Model

Domestic Violence Hospital Policy

A public health approach to providing optimal care to patients who are or may be victims or perpetrators of domestic violence

A Program of the Violence & Injury Prevention Program

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PURPOSE:

The purpose of this CHIIP Program model Domestic Violence Policy is to assist your health care providers provide optimal care to patients who are or may be victims or perpetrators of domestic violence. Domestic violence is a public health problem with serious and far-reaching consequences for patients, families, and communities. The presence of domestic violence in the life of a patient can create or aggravate acute and chronic health problems, interfere with recommended treatments for existing problems, and increase the cost of health care.

In the effort to prevent or reduce the public health impact of domestic violence, this model policy provides recommendations regarding screening for domestic violence, recognition of possible indicators, supportive counseling, safety planning, referral and documentation. Adherence to these policy recommendations will promote compliance with JCAHO, various professional association requirements (i.e. AMA, ACOG, AAP, ACS), any applicable legal reporting requirements and best practice recommendations regarding the care of abused patients.

Due to the trust bestowed upon them by their patients and their intimate involvement in the health and well-being of families, healthcare providers can play a unique and critical role in education about and identification of domestic violence. In some cases, a healthcare provider may the first non-family member a victim or perpetrator turns to for help. An informed and educated response to the problem of domestic violence by a healthcare provider can be crucial to the safety of patient, may improve patient health outcomes, and prevent further violence.

A review of sampling from nation-wide policies demonstrated policies that were either too lengthy of a policy to be accurately implemented, or too brief and narrow a policy to be effective and meet JCAHO standards. It meant for direct adaptation for your institution, with modification to be made to reflect state regulations and institutional procedures (see below).

EXAMPLE OF DIRECTIVES FOR POLICY ADAPTATION OR EXPLANATION

Text boxes throughout the policy such as this are meant to provide explanation or direction to make adaptations or modifications specific for your institution to reflect state regulations or institution policies.

The CHIIP Model Policy is meant to be directly adapted and implemented in hospitals across the country. Please contact the CHIIP Program for intention of adaptation or use in your institution.

For more information, contact Program Manager, Katherine J. Smith at 860.714.4807; email: IamKatSmith@aol.com; or go to www.connecticutprevention.com.

ABUSE POLICY
DOMESTIC VIOLENCE
DEPARTMENT OF XX

Input primary department from which policy is generated (i.e. Department of Patient Care Services, Department of Nursing, Emergency Department)

DISTRIBUTION TO: ALL MEDICAL DEPARTMENTS; HOSPITAL POLICY MANUAL; DEPARTMENT MANUALS FOR THE FOLOWING DEPARTMENTS: BEHAVIORAL HEALTH, EMERGENCY DEPARTMENT, FAMILY MEDICINE, INTERNAL MEDICINE, NURSING, OBSTETRICS/GYNECOLOGY, PEDIATRICS, SOCIAL WORK/CASE MANAGEMENT.

I. PURPOSE:

The purpose of this policy is to assist providers in the process of identifying, treating, and referring victims and perpetrators of domestic violence, support the provision of optimal care to patients, and meet JCAHO standards.

II. SUPPORTIVE DATA/ BACKGROUND:

A. Definitions:

Domestic violence (DV) is defined as a pattern of controlling, assaultive, and /or coercive behaviors that adults and adolescents use against their family members or intimate partners. These behaviors may involve physical, sexual, economic, and/or psychological coercion or abuse. This definition is specific in defining acts of violence, but general in defining the victim and perpetrator. This is especially important, as DV appears in all populations regardless of age, race, gender, ethnicity, income, relationship, and sexual orientation.

Elder abuse and child abuse is different from domestic violence as in those cases, the victim is of a certain age and the perpetrator is a caretaker.

B. Public Health Impact:

Domestic violence is a public health problem with serious and far-reaching consequences for patients, families and communities.

- The presence of domestic violence in the life of a patient can create or aggravate acute and chronic health problems, interfere with recommended treatments for existing problems, and increase the cost of health care.
- 30-40% of women report being physically or sexually abused by a husband or boyfriend at some point in their lives.
- Domestic Violence is more prevalent than diabetes, breast cancer, and cervical cancer.

C. JCAHO Standards:

The JCAHO Standards reviewed to ensure compliance include:
RI.2. 10 *The hospital respects the rights of patients;* ***RI.2. 140*** *The hospital creates a supportive environment for all patients;* ***RI.2. 150*** *Patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation;* ***RI.2. 170*** *Patients have a right to access protective and advocacy services; and* ***PC.3.10*** *Criteria for identifying and assessing victims of abuse, neglect, or exploitation should be used throughout the hospital.*

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) requires accredited hospitals to implement policies and procedures in their facilities for identifying, treating, and referring victims of abuse. These standards also require domestic violence education programs for staff.

