violence by an intimate partner in their lifetime were more likely than women who did not experience these forms of violence to report having asthma, diabetes, and irritable bowel syndrome.

ODVN/ODH/OAESV

The 1998 National Violence Against Women Survey reported 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 identifying intimate partner physical violence only. The prevalence would be much higher if emotional and sexual abuse were included.

- Studies have also shown a strong association between violence and unintended pregnancies;
- Adolescent girls who experience intimate partner violence are 4-6 times more likely to become pregnant than girls in non-abusive relationship;[1]
- Approximately 5% of survivors (over 32,000 women) will become pregnant as a result of rape every year, with 50% of those individuals choosing abortion;[2]
- 40% of pregnant women in abusive relationships report their pregnancy was unintended, as opposed to only 8% of women in non-abusive relationships.[3]

DEFINITION OF DOMESTIC VIOLENCE

Domestic Violence, also called intimate partner violence (IPV), is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners.

Physical abuse or violence and emotional or psychological abuse include intentional acts or coercive tactics that cause trauma to another person. Trauma is characterized by feelings of:

- Intense fear
- Helplessness
- Loss of control
- Threat of annihilation

Traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory.[4] Therefore, a trauma informed approach is recommended when treating patients who have experienced domestic violence.

[1] Holmes, M.M., Resnick, H.S., Kilpatrick, D.G. & Best, C.L. (1996). Rape-relayed pregnancy: Estimates and descriptive characteristics from a national sample of women. American Journal of Obstetrics and Gynecology, 175 (2), 320-325

[2] Silverman, J.G., Raj, A. & Clements, K. (2004) Dating violence and associated sexual risk and pregnancy among adolescent girls in the United States. Pediatrics, 114 (2), e220-225.

[3] Hathaway, J.E., Mucci, L.A., Silverman, J.G., Brooks, D.R., Mathews, R., & Pavlos, C.A. (2000). Health Status and health care use of Massachusetts women reporting partner abuse. American Journal of Preventative Medicine, 19 (4), 318-321.

[4] Trauma and Recovery: The Aftermath of Violence. Herman, Judith, MD. Basic Books. (1992)

A trauma informed approach is based on the recognition that many behaviors and responses expressed by survivors are directly related to traumatic experiences. Organizations utilizing a trauma informed approach have shifted the philosophical approach from "What is wrong with you?" to "What happened to you?"

CHARACTERISTICS OF TRAUMA INFORMED SERVICES INCLUDE

- A focus on understanding the whole individual and context of his or her life experience;
- Knowledge about the roles that violence and victimization play in the lives of individuals;
- A design to minimize the possibilities of victimization and re-victimization;
- An approach that is hospitable and engaging for survivors;
- An approach that facilitates recovery;
- An approach that facilitates growth, resilience and healing;
- An approach that respects an individual's choices and control over her recovery;
- Forms a relationship based in partnership with the survivor, minimizing the power imbalance between advocate and survivor;
- An emphasis on individual's strengths;
- A focus on trust and safety.

PATTERNS OF VIOLENCE

Scope and breadth of violence varies in relationships. However, three aspects remain consistent: isolation; intimidation; and coercive control. Domestic violence victims are often trapped as the violence increases in frequency and severity over time and may demonstrate symptoms associated with post-traumatic stress disorders (PTSD). The goal of intervention is to return control and decision making to patients, increasing their ability to stay safe.

LEGAL CONSIDERATIONS

REPORTING REQUIREMENTS

Mississippi Code requires that any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, family protection worker, family protection specialist, child caregiver, minister, law enforcement officer, public or private school employee or any other person having reasonable cause to suspect that a child is a neglected child or an abused child, shall cause an oral report to be made immediately by telephone or otherwise and followed as soon thereafter as possible by a report in writing to the Department of Human Services.

In addition, Mississippi law defines vulnerable adults as persons who are unable because of age or any other infirmity to protect themselves from harm. The infirmity may be a physical disability or a mental disability. The physical injury does not have to be life threatening or even serious. Allegations of abuse of a vulnerable adult in a home setting are investigated by the Mississippi Department of Human Services, and a report should be made to that agency by anyone who has reason to believe a vulnerable adult is being abused. Allegations of abuse of a vulnerable adult in a care facility, such as a nursing home, are investigated by the Office of the Attorney General, Medicaid Fraud Division.

CONFIDENTIALITY

Health care organizations should adopt a policy that all visits begin with providers discussing confidentiality and limits to confidentiality. The organization should adopt a policy that the patient is always screened privately for issues of domestic and sexual violence. Family, friends, partners and children over the age of 2 should not be allowed in the room or area when the provider is screening the patient; this includes a best friend, or a mother/father. 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.

Minors do not have confidentiality around issues of physical or sexual violence in the state of Mississippi and providers should make the patient very aware of those limitations. Often this may require reminding minor patients several times throughout the visit.

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 their personal experiences. Each step of subsequent violence assessment and intervention needs to be documented. All four steps of screening, assessment, intervention, and documentation are essential to provide necessary care for victims.

Who should be screened?

The National Consensus Guidelines developed by the former *Family Violence Prevention Fund* (FVPF), now *Futures Without Violence*, 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, it is recommended that screening for current and lifetime exposure is integrated into routine care. However, there will likely be times (particularly in emergency/urgent care) when screening for lifetime exposure to abuse will not always be possible due to many factors.

Therefore, *Futures Without Violence* 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 (having an understanding of batterer behavior, knowledge of local batterer's intervention programs) can be taken to protect victims whose batterers claim to be abused. Training providers on perpetrator dynamics is essential; and
- 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 Mississippi Coalition Against Domestic Violence 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. For additional information on adolescents and teen relationship violence visit http://mcadv.org/resources/ or http://mcadv.org/related-links/

In addition, to stand up against domestic violence visit our website at http://mcadv.org/dv-pledge/.

VIOLENCE INDICATORS

The following information developed by *Futures Without Violence* 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;
- Assault by alleged stranger;
- Chronic pain syndrome, migraine headaches, fibromyalgia;
- 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

- Any old unexplained injuries;
- Delay in seeking care;
- "Accident prone" patient;
- Documented history of family violence;
- High stress in family;
- Unintended pregnancy and rapid, repeat pregnancies;
- 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

- Partner answers questions for patient;
- Partner refuses to leave patient alone;
- 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 of partner or patient;
- Patient denies abuse too strongly;
- Patient minimizes injury or demonstrates unexpected responses (e.g. cries, laughs);
- Patient has intense and/or fearful behavior when partner is present;
- Patient appears angry and defensive "last straw phenomena";
- Patient defers to partner;
- Patient presents with psychiatric and/or suicidal ideation.

