Domestic Violence and Pregnancy:

Guidelines for Screening and Referral

August 2008 Revision

- **ASK**
- **ACKNOWLEDGE**
- **ASSESS SAFETY**
- **REFER**
- **ASSURE**
- **DOCUMENT**

Washington State Department of Health

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Guidelines for Screening and Referral

August 2008 Revision

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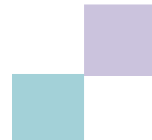

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INTRODUCTION

Domestic violence is one of the most serious public health problems facing women in this country. The Washington State Behavioral Risk Factor Surveillance System (BRFSS) found that in 2005, about 1 in 4 women age 18 or older (24%) reported experiencing some physical injury from an intimate partner during their lifetime. The prevalence of women who reported physical violence by a husband or partner before or during pregnancy (12 months prior to pregnancy and through the pregnancy) in Washington State is estimated to be 5% or approximately 4,200 women per year. The prevalence of women reporting physical violence or being threatened, frightened, controlled, or forced to have sex by their husband or partner before or during their pregnancy was 11% or about 9200 women per year. (Washington State PRAMS 2004-2006).

Perinatal health care professionals have a unique opportunity to identify, intervene, and refer pregnant and postpartum women to domestic violence resources. The prenatal care provider sees the woman often during pregnancy, talks with her alone during prenatal care visits, asks about lifestyle and issues that affect her health and the health of her unborn baby, and offers the health care setting as a safe place to disclose sensitive information.

Domestic violence is a complex issue and health care providers may feel that it is difficult to ask their clients about it. However, not asking questions about domestic violence during pregnancy may result in the provider spending more time intervening in the negative health complications from the abuse.

The role of the health care provider is not to solve the problem of domestic violence or to convince a woman to leave her abuser, but rather to screen for domestic violence at least once each trimester and once postpartum. The goal of screening is to identify and provide resources to women who are experiencing domestic violence in pregnancy. This happens when providers offer a safe setting in which to disclose abuse, give compassionate care and information, and where assistance from community resources is available. A safe setting in which to reveal this sensitive information, compassionate care and information from a provider, and assistance from community resources are essential in helping victims of domestic violence make choices to improve their health and safety.

Health care professionals can make a difference in the life of a woman and her newborn just by asking about violence. Thank you for taking the time to improve health care for pregnant and postpartum women in Washington State.

GENERAL FACTS

Domestic Violence Defined

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks, as well as economic coercion, that adults and/or adolescents use against their intimate partners to gain or maintain power and control. It involves learned behavior that is intentionally chosen by an abuser. Domestic violence occurs in heterosexual, gay, lesbian, bisexual, and trans-intimate relationships in which the individuals are dating, married, separated, divorced, or living together. Domestic violence knows no boundaries and affects people from all ages, races, socioeconomic levels, religions, cultures, and education levels. (This is a common practice definition of domestic violence and is broader than the Washington State legal definition [RCW 26.50]).

Causes of Domestic Violence

Domestic violence is behavior learned through observation, experience, and reinforcement. Illness, genetics or gender, alcohol and/or drugs, anger, stress, the victim's behavior, or relationship problems do not cause domestic violence. The abuser's behavior and tactics are chosen to get something from his/her partner, to establish domination, or to punish his/her partner. The abuser uses varying combinations of physical force and/or threats of harm and intimidating acts to instill fear. These acts require planning and are not due to poor impulse control.

Facts about Domestic Violence

- In 2005, about 1 in 4 Washington State women age 18 or older reported experiencing some physical injury from an intimate partner during their lifetime. Among those who had ever been hurt or had unwanted sex with an intimate partner, 36% reported injuries such as bruises, cuts, black eyes, vaginal or anal tears, or broken bones as a result of physical violence or unwanted sex with an intimate partner (Behavioral Risk Factor Surveillance System, 2005).
- Women who experience domestic violence during pregnancy are at increased risk for other health problems during pregnancy including delivering a low birth weight baby (The Health of Washington State, 2007).

- The prevalence of women who reported physical violence by a husband or partner around the time of pregnancy (12 months prior to pregnancy through postpartum visit) in Washington State is estimated to be 5% or approximately 4,200 women per year. The prevalence of women reporting physical violence or being threatened, frightened, controlled, or forced to have sex by their husband or partner before during their pregnancy was 11% or about 9,200 women per year (Washington State PRAMS 2004–2006).
- Domestic violence often co-occurs with other types of abuse such as child maltreatment, school and neighborhood violence (Gerwitz & Edleson, 2007).
- Studies indicate that child abuse occurs in 33% to 77% of families in which there is abuse of adults (American Academy of Pediatrics, 2004).

