2006

Domestic Violence Policy Guidelines

A Model for Maryland's Healthcare Community

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Endorsed in 2001 by Georges C. Benjamin, MD, Secretary
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Purpose

The Maryland Health Care Coalition Against Domestic Violence was created in 1998 to provide leadership within the health care community in promoting a proactive and effective response to domestic violence through screening, identification, education, intervention and treatment of domestic violence victims. In 2001, the Coalition created these guidelines to give guidance to health care providers in Maryland in developing protocols and procedures responding to domestic violence that create practice environments and models that are effective and reflective of an integrated coordinated community response.[1] The guidelines were updated in 2006.

According to the CDC, nearly 5.3 million U.S. women, ages 18 and older, are victimized by intimate partners each year. Domestic violence results in approximately 2 million injuries and 1300 deaths annually.[2] Health care providers have a unique opportunity and responsibility to respond to domestic violence. Medical practitioners are often the first, and sometimes the only, professionals to whom a victim of abuse turns to for help,[3] According to the American Medical Association, "battered patients often present with repeated injuries, medical complaints, and mental health problems, all of which result from living in an abusive situation. In general, women with a history of domestic violence describe 60% higher rates of overall health problems than do women with no history of abuse.[4] Medical care providers in all practice settings routinely see the consequences of domestic violence and abuse but often fail to acknowledge their violent etiologies."[5] Since January 1992, the Joint Commission Accreditation of Healthcare Organizations (JCAHO) has required that all accredited hospitals implement policies and procedures for identifying, treating, and referring victims of abuse.

Coordinated Community Response

Ongoing abuse within a family carries serious consequences throughout the entire community. It affects the home, workplace, religious institutions, the criminal justice system, law enforcement, education, and of course, the health care system. Without intervention, the cycle of violence will continue. Since domestic violence impacts so many parts of the community, it is up to the community to work together to reduce and prevent domestic violence.

Currently, medical treatment is often given to patients with little recognition of the underlying issue of domestic violence. While the focus of health care systems may be on diagnosis and

[1] Maryland Health Care Coalition Against Domestic Violence Bylaws, 1999.
[2] Centers for Disease Control. (2003). Costs of intimate partner violence against women in the United States. Atlanta, GA.
[3] Family Violence Prevention Fund, 1993.
[4] Campbell, J.C., Jones, A.S., Dienemann, J., Kub, J. Schollenberger, J., O'Campo, P., et al. (2002) Intimate partner violence and physical consequences. Archives of Internal Medicine; 162(10):1157-63.
[5] "Diagnostic and Treatment Guidelines on Domestic Violence," American Medical Association, 1992.

treatment, an optimal response to domestic violence necessitates that clinical interventions become part of the community response. Early identification, intervention and support in health care settings is an integral part of a coordinated community response to domestic violence and of benefit to victims in increasing their health and safety. Longitudinal studies show that intervention with abused victims has proven to be highly effective in increasing the safety of victims.[6]

A coordinated community response includes:

- Coordinating with organizations within the health care community addressing domestic violence.
- Creating a private setting within a practice for victims to discuss the violence in their lives.
- Learning what resources are available in the community and coordinate new initiatives with those that currently exist to develop community specific referral networks.
- Improving the commitment and availability of institutional support so that staff will routinely screen for domestic violence and provide appropriate intervention.
- Providing leadership in domestic violence prevention by participating in public education, victim advocacy and political action through community education, media campaigns, health departments, and professional organizations.
- Participating in local domestic violence coordinating councils.
- Supporting prosecution efforts through appropriate medical documentation.

Level of Responsibility

The Maryland Health Care Coalition Against Domestic Violence believes that the optimal response to domestic violence requires the coordinated efforts of all members of the health care community. In addition to seeking medical treatment in emergency departments, victims of family violence are likely to seek outpatient care for both routine health maintenance and the physical and psychosocial sequelae of victimization. Thus, practitioners in outpatient settings are in a unique position to provide early detection and intervention for victims. Specialized domestic violence training should be provided to health care providers in order to identify victims of domestic violence and provide effective intervention.

Definitions

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks that adults or adolescents use against their intimate partners. It may occur in a variety of relationships – married, separated, divorced, dating, heterosexual, gay and lesbian. Domestic violence victims and batterers represent all races, ages, religious, educational backgrounds and income groups. It is primarily a learned behavior, which has effects that, without intervention, become more destructive over time. Domestic violence is often directed at a particular victim and also victimizes children, families, strangers and the entire community.

[6] McFarlane, J. Parker B., Soeken, K., Silva, C., Reel, S. (1998). Safety Behaviors of Abused Women Following an Intervention Program offered During Pregnancy. *Journal of Obstetrical, Gynecological and Neonatal Nursing,* January, 1998.

