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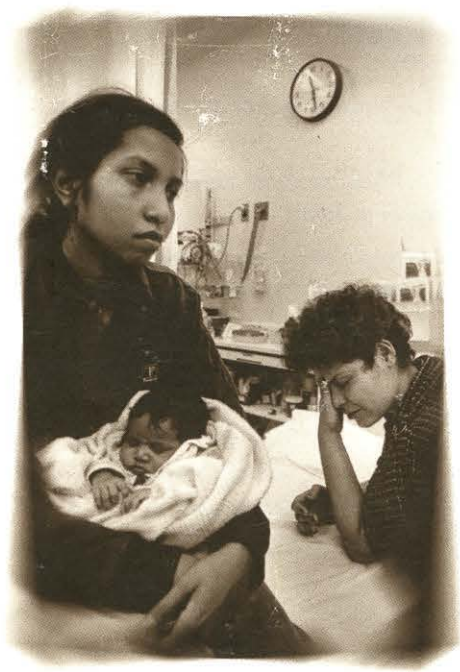

Best Practices:

Innovative Domestic Violence Programs

in Health Care Settings

THE FAMILY VIOLENCE PREVENTION FUND'S MISSION

Founded in 1980 by Esta Soler, the Family Violence Prevention Fund (FUND) is a leading national non-profit organization focusing on domestic violence prevention, education and public policy reform. Throughout its history, the FUND has developed pioneering strategies to address the problem of domestic violence in the justice, public health, child welfare, workplace, and public education fields; its publications and model programs have been distributed to every state and to several foreign countries.

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All photographs courtesy of Donna Ferrato

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This Guide is dedicated to our colleague and friend Nancy Cook von Bretzel — an inspiring teacher, service provider and leader who personifies the *truly* best practices in the effort to strengthen the health care response to domestic violence.

Best Practices: Innovative Domestic Violence Programs *in Health Care Settings*

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We gratefully acknowledge the many inspiring leaders in the health care and domestic violence fields that have helped to define and shape the health care response to domestic violence. Much gratitude is also extended to our talented Review Committee, the writing team, and the model programs featured for the standard of excellence they have established in this field.

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This Guide is written for health care and domestic violence professionals who are interested in establishing a domestic violence response within a health care setting. You may be aware that accreditation requirements for hospitals now mandate that protocols and referral lists be in place to identify and intervene on behalf of patients who are victims of domestic violence. In fact, all hospital and clinic patients must now be assessed for domestic abuse.

This manual explains how and why this requirement evolved, provides a field-tested, low-cost model of how to set up a clinic- or hospital-based domestic violence program, and describes some of the most innovative programs from around the country that help health care providers better respond to domestic violence. Numerous curricula, training guides, and patient and provider education materials are also identified.

How This Field Came To Be: A History of the Health Care Response *to Domestic Violence*

In 1997, as this Guide is published, unprecedented attention is being paid to the critical role that health care providers can play in intervening in the tragic spiral of domestic violence by screening, identifying, documenting, and appropriately referring those patients who are being abused by their intimate partners. Prestigious national health associations have mounted public and professional education campaigns. Hospitals have been mandated by their regulatory agency to develop and implement domestic violence protocols. Screening all patients for domestic violence is now required of hospitals and licensed clinics in at least one state (California). Scores of hospitals and clinics around the country have established services for abuse victims.

It has not always been so, of course. When the battered women's movement began in the mid-1970s, advocates' primary concern was to meet the immediate needs of women and children for safety and housing. Secondarily, advocates targeted the justice system and its appalling indifference toward and bias against victims of domestic violence. But very early on, a few individuals around the country began to look at what happened to battered women when they sought health care.