D. Legal Reporting Requirements:

This section should reflect current state regulations regarding mandated reporting responsibilities. As written, this reflects the reporting responsibilities for states that have no mandatory reporting law for domestic violence. If such a law exists in your state, this section should explicitly reflect the reporting responsibilities required by law; specifically to whom the report is being made (including contact agency, phone numbers, and relevant forms for completion); and the responsible party for the report in the institution (i.e. MD, RN, SW). It should also reflect the manner in which the report is discussed with the patient. This section should also reflect mandated reporting responsibilities regarding child and elder abuse and/or neglect.

There is no federal or state statute that requires providers or hospitals to report all incidents of domestic violence. Hospital personnel, however, are required to report the following circumstances to the local police if: (a) the victim dies or is in imminent danger of death; (b) the injuries the victim sustained involved a moving motor vehicle; (c) the injuries the victim sustained involved a firearm. Hospital personnel will assist any patient who wishes to contact the police to report domestic violence.

If a child under the age of 18 and abuse or neglect is suspected, a report must be made to the Department of Children and Families. Please refer to the Child Abuse Policy.

If a person over the age of 60 and abuse or neglect is suspected, a report must be made to the Elder Protective Services. Please refer to the Elder Abuse and Neglect Policy.

If a sexual assault is suspected, refer to the Sexual Assault Protocol

III. POLICY/PROCEDURES:

Victims often present with subtle signs or even no outward signs of abuse. Therefore, this section of the policy provides a procedural format for a consistent policy to address all patients in all clinical settings throughout the institution. It presents simple guidelines to: a. integrate standardized DV screens into regular health screening and anticipatory guidance as a means to identify victims and potential victims, as well as b. provide guidelines for the response and referral once identified (SAFE method).

The hospital is required by JCAHO to have a written policy guiding consistent procedures for the identification, treatment, response, and referral of victims and potential victims of abuse.

At the clinical core of the hospital domestic violence policy are the procedures used to identify and respond to domestic violence. A successful intervention occurs when patients are consistently provided with a safe environment to disclose and understand the health implications, NOT when a patient discloses he or she is a victim or a perpetrator. Identification, treatment, and referral of victims of domestic violence applies to all clinical settings within the medical facility. Any patient seen in a healthcare setting may be a victim or perpetrator of domestic violence.

A. Identification:

THROUGH STANDARDIZED SCREENING: Screening for domestic violence should be integrated into regular health screens and/or anticipatory guidance practices, allowing providers non-judgmental, clinical guideline to identify whether or not a full DV intervention (SAFE method) should be implemented. Such standardized integration is time-efficient, allows for consistency and adherence to the JCAHO standards, and provides an easy transition for both patients and providers.

Examples of integration into regular health screen questions include: "A number of things may affect your health, so I have begun asking all my patients some questions." :

a. FOR ADULT PATIENTS: "Do you smoke? How much alcohol do you consume? Do you feel safe at home?"
b. FOR PEDIATRIC PATIENTS: "Is your child in a carseat/booster seat? Does your child wear a helmet when riding his bike? Do you feel safe at home?"

c. FOR ELDERLY/DISABLED PATIENTS: "Has anyone you depend on refused to help you with an important need such as taking your medicine, getting to the bathroom, getting out of bed, bathing, getting dressed, or getting something to eat or drink?"

Written screens may also be used as a means of consistent, non-judgmental identification of victims in the health care setting. Such screens are best integrated into the general health questionnaire filled out upon presentation for a visit, prior to seeing the provider. Potential questions that can be integrated include:

1. ***Have you been hit, kicked, punched, or hurt by someone within the past year?***
2. ***Do you feel safe in your home or in your current relationship?***
3. ***Is there a partner from a previous relationship who is making you feel unsafe now?***

Clinical areas may initiate the above noted screen in written form if desired. If the patient is unable, or chooses not to answer the screening questions, this should be documented in the medical record.

If any patient indicates concerns from this or any other screen, the full SAFE method should be implemented as explained below.

