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NOTE: We hope you will find these materials useful. Most of the materials enclosed can be copied or adapted freely. Permission needs to be obtained on those documents or materials designated as “permission to reprint needed.”

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(*developed by Geisinger Medical Center, Danville, PA*)

Discharge Instructions: Domestic Violence (English, Spanish and Chinese versions)

Do things at home ever get too hot to handle? (*brochure*)

(*developed by the Domestic Violence Training Project, 900 State Str., New Haven, CT 06511, 203/865-3699*) *Permission to reprint needed.*

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LEGAL PROTECTIONS FOR BATTERED WOMEN¹

NOTE: The following is a general summary of the range of legal protections available to victims of domestic violence and their children throughout the country. Legal protections vary, sometimes markedly, from state to state. It is important to obtain specific information about the legal protections available in your community from your local domestic violence program or your state domestic violence coalition.

CIVIL REMEDIES

Civil protection orders are now available to battered women in every state and the District of Columbia. Civil protection order laws offer a powerful tool which provides legal protection for battered women and their children. A civil protection order is a special type of restraining order telling the defendant/batterer not to harm the victim again, available only to victims of domestic violence. Civil protection order laws also recognize that it is not merely enough to prohibit the perpetrator from further abuse, but batterers must be denied access to family and household members as well. Eviction of the perpetrator from the home, prohibitions against communication with the victim, provisions limiting the batterer's geographical mobility, awards of temporary custody and support, have been incorporated into many state civil protection order laws to minimize batterer access to the victim.

Civil protection orders may protect victims from further abuse and alert batterers that they can't continue the abuse with impunity. The police are also more likely to protect a battered victim when called to the scene of a domestic violence incident if they are shown a civil protection order. Research² reveals that civil protection orders work best in jurisdictions where police consistently enforce civil protection orders and arrest for violations.

The victim of domestic violence may file a civil protection order to receive temporary relief from an abusive situation whether or not a criminal charge is filed against the abuser. Issues such as custody and child support may also be temporarily resolved if evidence is

¹ The term "battered woman" and victim of domestic violence" will be used interchangeably. Studies by Dobash, R.E. and Dobash R., "Violence Against Wives", New York: The Free Press, 1979 and Browne, A., "When Battered Women Kill", New York: The Free Press, 1987, indicate that 94-95% of domestic violence victims are women. However, domestic violence may occur in any intimate relationship, including gay and lesbian relationships and either partner may be the victim.

² Bureau of Justice Statistics, U.S. Dept. of Justice, Special Report: Preventing Domestic Violence Against Women, August 1986 and Sherman and Berk, The Specific Deterrent Effect of Arrest for Domestic Violence Assault, 49 AM. Social Review, 261, 262, April 1984.

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available that an act of violence has occurred. In most jurisdictions, the violation of a civil protection order is a misdemeanor.

ELIGIBILITY

ELIGIBLE ABUSED PERSONS

Most state laws define a class of eligible victims as “family or household members”. Many state codes also include children as those eligible for protection. Eligibility provisions in state codes may include one, a few, or all of the following categories:

- Current Spouses
- Former Spouses
- Family Members
- Children
- Parents of a child in common
- Unmarried persons of different genders living as spouses or who have lived as spouses
- Parents and children
- Current or former sexual or intimate partners
- Intimate partners of the same gender
- Dating relationships
- Persons offering refuge

ELIGIBLE APPLICANTS

All state civil protection laws authorize competent adults to apply for civil protection orders for themselves. Most state laws permit competent parents to seek relief for their minor children. Other individuals eligible to apply for civil protection orders depending on state include emancipated minors, children over 16 yrs, court appointed guardians, household members on behalf of incapacitated adults, and police officers.

Most state laws provide that the right to petition for relief is not forfeited because the petitioner/victim of domestic violence has left the household to avoid abuse. Some states specify that a married person has the right to petition whether or not a petition for separation, annulment or divorce has been filed.

PROHIBITED BEHAVIOR

In most state laws, acts that are grounds for issuance of a civil protection order are defined as acts “which cause or attempt to cause physical harm or assault”. Grounds for issuance of civil protection orders may include:

- Criminal acts; assault, battery, homicide, rape, kidnapping, restriction of movement, child abuse, destruction of property, threats, stalking, reckless endangerment and disorderly conduct

- Sexual assaults and marital rape
- Interference with personal liberty; kidnapping, forceful detention, compelling a person by force/intimidation to do something illegal they don't want to do
- Threats or attempts to do violence or bodily harm
- Terrorization, intimidation, harassing behaviors
- Unlawful or forcible entry of the residence
- Damage to property

JURISDICTION AND VENUE

State civil protection orders are granted and enforced where the incident of domestic violence occurred or where the abused person is at continuing risk of violence by the perpetrator. The majority of state laws impose no time limits for filing a civil protection order after a qualifying incident of abuse has occurred.

RELIEF AVAILABLE THROUGH A CIVIL PROTECTION ORDER

Typically, civil protection laws authorize orders restraining the defendant/batterer from future acts of violence, orders granting exclusive possession of the victim's residence to the victim and/or eviction of the perpetrator of the abuse, orders awarding temporary custody to the non-abusing parent, orders for spousal or child support and stay away or no-contact orders.

The broad array of relief available through state civil protection laws can include the following:

- No further abuse to petitioner/victim of domestic violence, children, other household members.
- Stay away (no contact) with petitioner/victim of domestic violence, children, other household members, at the home of the victim or other locations frequented by petitioner/victim of domestic violence/ i.e., work, church.
- No contact in person, by telephone, through third parties, by mail.
- Orders to leave the residence, not to re-enter, surrender keys, not damage premises or property, not shut off utilities or discontinue mail delivery.

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- Orders concerning personal property-not to take/sell/damage/destroy/transfer property, use of automobile, police accompaniment to retrieve belongings.
- Orders concerning weapons-surrender weapons used.
- Orders for abusers to obtain treatment (batterers counseling), substance abuse testing/treatment, psychiatric counseling.
- Orders concerning custody-giving temporary custody to abused parent.
- Orders concerning visitation-supervised visitation, limits on visitation.
- Orders for monetary relief-child support, spousal support, out of pocket losses, relocation costs, counseling costs, attorney's fees, loss of earnings, medical/dental expenses.
- Orders for police assistance-serve notice, arrest for violations, remove weapons, assist with orders to leave the home.

Approximately one-half of the states provide twenty-four hour access to the courts for civil protection orders. In a few jurisdictions access after business hours is made by law enforcement communicating with the court by telephone and then providing written documentation of an oral order by the court.

TEMPORARY PROTECTION ORDER / *EX PARTE*

The first form of legal protection is the temporary protective order filed without the batterer being present (*ex parte*). The forms to be filed are relatively simple and an attorney is not required. However, having an attorney present may result in getting a more thorough order. If the woman is not represented by an attorney, it is important that she find a battered woman's advocate, often called a legal advocate (not an attorney), to go to court with her. To find an advocate trained in domestic violence issues, contact battered women's programs in your area. The most ideal representation and assistance in these civil remedies is probably a team approach that draws upon the expertise of an attorney, often a legal services attorney, and a domestic violence advocate/counselor. Most shelters provide advocacy for women who live both inside and outside of the shelter. Alternatively, victim advocates may be available through the county court or prosecuting attorney's office; such advocates either specialize in domestic violence or can refer battered women to local services.

A woman should get several filed, certified and endorsed copies of a protection order and keep one with her and at other locations where she spends time such as a relatives, a shelter, or work. If the protection order awards the battered woman temporary custody and specifies certain visitation times, a copy of the order should be given to the children's school or day care center so they can call the police if the batterer attempts to abduct the children. It is a good idea to file a certified copy of the protection order with the local police so they may respond more swiftly to crisis calls. Some states and jurisdictions have "central registries" where police can check if a civil protection order is in force.

If the batterer violates the protection order but the victim fears calling the police or if

numerous calls to the police have failed to result in an arrest, the victim may go back to the civil court which issued the protection order and file a complaint. If the batterer violates a civil protection order, he may be found in “contempt of court” and jailed, and/or fined. Because civil court judges may often be reluctant to punish (penalize) those in contempt of court, a battered woman may need to file several more contempt actions before a court will issue any sanctions against the batterer. Where this is true, the strong support of domestic violence advocates, lawyers and other persons throughout this process is essential.

Some civil court judges impose “mutual” protective orders on both parties. Domestic violence advocates oppose such orders because they place the battered woman in jeopardy. Mutual orders violate the intent of laws protecting the victims of domestic violence and fail to transmit the message to the batterer that his behavior is unacceptable and illegal. In most cases, mutual orders impede the victim’s ability to obtain meaningful police assistance when the batterer violates the order. Some states, such as New York, prohibit the use of mutual protective orders in cases of domestic violence because of the high rate of repeat violence.

