Reaching Out in New England

Health Care Response to Intimate Partner Violence

THE VERMONT Health PLAN

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About this Guide

Dear New England Health Care Provider,

Although the prevalence of intimate partner violence (IPV) is difficult to measure precisely, in a 1998 Commonwealth Fund survey, one third of American women reported being physically or sexually abused by a husband or boyfriend at some point in their lives. IPV can be viewed as a public health epidemic with significant consequences for the health care system. According to the U.S. Department of Justice, 37 percent of all women seeking emergency room care for violence-related injuries were injured at the hands of a current or former spouse or intimate partner.

Research suggests that early intervention, treatment and prevention of abuse can benefit the entire health care system. Yet, there is evidence that providers lack the tools they need to provide appropriate treatment. Nearly nine in ten victims of abuse do not discuss IPV incidents with their practitioners, creating a significant barrier to adequate care.

In four separate studies, however, 70 to 81 percent of patients reported that they wished their health care provider had asked them about the violence they experienced. A 1999 Journal of The American Medical Association study found that only one in ten primary care providers regularly screened patients for IPV. Lack of tools for screening and intervention could prevent providers from reaching out to patients affected by intimate partner violence who may be reluctant to initiate a discussion on their own.

For these reasons, as well as the extensive research identifying both the short and long-term health consequences associated with IPV, we have created this guide to help providers with confidential screening for IPV.

We hope the guide will help providers to screen patients and:

- Identify any associated health consequences;
- Treat patients (see symptoms and make diagnoses) more effectively; and
- Educate patients on the health-related aspects of abuse, as well as available local resources.

We hope that you will find the guide and the accompanying materials helpful.

Sincerely,

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Executive Summary

Barriers to Screening[1]

Barrier: *Not knowing how to intervene effectively if intimate partner violence (IPV) is identified.*

Solution: Know your local IPV resources. Develop a working relationship with them.

Barrier: *Not being able to screen for IPV in private/alone with patient.*

Solution: Create private space and have a privacy policy for all patients.

Barrier: *Feeling frustrated or angry if the patient does not leave their partner.*

Solution: Learn about the barriers to and safety issues associated with leaving an abusive relationship.

Barrier: *Concern that discussing social and/or psychological issues with a patient will take an overwhelming amount of time.*

Solution: Make IPV screening part of your routine practice. Routinely utilize community resources when a screen is positive.

Defining the Issue

Intimate partner violence (IPV) is a pattern of abusive and coercive behaviors perpetrated by a current or former intimate partner. It includes physical assaults, emotional abuse, sexual abuse, progressive social isolation, stalking, deprivation, and intimidation. The abusive partner employs these behaviors, over time, to gain and maintain power and control over the other. IPV perpetrators and victims may be of any age, gender, ability, sexual orientation, social or economic status, ethnicity, and religious affiliation.

Epidemiology

Approximately 22% of women and 7% of men report having experienced physical or sexual abuse by an intimate partner at some point in their adult lives.[2] Studies indicate that between 25–60% of adolescents have experienced some form of dating violence.[3] In 30–60 % of the families affected by IPV, children are also directly abused.[4]

Heterosexual women are 5-8 times more likely than heterosexual men to be victimized by an intimate partner.[5] The latest U.S. Bureau of Justice Statistics report on intimate partner violence found that 85% of victims are female.[6] The few available studies on IPV in lesbian, gay, transgender and bisexual relationships suggest rates similar to homosexual relationships, with higher rates in male same-sex relationships than in female.[7] In a recent survey of men in same-sex relationships, the lifetime prevalence of IPV was 39.2%.[8]

Studies have found the following rates of current (within the past 12 months) IPV victimization:

- In primary care settings: 3.4–5.5% of patients.[9]
- In emergency departments: 11.7–14% of patients.[10]
- In internal medicine practices: 14% of patients.[11]
- In OB/GYN settings: 0.9-20.1% of patients, with a majority of studies finding between 3.9-8.3%.[12]

Health Impact

Common health concerns of IPV victims include physical injuries, chronic pain, GI complaints, sexually transmitted infections, and pregnancy complaints.[13] IPV increases the risk of serious mental health consequences such as depression, post-traumatic stress disorder, anxiety and suicidal ideation.[14] IPV victimization can interfere with access to health care and thus with preventive health care behaviors and the management of chronic conditions. IPV victims are more likely to engage in injurious health behaviors like smoking, alcohol and substance abuse.[15] IPV can lead to homicide and suicide. Children witnessing intimate partner violence in their homes are more likely to suffer from physical and behavioral health problems. They are also more likely to attempt suicide, and abuse drugs and alcohol.[16]

IPV Victims' Use of Health Care System

The CDC found that the costs of intimate partner rape, physical assault and stalking exceed $5.8 billion each year, nearly $4.1 billion of which is for direct medical and mental health care services. Approximately 40% of women raped or physically assaulted by an intimate partner sustained injuries. Of those, around 30% received medical care, such as ambulance/paramedic services, treatment in an emergency department, dental care, or physical therapy. One third of rape victims, 26% of physical assault victims and 42.6% of stalking victims sought mental health care, averaging between 9–13 visits.[17]

The Role of the Health Care Provider

Health care providers are often the first and only outsiders who have the opportunity to witness the impact of IPV and to offer interventions. Clinical guidelines[18] recommend routine screening for IPV victimization, assessment of health impact and safety, documentation in medical records that will hold up in court, offering education and resources, and making effective referrals to community resources. Effective interventions by health care providers open the doors to a range of options and resources, potentially increasing the safety of patients and their children and preventing serious injuries and health problems.