SCREENING AND INTERVENTION

Goals of Screening

The goals of screening are SAFETY and injury prevention. The objective is to identify individuals who are experiencing domestic violence, provide support, and refer to resources to increase safety. A health care professional who screens for domestic violence and responds to the client with support and referral to community resources is offering the best possible intervention.

Benefits of Universal Screening

Because there is no typical client profile for the battered woman, the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) recommend universal screening for domestic violence and sexual assault for all clients. Using client characteristics such as socioeconomic status, marital status, and ethnicity and cultural background as a basis for screening will lead to bias and missed opportunities to identify women who are in violent or abusive relationships. While physical signs such as broken bones and unexplained injuries may indicate domestic violence, women experiencing violent threats, emotional attacks, economic coercion, and social isolation are much more difficult to identify without direct questioning. When universal screening is used, disclosures are more likely to occur.

Benefits of Screening During Pregnancy

Prenatal care requires frequent visits to a health care professional. These visits allow the health care provider to:

- Build a trusting non-judgmental relationship with the client
- Have time alone with the client during examinations and/or home visits
- Ask sensitive personal questions
- Provide a safe environment to disclose

When to Conduct Screening

All women seeking prenatal care should be asked about domestic violence at least once each trimester and once postpartum. This sensitive issue can take time and a willingness to bring the subject up in consecutive visits before client disclosure occurs.

Creating a Safe Environment for Screening

First, create a setting where the woman feels safe to disclose private and sensitive information. A safe setting includes important resource materials about domestic violence in waiting rooms, examination rooms, and restrooms (Appendix A), staff who are alert to signs and symptoms of domestic violence (Appendix B), a well articulated confidentiality policy, a private place for clients to make phone calls, and a standard policy that ensures privacy when screening clients about sensitive issues. Privacy is essential because the woman may choose not to disclose abuse if others are present. For example, if her children are present she may fear the impact of this disclosure on her children or fear for her safety because the abuser may use the children as informants.

Second, "frame" the domestic violence questions so that the subject is not suddenly and awkwardly introduced. A "framing statement" also helps to reduce the likelihood of the client being offended or caught off guard. Following are examples of direct language that providers can use to "frame" the issue before asking the questions:

> "I don't know if this is a problem for you, but some of my clients are in relationships where they don't feel safe. Some are afraid or uncomfortable to bring this up, so now I ask all my clients if they feel safe at home."

> "We know that domestic violence is a common problem in the United States. In Washington State about 20% of women report they are hit, threatened, or controlled by their partner. So now I always ask my clients direct questions about abuse."

ASK

The following are sample questions from the Prenatal History Questionnaire developed by Physician's Insurance: A Mutual Company (Appendix A). Questions can be either direct or indirect depending on interview style, the culture of the client and the perceived trust level in the client/provider relationship. These questions are:

- Do you feel safe? In your personal relationship? In your home? In your own neighborhood? Other?
- Have you ever had your feelings repeatedly hurt, been repeatedly put down, or experienced other kinds of hurting?
- Are you being, or have you ever been, hit, slapped, kicked, pushed, or otherwise been physically hurt? If yes, by whom?
- Are you experiencing or have you ever experienced uncomfortable touching or forced sexual contact? If yes, by whom?

Additional questions include:

- When was the last time you felt threatened by your partner?
- How often do you feel scared or hurt by your partner?

Beyond the Questions

Screening for domestic violence goes beyond asking questions. Language and behaviors of different cultures require careful assessment because they provide valuable cues to providers. Cues for domestic violence may include behaviors such as failing to keep scheduled appointments, being unable to speak in the presence of a partner, or being forced to accept blame for the partner's behavior.

The skillful practitioner has the ability to listen and observe behaviors that provide valuable cues about the presence of domestic violence. Listen carefully for verbal cues suggesting domestic violence such as:

> "He has a bad temper," may mean, "He beats me."
>
> "He acts funny," may mean, "He gets drunk and violent."
>
> "It was an accident," may mean, "He hit me."
>
> "Pen pal" and "mail order bride" may mean a potential victim who may be threatened with deportation.

> “My mother-in-law will not like that,” may mean that the mother-in-law and son are controlling or abusive.
>
> “My partner was just drunk,” may mean, “My partner attacked me under the influence.”

Make note of the behaviors and language choice over time. Use these cues to ask more questions directed at what is heard or observed.