A defendant/batterer charged with a crime of abuse may be ordered to stay away from the victim by the criminal court as a condition of release from detention. In many states, the criminal courts can also issue anti-harassment protection orders where the prosecuting attorney believes such an order is required to prevent harassment of, tampering with, or retaliation against, a victim/witness or informant. In some jurisdictions, the criminal protection order can include a custody determination, child support, and award control over property needed to assure no contact between the defendant and the victim.

STANDARD OF PROOF

In most states the standard of proof required for a temporary order of protection is good, reasonable or probable cause to believe that the petitioner/victim of domestic violence or a member of his or her household is in present danger of being abused or threatened with abuse by the respondent/batterer.

DURATION OF THE ORDER

A number of state laws provide for an automatic expiration of temporary orders at the end of a particular time period i.e. one day, one week, ten days, while others set expiration on the date of the full hearing.

ENFORCEMENT OF ORDERS

Many state codes require that police officers verify the existence and validity of a civil protection order before arresting for its violation. Verification methods vary from jurisdiction to jurisdiction.

Eighteen states mandate law enforcement officers to conduct warrantless arrests when an officer has probable cause (i.e. observes injuries to the victim, witnesses are available, doors/windows are broken, etc.) to believe that a person has violated a protection order. Twenty-three states authorize law enforcement to make warrantless arrests upon probable cause determination that the perpetrator/batterer has violated an order. Other states require

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arrest when the violation occurs in the presence of law enforcement or when the violation is a criminal act.

Some states have directed that civil protection orders remain enforceable even when the parties have reconciled and that the defense of reconciliation when a violation has occurred is not recognized.

In thirty-five states violation of a protection order is a misdemeanor and there can be an additional charge of civil or criminal contempt of court. Some statutes provide for a minimum jail term for violation of a protection order.

Criminal Remedies:

POLICE INTERVENTION AND INITIATING CRIMINAL PROSECUTION

Domestic violence calls are the most common types of calls to which police respond. Arrest is the preferred response to domestic violence articulated in virtually every state's domestic violence laws. Statutes in forty-eight states and the District of Columbia now authorize or mandate arrest for crimes involving domestic violence.

Most state laws permitting or mandating warrantless arrest for domestic violence crimes also specify that responding officers should inform victims of their rights whether or not an arrest is made. Victims are to be informed of the availability of civil protection orders, shelters, or other emergency facilities and transportation. Some codes also require police to notify victims of the right to file a criminal complaint. More than one-third of the states also require responding police officers to provide assistance to victims in acquiring medical aid. Some states specify that an officer accompany a victim to her residence to acquire belongings or to remain at the scene until a victim's safety is assured.

Twenty-eight states require responding law enforcement officers to make incident reports whether or not an arrest is made. Many state statutes require law enforcement training on domestic violence response.

Despite these changes, many communities may still find police reluctant to respond effectively to domestic violence cases because they believe domestic violence is a private matter or because they believe intervening in domestic violence is very dangerous. The danger to police has been exaggerated. However, given the serious and lethal nature of domestic violence to the victim of abuse, police intervention is often necessary to stop immediate injury and to make a clear statement of social disapproval.

A woman may decide to call the police to protect her during a domestic violence incident or because the batterer has violated a protection order previously obtained. When police arrive at the scene, they question both parties to determine if a crime has been committed and, if so, by whom. It is important that the police speak to the victim separately and privately to prevent intimidation by the batterer.

If the batterer is in violation of a civil protection or stay-away order, the victim should show her copy of the order to the police, or if she does not have the order on her person, she should inform the officers of its existence. In most states, police are required to arrest a batterer when the officer witnesses the violation of the court order. If the officer does not arrest the batterer, many states allow the woman to make a "private person's" arrest (formerly referred to as a "citizen's arrest", changed because citizenship is not required) and to request that the prosecuting attorney file a criminal complaint. If the batterer is no longer present when the police arrive, the woman should request that a report of the violation be written. She can then follow-up on the violation by contacting the prosecutor's office and asking that an arrest warrant be issued based on the violation. In many states, the police are required to make a report whether or not an arrest is made.

If an arrest is made for a misdemeanor such as violating a protection order, the offender may simply be given a citation and released. If the batterer is arrested and taken into custody, he may be released within a few hours. It is important, therefore, to advise a woman to use this time to gather her children and personal belongings, to find a safe place to stay, to begin the process of obtaining a protection order if she does not have one, or to seek out a domestic violence program.

If the police take the defendant into custody, the prosecuting attorney must either file charges or release the defendant within a specified number of hours. The prosecutor decides whether or not to pursue criminal charges against the defendant based on such factors as the severity of the victim's injury, statements from witnesses, the victim's willingness to testify against the batterer, a documented history of previous abuse, the likelihood of obtaining a jury conviction, and the defendant's prior criminal history. If the victim was the primary or only witness to the violence, her statement is a key factor in the prosecuting attorney's decision whether to file charges. For this reason, it is important to advise the victim to contact the prosecutor's office as soon as possible after the assault. She should be fully informed about the criminal justice process, her role in it, and the possible outcomes of a criminal case so that she can decide whether to turn to the criminal justice system for assistance.

If the prosecuting attorney decides to pursue a criminal complaint, there will be a hearing, known as an arraignment. In most states, the victim need not appear at the arraignment. During the arraignment, the court will inform the defendant/batterer of the charges against him and, in most states, ensure that he has legal representation. The court will also determine whether the offender will be released from custody. This can occur if the defendant/batterer posts bail or if the court releases him on his own recognizance upon promise that he will appear at a later hearing. The victim may be requested to testify at a bail hearing if her testimony would assist the court in setting appropriate bail.

After the arraignment, several other hearings may be held. The victim may be called to testify at an evidentiary hearing (e.g. preliminary examination) or at trial. If the victim does not want to testify, a court may issue a subpoena ordering her to testify; noncompliance with such a subpoena is a violation of law. Most cases are resolved before trial. However, if the case proceeds to trial, the victim will again be required to testify.

A battered woman needs a domestic violence advocate/legal advocate to assist her through the criminal process. Testifying in a criminal case may be traumatic and frightening. It may be very difficult for a woman to testify against someone she has cared for, and it may be difficult to recount the violence she experienced. Community domestic violence programs or victim witness assistance programs (located within the criminal justice or court system) may be able to provide such an advocate or may be able to help the battered woman find one.

RESULTS OF THE CRIMINAL PROCESS

Courts may impose a wide variety of penalties or sentences on batterers, including a fine or imprisonment or both, probation, victim restitution, and mandatory counseling, mediation, substance-abuse treatment or public service, or some combination of the above.

In some states, the court may order a defendant/batterer to attend treatment for his violent behavior with or without determining his guilt. If he fulfills the terms of the treatment program, he may have no criminal record. In some states this is called diversion.

The court may also order probation for defendants/batterers it finds guilty. These defen-

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dants/batterers will have a criminal record whether or not they fulfill the terms of their probation. The terms and conditions of probation may include orders to: report to probation officers; maintain a job; pay reparation or restitution; support legal dependents; submit to random drug or alcohol testing; and participate in treatment or counseling for batterers and forego visitation with children until treatment is completed. If a defendant/batterer violates a term of probation, he may be arrested. If his guilt has not been determined already, the court may find him guilty, revoke his probation and sentence him to imprisonment, to pay a fine, or both.

The information contained in Legal Protections For Battered Women was excerpted and is published with permission from:

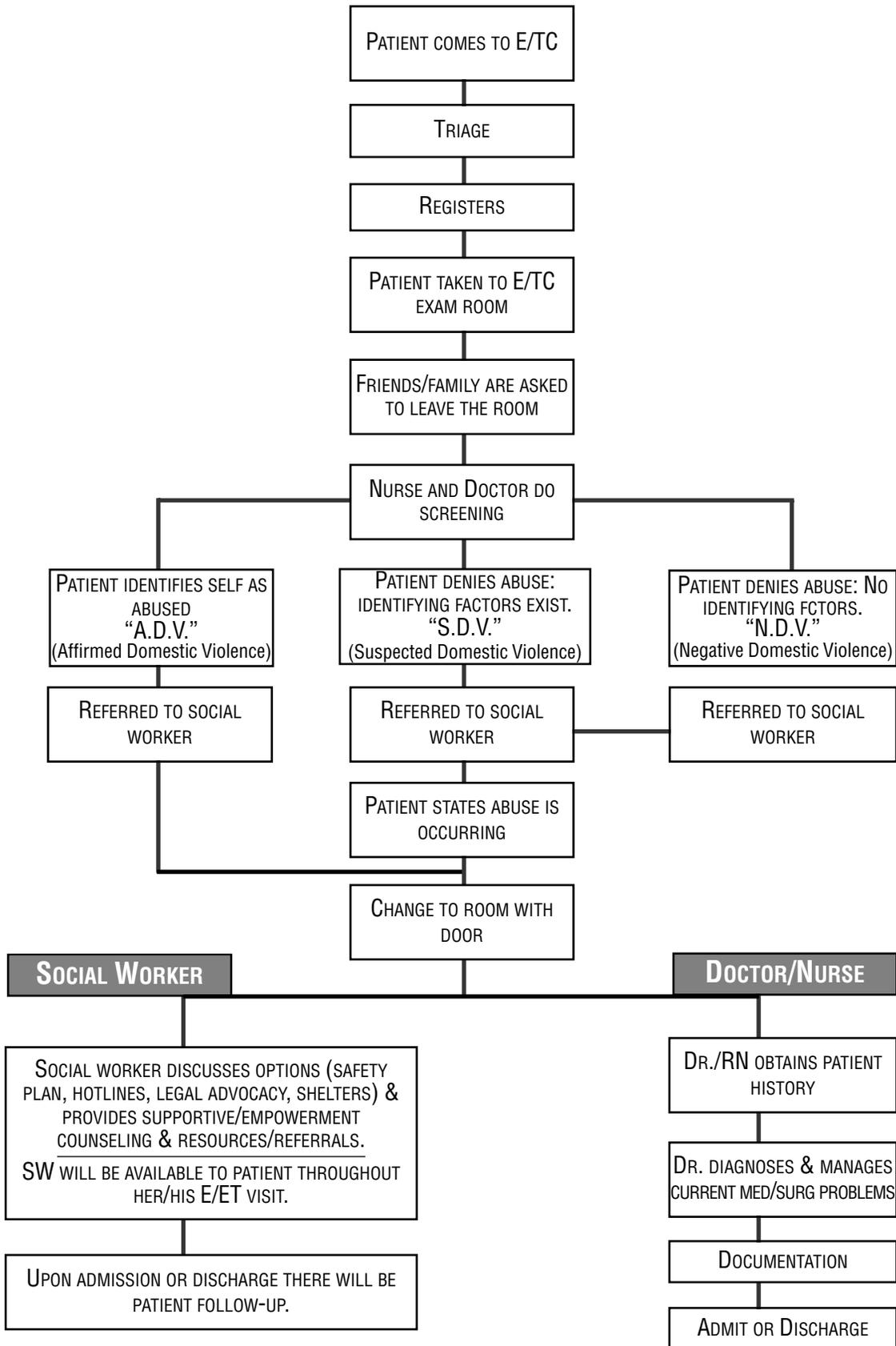
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CRITICAL / CLINICAL PATHWAYS



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Front Part



Inside Part



If you are in an abusive relationship, here are some ideas to help you become safe and stay safe. If possible, find a friend, neighbor or relative who will help you in an emergency. They may be able to store extra sets of items you will need if you have to leave in a hurry.

SURVIVAL TIPS FOR BATTERED WOMEN

----- FOLD HERE -----

REFERRALS:

IF THE POLICE RESPONDED

OFFICER'S NAME: _____

IF YOU NEED EMERGENCY MEDICAL TREATMENT:

Back Part



BE PREPARED TO GET AWAY:

1. Keep the following in a safe place:
 - keys (house and car)
 - important papers: social security cards and birth certificates for yourself & children, photo ID/driver's license
 - cash, food stamps, credit cards, checkbook, etc.
 - medications for yourself & children (children's immunization records, if you have them)
 - spare set of clothes
 - important phone numbers and addresses (friends, relatives, police, domestic violence shelter)
2. If possible, pack a change of clothes for yourself & children, personal care items, extra glasses, etc.
3. Plan the safest time to get away.
4. Call police if you are in danger or need help.
5. Plan with your children. Identify a safe place for them: a room with a lock, neighbor's house where they can go. Reassure them that their job is to stay safe, not to protect you.
6. Arrange a signal with a neighbor to let them know when you need help.
7. Contact the local domestic violence program listed on the back of this card to find out about laws and community resources before you need them

ARTICLES LIST

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DOMESTIC VIOLENCE VIDEOS SPECIFICALLY FOR THE HEALTH CARE PROVIDER

BATTERED WOMEN IN YOUR PRACTICE? (17 minutes), presented by Anne Flitcraft, M.D. \$175.00, available from the Network for Continuing Medical Education, Secaucus, NJ. (201) 867-3550. Target audience is physicians, also appropriate for other health care providers. This video discusses the Joint Commission for the Accreditation of Hospitals and Health Care Organization's (JCAHO) domestic violence standards. Specific JCAHO standards addressed include: (1) identifying and assessing battered patients; (2) maintaining lists and understanding available community resources for referral purposes; (3) documenting abuse in medical records; (4) educating staff about domestic violence. The importance of conducting routine inquiry/screening of all patients for the presence of domestic violence and questioning them directly about battering is also discussed.

CLINICAL ASPECTS OF DOMESTIC VIOLENCE FOR THE OBSTETRICIAN/GYNECOLOGIST (20 minutes). \$80.00, ACOG members, \$115 for nonmembers. Introduction by Richard F. Jones III, MD, ACOG Past President. To order call the American College of Obstetricians and Gynecologists at 800-762-2264, 9:00 a.m. to 9:00 p.m. EST. This ground-breaking video offers a unique opportunity for ob/gyns to become educated about the alarming national problem of domestic violence and its long-term effects on women. It teaches clinicians how to identify abusive relationships, detect abuse and intervene appropriately to prevent further deterioration of a woman's health and well-being. Two legal issues surrounding domestic violence — reporting and documentation requirements — are also covered. Purchase price includes a monograph.

CRIME AGAINST THE FUTURE (23 minutes), produced by the March of Dimes. \$75.00, available from the March of Dimes Birth Defects Foundation, 1275 Mamaroneck Avenue, White Plains, New York, 10605. (914) 428-7100. This video is aimed at health care providers (nurses, medical social workers, midwives, physicians) who work with pregnant women. It provides an overview of the problem of battering during pregnancy; its causes and effects. Also gives the health care provider some beginning tools for assessment and intervention.

DOMESTIC VIOLENCE (56 minutes). Purchase price: \$285.00, rental: \$70.00. Available from the American Journal of Nursing Company, 555 West 57th Street, New York, NY 10019; 1-800-Call-AJN. This video has been produced to help nurses understand the characteristics of the domestic abuser, how to identify a battered woman and recognize abusive situations, how to offer help to battered patients, what the legal obligations are for the health care worker, and how to write up a report.

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DOMESTIC VIOLENCE: MORE PREVALENT THAN YOU THINK (30 minutes). Presented by Boston prosecutor Sarah Buel with an introduction by Richard Jones III, MD, past president of the American College of Obstetricians and Gynecologists. Target audience is physicians, also appropriate for other health care providers. Ms. Buel talks about her experiences as a survivor of domestic violence and also discusses why women stay in abusive relationships; how battered women present in a health care setting; becoming familiar with community resources; assessing patient safety and creating a safety plan; the importance of maintaining multicultural awareness; and how to fully document domestic violence in the medical record. Contact The Fund for ordering information.

DOMESTIC VIOLENCE: RECOGNIZING THE EPIDEMIC (30 minutes), \$70.00, available from the Colorado Coalition Against Domestic Violence, P.O. Box 18902, Denver, CO 80218. (303) 573-9018. (\$15 PREVIEW CHARGE). Target audience is emergency department personnel, also appropriate for the full spectrum of health care providers. An excellent training video providing the general and health care dimensions of domestic violence presented by a survivor of domestic violence, physician, nurse, domestic violence service provider, psychologist, prosecutor and law enforcement officer. Specific issues addressed include: how to identify battered patients; the importance of direct questioning about abuse; safety considerations; after care instructions (including safety planning, intervention and referrals); involving law enforcement when necessary; the dynamics of domestic violence; why men are abusive; and the importance of documentation and its relevance to future legal/criminal action. A useful discussion is included about health care providers' frustration treating repeat victims and how to reconcile a "fix-it" mentality with the importance of empowering battered patients to make their own.

YOU CAN DO SOMETHING ABOUT IT (29 minutes), \$225.00, written and produced by Charles L. Robbins, DSW and Richard J. Zaino, ACSW. Available from the Department of Social Work Services at the University Medical Center at Stony Brook. Call (516) 444-2552 for ordering information. This video is appropriate for all health care workers confronted with family violence — from child abuse through elder abuse. The video highlights definitions, identification and responses. It also provides a strong overview of the subject and is a good tool for introductions to this subject matter and employee orientation programs.

GENERAL VIDEOS APPROPRIATE FOR INTRODUCING THE DYNAMICS OF DOMESTIC VIOLENCE

DEFENDING OUR LIVES (30 minutes), \$45.00-rental, \$150.00-purchase price. Available with a study guide and fact booklet. Call Cambridge Documentary Films at (617) 354-3677 for ordering information. This academy award winning documentary exposes the magnitude and severity of domestic violence in this country. The video tells the stories of four women imprisoned for killing their batterers in self-defense. The women share their personal histories of physical, sexual and emotional abuse, their attempts to leave abusive relationships and the failure of the criminal justice system to protect them. It is appropriate for people working on any aspect of this issue, for purposes of general education and training.