Resources for Health Care Providers and their Patients

Health care providers are only one part of the necessary community response to IPV. Collaboration with community resources can increase the effectiveness of referrals. Local domestic and sexual violence advocacy organizations commonly offer 24-hour hotlines, safety planning, support groups, emergency shelter, support through the legal system, and access to a range of financial and material resources. They can also provide information on culturally or linguistically appropriate services. There are local, statewide and national hotlines for sexual and domestic violence victims, as well as specialized services for underserved groups of victims. Check with your statewide or local domestic and sexual violence organizations. To find resources in your area, see Appendix E.

RADAR—(**R**outinely screen, **A**cknowledge patient's experience, **D**ocument your findings, **A**ssess patient's safety and **R**eview of options and referrals) is a tool commonly used by professionals that prompts an effective step-by-step approach to patients experiencing IPV. (See Appendix B)

Part 1: About IPV

Intimate Partner Violence Defined

Many people mistakenly believe that intimate partner violence (IPV) happens only in poor families or that it happens in certain geographic or demographic groups. In reality, IPV can happen to anyone—rich, poor, young, elderly. It can happen in the country or in the city in any racial or cultural groups.

Likewise, abuse doesn't necessarily manifest itself in visibly physical symptoms. IPV can be emotional or sexual as well. The following lists give limited examples of the myriad forms that abuse can take.

Physical Abuse

Physical abuse is usually recurrent and often escalates in both frequency and severity. It may include the following:

- Pushing, shoving, slapping, punching, kicking, choking
- Assault with a weapon
- Holding, tying down or restraining
- Leaving a person in a dangerous place
- Refusing to help when a person is sick or injured
- Withholding or controlling the victim's medication, or overmedicating

Emotional Abuse

Emotional or psychological abuse may precede or accompany physical violence as a means of controlling through fear, intimidation, and degradation. It may include the following:

- Threats of harm to the victim, her/his children and other relatives or friends
- Threats to abduct the children or report the victim to child protective services
- Threats of deportation or withdrawal of petition to establish legal status in the US
- Hiding or destroying important documents such as identification and passports
- Stalking
- Extreme jealousy and possessiveness
- Physical and social isolation
- Threatening to reveal gay/lesbian identity - "outing" the victim
- Deprivation, intimidation, degradation or humiliation
- Name calling, criticizing, insulting and belittling
- False accusations, blaming a person for everything
- Ignoring, dismissing or ridiculing a person's needs
- Lying, breaking promises, destroying trust
- Driving fast and recklessly to frighten and intimidate
- Threatening/attempting suicide
- Abuse or killing of household pets
- Economic entrapment

Sexual Abuse

Sexual assault in abusive relationships is often the most difficult aspect of abuse for patients to discuss. It may include any form of forced sex or sexual degradation, such as:

- Trying to make the victim perform sex acts against her or his will
- Withholding sex as a form of punishment
- Physically hurting the victim during sex or assaulting her or his genitals, including use of objects or weapons intravaginally, orally or anally
- Coercing the victim to have sex without protection against pregnancy or sexually transmitted diseases
- Criticizing the victim and calling her or him sexually degrading names

Prevalence of IPV

Health Impact of IPV

Physical Health
- Injuries
- Chronic pain
- Headaches and Migraine
- Gastrointestinal complaints
- Sexually transmitted Infections

Mental Health
- Depression
- Anxiety
- Traumatic and post-traumatic stress disorder
- Suicidal ideation

Health Behaviors
- Decreased preventive health behaviors
- Increased injurious health behaviors
- Decreased access to health care
- Problems complying with health protocols

Maternal/Child Health
- Unwanted pregnancies
- Late entry into prenatal care
- Low weight gain during pregnancy
- Infections
- First and second trimester bleeding
- Depression
- Suicide attempts
- Substance Abuse

Approximately 22% of women and 7% of men report experiencing intimate partner violence (IPV) over a lifetime.[19] IPV is a significant public health problem because of its associated morbidity and mortality, and this is particularly the case for women. Women are several times more likely than men to be injured during an assault by an intimate partner[20] and to experience more negative physical and psychological effects.[21] IPV accounts for an estimated one-quarter to one-half of all women presenting for treatment in emergency rooms.[22] Women who have been battered or sexually assaulted utilize health care services at much higher rates than women who have not experienced abuse[23, 24, 25] and experience health care problems that go beyond the original trauma.[26] Beyond the need for treatment from IPV related acute injuries, abused women are more likely to suffer from a range of acute injuries, exacerbation of existing problems, and development of new diseases and chronic illnesses at rates much higher than their non-abused counterparts.[27]

Studies indicate that women with disabilities experience higher rates of abuse and violent assault than women from the general population, yet are often unserved or underserved by systems designed to meet victims of violence.[28] For this population there are also unique risks such as neglect, withholding of medications and medical equipment, and if the primary caretaker is also the abuser, the patient's safety and health risks are increased. Inadequate social service systems, inaccessibility of many shelters, challenges within the criminal justice system, and lack of community supports serve as barriers that make getting and staying safe difficult and the recovery process challenging for individuals with disabilities.