When Domestic Violence Is Not Disclosed

In some instances, no matter how sensitively “the question,” is asked, some battered women feel unsafe revealing their situation. This may be due to a reasonable fear of retaliation by the abuser and fear of the consequences of disclosure. A victim of domestic violence may deny abuse because she believes it is unsafe to trust healthcare providers with this sensitive information. The astute provider responds in a nonjudgmental way that keeps the door open for future discussion.

The following statements build trust:

> “If things ever change, I am here for you and am willing to listen.”
>
> “If this becomes an issue for you in the future please know that I am open to talking with you. My job is not to tell people how to live their lives, but to talk about choices, safety, and resources for help.”
>
> “I am glad you are not being hurt by your partner. I always tell my clients that it is safe to talk about their fears or any abuse they may have experienced. We have resources that will help.”
>
> “I am glad to hear there is no abuse now. Should that ever change, this is a safe place to talk.”
>
> “Because many women are hurt by their partners, we are giving this brochure to every woman we see. You may have a friend who might find this useful.”

Many pregnant women are in safe and supportive relationships. Their answers indicate that domestic violence is not an issue for them and this should be documented. These clients may know someone who needs this information. The healthcare professional who frames and asks the screening questions has educated the client about domestic violence issues and the provider’s role as a trustworthy resource.

ACKNOWLEDGE

When a woman discloses domestic violence, the provider should acknowledge and validate the victim's experience. By asking about domestic violence and offering a safe place to disclose her situation, the prenatal care provider has provided support and information to the client. This supportive environment can reduce feelings of isolation for a battered woman.

When Domestic Violence Is Disclosed

When a client discloses domestic violence, follow these steps:

- Acknowledge the abuse and the victim's courage.
- Make the victim feel as comfortable as possible. Affirm the client's autonomy and right to control decision-making.
- Use supportive statements such as, "I'm sorry this happened. You don't deserve this. It's not your fault."
- Explain confidentiality of information and records.
- Assure her that you are committed to her health and safety and are available to help when she is ready. Let her know that you are concerned. Be sure to ask her if it is safe to go home.
- Encourage her to call with health concerns and offer resources and referrals for other types of support.
- Review a safety plan with her. A Safety Plan Pocket Guide is available free of charge in numerous languages from DSHS (see Appendix A).

ASSESS SAFETY

Assess the woman's immediate safety by asking:

- Do you feel safe to go home today? Are you afraid that your partner may seriously harm you?
- Are there weapons in your home? What type?
- Has your partner ever threatened you with homicide or suicide?
- Is confidential shelter an option you are interested in seeking?
- What is your plan if future violence occurs?
- What is one thing, in your opinion, that could be done to support you?

Safety Planning

Whenever the health care provider is concerned about a victim's safety, it is advisable to discuss the importance of safety planning. Inform the client that domestic violence advocates can help plan for her safety if she decides to leave or stay with her abuser. Choosing to reveal information about the abuse to anyone outside the relationship or leaving the abuser is a dangerous time for the survivor of domestic violence. **Most fatalities or serious injuries occur when the survivor tries to leave the abuser.** Inform the client that a domestic violence advocate can help to develop a detailed safety plan that includes the following elements:

- Strategize how and where to secure and hide money, an extra house or car key, important documents, ID, passports, immigration papers, social security cards, and children's immunization records.
- Develop a code with family/friends to signal the need for help.
- Identify a safe neighbor to call 911 if an altercation is heard.
- Plan escape routes, places to hide and store clothing, jewelry, and photos.
- Discuss referral resources, local advocates, shelters, legal options, and when to call 911.
- During abusive or violent altercations, avoid rooms where weapons or dangerous implements are present (for example, in the kitchen with knives).

Assess Her Children's Safety

Prior to assessing for child safety, please advise the woman that abuse or neglect of children mandates a report to Child Protective Services (CPS). Explain that, if possible, you would like her to make the report with you. RCW.26.44.020 (15) was modified in 2007 to say "Exposure to domestic violence that is perpetrated against someone other than the child does not constitute negligent treatment or maltreatment in and of themselves." For children with domestic violence exposures, there has to be abuse or neglect factors that would require a mandated report.

- Has your child ever been hit or shaken when your partner was trying to get at you?
- Has your partner ever hit your child that caused bruises or injuries to your child?
- Has your partner ever touched your child in a way that made you feel uncomfortable?
- Has your partner interfered in your ability to provide food, shelter, or medical care for your children?