DOMESTIC VIOLENCE: BROKEN WINGS SERIES. Women and Domestic Violence (16 minutes): Target audience is battered women. Video opens with a battered women getting medical treatment and being asked directly by her physician about the presence of domestic violence in her life. Also discusses characteristics/traits of batterers, the escalating nature of domestic violence, and the importance of a safety plan. A description of how battered women shelters work and legal options available (such as stay away orders) is also presented.

- **MEN AND DOMESTIC VIOLENCE** (19 minutes): Target audience is batterers. Video opens with a batterer talking about domestic violence as learned behavior and an active choice men make in relationships. Then shifts to a batterer treatment group where a counselor and batterers talk about male violence, where it comes from and its various manifestations including emotional, physical verbal and sexual abuse.
- **CHILDREN AND DOMESTIC VIOLENCE** (16 minutes): Target is battered women, also appropriate for general audiences. Discusses the effect of domestic violence on children both emotionally and physically. Specific symptoms such as withdrawal, anger/aggression, low self-esteem, frequent crying/sadness, guilt, etc. are discussed. Also addresses the difference between the use of punishment and discipline when empowering children to make their own choices.

NO PREVIEW INFORMATION AVAILABLE

BATTERED WIVES, (45 minutes), a condensed version of a TV movie starring Karen Grassle, available from Learning Corporation of America, 1350 Avenue of the Americas, New York, NY 10019.

BATTERED WOMEN: VIOLENCE BEHIND CLOSED DOORS,(24 minutes), available from MTI Teleprograms, Inc., 3710 Commercial Avenue, Northbrook, IL 60062.

A FAMILY AFFAIR, (28 minutes), \$350, available from Visucom Productions, Inc., Box 5472 Redwood City, CA 94063. (415) 364-5566. PREVIEW COPY \$40.00

THE FEAR THAT BINDS US, (52 minutes), 1980. Sliding scale pricing, available from New Front Films, Inc., Suite 505, 1409 Willow Street, Minneapolis, MN 55403.

A PLACE TO GO, (12 minutes), a 60 Minutes segment on domestic violence, available from MTI Teleprograms, Inc. 3710 Commercial Avenue, Northbrook, IL 60062.

She's Mine Ain't She?, (55 minutes), rental \$75, purchase \$170, available from Video Spectrum (ATTN: Distribution Coord.), 40 Harrison Street, NY, NY 10013. (212) 206-1402.

TO LOVE, HONOR AND OBEY, (52 minutes), \$210, available from Third World Newsreel, 335 West 38th Street, New York, NY 10018. (212) 947-9277. PREVIEW COPY \$25.00

THE MODEL DOMESTIC VIOLENCE EMERGENCY DEPARTMENT PROGRAM

A project of the Family Violence Prevention Fund
in collaboration with the Pennsylvania Coalition Against Domestic Violence

Between November and May 1995, twelve hospitals located in California and Pennsylvania implemented a model domestic violence program in their emergency departments as a part of the Family Violence Prevention Fund's National Health Initiative on Domestic Violence. They accomplished both the design and implementation of a comprehensive emergency department response in only six months. This paper is meant to help facilitate the creation of similar programs in emergency department or other hospital settings.

The purpose of the model domestic violence emergency department program was to:

(1) gauge the effectiveness of the resource manual's implementation strategies and their adaptability to a variety of hospital settings; (2) test the premise that multidisciplinary hospital teams could fully implement a comprehensive emergency department response to domestic violence equipped with training, planning tools, resource materials and limited technical assistance; and (3) measure positive changes in knowledge, attitudes, skills and practices on the part of health care providers trained under the FUND's model. Based on the findings of the emergency department program, the resource manual was revised accordingly and is in the process of being disseminated throughout the country.

What follows is a description of the model domestic violence program. This paper is meant to help facilitate the creation of similar training programs that encourage a comprehensive emergency department response to domestic violence. This guide can also help individual institutions set in place a planning process to develop their own domestic violence programs within specific departments or hospital-wide. Individual components of the program (i.e., the baseline survey, the training conference, the multidisciplinary small group work, etc.) can be utilized separately to complement other implementation strategies. While this program focused on emergency departments, it can also be adapted for use in other hospital settings.

HOW THE MODEL PROGRAM SITES WERE CHOSEN

In the process of conducting a 1993 survey of California emergency department response to domestic violence, the FUND asked respondent hospitals to identify their willingness to serve as "test-sites" for the emergency department program: Nearly 150 hospitals self-nominated themselves to be a part of the program.

The final selection of hospitals was based on the advice of State Advisory Committees recruited in California and Pennsylvania to oversee the statewide health-related activities of the FUND and PCADV respectively. Hospitals were chosen based on their diversity, as an aggregate, of the following characteristics:

- size (as defined by # of annual ED visits)
- location (urban, ultra-urban, rural, suburban)
- type of ownership (public, private)
- type of facility (HMO, teaching hospital or trauma center)
- diversity of patient population (race/ethnicity, language, economic status)

In California, the State Advisory Committee chose the following six hospitals to participate in the emergency department program: (1) a small, rural community hospital located in northern California; (2) a health maintenance organization located in an urban setting; (3) a large, teaching hospital located in California's central valley serving a diverse minority population; (4) a trauma center in an urban setting with a busy emergency department serving the county's indigent population; (5) a large hospital in a racially/ethnically diverse ultra-urban setting with four emergency departments that saw upwards of 750 patients a day and an active teaching program that rotated 70 residents per cycle; and (6) a medium size hospital in a suburban setting serving a mostly homogenous white, wealthy population. A similarly diverse mix was chosen in Pennsylvania.

PARTICIPATION IN THE EMERGENCY DEPARTMENT PROGRAM

Each of the twelve hospitals selected were asked to recruit a multidisciplinary team made up of an ED physician, nurse, social worker, hospital administrator and community domestic violence expert. Team members agreed to participate in a two-day intensive training conference and a 6 month implementation period where, with intensive technical assistance, they would design and implement a comprehensive emergency department response to domestic violence. In exchange, FUND and PCADV staff provided personalized phone consultation and technical assistance (including on-site assistance, where necessary), planning tools, and training and resource materials to the hospital teams.

THE EVALUATION PROCESS

Each hospital team responded to a pre-training and post-training evaluation survey. The pre-training evaluation of each hospital team was conducted in order to measure existing attitudes about battering and collect baseline information about ED policies and procedures currently in place. A post-training program evaluation measured attitudinal and behavioral changes on the part of the ED staff as well as structural changes to the emergency department. The post-training survey sought to determine if protocols were adopted as formal policy, whether the training program has been institutionalized, etc. Prior to receiving training on domestic violence, each hospital's full ED staff also responded to the attitudinal/behavioral survey. (Pre-and-post training evaluation surveys can be obtained by calling the Fund).

THE TRAINING CONFERENCE

The emergency department program was launched with a two-day domestic violence training conference held in San Francisco in mid-October and Pennsylvania two weeks later. The purpose of the conferences was to train the twelve multidisciplinary hospital teams on how to use the Fund-produced domestic violence manual and model implementation strategies to design a comprehensive emergency department response to domestic violence tailored to the specifics of their individual settings. The training program provided team members with an overview of the dynamics of domestic violence and helped them develop clinical skills to respond effectively to battered patients. In addition, participants spent a half-day working within their teams to develop a plan to design and implement a comprehensive response to domestic violence within their emergency departments. (See this Appendix for an annotated model training conference agenda)

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Each conference participant received the resource manual — *Improving the Health Care Response to Domestic Violence: a Resource Manual for Health Care Providers*. Participants also received a comprehensive binder of journal articles addressing the health care system's response, victims of domestic violence, pregnant women, special populations, perpetrators, the effects of battering on children, assessing for risk of homicide, and substance abuse and mental health. Each hospital team also received a domestic violence video, training slide show and accompanying narrative script.

DEVELOPING A COOPERATIVE, MULTIDISCIPLINARY APPROACH

One of the unique characteristics of the FUND's approach to strengthening the ED response to battering, is its incorporation of a multidisciplinary team response to assist victims of domestic violence. Given the challenges inherent in asking people from different professions to cooperate in a field that typically emphasizes specialization, small group discussions were conducted by discipline so that team members could talk about the challenges inherent in working with their colleagues across discipline. The small group discussions generated strategies to:

- identify obstacles and solutions inherent in working with/organizing their colleagues
- overcome professional distance and barriers to working together
- identify their discipline's role within the ED's team response to domestic violence
- construct a multidisciplinary team response to battering

These discussions were described as especially useful by conference participants who felt it was important to have the opportunity to talk to their colleagues from other hospitals and share strategies for working more effectively as a team within their home institutions.