THROUGH IDENTIFICATION OF SUBTLE PRESENTATIONS: Staff should be cognizant that victims of violence often present with subtle signs of abuse prior to serious injuries or obvious abuse. The following presentations may indicate possible domestic violence, necessitating a standard screening:

- Injury inconsistent with history provided
- There are multiple injuries present or multiple injuries at various stages of healing
- Fearfulness of significant other or health care professional
- Repetitive use of emergency services (Emergency Department or Walk-In Clinic)
- High pain medication use or symptoms of alcoholism or drug abuse
- Acute psychiatric manifestations (suicide attempts) or chronic psychiatric issues (anxiety, depression, and symptoms of post traumatic stress disorder)
- Repetitive psychosomatic complaints (Chronic pelvic pain, headaches, chest pains, choking sensations)
- Any injury during pregnancy, especially to abdomen and chest
- Injuries suggestive of a defensive posture (such as bruising to the inner aspects of the forearm or thighs or top of the head)
- Delay in seeking care
- History of children being abused
- Partner that hovers, speaks for patient, is overly attentive
- Common injuries that may indicate abuse include: black eyes, front tooth injuries, mid-face injury, injuries to neck, sites hidden by clothes, internal injuries and injuries to breast or abdomen, especially during pregnancy.

If, upon using these, or other guidelines for identifying victims or potential victims of violence, providers should take the following steps to respond to victims and provide appropriate support and resources.

Because of the lack of or subtly of warning signs, and because of the value of educating patients to domestic violence and its impact, standardized screening for all patients in all major departments is recommended. At a minimum, standardized screening for domestic violence should occur at all new patient and annual visits, in the following departments:

- ***Emergency***
- ***Internal Medicine***
- ***Pediatrics***
- ***Social Work/Case Management***
- ***Family Medicine***
- ***Obstetrics/Gynecology***
- ***Nursing***
- ***Behavioral Health***

A. Responding to Victims and Resource Referral:

The S.A.F.E. method should be utilized by all clinical providers as the efficient and effective guide for screening and responding to patients in health care settings who are victims of violence. The S.A.F.E. Method consists of: Screen, Assess, Forward, and Evidence documentation.

i. Screen

Framing questions about the presence of domestic violence facilitates dialogue with the patient about domestic violence, its impact on the health and well-being of patients and their families, and establishes the healthcare provider as a resource for that patient.

Additional Examples of more thorough Screening Questions located in Appendix I.

SCREENING FOR PERPETRATION:

While not required for JCAHO standards, for best practice standards the policy should also include guidance on how to screen, identify, treat, and refer perpetrators of domestic violence. Examples of screening questions for perpetration include: "Has your anger or jealousy led you to destroy property, be verbally abusive or physically violent (slap, grab, punch or kick) toward someone close to you?"; "What do you do when you get angry?"; "Do you have concerns about whether your behavior may be making family members feel scared or upset?"; and"Do you want to change your behavior?". The same follow-up steps should be taken (assessment, forward, evidence documentation) as with screening for victimization.

ii. Assess

While a healthcare provider cannot take the place of a domestic violence victim advocate or a batterer intervention professional, a positive identification of domestic violence requires further investigation to determine the seriousness of the abuse, any impact on patient's health or disease management, the current risks to the victim and any children involved, and the victim's current plan for safety. An assessment should include:

- A history of the abuse, patient's description of abuse and injuries to self and others
- The patient's perception of current risks and strengths.
- An exploration of the patient's safety plan for him or herself and any children. [This plan may include an emergency kit (money, medication, important papers, and phone numbers), identifying a safe place to go, alternative forms of communication, and teaching children to call 911.] (See Appendix II)
- Consideration of the cultural context. A patient's response to domestic violence and provider interventions can be affected by issues such as religious beliefs, values, social relationships, and discrimination. Furthermore, culturally appropriate behaviors may be interpreted as potentially abusive due to lack of cultural awareness. The availability of language/culture interpreters from diverse populations served must be a high priority to effectively assist patients of diverse cultures.

When the patient identifies him or herself as a perpetrator of domestic violence, a healthcare provider has an ethical responsible to determine if there is any risk of imminent harm to the patient or anyone else. When a domestic violence perpetrator is identified, any assessment of the risk represented by that person should include the presence of substance abuse, mental health issues, access to firearms or other weapons, and other potential aggravating factors.

iii. Forward to Resources

Referring or "forwarding" a patient to a hospital social worker, domestic violence advocate, and/or law enforcement allows the healthcare provider to effectively manage his or her time and connect the patient to critical, specialized supports.

Healthcare providers should provide specific information about referrals within and outside the hospital including: social work, hotline/counseling, emergency shelter, and legal resources. As part of the forwarding process the healthcare provider should also schedule a follow up appointment to follow up on all issues relating to their health care, including potential violence.

Specific referral sources are located in Section IV of this policy.

SAFETY NOTE: If written resource material is distributed to the patient, it should be provided in a way that does not increase the safety risk of patients (i.e. if the perpetrator finds them). The patient is the best person to assess his/her ability to accept written and/or verbal resources without implication or judgment.