FLITCRAFT AND STARK CONDUCT PIONEERING RESEARCH

Two of the earliest pioneers in this area were Anne Flitcraft, M.D., and Evan Stark, Ph.D., M.S.W. In 1976, Dr. Flitcraft, who was then attending Yale Medical School, began to examine the extent to which domestic violence was a cause of injuries presented by women at the Emergency Department (ED). In a one-month sample of injured patients, Flitcraft found that 25% of the women had been battered. Between 1978 and 1986, she and Stark replicated the initial study in a sample of 3600 patients, identifying domestic violence as the single most common cause of injury to women. She and Stark also documented that, in comparison to non-abused women, abused women manifested significantly higher rates of alcohol and drug use, psychiatric problems, and suicide attempts, and that these occurred after the first reported injury was brought to the hospital's attention, not before. Her research also showed that battered women had a greater utilization of the health care system than women who were not victims of domestic violence. With these findings, Stark and Flitcraft presented domestic violence as a health care concern, both in the primary care setting and in the ED.

Dr. Ronald Chez joined formerly battered woman, Courtney Esposito, to develop 5 different audiovisual and lecture training packages for physicians, nurses and ED staff

Flitcraft and Stark also laid out a new theoretical framework for domestic violence by positing that a "patriarchal" health care system and the unhelpful responses of medical providers reinforced the batterers' power, helping keep women entrapped in violent relationships. The researchers showed that medical providers gave abused women inappropriate medications, identified them with negative labeling ("hysteric," "borderline personality disorder," etc.) and offered punitive interventions.

In 1985, Flitcraft and Stark formed a small group of colleagues from throughout the country who, like them, were working to improve how the health care system responded to battered women. The first such group in the country, this group met regularly for several years.

FORMERLY BATTERED WOMEN WRITE MANUALS

A key member of this pioneering group was a formerly battered woman, Courtney Esposito, who had been working in a New Jersey shelter since 1978. In 1983 she was hired by the State of New Jersey's Division on Women to write a health care manual on domestic violence. She started by gathering material from all over the country and then augmented it with her own suggestions. "It helped having gone through it myself," Esposito recalls; "I knew what would have made a difference for me." (She reports that a hospital social worker had called her and asked her to take back her abuser because, the social worker said, "he said he loved her and would never do it again.") In 1984, *Domestic Violence: A Guide for Health Care Professionals,* one of the country's first training manuals, was published by the state of New Jersey.

Obstetrician-gynecologist Ronald Chez, M.D., (at the time on the faculty of New Jersey's University of Medicine and Dentistry) responded to Esposito's outreach activities. Realizing that something was wrong since, after delivering 7,000 babies, he had never identified a woman as battered, Chez joined Esposito in the work of educating physicians. The two of them developed five different audiovisual and lecture training packages for physicians, nurses, and ED staff, as well as a two-part program for mental health personnel co-authored by Susan Schechter. Dr. Chez continued focusing on the education of physicians, particularly obstetricians and gynecologists, and wrote numerous articles in the field. In large part because of his efforts, the American College of Obstetricians-Gynecologists (ACOG) became the first national medical society to address domestic violence: Dr. Ronald Chez gave the keynote speech on domestic violence at ACOG's annual meeting in 1987. In 1991, ACOG developed one of the first informational packets on domestic violence to be distributed by a national medical society. Richard F. Jones III, President of ACOG from

1992-93, further strengthened the organizational commitment to domestic violence and provided important national leadership on the issue.

Carla Digirolamo, also a survivor of domestic violence, headed the New York State Office of Domestic Violence Prevention in Albany under Governor Cuomo during this period. She collaborated with the New York Department of Health and Flitcraft and Stark to produce a manual and, in 1990, New York went one step further, becoming the first state to require that all licensed hospitals establish protocols and training programs to identify and treat domestic violence victims and utilize community referral lists. The Department also trained staff in surveillance and enforcement of these regulations.