DEVELOPING SITE APPROPRIATE PLANS

Conference participants broke out by hospital site and spent 2.5 hours developing an initial "action plan" for designing and implementing their ED response to battered patients. Action plan work sheets were designed to help the hospital teams think through what it would take to develop and implement the components of a comprehensive domestic violence program. The work sheets were also designed to help teams determine how they would work as a group logistically and who else they might need to involve for purposes of implementing the program. The action plan work sheets provided step-by-step instructions that helped each team design a program that incorporated the following elements of an emergency department response to domestic violence:

- routine screening to detect battered patients
- the development and formal adoption of domestic violence protocols
- conducting training for all ED staff and institutionalizing an ongoing training program
- developing printed resource material on domestic violence for patients and clinicians
- creating quality assurance mechanisms in order to monitor the ongoing response
- connecting the response institution-wide and community-wide

These six components and a team logistics action plan represented the minimum objec-

tives each hospital team was asked to complete by the end of the six month emergency department program. These minimum guidelines plus the specific technical assistance and consultation that was provided by the FUND and PCADV to the hospitals is described in the document entitled: *ED Domestic Violence Program Objectives and Expectations* attached in this Appendix. The Action plan work sheets and instructions have also been attached.

FOLLOW-UP CONSULTATION AND TECHNICAL ASSISTANCE

Following the training conference, the hospital teams worked closely with the FUND and PCADV over a six-month period receiving technical assistance, consultation and on-site assistance. A formal follow-up plan could include any of the following: monthly calls with individual team leaders, conference calls every other month with the group of team leaders, on-site technical assistance where needed, etc. The purpose of group conference calls is to share information and resources among hospital teams so that each hospital does not have to “re-invent the wheel” if a useful model has been developed by one of their counterparts. Another useful follow-up strategy is to highlight the progress and challenges experienced by individual hospitals and circulate the summaries via an informal newsletter. The FUND also compiled packets to help the hospitals generate local press regarding their participation in the emergency department program. The packets included: a draft press release, a draft op/ed article, a brief summary of the emergency department program, a summary of the FUND’s National Health Initiative on Domestic Violence and a fact sheet describing the incidence of domestic violence in health care settings.

CONCLUSION

Through their participation in the ED program, the hospital teams produced a vast array of training and resource materials. Some of the materials have been included in the Resource Manual’s appendix. For example, a number of the hospitals developed “domestic violence packets” which they pull when a health care provider identifies a battered patient (see Appendix E). These packets are easy to use and provide both the clinician and the battered patient with important resources such as reporting materials, documentation forms, referral information, safety plans, discharge instructions, etc.

The Model Domestic Violence Emergency Department Program was considered a great success by all involved. We were able to learn much from this experience. We learned that in order to truly *institutionalize* a program, the people involved in delivering the response must also be involved in designing and implementing it. We were also reminded of the importance of utilizing a multidisciplinary team approach to implementing a hospital-based domestic violence program and linking the facility with community domestic violence experts. Mutually beneficial relationships were realized as a result of the ED program and lasting community partnerships were forged. And most importantly, we witnessed first-hand that institutional change can happen because of the energy and commitment of a few concerned individuals. Without external financial assistance, the hospital teams creatively designed programs that utilized existing resources. The emergency department domestic violence program exemplified the depth of leadership that exists within the health care arena: Leadership capable of rallying community resources and strengthening community collaborations to prevent and reduce domestic violence.

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DOMESTIC VIOLENCE EMERGENCY DEPARTMENT PROGRAM OBJECTIVES AND EXPECTATIONS

A PROJECT OF THE FAMILY VIOLENCE PREVENTION FUND
IN COLLABORATION WITH THE
PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE

The following is a summary of the six components of a comprehensive emergency department response to victims of domestic violence. The Action Plan work sheets attached can be used in helping you develop an implementation plan.

I. Objectives

1. ESTABLISH SCREENING OF ALL FEMALE PATIENTS SEEN WITHIN YOUR HOSPITAL'S EMERGENCY DEPARTMENT.

Determine the procedures for screening: Is screening carried out verbally, through written questions or both? What screening instruments will be used? If written, will your E.D. utilize a separate screening form or incorporate questions into a medical history and/or intake form? What are the recommended questions? Are you recommending any other guidelines for screening (eg. a physician reference guide/decision tree)?

2. DEVELOP AND ADOPT EMERGENCY DEPARTMENT PROTOCOLS FOR RESPONDING TO VICTIMS OF DOMESTIC VIOLENCE.

The policies and procedures within the protocol should address screening/identification, assessment, treatment/intervention, referrals, reporting as required within your state, and documentation. Protocols should go through in-hospital procedure to assure formal adoption as hospital policy.

3. DEVELOP A DOMESTIC VIOLENCE TRAINING PLAN AND CARRY OUT TRAININGS.

Educate all Emergency Department physicians, nurses, and social workers through at least the following:

- (1) An initial 1 to 1 1/2 hour training presentation
- (2) A follow-up training using an interactive format (eg. discussion, case presentation, role-playing methods, etc.)

Ideally other staff should also be trained including intake personnel, admitting clerks, hospital security, interpreters and other allied health personnel in the ED. A staff education

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plan should be developed which addresses how on-going training will be conducted.

4. DEVELOP PRINTED RESOURCE MATERIALS.

For patients: Domestic violence resource materials should be developed and made available to patients. Such materials could include brochures, patient education posters, discharge sheets, referral cards, etc.

For clinicians: Domestic violence materials should be developed for clinicians and could include orientation and training materials for new staff, provider awareness posters, posted referral lists, reporting forms (if required in your state), reminder stamps for medical records, etc.

5. PLAN FOR MONITORING THE RESPONSE

The plan may include formal evaluations or discussions, periodic meetings to review progress of the implementation plan, quality assurance review or launching a study to evaluate the success of clinician intervention, patient identification and intervention strategies. The plan may include strategies that help ensure and monitor the continued success of the ED program activities.

6. INTEGRATING STRATEGIES THAT CONNECT THE ED RESPONSE TO A LARGER INSTITUTION-WIDE AND COMMUNITY-WIDE RESPONSE.

A. Hospital-wide: Future planning for implementing a hospital-wide response could include hospital-wide procedures for screening, adoption of protocols, ongoing domestic violence training programs, disseminating resource materials for clinicians and patients, etc.

B. Community collaboration: Collaboration with domestic violence advocacy programs is key to improving the healthcare system and community response to domestic violence. Strategies can include: collaborating with domestic violence programs to improve your hospitals' response to battered women, working with domestic violence programs to train health care providers in other settings; participating in community-wide domestic violence advisory committees; and supporting public education and awareness efforts and public health initiatives.

We'd appreciate receiving any materials your facility develops so we can share them with the other hospitals and clinics. If you have any questions, you can contact the:

FAMILY VIOLENCE PREVENTION FUND
383 Rhode Island St., Suite 304
San Francisco, CA 94103
(415)252-8900 • (415)252-8991 Fax

or the

PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE
6400 Flank Drive, Suite 1300
Harrisburg, PA 17112
(800)537-2238 • (717)545-9456 Fax

DEVELOPING MODEL DOMESTIC VIOLENCE EMERGENCY DEPARTMENT PROGRAMS **A TWO-DAY TRAINING CONFERENCE** **MODEL AGENDA**

DAY ONE

- I. **Introductions & Logistics (1-1.5 hours)**
 - Plan on 2-3 minutes per participant. Have each individual state their name, facility and any background or experience in domestic violence. Ask the team leader to briefly describe their facility.

- II. **A Victim's Story (15 minutes)**
 - Have a battered woman present her real-life experience(s) with the health care system including what the system could have had in place, or done differently, in order to better serve her needs. A video-taped story can also work here.

- III. **Overview of local or statewide health/domestic violence-related initiatives (.5 hour)**
 - Provide an overview of local and state efforts on the part of domestic violence and health care professionals so that conference participants can understand how their institutional change fits into the bigger picture.

- III. **Domestic Violence in the Health Care Arena (.5 hour)**
 - Set the context for domestic violence as a health care issue and the importance of health care professionals doing this work. Summarize the JCAHO domestic violence standards and any other state or federal health policy affecting them.

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IV. The Dynamics of Domestic Violence (1 hour)

- Present an overview of domestic violence including definition, dynamics, causes of domestic violence, why women stay, victims, perpetrators, the impact of abuse on kids, etc.

V. Small Group Work by Hospital Site: Conducting an “Institutional Assessment.” (1 hour)

- Hospital domestic violence teams meet during lunch in order to conduct an institutional assessment. Using the action plan worksheets, teams should list policies and procedures that exist within their ED to respond to domestic violence and any existing “gaps” in services.