This is one of the most sensitive areas of screening because of the risk and fear of the woman about the potential to lose her child. Because the vulnerability of the child in domestic violence is great, it is important to inform the woman of your role and screen for the child's safety. Here is an example of a sensitive way you can bring up this topic:

> "Often women who have had experience with domestic violence have concerns about their child's safety. Do you have any concerns for your child?"

If she answers NO, let her know that if she ever does become concerned, there are resources that can be of help and offer her a pocket safety card if she is interested.

If the answer is YES, interrupt her and inform her of your responsibility to report.

> "I care about you and your child, and I need to ask you some questions about the safety of your child. Because of my professional responsibilities, I'm required to report any abuse or neglect of a child. Before we begin, do you have any questions about this?"

If there are no questions, ask her the following to assess for the child's safety:

- Has your child ever been hit or shaken when your partner was trying to get at you?
- Has your partner ever hit your child that caused bruises or injuries to your child?
- Has your partner ever touched your child in a way that made you feel uncomfortable?
- Has your partner interfered in your ability to provide food, shelter, or medical care for your children?

If she answers YES to any of the above questions, ask her to make the call to CPS with you to report the abuse and offer her a quiet place to call a local domestic violence agency for support and resources.

There are many ways a mother may be concerned about her child as a result of domestic violence that are not reportable. For example, her child may be acting out by hitting her or others, or her child may be withdrawn or upset after witnessing an incident. See Appendix C, Basic Legal Issues, for more information.

REFER

It is important to have updated referral sources available to a woman when she discloses violence. Providing her with referrals is a tool to support her decisions, enhance her safety options, and plan for immediate and long-term needs.

- If the client is interested in developing a safety plan, a referral to a community based domestic violence advocacy program would be helpful. The domestic violence victim advocates support the victim and acknowledge her existing resources and strengths as a survivor. Domestic violence advocates are trained to assist victims with comprehensive safety planning and support the victim's connections to varied community resources (Appendix E).
- Introduce yourself to the local domestic violence service programs and build a relationship that will provide you with program information and facilitate future referral requests.
- See Appendix A for resource websites and information for ordering Safety Plan Pocket Guides. Use caution when giving women printed materials to take home. Taking home such materials may not be safe for her. Offer clients the option of using the phone to call the Washington State Domestic Violence Hotline (Appendix A).

ASSURE

A victim of domestic violence, especially a pregnant one, needs support for all facets of her life. Here are a few ways you can let her know you support her.

- Assure her that you care about her health and safety.
- Assure her that your office is a safe place for her to disclose and get resources for domestic violence.
- Assure her that the violence or abuse is not her fault.
- Make a follow-up appointment with the client.
- Do not recommend couples counseling or anger management classes.

DOCUMENT

Below are tips for documenting an incident of violence or abuse. Even if the victim does not give you all of the details or answer all of your questions, document what she does tell you. Please see Appendix E for a sample body map and documentation form.

- Ensure confidential documentation. Clinical judgment determines level of detail and location of medical record to ensure client safety and privacy.
- Write legibly.
- Note the date, time, place, identity, and relationship of assailant to victim.
- Specify the mechanism of injury (e.g. gun, knife, fist).
- Describe all injuries using a body map.
- Use factual statements, rather than summary statements.
- Note the client's demeanor, for example, whether she is crying, angry, or calm.
- Use client quotes that describe the abuse such as "my husband hit me in the stomach with a golf club this morning" rather than "client was hit in the stomach with a golf club." Avoid phrases such as "client claims" or client alleges" which obscure the client's credibility.
- Avoid the use of legal terms. Use terms such as boyfriend or partner instead of "alleged perpetrator" or "assailant" and use hit, punched, kicked, cut instead of "assault." Use the client's words to describe their abusive/violent experiences instead of the term "domestic violence"
- Photograph injuries if possible: obtain verbal or written consent of the client. The woman may refuse photography due to cultural or personal reasons.
    - If clinically appropriate, take photos before treating injuries: use color film, shoot different angles, include a full body shot, a close up shot, and include the face in at least one photo.
    - Label each photo with client's name, date of birth, date and time the photo was taken, and signature of photographer. Place photos in sealed envelope marked CONFIDENTIAL – DO NOT RELEASE and place in the chart. Release only with written client consent, subpoena, or other court order.