NURSES PLAY KEY ROLE

The nursing field jumped into this field early on. In 1977, nurse Barbara Parker, who was a founder of the House of Ruth shelter in Baltimore, published an article on domestic violence as a health care concern. That same year, the Ambulatory Nursing Department of the Brigham and Women's Hospital, working jointly with the social work department, developed one of the first ED-based domestic violence protocols. In 1981 Jacqueline Campbell, then a member of the Board of Directors of a Detroit shelter, Women in Transition, and on the faculty of Wayne State University School of Nursing, published a study showing that a major risk factor for homicide among women was domestic violence. This led her to develop, in 1985, a Danger Assessment Screen that identifies the risk factors for homicide in a battering relationship, and an Abuse Assessment Screen consisting of four questions which have been found to reliably identify the presence of domestic violence.

Jim Mercy, Mark Rosenberg and Linda Saltzman were instrumental in promoting domestic violence as a priority at the US Centers for Disease Control and Prevention

In 1985, eight nurses were invited to participate in a national health conference on violence against women convened by the federal government (see below). That same year, Christine King, a nurse on the faculty of the University of Massachusetts-Amherst, organized the first nursing conference on violence against women. It was at that meeting that the *Nursing Network on Violence Against Women* was founded by Campbell, Parker, King, McFarlane, and others. In addition to moving forward the issue of domestic violence in the nursing profession, this Network had the distinction of addressing the health consequences of a frequent component of domestic violence, marital rape (e.g., repeat STDs, HIV, unintentional pregnancy, vaginal tearing, urinary tract infections, etc.).

The nursing profession has focused on other important domestic violence-related subjects as well. For example, several nurses have researched the prevalence of battering during pregnancy. In 1987, nurse Ann Helton published a study that, for the first time, determined the incidence of battering during pregnancy to be 15%, which has been confirmed in subsequent studies. Other nursing research has focused on low birthweight associated with this problem, longitudinal studies of abused women, and the effects of domestic violence on children. By 1990, nurses had authored 46 published studies about domestic violence.

In 1987, as a result of the work many nurses had been doing throughout the country, the American Nurses Association passed a resolution in support of addressing domestic violence in health care settings, and in 1991 passed a second resolution encouraging that domestic violence be included in nursing education.

HOSPITAL-BASED PROGRAMS BEGIN

In 1983, Debbie Lee, staff member of the Family Violence Prevention Fund, began providing services to victims at San Francisco General Hospital, the city's public health hospital. This was the impetus for the

further development of the FUND's work in the health field.

In 1986, medical technologist Susan Hadley was finishing a masters program in public health at the University of Minnesota and volunteering at a victim hotline. After wondering what happens to a victim of domestic violence who seeks help in a health setting, she obtained the support of a pastoral care provider and a nurse administrator, and set up a private nonprofit organization within the Fairview Health System in Minneapolis, WomanKind, the first formal hospital-based domestic violence program in the country. (See page 22 for more information on this program.) WomanKind provides case management advocacy services for victims combined with education/consultation for providers.

That same year, at Chicago's Rush Presbyterian Hospital (a 1,200-bed tertiary care level II Trauma Center), Dan Sheridan was able to establish a domestic violence program in the ED. This was an outgrowth of a nursing and medical student group started several years earlier by Sheridan to address spouse abuse. The program learned as it evolved, and soon expanded beyond domestic violence to encompass child and elder abuse, and eventually absorbed sexual assault victim advocacy training as well.

In 1986, Boston social worker Susan Schechter found that it was possible to identify battered women when their abused children were brought to a hospital and started the program, AWAKE

In another major development which took place in Boston that year, social worker Susan Schechter began identifying and working with abused women within a hospital-based child abuse program at Children's Hospital. Because of the strong overlap between these two forms of abuse within families, she found that it was possible to identify battered women when their abused children were brought to a hospital. The program that was started, A.W.A.K.E. (Advocacy for Women and Kids in Emergency Situations), also demonstrated that ongoing advocacy services, not only identification and referral, could be provided to abused women in this setting. (see p. 21)

OTHER MILESTONES

In 1980, the federal Office of Domestic Violence under President Carter published and distributed a domestic violence protocol and a monograph summarizing the Stark and Flitcraft research findings from Yale. Then, in 1985, a major turning point occurred when then-Surgeon General C. Everett Koop convened a conference, "Violence as a Public Health Issue." Koop was the first national public figure, and the first representative of organized medicine, to expand the understanding of violence, particularly violence against women, beyond criminal justice to the health arena. Concern about domestic violence remained a theme throughout Koop's tenure, and his leadership was key in positioning the issue as a medical and public health problem.