IV. Overview/Dynamics of Domestic Violence - cont'd (1 hour)

VI. Working with the Battered Woman (1.5 hour)

- This section should address the clinical skills health care providers need to develop in order to work more effectively with battered women including: screening; identification/assessment; intervention; safety planning; referrals, non-shelter options for referrals (overnight hospital stays, etc.); and documentation. Also plan on covering barriers to identifying battered women, consequences of non-intervention; same-sex battering & ways to improve cultural competency. Triad role plays or a role play demonstration can be an extremely effective way to teach some of these necessary skills.

VII. Domestic Violence Referrals and Legal Issues/Resources for Battered Women (45 minutes)

- Present an overview of domestic violence resources available within your community. Also cover legal options and legal advocacy services available to battered women. Include a thorough overview (with ample time allotted for questions) to discuss any legal reporting requirements operating within your state.

VIII. When the Patient is a Perpetrator of Domestic Violence (1 hour)

- Equip providers with the skills they need to respond to patients they learn are perpetrators of domestic violence.

DAY TWO

IX. Training Presentations and Issues (1.5 hours)

- Present an overview of training issues and various formats for training including a sample slide show and role play. For the role play: pretend to be a battered woman presenting injuries to the ED inconsistent with your explanation. Ask 5-8 members of the audience to play the role of a physician, nurse or medical social worker attempting to get you to volunteer information about the abuse. Be sure to allow time for conference participants to de-brief regarding which questions they thought were direct yet sensitive to the patient's situation.
After watching the role play, team members should split up into diads and practice asking framing, indirect and direct screening questions. One person should play the role of the provider and the other the battered woman: After 5-10 minutes, instruct the diad members to switch roles.

X. Institutionalizing the Comprehensive ED Response (70 minutes)

- The purpose of this panel is to present the various components involved in institutionalizing a comprehensive ED response to domestic violence as well as case studies that demonstrate different approaches to responding to battered patients. The panel should be followed by 20 minutes of questions fielded by panelists. Your panel should be composed of health care providers and battered women advocates. A lecture, case study format or panel can cover the following issues:
 - assessing needs and resources
 - model programmatic responses and site specific strategies
 - establishing a referral network
 - producing resource materials
 - developing and adapting protocols
 - designing and implementing training
 - sustaining the response
 - evaluating and monitoring the response
 - coordinating the response hospital and communitywide

XI. Small Group Work by Hospital Site: Developing an Action Plan (1 hour)

Each hospital domestic violence team will spend approximately 2.5 hours developing an initial "action plan" for designing and implementing their ED response to battered patients. First, spend 10-15 minutes explaining how to use the action plan work sheets. Each action plan should address the following:

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- routine screening to detect battered patients
- the development and formal adoption of domestic violence protocols
- conducting training for all ED staff and institutionalizing an ongoing training program
- developing printed resource material on domestic violence for patients and clinicians
- creating quality assurance mechanisms in order to monitor the ongoing response
- connecting the response institution-wide and community-wide
- team logistics

XII. Lunch: Small Group Work by Discipline (1 hour)

Conference participants should break out by discipline for a lunch-time discussion designed so that team members can talk about the challenges inherent in working with their colleagues across discipline. Small groups should generate strategies to:

- identify obstacles and solutions inherent in working with/organizing their colleagues
- overcome professional distance and barriers to working together
- identify their discipline's role within the ED's team response to domestic violence
- construct a multidisciplinary team response to battering

XII. Small Group Work by hospital (cont'd) (2 hours)

Small groups continue to work on developing Action Plans. Assign facilitators and staff to serve as resource people to each hospital domestic violence team.

XII. Closing Session (1 hour)

- In this informal closing session, the facilitator asks small groups to highlight major obstacles to implementation identified & solutions generated through a report back to large group. The summation should pull together skills developed, learning accomplished and how it all relates to the work ahead. Conference participants should be asked to share any closing reflections.

DOMESTIC VIOLENCE STATE COALITIONS

- ALASKA NETWORK ON DOMESTIC VIOLENCE
AND SEXUAL ASSAULT
130 Seward Street, Room 501
Juneau, AK 99801
907-586-3650
- ALABAMA COALITION AGAINST
DOMESTIC VIOLENCE
PO Box 4762
Montgomery, AL 36101
205-832-4842
- ARKANSAS COALITION AGAINST VIOLENCE
TO WOMEN & CHILDREN
7509 Cantrell, #213
Little Rock, AR 72207
501-663-4668
- ARIZONA COALITION AGAINST
DOMESTIC VIOLENCE
100 West Camelback Road - Suite 109
Phoenix, AZ 85013
602-279-2900
- CALIFORNIA ALLIANCE AGAINST
DOMESTIC VIOLENCE
619 13th Street, Suite -I
Modesto, CA 95354
209-524-1888
- COLORADO DOMESTIC VIOLENCE COALITION
PO Box 18902
Denver, CO 80218
303-573-9018
- CONNECTICUT COALITION AGAINST
DOMESTIC VIOLENCE
135 Broad Street
Hartford, CT 06105
203-524-5890
- DC COALITION AGAINST
DOMESTIC VIOLENCE
PO Box 76069
Washington, DC 20013
202-783-5332
- DELAWARE COALITION AGAINST
DOMESTIC VIOLENCE
P.O. Box 847
Wilmington, DE 19899
302-658-2958
- FLORIDA COALITION AGAINST
DOMESTIC VIOLENCE
1521-A Killearn Center Boulevard
Tallahassee, FL 32308
904-668-6862
- GEORGIA ADVOCATES FOR BATTERED
WOMEN AND CHILDREN
250 Georgia Avenue, SE - Suite 308
Atlanta, GA 30312
404-524-3847
- HAWAII STATE COMMITTEE ON FAMILY
VIOLENCE
98-939 Moanalua Road
Aiea, HI 96701-5012
808-486-5071
- IOWA COALITION AGAINST
DOMESTIC VIOLENCE
1540 High Street, Suite 100
Des Moines, IA 50309-3123
515-244-8028
- IDAHO COALITION AGAINST SEXUAL &
DOMESTIC VIOLENCE
200 North Fourth Street, Suite 10-K
Boise, ID 83702
208-384-0419
- ILLINOIS COALITION AGAINST
DOMESTIC VIOLENCE
937 South Fourth Street
Springfield, IL 62703
217-789-2830
- INDIANA COALITION AGAINST
DOMESTIC VIOLENCE
2511 E. 46th Street, Suite N-3
Indianapolis, IN 46205
317-543-3908

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KANSAS COALITION AGAINST SEXUAL AND
DOMESTIC VIOLENCE
820 S. E. Quincy, Ste 416-B
Topeka, KS 66612
913-232-9784

KENTUCKY DOMESTIC VIOLENCE ASSON
PO Box 356
Frankfort, KY 40602
502-875-4132

LOUISIANA COALITION AGAINST
DOMESTIC VIOLENCE
PO Box 3053
Hammond, LA 70404-3053
504-542-4446

MASSACHUSETTES COALITION OF BATTERED
WOMEN'S SERVICE GROUP
210 Commerical Street -3rd Floor
Boston, MA 02109
617-248-0922

MARYLAND NETWORK AGAINST
DOMESTIC VIOLENCE
11501 Georgia Avenue - Suite 403
Silver Spring, MD 20902
301-942-0900

MAINE COALITION FOR FAMILY
CRISIS SERVICES
359 Main Street
Bangor, ME 04402
207-941-1194

MICHIGAN COALITION AGAINST
DOMESTIC VIOLENCE
PO Box 16009
Lansing, MI 48901
517-484-2924

MINNESOTA COALITION FOR
BATTERED WOMEN
1619 Dayton Avenue, Suite 303
St. Paul, MN 55104
612-646-6177

MISSOURI COALITION AGAINST
DOMESTIC VIOLENCE
331 Madison Street
Jefferson City, MO 65101
314-634-4161

MISSISSIPPI COALITION AGAINST
DOMESTIC VIOLENCE
PO Box 4703
Jackson, MS 39296-4703
601-981-9196

MONTANA COALITION AGAINST
DOMESTIC VIOLENCE
1236 North 28th Street
Billings, MT 59101
406-256-6334

NORTH CAROLINA COALITION AGAINST
DOMESTIC VIOLENCE
PO Box 51875
Durham, NC 27717
919-956-9124

NORTH DAKOTA COUNCIL ON ABUSED
WOMEN'S SERVICES
State Networking Office
418 East Rosser Avenue
Suite 320
Bismarck, ND 58501
701-255-6240

NEBRASKA DOMESTIC VIOLENCE AND
SEXUAL ASSAULT COALITION
315 South 9th - #18
Lincoln, NE 68508
402-476-6256

NEW HAMPSHIRE COALITION AGAINST
DOMESTIC & SEXUAL VIOLENCE
PO Box 353
Concord, NH 03302-0353
603-224-8893

NEW JERSEY COALITION FOR
BATTERED WOMEN
2620 Whitehorse/Hamilton Square Road
Trenton, NJ 08690
609-584-8107