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 injury (particularly during pregnancy);
- Neck injury;
- Injuries to hidden sites (covered by clothes);
- Internal injuries;
- Fibromyalgia and chronic pain syndromes;
- Other commonly seen domestic violence injuries.

Screening must be done in a private area with no one other than the patient and children under the age of 2 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 and clinic policy. Best practice models incorporate policies that include posting in waiting areas that all patients will be seen privately prior to family members joining them in the treatment area. Check to ensure that the visitor/s is 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 (e.g. have second party request to speak with visitor outside of exam room).

Listed below are some suggested screening questions and strategies developed by *Futures Without Violence*.

FRAMING QUESTIONS:

- "Because violence is so common in people's lives, we've begun asking all of our patients about it."
- "We know that experiencing violence places victims at increased risk for a number of health conditions so we have begun to ask all of our patients about it."
- "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 problems in their relationships like being in fear for their safety. Some are too afraid or uncomfortable to bring it up themselves, so I routinely ask about it. Is anything like that happening to you?"

DIRECT VERBAL QUESTIONS:

- "Did someone cause these injuries? Was it your partner/spouse?"
- "Has your partner ever put his/her hands on you in ways that you didn't want (push, pinch, restrain, wrestle when you didn't want to, etc.)?"
- "Do you change what you say or do, or always agree with your partner, to avoid consequences/angering him/her?"
- "Does your partner try to control you, make all the decisions, or tell you where you can go or who you can talk to?"
- "Ever use his/her body to intimidate you (i.e., corner you, block your path, punch a wall, lock you in a room)?"
- "Does your partner mess with your birth control or refuse to use protection during sex?"
- "Has your partner ever forced you to do anything sexually you didn't want to do?"
- "Does your partner make you have sexual contact that you don't want?"
- "Do you feel dread about home/your partner?"
- "Are you ever afraid to go home/be at home?"

CULTURAL CONSIDERATIONS

Smaller cultural communities are more closed (i.e. deaf, LGBT, immigrant, etc.):

- Services for these small closed populations are often limited especially if the survivor is in a rural area;
- Survivors who identify as a member of a specific cultural community may not have much support from family and friends. LGBT survivors may not be open about their sexual orientation among their peers.
- Abusers can use culture and identity to abuse (i.e. race, class, sexual orientation, gender identity, etc.):
  - ☐ Abusers may threaten to withhold money or resources that the survivor has become accustomed to;
  - ☐ The abuser may have connections to powerful people in the community that make it difficult for the survivor to access or utilize traditional resources;
  - ☐ Abusers may threaten to out their partner's sexual orientation to friends/family;
  - ☐ Abusers may use gender pronouns that are contradictory to how the patient identifies him/herself;
  - ☐ Abusers may threaten their partner with deportation if the survivor is without Immigration and Customs Enforcement (ICE) status to be in the U.S. legally.

Survivors from marginalized/oppressed communities are not likely to have the same options as other survivors and they often have additional barriers:

- Abusers may not allow their partners to learn English, thereby making it difficult to access services;
- Survivors may not seek help from law enforcement for fear of deportation;
- Because of racial/ethnic stereotypes, survivors often fear involvement of child protective services if they leave;
- Abusers may threaten to withhold welfare benefits or report that she/he is living in the home thereby decreasing the recipients' benefits. No one can be an expert on every culture; rather than guess or make assumptions, ask patients when you are not sure about a norm, language, what would be helpful and appropriate.

IMMIGRANT SURVIVORS:

- Let immigrant survivors know that DV/SV is against the law in the U.S., they may have legal options, and an advocate is available;
- Let immigrant survivors know you don't report to ICE;
- Undocumented survivors (those without ICE status to be in the U.S. legally) may be fearful of seeking legal options such as calling the police, getting a protection order or filing charges;
- Victims who are undocumented may be able to get a special visa (such as a U Visa, T Visa or what is called a VAWA "self-petition") because of their status as crime victims. If safe, give all immigrant patients and victims of trafficking the Information for Immigrant Survivors of Abuse handout. (Appendix 7)

USING INTERPRETERS WITH IMMIGRANT AND DEAF OR HARD OF HEARING SURVIVORS

If using interpreters, make sure they are never a child, and try to avoid using any family member or member of the victim's or abuser's community/social network. It is absolutely essential to have an interpreter when:

- The patient asks for one;
- There is any doubt about your effectiveness in communicating;
- You think it is better for the process if there is an interpreter as the patient is better able to communicate in their language;
- You feel that there are problems in being understood or understanding what the patient is saying.

Only use paid interpreters with whom the victim feels safe and comfortable. Even though you are required to pay for the interpreter, if the survivor does not want to work with the interpreter you choose, trust that and get a different interpreter.

When working with an interpreter, it is essential that you remember:

- The communication is between you and the patient;
- You should not be aware that the interpreter is even present, so arrange the seating in a way that allows you to talk to the patient;
- Use simple, clear language with short sentences;
- Allow for pauses, which will enable the interpreter to interpret;
- Always speak to the patient;
- Be patient;
- Do not use relatives or children to interpret;
- It is a best practice to use an interpreter that the patient does not know but make sure it is someone the patient is comfortable with;
- Use Language Line (800-752-6096) if you cannot get an interpreter or cannot identify the language the patient is speaking. If you do not have an account with them, you'll need a credit card number (please see Appendix 7 for further Language Line information).

It's okay, even preferable, to ask patients how they refer to their partner. It is okay and may be empowering to ask a patient how they refer to themselves, or how they refer to their partner. Remember that using the most up-to-date term is less "correct" than an individual's choice of how to identify themselves.

CULTURAL COMPETENCY

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. Gathering information on the survivor's interpretation of her or his culture helps paint a more complete picture of her or his context. 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/partner/spouse disrespect you?"
- Be culturally specific: "Abuse is widespread and can happen even in LGBT relationships. Does your partner ever try to hurt you?"
- Focus on behaviors: "Has your partner ever hit, shoved, or threatened to kill you?"
- Ask about reproductive health "Are you able to talk with your partner about sex, using condoms, or what form of birth control YOU want to use?"
- 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 *Mississippi Coalition Against Domestic Violence* from forms developed by *Futures Without Violence* 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.

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 regular intervals as an indication that it is safe to disclose to you;
- Display information and resources in exam and waiting rooms, or bathrooms;
- If patient says "no" but you believe she/he may be at risk, discuss the specific risk factors and offer information and resources;
- 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;
- Discuss possible repercussions if their partner finds the card;
- Do not write any domestic violence referral on discharge papers that will be taken home with the patient.

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 IDENTIFIED

If a patient discloses that they are currently being abused, at a minimum their immediate safety should be assessed. This could include asking:

- Are you in immediate danger?
- Is your partner in the facility now?
- Has the violence escalated or gotten worse over the past year?
- Has your partner threatened to kill you or your children?
- Does your partner have access to guns or other deadly weapons?