Some other early pioneers emerged within the Federal government, such as Jim Mercy, Mark Rosenberg and Linda Saltzman, who were instrumental in promoting domestic violence as a priority at the U.S. Centers for Disease Control and Prevention (CDC). In 1993, as a result of President Clinton and Congresswoman Pelosi's (D-CA) leadership, $7.3 million was designated to establish the Family and Intimate Violence Prevention Team within the Division of Violence Prevention, National Center for Injury Prevention and Control, at the CDC, and to fund community-based prevention efforts, studies on causality and consequences, evaluation programs, public education activities, and training. This was the first time that the CDC targeted funding for domestic violence. At the National Institute of Mental Health of the National Institutes of Health, another pioneer, Tom Lalley, head of the Violent and Anti-Social Behavior Research Division, supported many of the earliest government-funded studies on medicine and domestic violence.

HOSPITALS REQUIRED TO ACT

In Philadelphia, during the late 1980s, Susan McLeer, M.D., a psychiatrist at the Medical College of Pennsylvania, researched whether domestic violence protocols in the ED increased the identification rates of battered women seeking treatment there. She confirmed not only that identification of battered women increased, but also that if the policies and procedures were not *institutionalized,* the numbers went down to where they had been previously. Next, Dr. McLeer chaired a committee of the Philadelphia Coalition Against Domestic Violence; the purpose of this committee was to persuade the Joint Commission on the Accreditation of Hospitals and Health Care Organizations (JCAHO) to mandate the development of protocols for the identification and treatment of abused women. Dr. McLeer and the committee were successful, and JCAHO first introduced this requirement for emergency departments in 1990. These requirements went hospital-wide in 1992.

In the early '90s, California physician Patricia Salber worked with the Family Violence Prevention Fund to help develop the FUND's National Health Initiative on Domestic Violence. With Ellen Tallifero, she co-founded Physicians for a Violence-Free Society to help doctors understand how to incorporate violence prevention in the practice of medicine; for the last three years the focus of this group has been on violence against women. Having conducted hundreds of trainings around the country, Salber (with co-author Tallifer) wrote *A Physician's Guide to Domestic Violence,* published by San Francisco's Volcano Press in 1995.