Safety While in an Abusive Relationship

Survivors of domestic violence leave when they are ready and when they feel it is safe to do so. It often takes multiple attempts before a woman leaves for good. Reasons for staying in a violent relationship are different for each victim according to her situation and may include:

- Fear of increased violence towards herself or her children
- Immobilization due to psychological and/or physical trauma
- Dependence on the perpetrator for money, shelter, and health care
- Fear of being 'outed', deported, disloyal, or arrested
- Fear of exposure to Child Protective Services, to her employer, or to her family
- Cultural belief that promotes preservation of the family unit
- Lack of financial resources for legal assistance
- Immigration status
- Hope that the violence will stop
- Continued affection for the abuser during non-violent periods
- Religious or community values to preserve the family unit

Health care professionals can support a survivor's process of leaving by providing a culturally competent, institutionalized response affirming battered women and their decision-making ability. Make it standard practice to screen and provide follow up and referral as part of the routine prenatal care women receive. Trust that your client knows more about her/his safety than you do and support their decisions. Health care providers can also suggest that the client contact the domestic violence victim advocate to discuss what they can do to be safe at home. Offer a private place in your office for clients to place a phone call. If the client is unable or chooses not to contact the advocate, share the Safety Plan Pocket Guide with her (Appendix A). Introduce the card with the following statements:

> "I understand that you are an expert regarding your own situation. Here are some ideas that you might not have considered and may help you increase your safety. Will it help to take the materials with you? Is it safe for you to do so?"

> "I respect your decision. Only you know best what will work. Here are some ideas that have helped women stay safe. Can we review these together? Is it safe to take this with you?"

SUMMARY

Domestic violence afflicts women from all walks of life. Universal screening, identification, and appropriate interventions are keys to promoting the safety and well-being of the pregnant woman and her unborn child. Perinatal health care providers are in the unique and advantageous position of providing care in a very private and intimate setting, allowing an opportunity to address the sensitive issue of domestic violence. Respect, compassion, and empathy are valuable gifts health care professionals can offer to any women experiencing domestic violence. Knowledge of community resources to assist a client who is experiencing domestic violence, and understanding where and how to refer are basic skills for providers working with pregnant women.

APPENDIX A – Important Resources

Family Violence Prevention Fund
http://endabuse.org/
A variety of resources and material to help you better understand and deal with domestic violence when you encounter it. Please see the Preventing Domestic Violence: Clinical Guidelines on Routine Screening at http://endabuse.org/programs/healthcare/files/screpol.pdf .

Physicians Insurance: A Mutual Company
1-800-962-1399
http://www.phyins.com/pi/index.html
Prenatal record forms and listing of domestic violence providers in Washington State.

Washington State Coalition Against Domestic Violence
206-389-2515, ext. 104 /206-389-2900
http://www.wscadv.org
General information, public policy, advocacy education, training, and link to local programs.

Washington State Domestic Violence Hotline
1-800-562-6025 V/TTY
The hotline is a good first-step to obtain general information and referral for clients, perpetrators, the general public, and professionals. This line can link to battered women to advocates or to interpreters for any language in the victim's community.

Washington State Medical Association
1-800-552-0612 or 206-441-9762
e-mail: WSMA@ wsma.org
Information for members of WSMA addressing domestic violence.

Washington Violence Against Women Network
http://www.wavawnet.org
This website lists all of the Domestic Violence agencies in the State of Washington, provides complete contact information and services provided.

Safety Plan Pocket Cards

DSHS Safety Cards are available in the following languages:

Cambodian
Chinese
English
Korean
Laotian
Russian
Spanish
Vietnamese

Follow the instructions below for online ordering at no cost to you:

1. Go to http://www.prt.wa.gov
2. Register by submitting your e-mail address and a password
3. Once registered, go to "GENERAL STORE"
4. Select "Shop by Agency"
5. Select "DSHS"
6. Select "Economic Services Administration"
7. Select "General Economic Services"
8. Look for cards under number 22-276 and select language needed
9. Follow instructions for ordering the cards

APPENDIX B – Signs and Symptoms of Domestic Violence

The majority of victims present without any obvious signs or symptoms of domestic violence. The following signs and symptoms may exist when domestic violence is present but do not always indicate evidence of abuse. All women should be screened for domestic violence.

Behavioral Cues

- **Changes in appointment pattern** — This may reflect the abuser's desire to hide physical indicators of abuse (scratches, bruises, welts) and control the victim's access to information and possible support. Cancellation of two or more appointments by a male partner is indicative of possible domestic violence.
- **Overprotective partner** — The partner frequently or always accompanies the client, seems controlling, and always speaks for her.
- **Threatening partner** — Batterers may glare at their partners, use threatening words or gestures, restrict their partner's movements, or use other tactics designed to maintain power and control over victims and anyone offering assistance.
- **Multiple visits for vague somatic complaints** — Battered women use medical services eight times the rate of non-battered women, yet are identified and referred to domestic violence programs only 4–6% of the time.
- **Late entry or sporadic utilization of prenatal care** — The reasons for this may be similar to that of changes in appointment pattern above.
- **History of domestic violence** — A United States Department of Justice study found once a woman is victimized by a partner, she is at substantial risk of repeat victimization by that partner. During 6 months following a domestic violence incident, approximately 32% of victims were victimized again.