If the patient answers yes to any of these, encourage her/him to speak with a domestic violence advocate to develop a safety plan even if the patient does not intend to leave her/his abuser. Provide a phone and a safe place for her/him to contact an advocate. Offer to make the call for them if they would prefer that. Be mindful that your phone may be the only link a survivor has to a domestic violence advocate since cell phones and land lines are easily traceable.

KEY ELEMENTS FOR RESPONDING TO A DOMESTIC VIOLENCE DISCLOSURE

Empathy

- "I believe you and I am sorry this has happened to you."
- "No one deserves to be treated like that and it is not your fault."

Generalize

- "This happens to many people, and we often feel alone with it."
- "Domestic violence happens more frequently than we know and in all types of relationships."

Empowerment

- "I believe you know what is best for you (and your children). I have information that can be helpful now and later."
- "When you are ready, I can help connect you with [advocate's name]. She/he is very knowledgeable about domestic violence and really knows how to help in situations like yours."

Autonomy

- Resist being directive (i.e. "You should," "You need to").
- "What would be helpful right now?"
- "Is there one person, be it a family member or friend, that you can tell in case you need help one day?"

Confidentiality

- Explain limits of confidentiality;
- Adults: "Everything you tell me is confidential unless you tell me someone has harmed your children or if you intend to harm yourself or someone else."
- Teens: "Everything you tell me is confidential unless you tell me someone is harming you or if you intend to harm yourself or someone else. Depending on your age there are instances where I may need to report sexual contact or conduct."

Linking to resources

- "I want to give you the number to the National Domestic Violence Hotline, and the number to the local program…."
- "I can call my friend [advocate's name] at the local domestic violence program and you can talk with her/him in my office if you would like."

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, obstetrics/gynecology, or 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 unintended pregnancies, miscarriages not attributable to a medical condition, and abortions (when not the survivor's choice);
- 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 unwanted sexual contact occurred recently, first refer to SANE nurse;
- If survivor declines referral, assess for gynecological problems including sexually transmitted infections (STI), offer STI treatment, and emergency contraceptive;
- Assess for exposure to dating and sexual violence, or forced use of drugs such as alcohol or other drugs, in a nonjudgmental manner; even if the survivor was using alcohol or other drugs, remind the survivor that they are not at fault for the violence;
- 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?
- Does the batterer have access to weapons?

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

- Assess if the patient is expressing anger or a genuine intent to kill.
- 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?

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, clergy, 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.

Patient Safety Tips

Any domestic violence situation can escalate quickly, resulting in serious injury or death. This can be hard to predict.

Here are some known indicators of high danger:

- If you have started thinking about, planning to, or are taking steps to end the relationship;
- Abuser is depressed; higher risk if the abuser has talked about or attempted suicide;
- History of threats to seriously harm or kill;
- Stalking (frequent calling, texting, following, etc.);
- Access to weapons, especially guns;
- History of serious injury, strangulation/choking, prior use of weapons Against victim;
- Mental impairment of abuser due to alcohol, drugs, or mental illness;
- History of failed community controls on abuser (multiple contact with police, courts, protection orders, etc. with no corresponding reduction in violent behavior);
- Injuring or killing pets.

Discharge Checklist for Health Care Providers

- Did you screen the patient for domestic violence?
- Did you screen the patient for sexual violence or coercion?
- Did the patient identify who assaulted them (spouse, boyfriend/girlfriend, partner, child, family member)?
- Did you screen for reproductive coercion?
- Did you offer the patient emergency contraception and/or birth control?
- 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 get the patient's consent to take the photographs?
- Did you take multiple photographs, including a full head and body shot and the injury from different angles?
- 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

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;
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. Providers should not "clean up" a survivor's language;
8. Providers should not use legal terms in their documentation unless it is used by the patient. (i.e., "patient states she was raped" rather than "patient was raped");
9. If non-consensual sex is reported, document if emergency contraception is offered;
10. Follow agency protocol or practice guidelines for photographing injuries (see photo documentation section below);
11. Include documentation of safety plan, specific referrals and follow-up plans made;
12. Document contacts with social work, police, and other resources that were initiated during the patient care interaction;
13. Describe discharge plans (patient's plans for safety after leaving health care site).

PHOTO DOCUMENTATION

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.
2. Each health care system should develop a protocol for storage and retrieval of photos in consultation with local prosecutors and hospital risk management.
3. All photographs should be taken by a forensically trained medical staff or law enforcement photographer. If a law enforcement photographer is not available, photos should be taken by a trained forensic staff member or forensic nurse.
   a. Close-up photographs should be taken of the patient's face and trauma areas with measuring device to document the size of the injury (cut, bruise, scratch, etc.). The photographs should be identified (labeled) with the patient's name, hospital/facility number and date. It is recommended that photographs of the genitals be taken when indicated by trained forensic staff members or the forensic nurse.
   b. The law enforcement photographer is responsible for documenting the patient's face and full body photographs. Forensically trained medical staff is responsible for photo documentation of any evident trauma including photographs of the genitals.

c. Two sets of photographs are recommended. Both sets remain with the medical records unless a law enforcement agency requests the trauma photos for their files. One set should be given to the law enforcement agency with a proper release form.

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 third set can be made. 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 violence free.

APPENDIX 1

POWER & CONTROL WHEEL

Physical and sexual assaults, or threats to commit them, are the most apparent forms of domestic violence and are usually the actions that allow others to become aware of the problem. However, regular use of other abusive behaviors by the batterer, when reinforced by one or more acts of physical violence, make up a larger system of abuse. Although physical assaults may occur only once or occasionally, they instill the threat of future violent attacks and allow the abuser to take control of their partner's life and circumstances. The Power and Control Wheel is a particularly helpful tool in understanding the overall pattern of abusive and violent behaviors, which are used by a batterer to establish and maintain control. Very often, one or more violent incidents are accompanied by an array of these other types of abuse. They are less easily identified, yet firmly establish a pattern of intimidation and control in the relationship.

The Power and Control Wheel was created to represent the lived experience of women who live with a male abuser. It doesn't attempt to give a broad understanding of all violence in the home of community. Although this wheel uses a female pronoun we acknowledge and respect the men who are survivors of domestic and sexual violence as well.