If written resource material is distributed to the patient, it should be provided in a way that does not increase the safety risk of patients. Written resource materials should either be integrated into other listings of community resources or small enough that the patients can safely carry them. The patient is the best person to assess his/her ability to accept written and/or verbal resources without implication or judgment. Resource materials are available by various organizations:

- *Family Violence Prevention Fund www.endabuse.org (415) 252-8900*
- *National Coalition Against Domestic Violence www.ncadv.org (888) 774-2900*
- *The Non-Violence Alliance www.endingviolence.com (860) 347-8220*
- *Ct Coalition Against Domestic Violence www.ctcadv.org (888) 774-2900*

iv. Evidence Documentation

Careful documentation in the medical record is essential and should include all of the SAFE method steps the provider has done: indication that domestic violence screen was completed, the type of abuse and abuse history, description of injuries (if applicable), safety assessment, referrals made, resources provided, and follow-up plan. It should also be documented on the encounter form, including coding and diagnosis. Forensic photographs and/or a body map should be used to document injuries and preserve evidentiary materials.
SAFETY NOTE: Domestic violence should not be written on the discharge information due to the increased safety risk to victims if the perpetrator acquires this information.

A Domestic Violence Documentation form is available for use to efficiently document all steps of the SAFE methodology (See Appendix III.)

DOCUMENTATION
REGARDING CODING AND ENCOUNTER FORMS:
For in-patient care, the AMA, AHA, American Health Information Management Association indicate that if DV is identified, a DV diagnostic code MUST be used as primary diagnosis. CPT codes for out-patient settings include: Complex evalutation and management (99303), Team conferences (99374-2), Care plan oversight (99374-5), Preventive medicine services (99381), Preventive medicine counseling (99401). The Adult Physical Abuse/Maltreatment code (995.81) is the primary code that identifies each recorded incidence of DV. Other codes in the 995.8 range add specificity about the abuse such as physical and sexual abuse.
REGARDING A DOCUMENTATION FORM
While an official documentation form is not required, it is a beneficial tool for hospitals to use to ensure that all steps have been taken when interaction with patients who are victims of violence. This is especially valuable for staff that is not well-versed in interacting with patients affected by DV. If there is a state mandatory reporting law for DV in your state, this should be added on the DV documentation form, as well as specifics regarding any other required documentation.

IV. COMMUNITY RESOURCE REFERRAL INFORMATION

In- House Resources:

Case Management/ Social Workers: (xxx)xxx-xxxx (for in-patients)
(xxx)xxx-xxxx (for ambulatory clinic patients)

Emergency Dept. Crisis Services: (xxx)xxx-xxxx (for ED patients)
Employee Assistance Program: (xxx)xxx-xxxx (for employees with domestic violence concerns)

Dept. of Security: (xxx)xxx-xxxx

Community

(Community DV Shelter): (xxx)xxx-xxxx 24 Hour Hotline
(xxx)xxx-xxxx TTD/TTY

National Domestic Violence Hotline: 1-800-799-SAFE
Statewide Legal Services: (xxx)xxx-xxxx

State Domestic Violence Hotline: (xxx)xxx-xxxx
(Perpetrator Intervention Services): (xxx)xxx-xxxx Hotline
(xxx)xxx-xxxx local number

RESOURCES
Specific in-house and community resources should be listed within the policy. The above organizations provide you guidelines for minimum resources that should be listed. Specific names and numbers of local organizations should be integrated within your policy.

V. ADDITIONAL CONSIDERATIONS:

A. Staff Education

All social workers, hospital crisis workers, and medical/clinical staff with direct service care responsibilities for patients, and their supervisors, shall have mandatory education in the identification, assessment, and interventions of domestic violence. Within the first year of employment, every new employee with direct service care responsibilities for patients will attend a minimum of one training session on the identification assessments and interventions regarding domestic violence. Periodicity of domestic violence training will be established and monitored by the Department of Human Resources.

STAFF TRAINING
The hospital training plan should incorporate information on domestic violence into new employee orientations and regular annual trainings for clinical, administrative, and support staff. Information about the S.A.F.E. standardized screening methodology (see above) should be integrated into new employee orientation, annual mandatory trainings for all clinical staff, and ongoing specialty specific trainings. Whenever possible, the hospital should seek to develop collaborative training relationships with community providers (i.e. domestic violence victim programs, batterer intervention programs and agencies that serve children exposed to domestic violence).
HealthStream Training for Domestic Violence in the HealthCare Setting has been made available by the CHIIP Program.

B. Support for Employee Victims and/or Perpetrators

The Employee Assistance Program (EAP) in the Human Resources Department will provide support to employees (and their families) affected by domestic violence. This includes ensuring the accessibility of assessment and treatment expertise for victims, perpetrators, and children exposed to the perpetrator's behaviors.