Emerging research shows that for lesbian gay, transgender and bisexual (LGBT) patients, intimate partner violence occurs at similar rates. It is important to ensure that your screening for IPV include gender-neutral language so as not to assume the gender of the abusive intimate partner. It is recommended that providers be aware of their own biases about victimization and homophobia and become familiar with any LGBT resources available in your community.

Health Consequences

Physical injury is a significant issue for women experiencing IPV. IPV is a leading cause of injuries requiring medical attention for women,[29] a leading cause of homicides for women[30] and a leading etiologic factor of female suicide.[31] Whether the abuse is a first time event or chronic, the patient may present with a variety of chief complaints and behaviors. The patient may display multiple injuries in different stages of healing or may provide a vague history, inconsistent with the injuries or chief complaint. Battered women are more likely to have been injured in the head, face, neck, thorax, breasts, and abdomen than women injured in other ways.[32] She may not make good eye contact during history-taking, or may allow her partner to answer all questions, even when she is addressed directly.

The associated health consequences of IPV, whether they be the consequences experienced directly by the victim, or by the children who witness, are long-term, profound and chronic in nature whether the abusive relationship has ended, or not. It is imperative that health care professionals address this problem with the same attention as has been given to diabetes, coronary artery disease and cancer.

However, providers who are only looking for physical injuries may miss numerous other health problems associated with the abuse such as arthritis, chronic pelvic pain, chronic back pain, migraine and other headaches, sexually transmitted

infections, diarrhea, constipation, indigestion and spastic colon, or dismiss them as unrelated diagnoses.[33] Conversely, focusing on just the presenting complaint without questioning for precipitating factors like IPV may make the workup and treatment of a medical problem less effective.

Patients often present with a combination of medical and psychological symptoms from IPV. Exacerbations of chronic medical problems such as diabetes, seizure disorder, asthma, or high blood pressure may be related to IPV in that the abuser may be restricting the patient's access to medications, or discarding medication as part of the abusive control. Post-traumatic stress disorder, sleep disorders, depression, panic attacks and suicidal intentions or attempts are also indications that IPV may be occurring.[34]

What helped me with my health care provider was when we finally were able to talk a little about domestic violence, just him being there and knowing that he was there validating what I was feeling, telling me that I wasn't going crazy, having a safe place to talk whether it was by phone or in his office that he made that time and not giving up on me, knowing that it could take me a year or five years, that it had to be my choice, that I was the best person to know when it was going to be OK and how I could do that to survive. Little things that your health provider does for you are meaningful and to know that there is not a prescription that you can give to your patient that's going to make it go away but understanding that it's going to take time.

— From "A Vermont Story: Julie, Survivor of Domestic Violence" in Voices of Survivors and Perpetrators

In gynecologic, family practice and pediatric settings, it is important for the provider to understand the high co-occurrence of sexual assault in abusive relationships in order to address the medical/forensic implications for this patient population. The 1992 National Victim Center report Rape in America indicated that 10% of all rapes were by husbands or ex-husbands. According to the Department of Justice, 17.8% of high school girls report that they have been forced to engage in sexual activity against their will by a dating partner.[35] In addition, a study in Massachusetts revealed that 1 in 5 female high school students reported experiencing physical or sexual violence from dating partners.[36]

Women who are experiencing IPV, regardless of their marital status, are more likely to suffer complications associated with unprotected sexual intercourse. Women whose pregnancies are unwanted or mistimed are four times more likely to be physically hurt by their husband or partner than women with an intended pregnancy.[37] Women who disclosed a history of physical, emotional, and/or sexual abuse were more likely to have one or more sexually transmitted infections (40% vs. 18%) than

non-victimized women.[38] A review of 13 studies indicated that there is a correlation between forced sex and HIV risk.[39] Additionally, among 310 HIV-positive women, 68% had experienced physical abuse and 32% experienced sexual abuse as an adult.[40]

Complications of pregnancy are also more common in patients experiencing IPV than in the general OB patient population. The risk of pre-term labor was 4.2 times greater in women who experienced severe violence compared to women with no history of maternal abuse, and twice as likely in women who reported moderate violence. Researchers also observed that with increasing incidence of violence against pregnant women, the risk of premature rupture of membranes increased.[41] Abused women were half as likely as non-abused women to start prenatal care during the first trimester.[42] Two separate studies indicated that pregnant adolescents experiencing abuse had increased rate of pre-term labor or premature delivery.[43, 44]

Part 2: The Role of the Provider

Patient History/Routine Confidential Screening

Screening for Intimate Partner Violence

Several health professional organizations have supported public policies acknowledging IPV as a potential health issue. Many advocate for universal IPV screening in all health care contexts, training of emergency department staff to refer patients for help, and implementation of screening protocols.[45] Screening for a history of IPV and traumatic experiences can be a valuable tool to help make sense of a seemingly unrelated set of symptoms.[46] Yet, despite the advisability of screening,[47,48] there are no guarantees that screening protocols will be implemented or that patients will disclose abuse.[49, 50] Patients may be reluctant to share information about their risks and experiences with health care practitioners because of several concerns including the lack of privacy protections for their health information, possible discrimination in receipt of insurance benefits, stigmatization, and threats to personal safety.[51] However, several studies show that consistent screening of patients in health care settings can increase the rates of IPV identification.[52, 53] Although not all patients are at a point where they are ready to disclose sensitive information about their lives when they enter a particular healthcare setting, without direct questioning abuse may remain hidden, physical and psychological distress can persist and appropriate interventions may not be delivered.[54]

It is also necessary to screen patients with disabilities for intimate partner violence. It is important to create an office environment that is accessible and presents positive messages about disability. Be aware of the intimate partner violence resources in your community and what accessibility accommodations they have available.