Physical Cues

- Poor management of asthma, diabetes, or other chronic conditions
- Chronic pain
- Headache
- Pelvic or abdominal pain
- Dyspareunia
- Irritable Bowel Syndrome
- Somatization Disorder
- Frequent vaginal or urinary tract infections

Visible Injuries

Injuries during pregnancy may follow a pattern and provide cues for domestic violence. Be alert for injuries primarily to the central region of the body (especially the abdomen) and for multiple injuries—often seen on the chest and genitalia. Other common injuries resulting from domestic violence include:

- Fractured mandible, peri-orbital hematoma, perforated tympanic membrane, lacerations around eyes and lips. Accidental bumps to the head usually occur on the forehead or upper occipital area—not on sides or directly on top of the head. Suspect physical assault with evidence of ruptured eardrums, loosened teeth, and scalp injuries. Black eyes may be hidden beneath sunglasses or heavy make-up. Injuries may also be hidden under long sleeves, turtlenecks, or scarves.
- Old injuries and bruises in various stages of healing. Consider assault when injury explanation is implausible, medical care is delayed, or multiple injuries exist. Unintentional extremity bruises are usually seen on the outer part of extremities; whereas intentional injuries are seen on the inner aspect of arms or thighs.
- Recurrent minor trauma, human bites, burns.
- Injury to the abdomen. Pregnancy does not make women particularly clumsy. Falls or any injury in a pregnant woman, especially an injury to the abdomen, should raise the index of suspicion and be documented.

Psychosocial Cues

- Chronic substance misuse/ alcohol or other drug addiction. While not a cause of addiction, domestic violence may be a co-occurring problem.
- Stress-related symptoms such as fatigue, anxiety, headache, difficulty concentrating, appetite disturbances, palpitations, dizziness, paresthesia, and dyspnea.
- Post traumatic stress disorder (PTSD) symptoms including hypervigilance, exaggerated startle response, feeling detachment from others, sense of shortened future, difficulty sleeping, and irritability or outbursts of anger. (For many battered women there is nothing 'post' about their stress. Providers are encouraged to screen all women presenting with PTSD symptoms for both past and current abuse histories).
- Eating disorders
- Depression
- Suicide attempts

APPENDIX C – Basic Legal Issues

Most acts of domestic violence do not require mandatory reporting by medical professionals in Washington State. In 2007, RCW 26.44.020 (15) was modified to say “Exposure to domestic violence that is perpetrated against someone other than the child does not constitute negligent treatment or maltreatment in and of themselves.” For children with domestic violence exposures, there has to be abuse or neglect factors that would require a mandated report.

Some acts of domestic violence are against the law. The legal definition of domestic violence is narrower than the behavioral definitions, and is generally restricted to physical acts of violence or the threat of imminent physical harm.

In Washington State, the police are mandated to arrest a perpetrator if there is probable cause to believe a domestic violence assault has occurred within the last four hours. However, if a domestic violence assault occurred after four hours, the police still have the discretion to make an arrest with probable cause.

Civil Orders for Protection are available for victims of domestic violence who are at least 16 years old, and do not require police involvement when seeking an order. The victim initiates the civil order process; an attorney is not needed. If the criminal provisions of the civil order are violated and reported, police must become involved.

Civil Orders for Protection:

- Provide options for victims
- Are free of charge
- Do not require police involvement or attorneys
- Are available at district or superior court (or in special circumstances by phone)
- Are available to people age 16 and older and to those under age 16 with parent/guardian
- Grant temporary custody of children
- Require the state to provide qualified interpreters at court hearings.
- Civil order forms are printed in multiple languages.

APPENDIX D – Barriers to Universal Screening

Domestic violence is a complex issue, and there are many reasons why health care providers fail to routinely screen pregnant women. Lack of awareness, perceived lack of time, hesitation to intrude on private matters, inability to "fix" the problem, and lack of education and resources can present barriers to screening. However, failure to screen for domestic violence during pregnancy can result in the care provider spending more time to address the repeated and long-term consequences of abuse.