EAP SUPPORT FOR EMPLOYEES
The Human Resources Department will develop policy and procedures to assist domestic violence victims. These policies and procedures would address the ability of domestic violence victims to use flexible schedules, transfers, counseling, paid and unpaid leave, and other personnel policies. It should also address how to assist in safety planning and minimizing the negative impact of domestic violence on the employee's ability to work and maintain their position. This section should clearly delineate the employer's response to employees affected by domestic violence.

C. Security

The Security Department is charged with the responsibility of the security of the people, property, and information of the Hospital. This includes staff and patients whose lives are affected by domestic violence. Security should be notified for problems requiring patient or visitor restraint, cases of unruly patients and/or visitors, or patients and/or personnel at risk. Security is often preventive in nature; that is, if one ever contemplates that the Security Force may be necessary, Security should be called. Often the arrival of Security prevents a situation from escalating.

The Security Department will prioritize victim and staff safety, and will coordinate with medical personnel and local law enforcement (when appropriate) to ensure the safety of the victim in different areas of the hospital, separate the perpetrator from the victim, and address the threat of workplace violence for an employee. All procedures respect the dignity of the victim, and value giving the victim control over the decisions made related to his or her safety.

SECURITY
The Hospital Security Department will develop procedures and protocols for responding to domestic violence within appropriate department policies (i.e. Emergency Department, clinics). These policies should also reflect procedures, if appropriate, for involvement of local law enforcement.

D. Policy Evaluation and Implementation

As part of its policies and practices, the hospital has created a Domestic Violence Committee. This committee includes representatives from the major medical departments (ED, OB/GYN, Pediatrics, Social Work), Security, Hospital Administration, Human Resources, and community Domestic Violence Victim Advocates. The committee meets quarterly to ensure that the institution is meeting the needs of patients, regarding the right of patients to be free of abuse. These procedures include XX(insert)XX.

POLICY EVALUATION

While not required for JCAHO, best practice dictates regular evaluation of the policy and its adherence by staff. A Domestic Violence Task Force or Committee that meets regularly can serve this purpose. The goal of this Committee is to help the hospital meet JCAHO standards regarding the right of patients to be free of abuse. The Committee should also address the presence of domestic violence among hospital personnel. The Medical Director of the hospital should appoint the Chair.
The implementation of domestic violence policies and procedures should be supported by administrative enforcement procedures. These procedures may include periodically reviewing staff training, and chart reviews for appropriate screening and follow-up of domestic violence. It should also address sanctions for staff that fail to adhere to the policy or other methods of review and remediation. It may also include surveying the medical, administrative, nursing, and security staff regarding their knowledge of domestic violence and related policy and procedures. Patients and employees should be given the opportunity to comment on their satisfaction with the hospital domestic violence policy.
When possible, the Committee can also include a representative from local batterer intervention programs and agencies that serve children exposed to domestic violence.

E. EMERGENCY SHELTER:

While all efforts will be made for safe discharge with DV advocates and/or patient supports, patient safety upon discharge is priority. The victim leaving the relationship is not the goal of the patient interaction. Any safety planning, including safe discharge decisions should be led by the patient's safety assessment in collaboration with staff social workers and/or community DV advocates. Victims of domestic violence who are in imminent danger from their abuser, and have no alternative safe refuge, will be given temporary refuge in the hospital for up to 24 hours until alternative forms of safe discharge can be found.

EMERGENCY SHELTER
The hospital should also have a policy regarding victims who may not able to safely go home and have not yet secured shelter. This policy should address how the hospital staff will work with law enforcement and domestic violence advocates regarding the provision of shelter for a victim while providing a victim with a temporary safe location in hospital.

APPENDICES:

APPENDIX I: **ADDITIONAL DOMESTIC VIOLENCE SCREENING QUESTIONS**
APPENDIX II: **PERSONAL SAFETY PLANNING GUIDE**
APPENDIX III: **DOMESTIC VIOLENCE DOCUMENTATION FORM**

APPROVED BY:

APPROVED DATE:

REVISED DATE(S):

Revised DV policy (dates of previously approved policies).