Battering in same-sex intimate relationships has many of the same characteristics of battering in heterosexual relationships, but happens within the context of the larger societal oppression of same-sex couples. Resources that describe same-sex domestic violence have been developed by specialists in that field such as The Northwest Network of Bi, Trans, Lesbian and Gay Survivors of Abuse, www.nwnetwork.org

APPENDIX 2

MISSISSIPPI DOMESTIC VIOLENCE LAW

Domestic Violence Laws in Mississippi

Mississippi law defines domestic violence in its Domestic Abuse Protection Act. It begins by defining "abuse" as an occurrence of one or more of the following acts:

1. attempting to cause or intentionally, knowingly, or recklessly causing serious bodily injury with or without a deadly weapon;
2. placing, by physical menace or threat, another in fear of imminent serious bodily injury;
3. criminal sexual conduct committed Against a minor (fondling a minor);
4. stalking;
5. cyberstalking; and
6. rape and sexual battery (including statutory rape).

To be considered domestic violence under Mississippi law, these acts must occur between spouses, former spouses, persons living as spouses or who formerly lived as spouses, persons having a child or children together, other individuals related by blood or marriage who reside together or who formerly resided together, or between individuals who have a current or former dating relationship.

Specific Laws:

Simple and aggravated assault; simple and aggravated domestic violence: MCT 97-3-7

Simple assault means causing or attempting to cause bodily injury to another person, either on purpose or recklessly. This may include hitting, slapping, punching, kicking, or other forms of physical attack. Simple assault includes actually causing bodily injury as well as attempting to cause injury, which means that something may qualify as simple assault even if no injury occurs. Simple assault qualifies as simple domestic violence if the person who is assaulted is the spouse or the former spouse of the defendant (the person accused of the crime); a person with whom the defendant is currently living with as a spouse or who formerly lived with the defendant as a spouse; a family member related by blood or marriage to the defendant who lives with the defendant or who used to live with the defendant; a person who has a child in common with the defendant; or a person who is currently dating the defendant or who formerly dated the defendant.

Simple assault and simple domestic violence are both considered misdemeanors and are punishable by a fine of up to $500 and a term of not more than six months in the county jail if the defendant is convicted. One difference between these two crimes is that if a person is convicted of two or more charges of simple domestic violence, and is charged with a third act of simple domestic violence within a seven-year period, the third offense may be treated as a felony. If convicted of that offense, the person could be sent to the penitentiary for a term of five to 10 years.

Aggravated assault occurs when a person either intentionally or recklessly causes or attempts to cause serious bodily harm. In other words, if a person is hit or kicked so hard that a bone is broken, this could be aggravated assault. If a person is choked, this could be aggravated assault. Aggravated assault also occurs if a person uses or attempts to use a deadly weapon or other means likely to produce death or great bodily injury. If a person injures another person with a weapon such as a gun or knife, or attempts to injure a person with a weapon, this could be aggravated assault.

Aggravated assault qualifies as aggravated domestic violence if the person who is assaulted is the spouse or the former spouse of the defendant; a person with whom the defendant is currently living with as a spouse or who formerly lived with the defendant as a spouse; a family member related

by blood or marriage to the defendant who lives with the defendant or who used to live with the defendant; a person who has a child in common with the defendant; or a person who is currently dating the defendant or who formerly dated the defendant.

Aggravated assault and aggravated domestic violence are considered felonies. A person suspected of having committed either of these felonies can be arrested without the need for a warrant. They are punishable by a prison sentence of one to 20 years in the state penitentiary if the defendant is found guilty. If there is a third conviction of aggravated domestic violence within seven years, the sentence must be no less than ten years in prison and no more than 20 years. If there is a fourth conviction of aggravated domestic violence, the sentence must be no less than fifteen years in prison and no more than twenty years.

Felonious Abuse and/or Battery of a Child: MCT 97-5-39

If a child is intentionally hurt or injury occurs to a child, the crime is reported as child abuse, which is a different crime than simple or aggravated assault or domestic violence. Certain severe actions when taken against a child constitute felony child abuse regardless of whether harm actually results to the child. Such actions include burning, torturing, strangling, poisoning, starving, or using any type of deadly weapon on the child. Other actions such as striking a child on the face or head, disfiguring or scarring a child, whipping, striking or otherwise abusing a child require serious bodily injury to the child to be considered felony abuse. Should the child incur some bodily injury as the result of being thrown, kicked, bitten, cut, or hit a person may also be found guilty of felony child.

Reporting abuse or neglect: MCT 43-21-353

Any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, family protection worker, family protection specialist, child caregiver, minister, law enforcement officer, public or private school employee or any other person having reasonable cause to suspect that a child is a neglected child or an abused child, shall cause an oral report to be made immediately by telephone or otherwise and followed as soon thereafter as possible by a report in writing to the Department of Human Services.

Reporting abuse, neglect, or exploitation; establishment of central register; confidentiality: MCT 43-47-7

Mississippi law defines vulnerable adults as persons who are unable because of age or any other infirmity to protect themselves from harm. The infirmity may be a physical disability or a mental disability. The physical injury does not have to be life threatening or even serious. Any hitting, slapping, biting, choking, etc., of a vulnerable adult – anything that causes pain – is punishable by up to 20 years in prison. Allegations of abuse of a vulnerable adult in a home setting are investigated by the Mississippi Department of Human Services, and a report should be made to that agency by anyone who has reason to believe a vulnerable adult is being abused. Allegations of abuse of a vulnerable adult in a care facility, such as a nursing home, are investigated by the Office of the Attorney General, Medicaid Fraud Division.

Sexual Battery: MCT 97-3-95; Rape: MCT 97-3-7

Anytime physical violence or the threat of physical violence is used to force a person to submit to an act of sexual intercourse that is unwanted, the crime of rape has been committed. It is also considered rape if someone administers a substance, such as alcohol or a drug that renders a person unable to consent, and engages in sexual intercourse with them. Sexual intercourse is defined to include sex as well as the insertion of objects into the genitals of a male or female. Sexual battery is also a form of sex offense and involves other types of sexual behavior that do not necessarily rise to the level of sexual intercourse, such as oral sex. For the crime of rape, a jury can give a sentence of life in prison. If the jury does not set the sentence as life in prison, the judge can give any number of years up to life in prison as punishment for this crime. The maximum punishment for the crime of sexual battery of an adult is 40 years in prison. In Mississippi, there is no parole for sex crimes.

Statutory rape: MCT 97-3-65; Touching or handling a child or mentally defective, incapacitated, or physically helpless person MCT 97-5-23

Under the law, a child under the age of 16 is too young to consent to an act of sex with any adult or older teenager 17 years or older. Having sex with a child under age 16 is against the law, even if the child "wanted" to have sex with the person, unless parties are married to each other. If the child is 13 years of age or younger, any person more than 24 months older than the child having sexual intercourse with that child has committed statutory rape. The sentence for these crimes varies depending upon the facts and circumstances. If the person committing the act is at least 18 years of age but under 21, he or she can be sentenced up to five years in prison and fined up to $5,000. If the person committing this act is over the age of 21, he or she can be sentenced to 30 years in prison and fined up to $10,000. If any person 18 years of age or older has intercourse with a child 13 years old or younger, the sentence is life imprisonment. A judge may give a lighter sentence if the person committing the act is between the ages of 13 and 18 years old.