Health care providers are taught to take a history, formulate a diagnosis, and prescribe appropriate treatment. In this instance, however, the traditional approach can mirror the controlling and disempowering behavior of an abuser. The most effective approach is to convey respect and concern and avoid body language that exhibits impatience, indifference, or discomfort. Providers should listen and believe the client, assess immediate safety concerns, and let the client know about local domestic violence resources. For victims of domestic violence, it is essential for the health care provider to respect the client's ability to make choices she feels are best for her. With this approach, the client is made aware of her options and feels supported as she goes through the process of finding safety.

Myths about Screening for Domestic Violence

Myth #1: There is not enough time

A simple protocol for domestic violence screening can easily be incorporated into your routine practice. This booklet is designed to help you frame your questions, ask appropriate questions, assess safety, and make a referral. In most cases, assessment and intervention takes no more than five minutes. In some cases, the medical assistant or office nurse may ask the routine screening questions.

If the client screens positive for domestic violence, the provider should do the follow up intervention. If time is short, validate the woman's response and offer support: "I see how upset you are and want you to get the best possible help. This is not your fault and I'm sorry it happened. I'm not an expert on domestic violence but I do know of a great resource in the community (name your local domestic violence victim service provider.) We can call the hotline now and you can talk with an advocate about your situation in private. Does this sound like a good option for you?" Ask if the woman feels safe to go home at this time. If not, encourage her to talk privately with the advocate on the hotline to work out a safety plan before leaving your office.

Myth #2: Domestic violence is an insurmountable problem

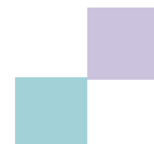
Health care providers are not expected to fix the problem. Providers should call a domestic violence hotline for consultation or to connect the client directly with the hotline. Domestic violence advocates are experts in the community who know the system and are trained in facilitating the victim's decision-making and safety planning.

Myth #3: It is too dangerous to screen for domestic violence when the perpetrator is in the waiting room or is also a client

Your priority is to keep your client and your office staff safe. Once again, developing a simple protocol for your practice is the best solution. For example, always interview the client alone (without her partner) when asking about domestic violence. Never confront the abuser. Never attempt to mediate between the abuser and victim. Have the referral information readily available for the client. Although it is unlikely that the perpetrator will become verbally or physically abusive in the health care setting, make a plan in case the perpetrator does become difficult. Ask your local domestic violence agency for some assistance with this (Appendix A).

Myth #4: Asking about domestic violence is too intrusive, interferes with family matters, or offends clients

When survivors are interviewed they frequently state that they wish their physician had asked them about domestic violence. They are often surprised when the medical professional treats the injury and never asks about domestic violence. Ninety percent of female clients in a primary care population believe that physicians can help with problems related to abuse (American College of Obstetricians and Gynecologists, 2006).

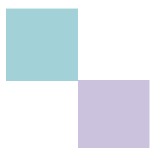


APPENDIX E – About Domestic Violence Advocates

Domestic violence advocates are trained staff who work in domestic violence services and provide advocacy based counseling, counseling, and supportive temporary shelter services to clients (WAC 388-61A-0025).

Advocates are required to have at least 20 hours of training with ongoing yearly training requirements on a variety of topics pertinent to their field. Services may vary from shelter to shelter. Domestic violence agencies may be able to provide the following services to your client:

- Emergency shelter
- Systems advocacy—navigating housing, legal, and medical systems
- Referrals to assistance programs such as Section 8, Temporary Assistance for Needy Families, health care
- Referrals to counseling, perpetrator treatment
- Legal advocacy in obtaining a protection order
- Children's advocacy or children's programs in shelter
- Support groups
- Safety planning
- 24-hour availability
- Other languages
- Someone to listen



APPENDIX F – Body Map

Date: ______________ DOB: ______________ Age: ____ Name: ______________________________

T: _______ BP: _______ / ______ P: ______ R: ______ Ht: ________ Wt: _____ Pain? ☐ N Y: ______/ 10

New meds since last visit (☐ None) ______________________________

Allergies (☐ NKDA): ______________________________ LMP: ________________

Patient concern: ______________________________

Signature/Title: ______________________________ **Date:** ____________________

Name of alleged assailant: __________________________ **Relationship to patient:** ______________________

Social History: ______________________________

____

____

Names and ages of any children present in the home: ______________________________

____

History of acute events: ______________________________

____

____

____

S: ______________________________

____

____

____

____

____

____

____

____

____

____

Y	N	System
☐	☐	Headache
☐	☐	Fever/Chills
☐	☐	Blurry vision
☐	☐	Ear pain
☐	☐	Chest pain
☐	☐	SOB
☐	☐	Abd pain
☐	☐	Dysuria
☐	☐	Joint pain
☐	☐	Rash
☐	☐	Fatigue
☐	☐	Depressed