APPENDIX I: ADDITIONAL SCREENING QUESTIONS

ENGLISH	ESPAÑOL
Questions for Victims:	Preguntas para las víctimas:
Do you feel safe at home?	Se siente usted seguro(a) en su casa?
Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?	Durante el último año, ¿fue usted golpeado(a), abofeteado(a), pateado(a) o lesionado(a) por alguien, de alguna forma?
Within the past year, has anyone forced you to have sexual activities?	Durante el último año, ¿fue usted alguna vez obligado(a) a someterse a relaciones sexuales?
Are you afraid of your partner or anyone in your life?	Tiene usted miedo de su pareja o de otras personas en su vida?
Every couple has disagreements. How do you and your partner work out arguments?	Todas las parejas tienen sus desavenencias. ¿Cómo manejan usted y su pareja, sus pleitos?
How are disagreements handled in your family?	Cómo son los desacuerdos manejados en su familia?
Do arguments ever result in you feeling put down or bad about yourself?	Algunas veces sus pleitos le hacen sentirse deprimido(a) o mal acerca de usted?
Has your partner ever harmed any of your children?	Llegó alguna vez su pareja a maltratar físicamente a sus niños?
Does your partner ever prevent you from doing things you want to do? Ever force you to do things you don't want to do?	Le impide su pareja hacer cosas que usted quiere hacer? ¿Le obligó por la fuerza a hacer cosas que no quería hacer?
Are alcohol or drugs involved in your situation?	Tienen que ver el alcohol o las drogas algo que ver con su situación?
If you were experiencing violence in your home, would you know where to go for help?	Si estuviera sufriendo maltratos o violencia en su casa, ¿sabría usted dónde procurar ayuda?
When you say your partner "loses it" (freaks out, etc.) can you describe what he/she does?	Cuando usted dice que su pareja "pierde el control", etc., ¿podría describir lo que hace?
Are there any guns or other weapons in your house?	Hay armas de fuego o de otro tipo, en su casa?
Has your partner ever used or threatened to use a weapon?	Usó su pareja alguna vez un arma o amenazó con usarla?
Has your partner ever refused to practice safe sex?	Se negó su pareja alguna vez a practicar un sexo seguro?
Are you here today because of injuries caused by your partner?	Está usted aquí debido a lesiones infligidas por su pareja?
When I see bruises of this type, it often means someone has been hit with a fist. Has this happened to you?	Cuando veo contusiones de este tipo, me hacen pensar que alguien fue golpeado por un puñetazo. ¿Le sucedió esto a usted?
Patients with Disabilities:	Pacientes con discapacidades:
Has your partner ever prevented you from using your wheelchair? (cane, respirator or other assistive device)	Le impidió alguna vez su pareja usar su silla de ruedas? (bastón, respirador o cualquier otro dispositivo asistencial)
Has your partner ever refused to help you with an important personal need, like taking your medicine, going to the bathroom or getting out of bed (bathing, getting dressed or getting food or drink)?	Se negó su pareja alguna vez a ayudarle a resolver una necesidad personal importante, como, por ejemplo, tomar sus medicinas, ayudarle a ir al baño, o levantarse de la cama ayudarle a ir al baño, (levantarse de la cama, bañarse, vestirse, comer o beber)?
Questions for Perpetrators:	Preguntas para los perpetradores:
Do you think that you have a problem with your temper or jealousy?	Cree usted tener un problema con su temperamento o sus celos?
What do you do when you get angry?	Qué hace usted cuando se enoja?
Do you have concerns about whether your behavior	Le preocupa a usted la posibilidad de que su conducta

ENGLISH	ESPAÑOL
may be making family members feel scared or upset?	pueda atemorizar o enojar a otros miembros de su familia?
Do you want to change your behavior?	Le gustaría cambiar su forma de ser?
In the course of an argument or disagreement with your partner, have you destroyed property or hurt someone?	En el curso de una discusión o desavenencia con su pareja ¿destruyó usted, alguna vez, algún objeto o agredió usted físicamente a alguien?
Have your children ever been around when you and your wife fought? Did they ever get physically hurt?	Presenciaron alguna vez sus hijos una pelea entre usted y su pareja? ¿Fueron maltratados físicamente?
Do you own or have access to weapons?	Posee usted o tiene usted acceso a armas de cualquier tipo?
Cultural Concerns:	Consideraciones culturales:
(Patient who is not a U.S. citizen) Has your partner ever threatened to report you to immigration authorities?	(Para los pacientes inmigrantes) ¿Alguna vez su pareja le amenazó con denunciarle a las autoridades de inmigración?
O.B. Patients:	Para pacientes obstétricos:
Since you've been pregnant, have you been hit or otherwise hurt by your partner?	Ya que estuvo embarazada, ¿fue usted alguna vez golpeada o maltratada en forma alguna, por su pareja?
Has your partner ever forced you to have sexual activities?	Alguna vez su pareja la obligó a mantener actividades sexuales?
Pediatrics:	Pacientes pediátricos:
Seeing parents or other adults fight can feel as bad as being hit yourself. Has this happened to you?	El ver pelear a sus padres y otros adultos puede hacerte sentir tan mal como si alguien te golpeara
Teens:	Adolescentes:
Are you dating anyone?	Estás saliendo con alguien?
How is your relationship going?	Cómo va tu relación?
What are your friends dating relationships like?	Cómo son las relaciones entre tus amigos y amigas?
What can you do if you have a friend who is threatened or a friend who is abusive?	Qué podrías hacer si tienes un amigo o amiga que ha sido amenazado(a) o que le gusta maltratar a los demás?
Lesbian, Gay, Transgender or Bisexual Patients:	Pacientes lesbianas, homosexuales, transexuales o bisexuales:
Are you currently in a relationship?	Mantienes una relación en este momento?
How do you refer to your partner? What terms do you use (lover, spouse, significant other, etc)?	Cómo te refieres a tu pareja? ¿Qué términos usas (amante, esposo, esposa, novio, novia, pareja, etc)?
Has your partner ever insulted you because of your orientation/trans experience?	Te insultó tu pareja alguna vez debido a tu orientación o experiencia transexuales?
Threatened to reveal your sexual orientation to others?	Amenazó con revelar tu orientación sexual a otras personas?