Intervention and Management

In 1991, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated protocols for assessment of victims of IPV in all emergency rooms. The 2004 JCAHO revisions call for assessment of all patient populations. In addition, the American Medical Association (AMA) published guidelines that suggested physicians must be willing to routinely ask all women about IPV and screen for abuse because of the associated prevalence.[55] While we hope this guide is helpful to providers as they deal with patients who are victims of IPV, we also recommend that providers receive adequate education on the topic prior to employing a screening technique and response. Failure to do so when IPV is involved risks endangering the lives of patients, and patients' children. Components that are considered essential include the dynamics, associated health consequences, cultural competency, screening techniques and methods, clinical management, documentation, community resources, safety planning and forensic issues.

A provider's validation of the patient's experience remains the single most important component of IPV identification. Other important issues include educating the patient that abuse can impact their health, that options are available, and that regardless of the patient's individual choice, the health care environment is a safe one in which the patient can talk about the abuse.

Safety Planning

Emotional support of patients is often challenging because of the many time constraints placed on providers today. Utilizing available community-based crisis centers, social workers, case managers, and Employee Assistance Programs can be very effective in addressing the unique safety concerns of this patient population. It is helpful to know which resources are best suited to address the safety concerns

of patients who are being abused and their availability. More often than not, the community-based IPV agencies have staff who are prepared to respond on an emergent basis to address risk-assessment and safety planning with patients affected by IPV. Their services may also include shelters, assistance with protective orders, peer and group counseling, education and advocacy.

Clinical management for the patient should always include an assessment of immediate safety concerns. The provider may opt to ask a few simple safety questions, or use a formal Danger Assessment Tool, which identifies several risk factors associated with the homicides of batterers and battered women. Women appear to be at greatest risk when they decide to leave an abusive relationship. Thus, asking patients who are being abused if they are in danger right now, where their partners are, and whether they feel safe going home or have a another place to go, will allow them to begin to make plans for their own safety. An abuser's habitual use of weapons, alcohol or drugs, a history of harming household pets or of escalating violence can also place the patient in grave danger. Stalking can also be a powerful intimidation tactic—the patient may feel that she or he can never escape from the abuser.

Many IPV advocates will complete a formal safety plan with the victim. Since each victim's circumstances are unique, a printed safety plan is designed to assist the victim in choosing what resources and methods are available to achieve safety. This may include an initial choice to start planning how to increase personal safety while remaining in the relationship. The health care provider (HCP) should realize that the patient who is being abused has more knowledge about the abuser and how s/he may react than anyone else. Thus, patients should be assisted in developing a safety plan that maximizes autonomous choices for safety strategies employed during a violent incident, when preparing to leave, in their own residence, and/or if they choose to get a protection order against their abusers (See Appendix C). Since most HCPs are not familiar with the legal process of applying for a protection order, it is recommended that they contact their health care center's social worker and their local IPV crisis center to define roles and procedures for referring a patient for assistance in these matters.

It may not be safe for the patient to take home written information that addresses abuse, as the abuser may find it. If the patient is intending to leave the relationship that day, it is critical that the provider encourage the use of a community IPV advocate to walk the patient through effective safety planning and a discussion of options. Most crisis centers can send trained advocates to the provider's office to expedite this process.

Sending validating messages to a patient who discloses abuse can be a powerful intervention, because patients experiencing IPV are exposed to destructive messages from their abusers. They are typically made to believe that they are worthless or crazy, or that they deserve the abuse and that nobody will believe them anyway. Validating a patient's experiences after a disclosure and sending therapeutic messages can directly counteract the abuser's destructive messages.

Remember to send validating and therapeutic messages to the patient, such as:

- I'm glad you told me. That must have taken a lot of courage.
- I'm sorry to hear what you are going through.
- I'm concerned for your safety (and that of your children).
- You don't deserve to be treated like this. Nobody deserves to be treated like this.
- It's not your fault. It's your partner's responsibility to stop the abuse, not yours.
- You're not alone. There is help available.

Note: When safety planning with a patient with a disability, rely on your knowledge and resources for all victims, but keep in mind the disability-related limitations or challenges that make safety more difficult to achieve.

Health Assessment

Once a patient's immediate safety needs have been addressed, the HCP should conduct a thorough medical assessment of the patient. This health assessment should include not only screening for any physical injuries which the patient may have suffered as a result of past or present IPV, but also an assessment of how the IPV has affected the patient's activities of daily living and psychological status. Many women have survived years of IPV by developing withdrawal or dissociative behaviors; others have submitted to a series of marital rapes in order to avoid other forms of abuse; others may have been blocked from obtaining regular medical check-ups by their abuser for fear of disclosure; many have been repeatedly threatened that they will lose their children, or be killed, if they disclose the abuse or try to leave. These intimidation tactics often lead to a victim who suffers from unrecognized and/or untreated posttraumatic stress disorder or depression, or who has tried to escape the abuse by self-medicating with alcohol or drugs.

The consequences of the stress of living as a victim of IPV cannot be minimized or overlooked. The provider should be acutely aware of the additional damage his or her own words or actions may cause if they are interpreted as blaming the patient for being in an abusive relationship, even as chronic medical problems, exacerbated by ignorance or denial, are identified in the health screening process. All providers should be prepared to emphasize key supportive messages such as, "It's not your fault. No one deserves to be treated this way."