Routine Screening: Routine inquiry, either written or verbal, by health care providers to patients about personal history with domestic violence. Unlike indicator-based screening, routine screening means screening conducted regularly on all individuals.[7]

Screening

The Maryland Health Care Coalition Against Domestic Violence endorses universal screening. All patients should be routinely screened for domestic violence. Routine and multiple screenings by skilled health care providers, when conducted face-to-face, markedly increase the identification of domestic violence.[8] Screening of all patients should include questions about behavior as well as the patient's perception of fear and safety. In addition to questions, health care providers should be vigilant for observable signs and symptoms, both direct and indirect, of possible abuse. Screening should be ongoing as a patient's abuse status can change over time. Health care administrators should use objective data to track compliance with screening protocols and should maintain statistics of numbers of victims identified.

Screening should:

- Take place in a safe environment.
- Be conducted privately.
- Use questions that are direct, specific and easy to understand.
- Have questions available in the patient's primary language.
- Use questions that are age and developmentally appropriate.
- Be culturally-appropriate, using professional interpreters when needed, rather than a patient's friend or family member.
- Include clinical observations by the provider.
- Have results documented in the patient record.
- Be postponed if privacy or a safe environment is not available.

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Assessment

Essential elements of initial assessment include a history of presenting chief complaint, physical examination, history, current abuse, and immediate safety needs. Further assessment also includes assessment of the patient's family constellation since domestic violence is intricately connected to child health. Child abuse occurs disproportionately in homes where domestic violence exists.[9] Additional assessments should be completed by appropriate personnel, such as a domestic violence advocate, social worker, or counselor who is a member of the healthcare team. Appropriate assessment includes the following elements.

Assessment of:

- Immediate safety needs.
- Patient's state of mind.

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[7] Family Violence Prevention Fund, Clinical Guidelines on Routine Screening, October 1999.

[8] McFarlane J, Christoffel K, Bateman L, Miller V, Bullock L. Assessing for abuse: self-report versus nurse interview. *Public Health Nursing,* 1991; 8: 242-250.

[9] Wright RJ, Wright RO, Isaac NE. "Response to battered mothers in the pediatric emergency department: a call for an interdisciplinary approach to family violence", *Pediatrics.* 1997; 99: 186-192.

- Chief complaint and present illness.
- Past safety strategies used by patient.
- Degree of control exercises over patient.
- Victim's current access to advocacy and support resources.
- The pattern and history of the abuse.
- Patient's present intact coping skills.
- Patient's present intact resources.
- Effects of abuse on patient's health.
- Effects on children in the family.
- Patient's mental health issues (depression, suicide, homicide, substance abuse, etc).
- Abuser's danger/lethality assessment.

Interventions

All patients suspected or known to be victims of domestic violence should receive intervention.

Appropriate intervention may include:

- Verbal reassurance that they are not alone.
- Verbal reassurance that no one deserves to be abused.
- Verbal reassurance that the violence is not their fault.
- Verbal reassurance that they can talk to someone privately for information and support.
- Written information about domestic violence and resources for help in their geographic area.
- Witten information available in the patient's primary language.
- Written information that is culturally appropriate.
- Written information appropriate to different literacy, developmental and comprehension levels.
- Assistance in making a safety plan which respects the integrity and authority of the victim in making his or her own choices about the abusive relationship
- Advocacy and assistance in accessing the services of other agencies.
- Information about legal options, such as civil Protective Orders.
- Information regarding confidentiality.
- Information about the requirement to report child abuse.[10]
- Information about the requirement to report vulnerable adult abuse.[11]
- Reassurance that they will continue to be offered assistance whenever they seek help.
- Documentation of injuries which includes:
    - *Objectively quoting the patient's statements directly whenever possible including documentation of patient's state of mind at the time the statements were made.*
    - *Attachment of safety/danger assessment to chart, when feasible.*
    - *Record of relevant social history.*
    - *Attempt to record name, address and phone number of anyone accompanying the patient.*
    - *Attempt to record any identifying information of alleged abuser.*

[10] Maryland Law Subtitle 7 of Maryland Family Law Code Annotated (COMAR 07.02.07.02).
[11] Maryland Law Subtitle 7 of Maryland Family Law Code Annotated (COMAR 07.02.07.02).