**additional questions compiled and translated by the Connecticut Health Initiative for Identification & Prevention. Kat Smith, Program Manager. IamKatSmith@aol.com or 860.714.4807.

APPENDIX II: Personalized Safety Plan Guide

Below is a seven step safety plan. Please take the time to print this and fill it out with a friend, family member or someone in need.

Step 1. Safety during violence.

I can use the following options:

a. If I decide to leave, I will____

b. I can keep a bag ready and put it______________________ so I can leave quickly.

c. I can tell________________________________about the violence and have them call the police when violence erupts.

d. I can teach my children to use the telephone to call the police and the fire department.

e. I will use this word code________________________________for my children, friends, or family to call for help.

f. If I have to leave my home, I will go_______________________________. (Be prepared even if you think you will never have to leave.)

g. I can teach these strategies to my children.

h. When an argument erupts, I will move to a safer room such as____________________________________.

i. I will use my instincts, intuition, and judgment. I will protect myself and my children until we are out of danger.

Step 2. Safety when getting ready to leave.

I can use the following strategies:

a. I will leave money and an extra set of keys with____.

b. I will keep important documents and keys at____.

c. I will open a savings account by this date_________________________________ to increase my independence.

d. Other things I can do to increase my independence are: ____

e. The domestic violence hotline is _____________________.

f. The shelter's hotline is _________________________.

g. I will keep change for phone calls with me at ALL times. I know that if I use a telephone credit card, that the following month the telephone bill will tell the batterer who I called after I left. I will keep this information confidential by using a prepaid phone card, using a friend's telephone card, calling collect, or using change.

h. I will check with_________________________ and ______________________ to know who will let me stay with them or who will lend me money.

i. I can leave extra clothes with___________________________.

j. I will review my safety plan every ___________________(time frame) in order to plan the safest route.
I will review the plan with ______________________________ (a friend, counselor or advocate.)

k. I will rehearse the escape plan and practice it with my children.

Step 3. Safety At Home

I can use the following safety methods:

a. I can change the locks on my doors and windows as soon as possible.

b. I can replace wooden doors with steel doors.

c. I can install security systems- i.e. additional locks, window bars, poles to wedge against doors, electronic sensors, etc.

d. I can purchase rope ladders to be used for escape routes from the second floor.

e. I can install smoke detectors and buy fire extinguishers for each floor of my home.

f. I can install an outside lighting system that lights up when someone approaches my home.

g. I will teach my children how to use the phone to make collect calls to me and to __________________________ (friend, family, minister) if my partner tried to take them.

h. I will tell the people who care for my children, who has permission to pick up my children. My partner is NOT allowed to. Inform the following people:

School_____________________________________
Day Care__________________________________
Babysitter________________________________
Sunday School______________________________
And____
Others_____________________________________
Teacher____________________________________

i. I can tell my the following people that my partner no longer lives with me and that they should call the police if he is near my residence:
Neighbors_________________________________ Church Leaders___________________________
Friends___________________________________ Others___________________________________

Step 4. Order of Protection
The following steps will help enforce the order of protection:

a. I will keep the protection order_____________________(the location). Always keep it with you.
b. I will give my protection order to police departments in the areas that I visit my friends, family, where I live, and where I work.
c. I will tell my employer, my church leader, my friends, my family and others that I have a protection order.
d. If my protection order gets destroyed, I know I can go to the courthouse and get another copy.
e. If my partner violates the protection order, I will call the police and report it. I will call my lawyer, my advocate, counselor, and/ or tell the courts about the violation.
f. If the police do not help, I will call my advocate or my attorney AND I will file a complaint with the Chief of the Police Department.
g. I can file a complaint with the police in the jurisdiction where the violation took place. A domestic violence advocate can help me do this.