Documentation

As in all cases of patient care, the documentation provided by the health care professional allows for accurate ongoing assessment of a patient's health and well being. IPV is no different. Well-documented health histories in conjunction with the identification of IPV can lay the foundation for the provider's understanding of the health impact IPV has had on a given patient, not to mention facilitate improved treatment. Many professionals, however, feel threatened at the mere possibility they

may be required to testify in court. This fear may lead to failure to adequately record patient statements regarding the abuse, failure to document findings consistent with that abuse, and failure to correlate the patient's health-related issues with the abuse. Using legal terms such as "alleged" on a medical record is one example of allowing the forensic implications associated with a particular patient population to interfere with that patient's care.

There may also be concern that the documentation will harm rather than help a patient when the time for legal interface arises. From an ethical standpoint, care of the patient outweighs any potential or actual interaction with the legal system. If the focus of the professional's documentation is on "helping" the patient in court or "avoiding" a court appearance, the focus is no longer on the patient's health care needs. It is critical that the health care professional realize it is the attorney's role to address the positive and negative implications of a given patient's health record as it relates to the court case. It is the role of the health care professional to document facts, concrete observations and patient statements accurately.

The Family Violence Prevention Fund's National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings include the following recommendations:

Document Relevant History:

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

Document results of physical examination:

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

Document laboratory and other diagnostic procedures:

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

Document results of assessment intervention and referral:

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

If patient does not disclose IPV victimization:

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

Because patients' life situations and relationships change, continuing to address IPV in the form of ongoing screening is very important. The Family Violence Prevention Fund's National Consensus Guidelines recommend at least one follow-up when IPV is disclosed solely for the purpose of ongoing assessment and documentation of the abuse. In addition the IPV should be discussed at all future visits while the patient remains in the relationship.[56]

Legalities of Treating Patients experiencing IPV

During my second pregnancy and birth if I would have felt safe with the nurses, OB/GYN, and was able to disclose something, if they would have some kind of info for me, or something... "Do you really want to go home? We have some other options. Here's a social worker you can talk with... so you don't have to go back." I think just to have that info would have been a big help.

—From "A Vermont Story"

Mandatory reporting in some states may introduce tension into the doctor/patient relationship, since it appears to take decision-making out of the patient's hands. When IPV is disclosed and a report made, for instance, it is vital that patient safety needs be addressed. Providers should discuss with the patient their legal obligation to report, explain follow-up procedures that may ensue, and address the risk of reprisal and possible need for shelter or protective orders.[57] It is important to note that state statutes do not require reports for cases of intimate partner violence, but rather reports are required based on the weapons used and the severity of the injury. The patient's needs and safety concerns should be communicated to the agency that receives the report. If the patient wants immediate help, the provider should advocate for priority assistance. If the patient believes police intervention will jeopardize her or his safety, the provider should work with the patient and report recipient on how best to meet the patient's safety needs. The provider should strive to maximize the patient's input in the process.

Clinicians and health care institutions must recognize that their role in the care of the abused patient goes beyond simply obeying reporting laws; they need to provide appropriate ongoing care and try to mitigate the potential harms resulting from those laws.[58] Case law in several jurisdictions also suggests that providers could be held liable for breaching confidentiality or privacy by reporting where not required by law.[59]

Appendix A: State-by-State Reporting Requirements

New England Statutes: Mandatory Reporting by Health Care Professionals

For some IPV victims, it is necessary to seek medical attention for injuries due to violence. Although patient/provider confidentiality exists, some providers must override this privacy in order to remain in compliance with statutory reporting requirements. These requirements vary from state to state and specific statutory language should be reviewed for detailed information. However, in general most states have reporting requirements for actual or suspected child abuse and elder abuse and many states have additional reporting requirements when certain types of weapons are involved in producing the injury such as fireams.

What follows are listings of some relevant statutory titles for each of the New England states along with internet addresses where one can find the complete language for each of state's reporting requirements. This list should be used as a guide only and not as a definitive listing of all reporting requirements.

Connecticut

www.cga.state.ct.us/asp/menu/Statutes.asp

Title 17a, Chapter 319a, Sec 17a-101. Protection of children from abuse. Mandated reporters. Educational and training programs

Title 17a, Chapter 319a, Sec 17a-101a. Report of abuse, neglect or injury of child or imminent risk of serious harm to child. Penalty for failure to report.

Public Act NO. 03-267, Section 1. Section 17b-407. Elder abuse, neglect, exploitation or abandonment

Maine

janus.state.me.us/legis/statutes/

Title 22, $3477 Persons mandated to report suspected abuse, neglect or exploitation

Title 22, $4011-A. Reporting of suspected abuse

Massachusetts

www.mass.gov/legis/laws/mgl/

Chapter 112: Section 12A: Reporting firearm wounds

Chapter 112: Section 51A: Reporting of child abuse

Chapter 19A: Sections 14-26: Reporting of elder abuse

Chapter 19C: All Sections: Abuse of disabled persons

New Hampshire

www.gencourt.state.nh.us/rsa/html/indexes/default.html

RSA 631:6. Failure to report injuries

RSA 169-C:29. Persons required to report

RSA 161-F:46. Reporting of Adult Abuseparagraph I if the person seeking or receiving treatment or other