If the defendant does not have sexual intercourse with a child but engages in other sexual activities such as oral sex, the crime is sexual battery and the same age limits and penalties apply as apply to the crime of rape. If the minor is 16 or 17 years old, a person holding a position of authority (such as a teacher, coach, school resource officer, choir director, etc.) who has sexual relations with that child commits sexual battery, regardless of whether or not the minor consented.

If there is no sexual penetration of any part of the child's body but there is any kind of sexual touching or rubbing of a child under the age of 16 by a person over the age of 18, the crime charged is fondling. The penalty for this crime is not less than two years or more than 15 years in the penitentiary and/or a fine of not less than $1,000 or more than $5,000. As part of the sentencing, the judge may issue a criminal sexual assault protection order for a minimum of two years after the expiration of any sentence.

TABLE OF STATUTES

- Miss Code Annotated §43-47-19 ..... (Abuse of Vulnerable Adults)
- Miss Code Annotated §93-21-1 through 23 ..... (Domestic Violence Protection Act)
- Miss Code Annotated §93-21-28 ..... (Response by Law Enforcement Officials)
- Miss Code Annotated §97-3-51 ..... (Interstate Removal of a Child)
- Miss Code Annotated §97-3-53 ..... (Kidnapping)
- Miss Code Annotated §97-3-65 ..... (Rape)
- Miss Code Annotated §97-3-85 ..... (Harassment)
- Miss Code Annotated §97-3-95 ..... (Sexual Battery)
- Miss Code Annotated §97-3-107 ..... (Stalking)
- Miss Code Annotated §97-5-23 ..... (Fondling of a Child)
- Miss Code Annotated §97-5-39 ..... (Physical Abuse of Children)
- Miss Code Annotated §97-45-15 ..... (Cyberstalking)
- Miss Code Annotated §99-43-1 through 49 ..... (Crime Victim's Bill of Rights)
- 18 USC 2261 ..... (Interstate Domestic Violence and Stalking)
- 18 USC 2262 ..... (Interstate Violation of a Protection Order)
- 18 USC 992 ..... (Possession of Firearms)

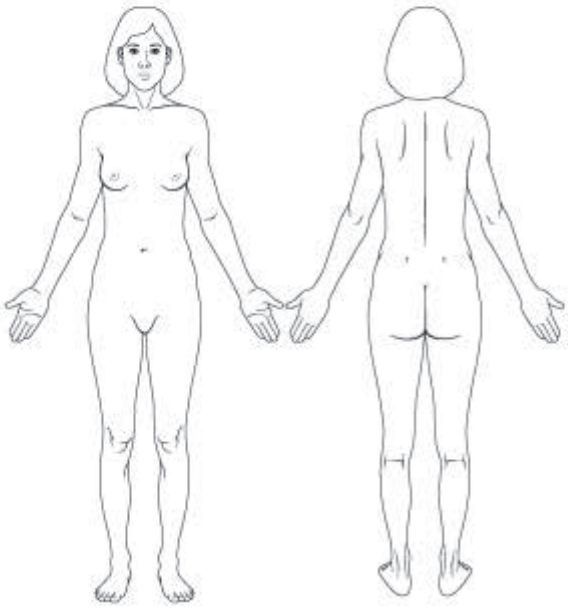
APPENDIX 3

DOMESTIC VIOLENCE SCREENING/ DOCUMENTATION FORM FEMALE

DV Screen

☐ DV+ (Positive)

☐ DV? (Suspected)



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 Were safety planning options discussed?

Date _____ Patient ID # _____

Patient Name _____

Provider Name _____

Patient Pregnant? ☐ Yes ☐ No

ABUSE ASSESSMENT

☐ Has your partner ever put his/her hands on you in ways that you didn't want (push, pinch, restrain, wrestle when you didn't want to, etc.)?

☐ Who?

☐ Has anyone ever forced you to do anything sexually you did not want to do?

☐ Who? Have you been forced into unwanted sexual activities in the last 72 hours?

☐ Are you afraid of anyone?

☐ Who?

☐ Does anyone criticize you, make you feel bad about yourself, or try to control you?

☐ Who?

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 _____

Patient Pregnant? ☐ Yes ☐ No

ABUSE ASSESSMENT

- ☐ Has your partner ever put his/her hands on you in ways that you didn't want? (push, pinch, restrain, wrestle when you didn't want to, etc.)
- ☐ Who?
- ☐ Have you ever been forced into unwanted sexual activities?
- ☐ Who?
- ☐ Are you afraid of anyone?
- ☐ Who?
- ☐ Does anyone criticize you, make you feel bad about yourself, or try to control you?
- ☐ Who?

REFERRALS

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

Describe: _____

☐ Other referral made

Describe: _____

REPORTING

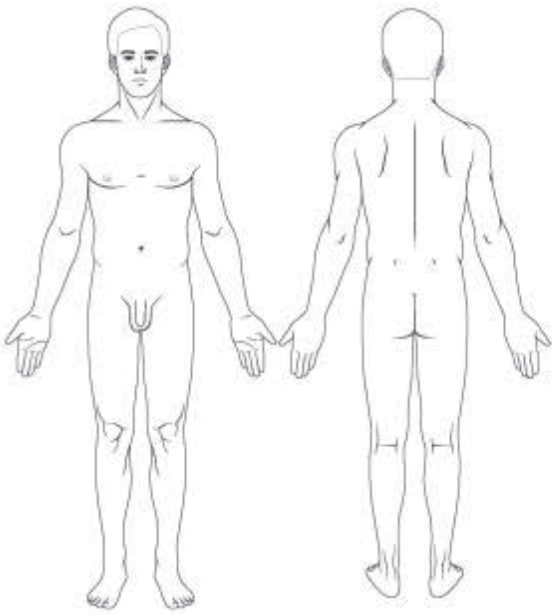
- ☐ Law enforcement report made
- ☐ Child Protective Services report made
- ☐ Adult Protective Services report made

PHOTOGRAPHS

☐ Yes ☐ No Consent to be photographed?

☐ Yes ☐ No Photographs taken?

Attach photographs and consent form



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?

INTERVENTION

☐ Yes ☐ No Were safety planning options discussed?