O: ☐ **Pertinent medical, family, and social history reviewed**

EXAM	NE	NL	ABNL	COMMENTS
Constitutional (General appearance, NAD)	☐	☐	☐	
Psych (A & O x 3, nl mood & affect)	☐	☐	☐	
Head (normalocephaiic/atraumatic)	☐	☐	☐	
Eyes (nl conjunctivae/lids; nl pupils/irises)	☐	☐	☐	
ENT (nl TM/ext canal B/L; nl oral mucosa; nl nasal mucosa)	☐	☐	☐	
Neck (supple; no LAD; no bruits; no thyromegaly)	☐	☐	☐	
Respiratory (CTA, no RRW)	☐	☐	☐	
CV (RRR, nl S1S2, no MRG; no edema)	☐	☐	☐	
GI (soft, NABS, NT/ND, no mass; no HSM)	☐	☐	☐	
MS (nl gait; no clubbing/cyanosis)	☐	☐	☐	
Skin (no rashes/lesions/nodules/thickening)	☐	☐	☐	
Neuro (CN; sensation nl; DTRs)	☐	☐	☐	
Lymphatic/Breast/GU				

Physical exam note: If sexual assault is included, follow Sexual Assault Protocols: Warm Springs Health and Wellness Center. Describe all injuries, location, size, and cause per the patient's report (i.e. "kicked with boot," "thrown into wall"). With patient's written consent, photograph her. Include at least one face photo for identification, and photograph all wounds. For bruises, lacerations, etc., place a ruler in the photo for a size reference.

Labs/Orders: ____________________

A/P: ____________________

☐ 10/15/25/40 min with >50% in Couns/Coord of care Re: ____________________

☐ Photos taken ☐ Release signed ☐ Refer to DV clinic

☐ Rotary Grant recipient

Follow-up: ____ days/weeks/months/PRN

Patient Education: ☐ Patient ☐ Family/significant other ☐ Oral ☐ Printed

☐ Barriers to learning accommodated ☐ Acknowledges understanding

Educated on ☐ DV resources ☐ Other: ____________ ☐ Risks/benefits & SE's of new meds

Signature/Title ____________________ **Date** ____________

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TECHNICAL NOTES

Behavior Risk Factor Surveillance System (BRFSS): A Centers for Disease Control and Prevention survey that collects information, via telephone, from non-institutionalized English-speaking Washington State adults on personal behaviors and practices that promote health and prevent the leading cause of death. The Washington State Department of Health has been collecting BRFSS data on domestic violence since 1998. For more information, contact Katrina Wynkoop Simmons at 360-236-4248.

Pregnancy Risk Assessment Monitoring System (PRAMS): An ongoing population based surveillance system sponsored by the Centers for Disease Control and Prevention that surveys new mothers who are representative of all registered births to Washington State residents. The Washington State Department of Health has been collecting PRAMS data since 1993. For more information on PRAMS data, contact MCH Assessment at 360-236-3533 or visit the website at www.doh.wa.gov/cfh/prams/.

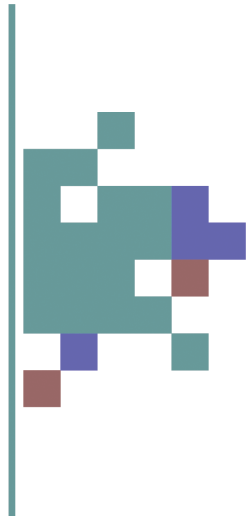
The PRAMS questions included in the definition of physical violence were:

- During the 12 months before you got pregnant, did an ex-husband or ex-partner push, hit, slap, kick, choke, or physically hurt you in any other way?
- During the 12 months before you got pregnant, were you physically hurt in any way by your husband or partner?
- During your most recent pregnancy, did an ex-husband or ex-partner push, hit, slap, kick, choke, or physically hurt you in any other way?
- During your most recent pregnancy, were you physically hurt in any way by your husband or partner?

The PRAMS questions included in the definition of being threatened, frightened, controlled, or forced to have sex were:

During your most recent pregnancy (check yes or no)—

- Your husband or partner threatened you or made you feel unsafe in some way
- You were frightened for safety of yourself or your family because of anger or threats made by your husband or partner.
- Your husband or partner tried to control your daily activities, for example, controlling who you could talk to or where you could go.
- Your husband or partner forced you to take part in sexual activity when you did not want to (including touch that made you uncomfortable).



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