Rhode Island

www.mrrllc.com/statecodes/Rhode_Island.htm

RI 11-47-48: Reporting of firearm wounds

Title 4 Chapter 11: Reporting of child abuse

Title 42 Chapter 66: Section 8: Reporting of Elder Abuse

Title 40 Chapter 27: Reporting abuse of disabled persons

Vermont

www.leg.state.vt.us/statutes/statutes2.htm

13 VSA 4012: Reporting of firearm wounds

33 VSA Section 49-12:Reporting of child abuse

33 VSA Section 69-04: Reporting of elder abuse and abuse of the disabled

Appendix B: RADAR Screening Tool[60]

R - Routine Confidential Screening

A - Acknowledge Patient's Experience

D - Document Your Findings

(Patient report in her/his own words using quotes) (Date, time, location of incident, name and relationship of abuser, use of weapons) (Description of assault-struck with fist, thrown, kicked, etc.)

_____

_____

_____

_____

_____

_____

Examination findings:

_____

_____

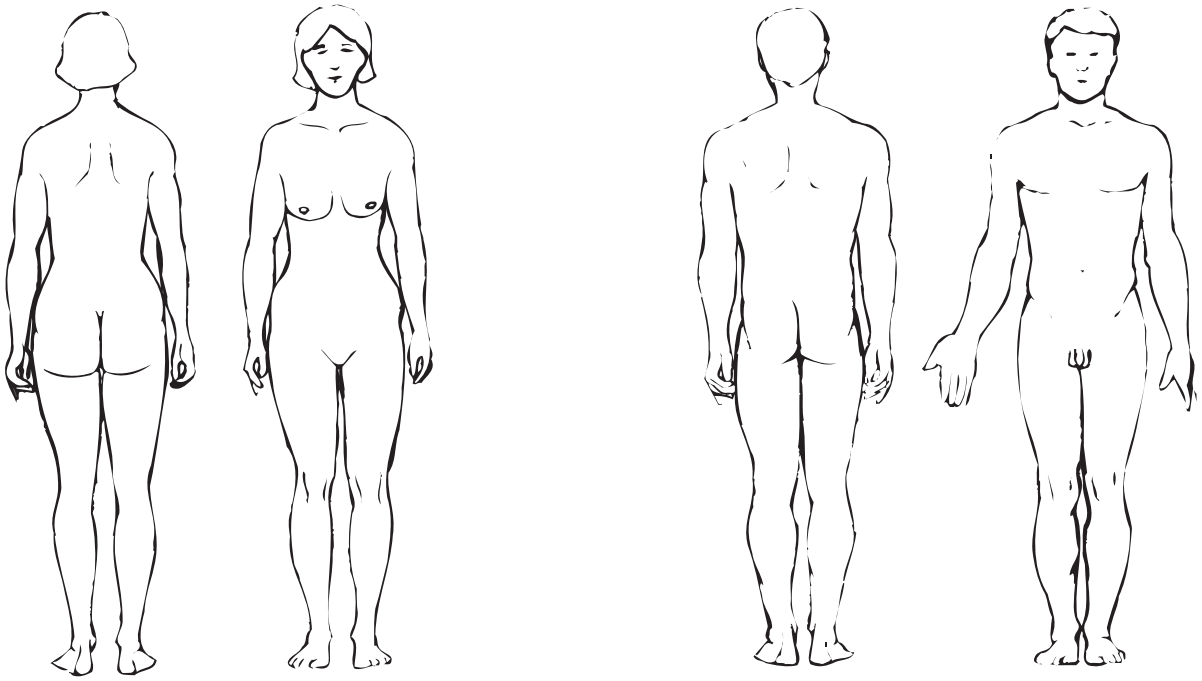
_____

_____

_____

_____

Examination findings:



A - Assess Patient Safety

Does the patient feel safe going home?	Yes No
Is there a gun in the home?	Yes No
Is the abuser there now?	Yes No
Is the patient suicidal?	Yes No
Is the patient homicidal?	Yes No
Is the abuser suicidal?	Yes No
Is the abuser homicidal?	Yes No
Is the violence increasing in severity or frequency?	Yes No
Is the abuser also abusing the children?	Yes No
Are the children safe now?	Yes No
Does the abusive partner abuse alcohol or drugs?	Yes No
Is the patient being stalked?	Yes No

R - Review of Options/Referrals

Safety plan discussed	Yes No
DV Crisis Center advocate in to see patient	Yes No
Social work referral	Yes No
DV Crisis Center hotline given	Yes No
Shelter information given	Yes No
Follow-up appointment made	Yes No
Translator available	Yes No
Translator utilized	Yes No
What language?	
Translator non-family member or friend	Yes No
Reporting	
Law Enforcement notified? City/Town_____	Yes No
Patient received/requested protective order	Yes No
Adult protective services notified (if mandated by law)	Yes No
Child protective services notified (if mandated by law)	Yes No
Photographs	
Photograph consent obtained	Yes No
Photographs taken	Yes No
Evidence	
Evidence collected	Yes No
Chain of custody maintained	Yes No

ICD-9 Code_____

Appendix C: Immediate Safety Assessment and Planning[61]

Immediate Safety Assessment

- Do you believe you are in danger right now?
- Is your partner here with you?
- Are you planning to go home with or to your partner today?
- If not, is there some place safe you can go?
- Has the abuse been getting worse, or is it happening more often?
- Does your partner use weapons, alcohol or drugs?
- Has your partner ever threatened to kill you or your children?
    - Ever sexually assaulted you?
    - Or held you against your will?
- Does your partner follow you?
    - Stalk you?
    - Track your whereabouts?
    - Call you repeatedly on your cell phone?