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

APPENDIX 5

VALIDATED ABUSE ASSESSMENT TOOL

Abuse Assessment Screen

1. Have you 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 injury on the body map below and score each incident according to the following scale:

1 = Threats of abuse including use of a weapon

2 = Slapping, pushing; no injuries and/or lasting pain

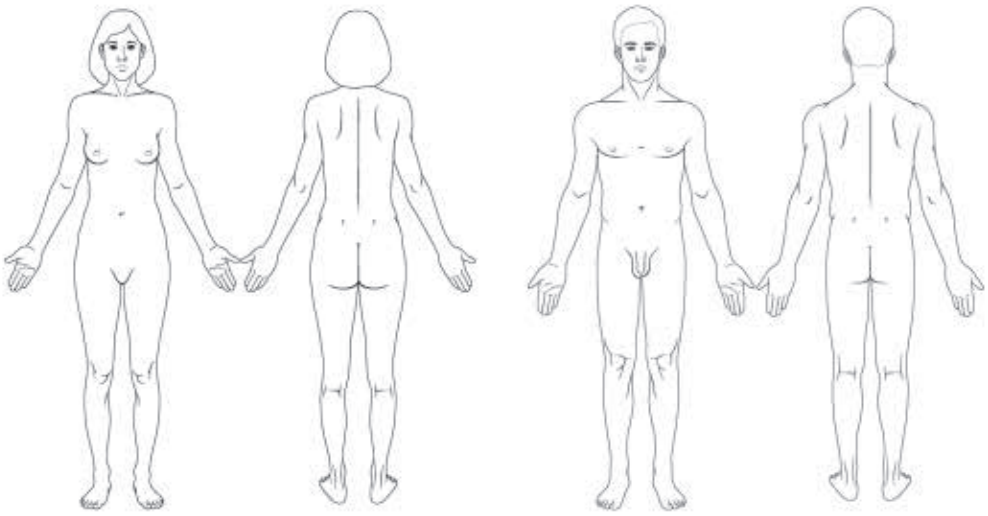
3 = Punching, kicking, bruises, cuts and/or continuing pain

4 = Beating up, severe contusions, burns, broken bones

5 = Head injury, internal injury, permanent injury

6 = Use of weapon; wound from weapon

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



APPENDIX 6

SAFETY PLANNING GUIDE FOR SURVIVORS OF ABUSE

Any domestic violence situation can escalate quickly, resulting in serious injury or death. This can be hard to predict.

There are hotlines to help provide information:

NATIONAL HOTLINE: 1.800. 799.SAFE (7233)

STATE HOTLINE: 1.800.898.3234

Here are some known indicators of high danger:

- If you have started thinking about, planning to, or are taking steps to end the relationship;
- Abuser is depressed; higher risk if the abuser has talked about or attempted suicide;
- History of threats to seriously harm or kill;
- Stalking (frequent calling, texting, following, etc.);
- Access to weapons, especially guns;
- History of serious injury, strangulation/choking, prior use of weapons against victim;
- Mental impairment of abuser due to alcohol, drugs, or mental illness;
- History of failed community controls on abuser (multiple contact with police, courts, protection orders, etc. with no corresponding reduction in violent behavior);
- Injuring or killing pets.

Here are some topic-specific tips on safety. Also see the fully articulated safety planning resources in the appendix of this manual for you to use to create something specific to your life and situation:

PHYSICAL SAFETY ñ GENERAL

- Avoid high danger rooms with batterer (kitchen, small rooms w/out exit).
- Are there guns in your home? Can someone remove them?
- Where are the phones in your home located? Pre-program to dial 911.
- If you don't have a phone:
  - ☐ Create a signal with neighbors, if you need them to call the police;
  - ☐ Your local shelter may distribute cell phones; or
  - ☐ You can contact Safelink Wireless for free cell phone/airtime (www.safelinkwireless.com).
- Schedule regular contact with friends/family (someone you call every day, etc.), signals, and code words with friends/family.
- Make a plan for where you'll go if you leave; does your abuser know this place? Is it safe? Attempt to go somewhere your abuser cannot find you.
- If you leave, take legal and important documents, as well as any important property.

KEEPING CHILDREN SAFE

- Keep important papers (i.e. birth certificates), social security numbers, a couple days supply of any medications and some of their belongings (i.e. clothing, favorite toys), in a safe location so they have some familiarity if you need to flee.
- Teach them not to get in the middle of a fight, even if they want to help.
- Teach them how to get to safety, to call 911, and to give your address and phone number to the police.
- Give the principal at school or the daycare center a copy of your court order; tell them not to release your children to anyone without talking to you first; use a password so they can be sure it is you on the phone; give them a photo of the abuser.
- Make sure the children know who to tell at school if they see the abuser.
- Make sure that the school knows not to give your address or phone number to ANYONE.

WORK

- Talk to a supervisor, if it is safe, about what is going on and find out if the abuser can be kept off the premises. If you can, find out if your employer has a policy about domestic violence, and if they are likely to be sympathetic if you ask for help.
- Work a different shift, if possible. Talk to a supervisor about not scheduling you to work alone.
- If possible, change your work location. If you cannot change locations, if it's safe, talk to your supervisor about changing job duties and schedule so you are not as visible and accessible.
- If you have a civil protection order, consider providing a copy to your employer.
- Change the route that you travel to and from work, and if allowed, stagger when you arrive and leave.

FINANCIAL SAFETY

- Secure all your personal identification numbers (PIN) on financial resources.
- Consider changing passwords and PINs on accounts your partner can access.
- Consider removing all funds from bank accounts that are yours and at least half the funds in any accounts shared with your partner.
- Consider freezing any credit and debit cards held jointly with abuser.
- Get a monthly credit monitoring service (for example, myfico.com) to watch for abuser taking out new accounts in your name.
- If potential landlords or employers want your credit report, offer to provide them with a copy.
- If your abuser can access your credit report, he/she may be able to see who has been checking your credit score, and see where you are applying for apartments or jobs.
- If you are stashing money away, open an account at a separate bank and have monthly statements mailed to a secure location.

TECHNOLOGY

Cell Phones

- If you think your abuser may use GPS to track where you are, turn off the GPS in your cell phone. (If there is GPS on your car, you can also turn that off)
- Try to use a landline or public phone to make calls. If you must use a cell be sure to delete the history and keep in mind the bill will show the numbers, you call.
- Do not respond to hostile, harassing, abusive or inappropriate texts or messages. Responding can encourage the person who sent the message. You won't get them to stop – and responding could make it harder to get a protection order or file a criminal report.
- Consider saving harassing voicemails in case you want to take legal action in the future. See if your phone has a voice recorder. If so, you can record and save any threats made.
- Many phone companies can block up to ten numbers from texting or calling you. Contact your phone company or check their website to see if you can do this on your phone.
- If you are in or coming out of a dangerous relationship, it is probably not a good idea to use any form of technology to contact your abuser. It can be dangerous and could have a negative impact on future legal actions you may want to take.
- Some victims decide to change their cell phone numbers. Others want to know what the abuser is saying and thinking, to gauge their risks. Decide what works best for you.
- If you do keep the same cell phone number, consider changing the message to a standard greeting. Abusive partners sometimes call over and over just to hear the victim's voice.
- If you are getting harassing messages and you want to monitor the calls for safety reasons, consider having someone you trust listen to your messages so that you don't have to hear the harassing messages. Ask that person to tell you about any threats they hear in the messages.