NEW MEXICO STATE COALITION AGAINST
DOMESTIC VIOLENCE
P.O. Box 25363
Albuquerque, NM 87125
505-246-9240

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NEVADA NETWORK AGAINST
DOMESTIC VIOLENCE
2100 Capurro Way, Suite E
Sparks, NV 89431
702-358-1171

NEW YORK STATE COALITION AGAINST
DOMESTIC VIOLENCE
79 Central Avenue
Albany, NY 12206
518-432-4864

OHIO DOMESTIC VIOLENCE NETWORK
4041 North High Street , Suite 101
Columbus, Oh 43214
614-784-0023

OKLAHOMA COALITION ON DOMESTIC
VIOLENCE AND SEXUAL ASSAULT
2200 Classen Blvd. - Suite 1300
Oklahoma City, OK 73106
405-557-1210

OREGON COALITION AGAINST DOMESTIC
AND SEXUAL VIOLENCE
520 N.W. Davis, Suite 310
Portland, OR 97209
503-223-7411

PENNSYLVANIA COALITION AGAINST
DOMESTIC VIOLENCE
6400 Flank Drive - Suite 1300
Harrisburg, PA 17112
717-545-6400

RHODE ISLAND COALITION AGAINST
DOMESTIC VIOLENCE
422 Post Road, Suite 104
Warwick, RI 02888
401-467-9940

SOUTH CAROLINA COALITION AGAINST
DOMESTIC VIOLENCE & SEXUAL ASSAULT
PO Box 7776
Columbia, SC 29202-7776
803-254-3699

SOUTH DAKOTA COALITION AGAINST
DOMESTIC VIOLENCE AND SEXUAL ASSAULT
3220 South Highway 281
Aberdeen, SD 57401
605-225-5122

TENNESSEE TASK FORCE AGAINST
DOMESTIC VIOLENCE
PO Box 120972
Nashville, TN 37212
615-386-9406

TEXAS COUNCIL ON FAMILY VIOLENCE
8701 North Mopac Expressway
Suite 450
Austin, TX 78759
512-794-1133

DOMESTIC VIOLENCE ADVISORY COUNCIL
120 North 200 West
Salt Lake City, UT 84145
801-538-4100

VIRGINIANS AGAINST DOMESTIC VIOLENCE
2850 Sandy Bay Road - Suite 101
Williamsburg, VA 23185
804-221-0990

VERMONT NETWORK AGAINST DOMESTIC
VIOLENCE AND SEXUAL ASSAULT
PO Box 405
Montpelier, VT 05601
802-223-1302

WASHINGTON STATE COALITION AGAINST
DOMESTIC VIOLENCE
2101 4th Avenue, E, Suite 103
Olympia, WA 98501
360-352-4029

WISCONSIN COALITION AGAINST
DOMESTIC VIOLENCE
1400 East Washington Avenue
Suite 103
Madison, WI 53703
608-25-0539

WEST VIRGINIA COALITION AGAINST
DOMESTIC VIOLENCE
PO Box 85, 181B Main Street
Sutton, WV 26601-0085
304-765-2250

WYOMING COALITION AGAINST DOMESTIC
VIOLENCE & SEXUAL ASSAULT
341 East E Street - Suite 135A
Casper, WY 82601
307-266-4334

APPENDICES

NATIONAL DOMESTIC VIOLENCE ORGANIZATIONS

FAMILY VIOLENCE PREVENTION FUND 383 Rhode Island Street - Suite 304 San Francisco, CA 94103 - 5133 415-252-8900	NATIONAL RESOURCE CENTER ON DV c/o Pennsylvania Coalition Against Domestic Violence 6400 Flank Drive, Suite 1300 Harrisburg, PA 17112 800-537-2238
HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE c/o Family Violence Prevention Fund 383 Rhode Island Street, Suite 304 San Francisco, CA 94103-5133 800-313-1310	BATTERED WOMEN'S JUSTICE PROJECT (Criminal Issues) Minnesota Program Development, Inc. 4032 Chicago Avenue South Minneapolis, MN 55407 800-903-0111
RESOURCE CENTER ON CHILD CUSTODY AND CHILD PROTECTION c/o National Council of Juvenile and Family Court Judges PO Box 8970 Reno, NV 89507 800-527-3223	BATTERED WOMEN'S JUSTICE PROJECT (Self-Defense for Battered Women) c/o National Clearinghouse for the Defense of Battered Women 125 South 9th Street - Suite 302 Philadelphia, PA 19107 215-351-0010
NATIONAL COALITION AGAINST DOMESTIC VIOLENCE PO Box 18749 Denver, CO 80218 303-839-1852	BATTERED WOMEN'S JUSTICE PROJECT (Civil Issues) c/o PCADV- Legal Office 524 McKnight Street Reading , PA 19601 610-373-5697
NATIONAL COALITION AGAINST DOMESTIC VIOLENCE Policy Office PO Box 34103 Washington, DC 20043-4103 703-765-0339	NATIONAL NETWORK TO END DOMESTIC VIOLENCE Policy Office 701 Pennsylvania Avenue N.W. Suite 900 Washington, PA 20004 202-434-7405
NATIONAL BATTERED WOMEN'S LAW PROJECT 799 Broadway, Room 402 New York, NY 10003 212-674-8200	NATIONAL NETWORK TO END DOMESTIC VIOLENCE Administrative Office c/o Texas Council on Family Violence 8701 North Mopac Expressway, Suite 450 Austin, TX 78759 512-794-1133
CENTER FOR THE PREVENTION OF SEXUAL AND DOMESTIC VIOLENCE 936 North 34th Street Suite 200 Seattle, WA 98103 206-634-1903	

**OTHER STATE/REGIONAL
DOMESTIC VIOLENCE STATE ORGANIZATIONS**

SOUTHERN CA COALITION ON
BATTERED WOMEN
PO Box 5036
Santa Monica, CA 90405
213-655-6098

DELAWARE DOMESTIC VIOLENCE
COORDINATING COUNCIL
900 King St.
Wilmington, DE 19801
302-762-6111

ACTION OHIO COALITION FOR
BATTERED WOMEN
PO Box 15673
Columbus, OH 43215
614-221-1255

MISSOURI SHORES WOMEN'S
RESOURCE CENTER
210 Governor's Drive
Pierre, SD 57501
605-224-7187

WHITE BUFFALO CALF WOMEN'S SHELTER
PO Box 227
Mission, SD 57555
605-856-2317

NATIONAL NETWORK ON BEHALF OF
IMMIGRANT BATTERED WOMEN
c/o Family Violence Prevention Fund
383 Rhode Island St., Suite 304
San Francisco, CA 94103-5133
415-252-8900
and
c/o AYUDA
1736 Columbia, N.W.
Washington, D.C. 20009
202-387-0434

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LETHALITY ASSESSMENT WITH THE PERPETRATOR

Assessing lethality is not merely trying to predict whether or not the perpetrator will kill the victim. It also requires assessing the risk of life threatening behaviors against others or self committed by the perpetrator, victim, or children.

GATHER INFORMATION FROM

- the perpetrator
- the victim
- the children
- other family members
- others (probation officers, other counselors, anyone having contact with family)

FACTORS TO CONSIDER IN MAKING ASSESSMENT

- 1. perpetrator's access to victim**
- 2. pattern of the perpetrator's abuse**
 - a. frequency/severity of abuse in current, concurrent, and past relationships
 - b. use and presence of weapons
 - c. threats to kill
 - d. hostage taking
- 3. perpetrator's state of mind**
 - a. obsession with victim
 - b. increased risk-taking by perpetrator
 - c. ignoring consequences
 - d. depression
 - e. desperation
- 4. individual factors that reduce behavioral controls of either perpetrator or victim**
 - a. substance abuse
 - b. certain medications
 - c. psychosis
 - d. brain damage, etc.
- 5. situational factors**
 - a. separation violence
 - b. increased autonomy of victim
 - c. presence of other stresses

Developed by Anne L. Ganley, Ph.D. This material was reprinted from the Family Violence Prevention Fund's publication entitled "Domestic Violence: A National Curriculum for Family Preservation Practitioners", written by Susan Schechter, M.S.W. and Anne L. Ganley, Ph.D.

BOOKS LIST

ADAPTED FROM MATERIAL DEVELOPED BY THE NATIONAL RESOURCE CENTER,
6400 FLANK DRIVE, HARRISBURG, PA 17112-2778, 800/537-2238.