Step 5. Job and Public Safety
I can do the following:

a. I can tell my boss, security, and ______________ at work about this situation.
b. I can ask_________________________________ to help screen my phone calls.
c. When leaving work I can do the following: ____
d. When I am driving home from work and problems arise, I can ____________________________________
e. If I use public transportation, I can____
f. I will shop at different grocery stores and shopping malls at different hours than I did when I was with my partner.
g. I will use a different bank and bank at different hours than I did when I was with my partner.
h. I can also do the following:____

Step 6. Drug and Alcohol Use.
I can enhance my safety if I do the following:

a. If I am going to use, I am going to do it in a safe place with people who understand the risk of violence and who are committed to my safety.
b. I can also____
c. If my partner is using, I can____
d. I can also____
e. To protect my children, I can____

Step 7. Emotional Health
I can do the following:

a. If I feel depressed and ready to return to a potentially violent situation/ partner, I can______________________
____
I can call ____
b. When I have to talk to my partner in person or on the phone, I can______________________________________
c. I will use "I can..." statements and I will be assertive with people.
d. I can tell myself "________________________________" when I feel people are trying to control or abuse me.
e. I can call the following people and/ or places for support:____
f. Things I can do to make me feel stronger are:____

APPENDIX III Domestic Violence Documentation Form

DV SCREEN

O DV + (POSITIVE)

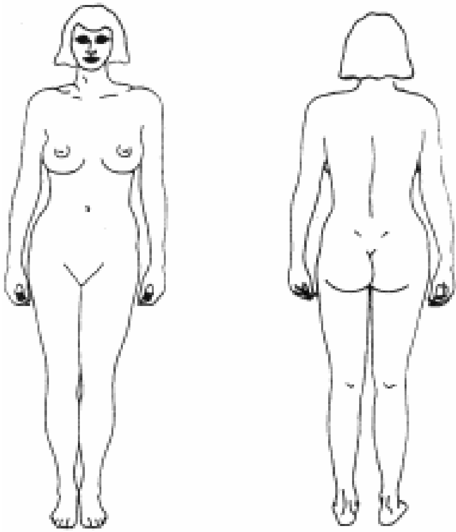
O DV? (SUSPECTED)

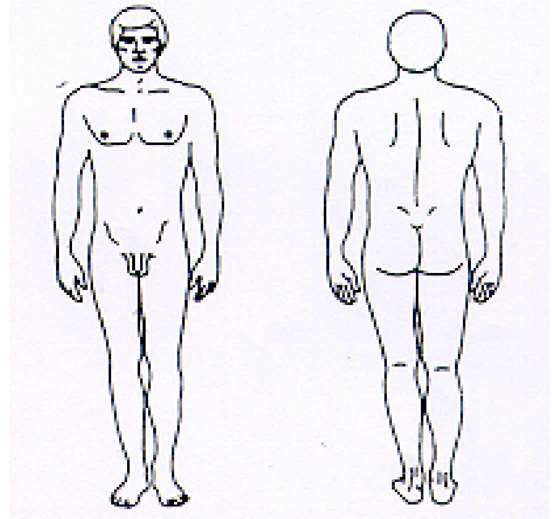
Date: __________________ MR#: _____________

Patient Name: ________________________________

Provider Name: _______________________________

Patient Pregnant? O Yes O No





ASSESS PATIENT:

Most Recent Incident: Date: ________________________

Injuries? ______________________________________

____

First Incident? __________________________________

____

Worst Incident? _________________________________

____

ASSESS PATIENT SAFETY:

O Yes O No Is abuser here now?

O Yes O No Is patient afraid of their partner?

O Yes O No Is patient afraid to go home?

O Yes O No Has physical violence increased in severity?Frequency?

O Yes O No Has partner physically abused children?

O Yes O No Have children witnessed violence in the home?

O Yes O No Threats of homicide?

By whom: ____________________________

O Yes O No Threats of suicide?

By whom: ____________________________

O Yes O No Is there a gun in the home?

O Yes O No Alcohol or substance use/abuse?

By whom: ____________________________

Form Developed by Family Violence Prevention Fund & Modified by
K. Smith, MSW 12-01 for St. Francis Hospital & Medical Center.

SAFETY ASSESSMENT:

Was a Safety Plan discussed? _________________________

____

____

REFERRALS:

O Hotline number given

O Shelter number given

O Legal Referral made

O DV Safety Card given

O Educational materials given:

____

O Other referral made:

____

Patient assessment of plan & decisions regarding referral options: ______________________________

____

Follow-up apt. scheduled: ________________________

REPORTING:

O Law enforcement report made

O DCF referral made

O Adult Protective Services report made