Internet

- Set privacy settings as high as possible on all your online profiles.
- If your abuser can access your computer, be careful which websites you visit. If you are seeking information to get help about the abuse, use a public computer, at the library or other safe place.
- When you do use a shared computer, be sure that your partner does not have tracking software installed and always delete your history after using the Web.
- Save or keep a record of all harassing or abusive messages, posts, and emails in case you decide later to tell the police or get a protection order.
- Never give your passwords to anyone. It's a good idea to choose passwords that aren't easy to guess, to not use the same password for all your accounts, and to change passwords regularly.
- It may seem extreme, but if the abuse and harassment will not stop, changing your usernames and email addresses may be your best option.
- Do not use unsecured Wi-Fi. Every key stroke can be traced and monitored.

APPENDIX 7

INFORMATION FOR IMMIGRANT SURVIVORS OF ABUSE

Information from www.tapestri.org and www.ilw.com

T VISAS

- T visas may be available to victims of severe forms of trafficking who have complied with any reasonable requests for assistance in the investigation or prosecution of acts of trafficking. To be eligible for the T visa, the victim must:
  - ☐ Be a victim of a severe form of human trafficking;
  - ☐ Be willing to assist in every reasonable way in the investigation and prosecution of severe forms of trafficking in persons;
  - ☐ Be physically present in the United States, American Samoa, the Commonwealth of the Northern Mariana Islands, or at a port of entry because of such trafficking;
  - ☐ Have either made a bona-fide application for a T visa with the Bureau of Citizenship and Immigration Services (CIS) (formerly called INS) or must be a person whose continued presence in the United States the Attorney General is ensuring in order to effectuate prosecution of traffickers in persons, and
  - ☐ Be likely to suffer extreme hardship involving unusual and severe harm upon removal.
- Minors under the age of 15 do not have to comply with such requests to be eligible for a T visa.

Crime Victims U Visa

The U visa may be available to undocumented victims who have suffered substantial physical or mental abuse as a result of certain crimes designated by the Victims of Trafficking and Violence Prevention Act (VTVPA) that violate federal, state, or local laws or have occurred while in the United States (including in Indian country and military installations) or its territories or possessions. In order to be eligible for a U visa, the victim must possess information concerning the crime and the U visa petition must include a certification from a government official stating that the victim is helping, has helped, or is likely to be helpful in the investigation or prosecution of the crime.

There is no filing fee for the application regardless of the petitioner's income. Supplemental forms may carry a fee, but you can ask for a waiver **(www.ilw.com)**. After three years, U visa holders may be eligible to adjust their status to that of lawful permanent residence in accordance with federal law and CIS regulations.

Recipients of T and U visas are eligible for employment authorization, and may, after three years, adjust their status to that of lawful permanent resident in accordance with federal law and CIS (formerly INS) regulations. In appropriate circumstances, these visas may be available to family members of the victim.

VAWA

A self-petition under the Violence Against Women Act (VAWA) is an option for women who are victims of servile marriage or have suffered domestic violence as Internet or "mail order" brides. Women whose husbands are U.S. citizens or permanent residents are eligible for this form of relief. Victims can apply for this type of visa without their husband's help or knowledge and remain in the home while petitioning. Victims may also be sponsored or apply for other immigration benefits for which they may be eligible, such as an S visa or asylum.

Victims should consult with a qualified immigration law practitioner for advice concerning the full range of benefits for which they may be eligible. For help, go to: http://www.mscenterforlegalservices.org/

Using Language Line

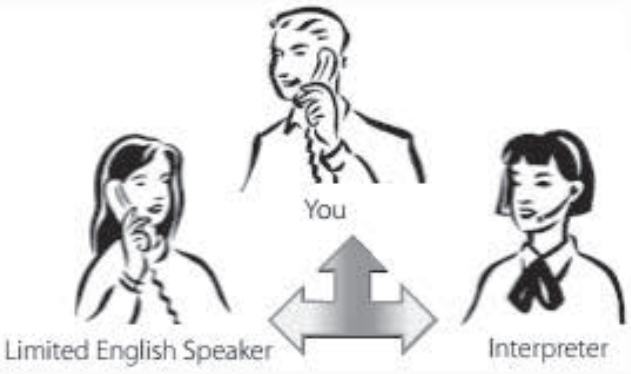
There Are Three Ways You Can Use Language Line®

1. Over-the-Phone Interpretation Service With Limited English Speakers

Note: Depending on your organization's requirements, the following process may be somewhat different. If you have any questions please contact your account manager or

2. Customer Service at 1-800-752-6096, Option 2.

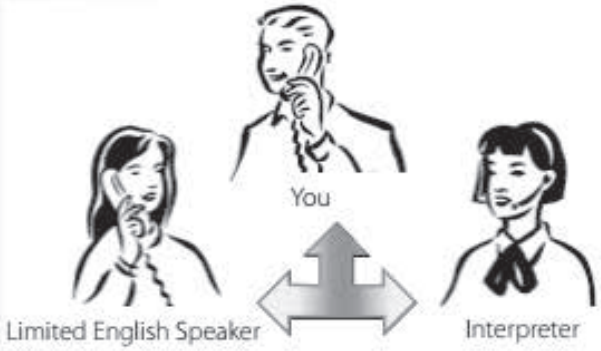
3. You Receive a Call From a Limited English Speaker



Place the **Limited English Speaker** on conference hold.

- Dial the Language Line Services designated toll-free number you have been provided at sign-up.
- Request the language your caller speaks through our easy-to-use interactive voice response (IVR) system.
- When the interpreter is connected, explain the situation.
- Conference in your limited English-speaking caller.