- *Detailed description of injuries. Include type, number, size, location, resolution, possible causes and explanation from patient of how injury occurred.*
- *Detailed description of injuries on a body map diagram.*
- *Photographs, when permitted by patient prior to treatment, from different angles, at least 2 photos of every major injury.*
- *Record patient's name, date and time, and the name of the photographer on the back of all photos.*
- *Document referrals and reports.*
- *Patient disposition, always taking into account patient safety.*

Confidentiality and Reporting Requirements

All health care professionals in Maryland must be aware of and abide by the state's mandatory reporting laws and confidentiality expectations particularly those mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1. **Child Abuse - ANYONE who suspects the physical abuse, sexual abuse or neglect of a child (up to age 18) is required to report to Child Protective Services (CPS) or law enforcement.** By law, reportable child abuse is abusive acts committed by a parent, guardian or other person with permanent or temporary care or custody, or family or household member. Reports may be made confidentially.

2. **Intimate Partner Abuse & Sexual Assault –**To protect patient confidentiality, **Maryland does not have mandatory reporting laws for domestic violence or sexual assault.** You may **not** report suspected or confirmed domestic violence or sexual assault **unless** the adult victim consents **or** if disclosure is required or authorized by state law as follows:

    - The case involves abuse of a child or vulnerable adult, report to CPS, APS or law enforcement.

    - A health care provider must report to law enforcement if he or she treats a person for an injury caused by:

        - a gunshot or moving vessel of any type.

        - an auto accident or a lethal weapon only in the following counties: Allegany, Anne Arundel, Charles, Kent, Montgomery, Prince George's, Somerset, Talbot and Wicomico.

3. **Vulnerable Adult Abuse** -Health care professionals, human service workers and police who have reason to believe there is abuse, neglect, self-abuse or exploitation of a vulnerable adult in the community **must** report it to Adult Protective Services. All persons are permitted to make reports.

Safety and Security in Health Care Institutions

Health care institutions should develop and implement policies and procedures with security staff to ensure the privacy and safety of patients as well as employees. Domestic violence in the workplace policies are available from the Maryland Network Against Domestic Violence.

Safety guidelines should include:

- Training for all security personnel on domestic violence and workplace violence.
- Notifying (when appropriate) the security department of any patient or employee who is a victim.
- Notifying staff when security officers witness threats or abusive behavior toward patients.
- Implementing privacy procedures to protect information regarding the identity and location of victims, support or treatment groups and domestic violence programs.
- Implementing procedures for the enforcement of Protective Orders by security personnel.
- Creating safety plans for the protection of victims who need to be admitted (e.g. admitting a patient under an alias).
- Coordinating with local law enforcement.

Cultural Competence

The growing cultural diversity of our nation is reflected in the patients being treated by Maryland's healthcare community. For successful health care interaction with a diverse population, health care providers must recognize the importance of engaging in culturally competent care. Cultural competence is not defined by an endpoint but as a commitment and active engagement in a lifelong learning process.

A culturally competent response to domestic violence includes:

- Exploring one's own biases, prejudices and knowledge concerning the patient and her/his community.
- Avoiding assumptions based on personal appearance.
- Becoming knowledgeable regarding the cultural beliefs of patient populations.
- Routinely engaging in self-assessment to monitor one's own attitude and response to patients of diverse cultures.
- Recognizing one's own professional power.
- Avoiding use of that power to impose one's own values on the patient.
- Using language that is comfortable for the patient.
- Allowing the patient to give a history, ask questions, verbalize concerns and participate in planning his or her care.
- Gathering information from the patient about his or her community.
- Learning about the patient's cultural norms regarding access to health care, role in the family, privacy, dignity.
- Developing linkages with the patient's community.

- Providing culturally specific information and whenever possible to use those agencies serving the patient's community.
- Remaining open and respectful toward cultural differences.

Education

The high rates of incidence and prevalence, together with low rates of inquiry, call for the development of programs for training health care providers to identify victims of family violence **and** provide effective intervention in the health care setting.[12] The following outline reflects the content that should be included in basic domestic violence training for healthcare providers.

Standards for domestic violence education include:

- Statistics – Domestic Violence as a Public Health Problem
- Definition of Domestic Violence
- The etiology of Domestic Violence
- Barriers to identifying victims
- The importance of routine screening
- Diagnosis and clinical indicators
- Documentation
- Appropriate intervention
- Legal considerations for health care[13]

The Maryland Health Care Coalition Against Domestic Violence recommends its own educational materials and educational materials developed by the Family Violence Prevention Fund, which has a variety of useful materials. These materials are available at nominal or no cost and are developed specifically for health care providers. Education materials developed by the American College of Obstetricians and Gynecologists are also recommended. It is recommended that providers contact the Coalition for guidance and support in seeking educational materials and training.

[12] Rodriguez, M., Bauer, H., McLoughlin, E., Grumbach, K.. Screening and Intervention for Intimate Partner Abuse; Practices and Attitudes of Primary Care Physicians. *The Journal of the American Medical Association*, 282, No. 5, August 4, 1999.

[13] Warsha, C., Ganley, A. Family Violence Prevention Fund, 1998.