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Fairstein, Linda A. *Sexual Violence: Our War Against Rape*. New York: William Morrow and Company, Inc., 1993. (212/261-6500, 800/843-9389, 800/237-0657, ISBN: 0-688-06715-8)

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Rush, Florence. *The Best Kept Secret: Sexual Abuse of Children*. Englewood Cliffs: Prentice-Hall, Inc., 1980. (800/922-0579, 201/592-2000, ISBN: 0-13-074781-5)

SURVEY INSTRUMENTS

CALIFORNIA HOSPITAL EMERGENCY DEPARTMENTS RESPONSE TO DOMESTIC VIOLENCE: A 1993 survey of California's 397 hospital-based emergency departments was conducted by the Family Violence Prevention Fund in collaboration with the San Francisco Injury Center for Research and Prevention. Eighty-seven percent of California hospitals responded to the survey which was administered to gather baseline information on the California emergency department response to domestic violence and the range of compliance with JCAHO domestic violence standards. Both Nurse Managers and Physician Directors were surveyed. The survey results were published in the August 20, 1993 issue of Morbidity and Mortality Weekly Report and by the Journal of the American Medical Association. For a copy of the survey instrument and more information contact:

FAMILY VIOLENCE PREVENTION FUND
(contact person: Debbie Lee)
383 Rhode Island Street, Suite 304, San Francisco, CA 94103
415/252-8900, Fax: 415/252-8991

ALASKA NURSE PRACTITIONER'S EXPERIENCE WITH PARTNER ABUSE IN ALASKA: The State of Alaska Section of Maternal Child and Family Health is conducting a statewide domestic violence training needs assessment of health care providers. Following fifty semi-structured interviews with health providers throughout the state, a mailed questionnaire was sent to primary care physicians, nurse practitioners, public health nurses and physician assistants currently licensed to practice in the State of Alaska. A customized version of the survey (see survey enclosed) was developed for provider type. The assessment is now being expanded to include other provider types and specialties including dentists, dental hygienists, x-ray technologists, eye care specialists, physical therapists, emergency medicine technicians, community health aides and health representatives. Data from this assessment is being used to develop training and resources that are responsive to providers' experiences, needs and concerns. For more information contact:

THE ALASKA DOMESTIC VIOLENCE PROJECT
(Contact person: Linda Chamberlain)
Section of Maternal Child and Family Health
1231 Gambell Street, Suite 314, Anchorage, AK 99501
800/478-2221 or 907/272-1534, fax 907/277-6814

HARVARD INJURY CONTROL CENTER'S SURVEY ON EMERGENCY DEPARTMENT RESPONSE TO BATTERED WOMEN: The following survey was carried out in 1992, and will again be conducted in 1996. For more information contact:

HARVARD INJURY CONTROL CENTER
(Contact person: Nancy Isaac, Sc.D.)
677 Huntington Ave., Boston, MA 02115
617/432-3768, fax 617/432-3199

DEVELOPING MODEL DOMESTIC VIOLENCE EMERGENCY DEPARTMENT PROGRAMS

A ONE-DAY OR TWO-DAY TRAINING CONFERENCE MODEL AGENDA

Day one of the training is recommended for individual practitioners or Clinic/Hospital Teams. Recommended audience: all types of health care providers, from 50-75 up to 350 participants. Day two is only recommended for clinic or hospital teams that have attended day one.

DAY ONE

- I. **Welcome and Introduction of Participants (1 hour 15 minutes)**
 - Plan on 2-3 minutes per participant. Have each individual state their name, facility and any background experience with domestic violence. Ask the team leader to briefly describe their facility. If training more than 50-75 participants, replace the individual introductions with an introduction to the training and a brief review of the agenda.

- II. **Testimonial: A Domestic Violence Survivor (15 minutes)**
 - Have a battered woman present her real-life experience(s) with the health care system, including what the system could have had in place, or done differently, in order to better serve her needs. A video-taped story can also work here.

- III. **Dynamics of Domestic Violence (1 1/2 hours)**
 - Present an overview of domestic violence including definition, dynamics, causes of domestic violence, why women stay, victims, perpetrators, the impact of abuse on kids, and so forth.

IV. Clinical Skills: Screening, Assessment, Intervention and Documentation (1 hour 20 minutes)

- This section should address the clinical skills health care providers need to develop in order to work more effectively with battered women, including screening and identification, assessment, intervention, safety planning, referrals and documentation. Also plan on covering barriers to identifying battered women, consequences of non-intervention, same-sex battering and ways to improve cultural competency.

V. Demonstration Role Play and Instructions for Practical Application (20 minutes)

- One trainer will play the practitioner and one trainer will play the victim. In ten minutes, the practitioner will demonstrate a short and effective intervention through the use of direct questioning. The practitioner will elicit the information helpful to assess severity, frequency, and find out what the victim has pursued and how she views her situation. Finally, the practitioner will demonstrate the three elements of intervention: giving validating messages, providing information on domestic violence, and helping the patient develop a safety plan.

VI. Practical Application Workshops (1 hour and 15 minutes)

- These workshops give the participants an opportunity to apply learned information through role playing case studies. Split the participants into groups of three, and make sure every participant has a chance to play a practitioner, a victim and an observer. The role plays will include opportunities for screening, assessment and intervention. Three role plays can be completed in an hour and 15 minutes with enough time for debriefing in between each role play and at the end of the session. (For case studies, write your own or contact the Family Violence Prevention Fund.)

VII. Legal Issues (50 minutes)

- Present an overview of the legal options and legal advocacy services available to battered women. Include a thorough overview (with ample time allotted for questions) to discuss any legal reporting requirements operating within your state.

VIII. Community Resources and Closure (25 minutes)

- Provide an overview of local and state efforts on the part of domestic violence and health care professionals so that conference participants can understand how their institutional change fits into the bigger picture, or have a panel of local experts or agency representatives talk about the domestic violence resources available within the community.

APPENDICES

DAY TWO

For hospital or clinic teams only. Each team should consist of a physician, a nurse, a social worker, an administrator and a local domestic violence expert. Recommended audience: 50-75 participants.

I. Welcome and Review of Agenda (10 minutes)

II. Day One Recap and Debriefing (1 hour)

- Give participants a chance to reflect and ask questions about what they've learned about domestic violence and the health care response.

III. Pilot Program Orientation: Objectives, Expectations, Questions & Answers (20 minutes)

- Explain to participants that their objective is to institutionalize a response in their setting. Review the following "Domestic Violence Program Objectives and Expectations" with participants. Allow time for questions and answers. Spend 10-15 minutes explaining how to use the action plan work sheets (attached).
 - Establish screening of all female patients within your facility
 - Develop and adopt protocols for responding to victims of domestic violence
 - Develop a domestic violence training plan and carry out trainings
 - Develop printed resource materials
 - Plan for monitoring the response
 - Integrate strategies that connect your facility's response to a larger institution-wide and/or community-wide response

IV. Panel: Planning and Implementing an Improved Medical Response (50 minutes)

- The purpose of this panel of health care providers and a battered women advocate is to present testimony regarding the various components involved in institutionalizing a comprehensive response to domestic violence and case studies that demonstrate different approaches to responding to battered patients. Have your panelists speak about their successes in instituting a response within their setting, as well as attitudinal, institutional, clinical and logistical barriers that they encountered. The panel should be followed by 20 minutes of questions fielded by panelists. Topics that could be covered include:
 - assessing needs and resources

- model programmatic responses and site specific strategies
- establishing a referral network
- producing resource materials
- developing and adapting protocols
- designing and implementing training
- sustaining the response
- evaluating and monitoring the response
- coordinating the response hospital- and community-wide

V. **Planning Session #1: Institutional Assessment (30 minutes)**

- Domestic violence teams meet in order to conduct an institutional assessment. Using the action plan worksheets, teams should list policies and procedures that exist within their setting to respond to domestic violence and any existing “gaps” in services.

VI. **Planning Session #2: Discussing the Components of an Action Plan (2 1/2 hours)**

- Using the action plan worksheets, each domestic violence team will develop an initial action plan for designing and implementing their response to battered patients. Each action plan should address the following:
 - routine screening to detect battered patients
 - the development and formal adoption of domestic violence protocols
 - conducting training for all staff and institutionalizing an ongoing training program
 - developed printed resource material on domestic violence for patients and clinicians
 - creating quality assurance mechanisms in order to monitor the ongoing response
 - connecting the response institution-wide and community-wide
 - team logistics

VII. **Small Group Highlights/Creative Moments and Conference Closure (1 hour)**

- In this informal closing session, the facilitator asks small groups to report back to the large group and highlight some of the ideas and plans generated during the planning sessions. The summation should pull together skills developed, learning accomplished and how it all relates to the work ahead. Conference participants should be asked to share any closing reflections.

Emergency Shelter IVS provides temporary and safe emergency shelter for victims of domestic violence and their children. Shelter services include individual and group counseling, advocacy, referrals to local providers, children's counseling/programs, safety education and planning, and other support services as needed. Emergency shelter is for women and children only, however separate arrangements are made for sheltering male victims of domestic violence who need to be in a safe place. Counseling & Support Groups. Safety Planning for survivors & their children.