Safety Plan

Note: Discuss with patient but do not give to take home if unsafe to do so.

Step 1: Safety during a violent incident. I can use some or all of the following strategies:
If I have/decide to leave my home, I will go _____.
I can tell _____ (neighbors) about the violence and request they call the police if they hear suspicious noises coming from my house.
I can teach my children how to use the telephone to contact the police.
I will use _____ as my code word so someone can call for help.
I can keep my purse/car keys ready at _____ (place), in order to leave quickly.
I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.

Step 2: Safety when preparing to leave. I can use some or all of the following safety strategies:
I can contact the local IPV program for help with safety planning. The number is _____.
I will keep copies of important documents, spare keys, clothes and money at _____.
I will open my own savings account by (date) _____, to increase my independence.
Other things I can do to increase my independence include: _____

_____.
I can keep change for my phone calls on me at all times. I understand that if I use my telephone credit card, the telephone bill will show my partner those numbers that I called after I left.
I will check with _____(family, friends) to see who would be able to let me stay with them or lend me some money.
If I plan to leave, I won't tell my abuser in advance face-to-face, but I will leave a note or call from a safe place.

Step 3: Safety in my own residence. Safety measures I can use include:
I can change the locks on my doors and windows as soon as possible.
I can replace wooden doors with steel/metal doors.
I can install additional locks, window bars, poles to wedge against doors, and electronic systems etc.
I can install motion sensor lights outside.
I will teach my children how to make a collect call to_____ if my partner takes them away.
I will tell people who take care of my children that my partner is not permitted to pick up my children.
I can inform _____ (neighbor) that my partner no longer resides with me and they should call the police if he is observed near my residence.

Step 4: Safety with a protection order. The following are steps that help the enforcement of my protection order:
Always carry a certified copy with me and keep a photocopy in a safe place.
I will give my protection order to police departments in the community where I work and live.
I can get my protection order to specify and describe all guns my partner may own and authorize a search for removal.

Discharge Instructions

If you are currently being abused…

As you read this, you may be feeling confused, frightened, sad, angry or ashamed. You are not alone! Unfortunately, what happened to you is very common. IPV does not go away on its own. It tends to get worse and more frequent with time. There are people who can help you. If you want to begin talking about the problem, need a safe place to stay, or want legal advice—call one of the resources given to you today.

While still at the clinic/hospital…

- Think about whether it is safe to return home. If not, call one of the resources given to you today, or stay with a friend or relative.
- Battering is a crime and you have the right to legal intervention. You should consider calling the police for assistance. You may also obtain a court order prohibiting your partner from contacting you in any way (including in person or by phone). Ask your doctor for information on your local IPV program and the number of their crisis line. You may also contact an attorney for more information.
- Ask the doctor or nurse to take photos of your injuries to become part of your medical record.

When you get home…

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

Appendix D: The Use of Photography

No aspect of documentation in the medical record has moved as rapidly as the one involving photo-documentation as an adjunct to the written word. Injuries, whether self-inflicted, intentional at the hands of others, accidental or occupational in nature take on a dimension and scope all their own, often giving life to the verbal or non-verbal history obtained by the patient. Instant photography, by Polaroid® or digital camera have all but become the standard of care in documenting injuries caused by IPV. Both require relatively limited knowledge about photography on the part of the user, and produce instant results that can be redone immediately if necessary. It is important to understand however that photographs do not replace the written word.

Some caveats that the provider should understand prior to employing photography as a form of documentation are as follows:

- Explaining to the patient why you would like to take photographs, how you will do it and what they will be used for, as being photographed can be embarrassing and humiliating to the patient.
- A signed consent to photograph is required, unless it is a case of suspected child maltreatment.
- The photographs become a permanent part of the patient's medical record.
- Instant photographs (Polaroid ® or digital) will require a minimum of two printed hard copies. One to remain in the medical record, one to be given to or subpoenaed by the criminal justice system.
- It is recommended that a copy be made for the patient if s/he has a safe place to store them, and if not that s/he be reminded she can obtain copies of his or her record whenever necessary.
- Digital photos should be burned onto a non-rewriteable CD-ROM and stored in the medical record whenever possible to prevent alterations.
- If the patient has extensive injury, such as bruising, it is recommended that repeat photographs be taken in 24–48 hours as bruises evolve over time.

It is important that the photographs result in pictures that accurately depict the injury the provider is seeing with the naked eye. Some suggestions on how to photograph injuries include the following:

- Use color film.
- Photograph the injury with and without a standard (ruler, ABFO #2, etc.).
- Make sure the standard is in focus in the photograph.
- When possible, take pictures prior to medical treatment.
- Avoid bright backgrounds.
- Keep the film plane parallel to the plane of the patient's body surface being photographed.
- Include the patient's face in at least one photograph (usually full-length or long-range photo).
- Take mid-range and close-up photographs when possible.