You Need to Make a Call to a Limited English Speaker

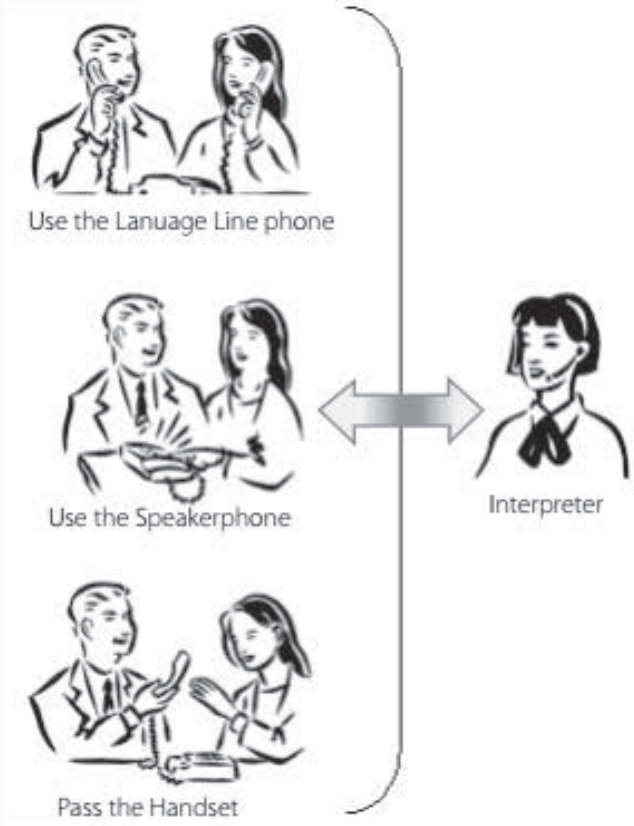


- Dial the Language Line Services designated toll-free number.
- Request the language your patient speaks through our easy-to-use interactive voice response (IVR) system.

When the interpreter is connected...

- Call your limited English-speaking patient...
- Or the interpreter can place the call for you within the U.S. or Canada.

You Are Face-to-Face With a Limited English Speaker



- Dial the Language Line Services designated toll-free number.
- Request the language your patient speaks through our easy-to-use interactive voice response (IVR) system.
- When the interpreter is connected, use the Language Line® Phone, or your speakerphone, or pass your handset back and forth.

APPENDIX 8

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

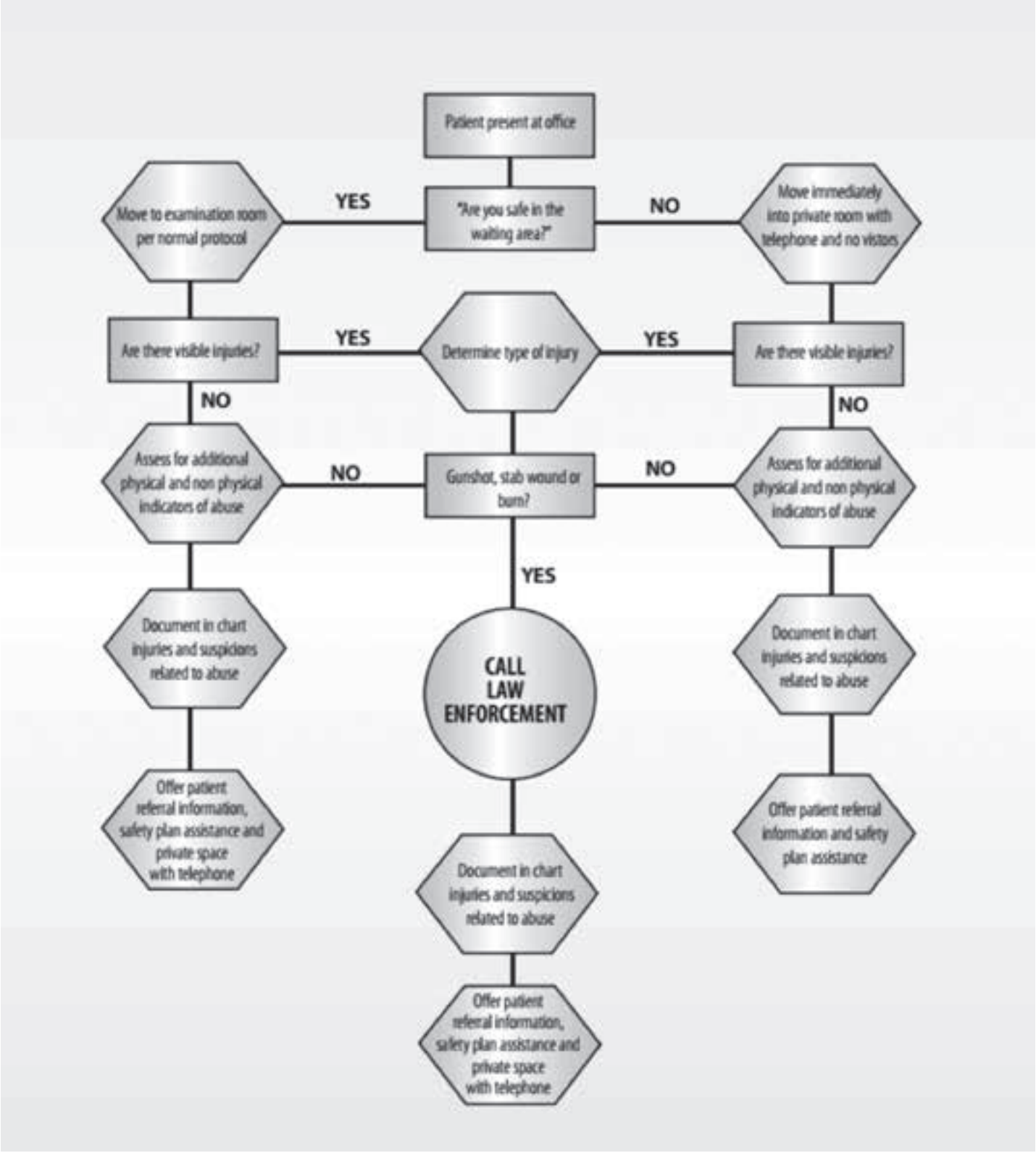
Entry Point	Screening	Assessment	Intervention	Documentation	Referral & Follow Up
· ED, Urgent Care · Same Day & Episodic visits · In-patient · Orthopedic Surgery	· Routinely screen at every visit · Screen for current abuse and if time allows, screen for past history of abuse · Privately (1 on 1) or with 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 screening · 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	· Carefully 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?"	· 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	· 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: ▪ DV program ▪ Legal Services ▪ Children's programs ▪ Mental health services ▪ Law enforcement ▪ Substance abuse ▪ Transportation ▪ Local clergy or other community organization
· Adult/Teen Primary Care · Family Practice · Public Health · School Health Settings	· 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	· Conduct assessment immediately after disclosure · Assess immediate safety · Health impact of abuse · Assess patter 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?"	· 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 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 kid 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	· 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: ▪ 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

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, 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	· 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?"	· 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 proveders · 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 · Result 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 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 number for: ▪ DV program ▪ 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 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	· 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"	· Careful listening and support · I'm concerned with your health and safety · You are not alone, it is not your fault, you don't deserve it · Help is available · 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 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 descriptions of patient's appearance, behavioral indicators, injuries and cc's · Referrals and materials offered	· If patient desires, refer back to health care provider or other provider · Offer dose follow-up visits as situation · Offer group or individual therapy · Identify follow-up strategy with patient: (next visit, safe contact number, address) · Know phone numbers for: ▪ 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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