Photographs need to be individually labeled so that the examiner, as well as any subsequent provider can identify the patient, the injury and when the injury occurred. The following is a list of recommendations regarding how to minimally label individual photographs:

- Patient's name
- Date and time photo was taken
- Medical record number
- Photographer's name and title
- Anatomic location of injury

Written documentation of all injuries, whether or not photography is employed should minimally include the following:

- Anatomic location of injury
- Type/description of injury (abrasion, tear, bruise, etc.)
- Size of injury
- Color of injury

Consent to Photograph

The undersigned hereby authorizes _____
Name of Organization

and the attending physician to photograph or permit other persons in the employ of this facility to photograph _____ while under the care of this facility,
Name of Patient

and _____ agrees that the negatives or prints be stored in the client's medical record, sealed in a separate envelope, so that they may be used later for evidence. These photographs will be released only to the police or the prosecutor when the undersigned gives permission to release the medical records or in case of a court order. The undersigned does not authorize any other use to be made of these photographs.
Name of Patient

_____
Date

_____
Patient Signature

_____
Witness

_____
Street Address

_____
City State Zip Code

Appendix E: Referral Resources and Other Information

State Referral Resources

Connecticut
Connecticut Coalition Against Domestic Violence
106 Pitkin Street
East Hartford, CT 06108
Tel: (860) 282-7899
Fax: (860) 282-7892
www.ctcadv.org

Maine
Maine Coalition to End Domestic Violence
170 Park Street
Bangor, ME 04401
Tel: (207) 941-1194
Fax: (207) 941-2327
www.mcedv.org

Massachusetts
Jane Doe Inc: The Massachusetts Coalition Against Sexual Assault and Domestic Violence
14 Beacon Street
Suite 507
Boston, MA 02018
Tel: (617) 248-0922
Fax: (617) 248-0402
www.janedoe.org

New Hampshire
New Hampshire Coalition Against Domestic and Sexual Violence
Tel: (603) 224-8893
www.nhcadsv.org

Rhode Island
RI Coalition Against Domestic Violence
422 Post Road
Warwick, RI 02888
Tel: (401) 467-9940
Fax: (401) 467-9943
www.ricadv.org

Vermont
Vermont Network Against Domestic Violence and Sexual Assault
PO Box 405
Montpelier, VT 05601
Tel: (802) 223-1302
Fax: (802) 223-6943
www.vtnetwork.org

Resources for Lesbian, Gay, Transgender & Bisexual (LGTB)
Women and Men
Community United Against Violence (CUAV)
24-Hour Hotline
Tel: (514) 777-5500
www.cuav.org

Gay Men's Domestic Violence Project
Tel: 1 (800) 832-1901
www.gmdvp.org

National Resources

National Domestic Violence Hotline
1 (800) 799-SAFE (7233), 1 (800) 787-3224 TTY)

Rape, Abuse & Incest National Network (RAINN)
1 (800) 656-HOPE (4673)

New England Statewide Hotlines:

CT	IPV	1 (888) 774-2900
ME	IPV	1 (800) 799-7233
MA	IPV	1 (877) 785-2020
NH	Domestic Violence	1 (866) 644-3574
	Sexual Violence	1 (800) 277-5570
RI	Domestic Violence	1 (800) 228-7395
	Sexual Violence	1 (800) 489-7273
VT	Domestic Violence	1 (800) 228-7395
	Sexual Violence	1 (800) 489-7273

Internet Resources

The Family Violence Prevention Fund
www.endabuse.org

Center for Disease Control
www.cdc.gov/ncipc/factsheets/ipvfacts.htm

National Network to End Domestic Violence
www.nnedv.org

Physicians for a Violence-Free Society
www.pvs.org

Nursing Network on Violence Against Women International
www.nnvawi.org

National Women's Health Information Center
www.4woman.gov

International Association of Forensic Nurses
www.forensicnurse.org

American Medical Association
www.ama-assn.org/ama/pub/category/3248.html

American College of Obstetrics and Gynecology
www.acog.org

American Academy of Pediatrics
www.aap.org

Blue Cross and Blue Shield Plans:

Additional copies of this guide are available online at the following web sites:

Anthem
www.anthem.com

Massachusetts
www.bcbsma.com

Rhode Island
www.bcbsri.com

Vermont
www.bcbsvt.com

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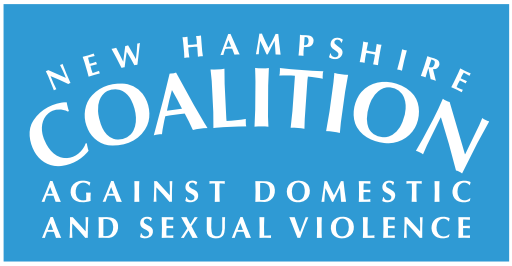
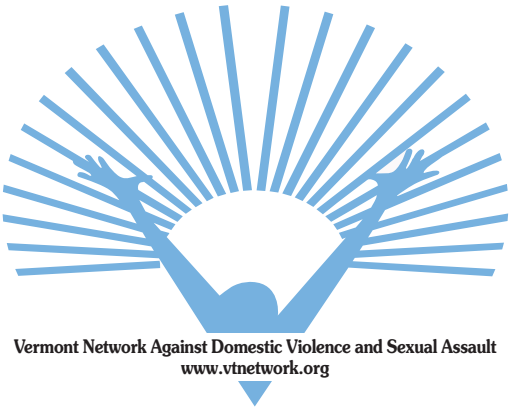
BEHAVIORAL HEALTH NETWORK INC.

The Massachusetts Coalition Against Sexual Assault and Domestic Violence



Founded in 1977



Vermont Network Against Domestic Violence and Sexual Assault
www.vtnetwork.org

FAMILY VIOLENCE
PREVENTION FUND

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