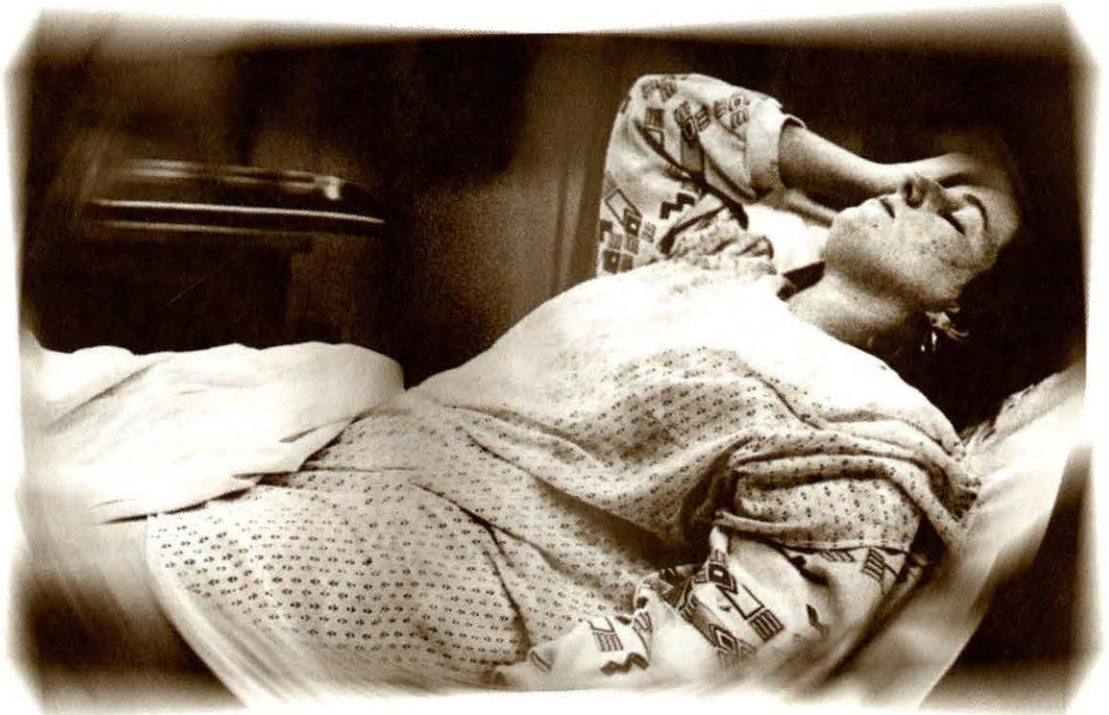
In 1992, Dr. Kevin J. Fullin, co-founder of the Domestic Violence Project, Inc., in Kenosha, Wisconsin (see p. 20), proposed several domestic violence resolutions to the Wisconsin State Medical Society. These led to the formation of the State Medical Committee on Domestic Violence, which introduced protocols for screening, established a series of CMEs within the Medical Society, and generated activism within the medical profession throughout the state.

In 1993, organized medicine officially joined the effort: the American Medical Association (AMA), under the leadership of Dr. Robert McAfee, launched a Campaign Against Family Violence and formed a National Coalition of Physicians Against Family Violence as well as a National Domestic Violence Council, comprised of 35 national medical specialty organizations. The AMA produced a series of Diagnostic and Treatment Guidelines on domestic violence, child abuse, elder abuse, sexual assault, and the mental health effects of family violence; and in 1992 produced, for the first time, an edition of *JAMA (the Journal of the American Medical Association),* entirely dedicated to domestic violence.

In 1995, with the passage of AB 890, California became the first state in the country to mandate that *all hospitals and licensed clinics* routinely screen patients for the presence of violence, document such violence in medical records, and use domestic violence referral lists. This landmark legislation also made domestic violence coursework or training a part of the licensure and recertification process for health care providers. Florida and New York also require domestic violence training for relicensure of physicians.

In 1995, California became the first state to mandate that all hospitals and licensed clinics routinely screen patients for the presence of violence, document it and use domestic violence referral lists

However, the state of California has also legislated mandatory reporting to the police by health care providers specifically when domestic violence is determined to be a cause of injury. The legislation requires that practitioners report to the police when they provide medical services to a patient who may be suffering from a physical injury caused by "assaultive or abusive conduct." As of 1996, Kentucky, New Mexico, New Hampshire, Colorado, and Rhode Island have passed similar laws. This is seen by leading domestic violence advocates, as well as the American Medical Association, as a dangerous and misguided approach. Mandatory reporting may decrease the willingness of some battered women to seek medical assistance or, when they do, to be candid about the violence they are experiencing. It may actually put some victims at greater risk of further injury. Moreover, ethical issues, including patient autonomy, confidentiality, and informed consent, arise. One way to respond to these unintended consequences is to amend, or promote legislation requiring "patient consent" before the report is made. (For more information, please see Hyman et al, Laws mandating reporting of domestic violence: do they promote patient well-being?, *JAMA,* June 14, 1995; Vol 273, No. 22, 1781-1787.)



How to Create Your Own Domestic Violence Program *in a Health Care Setting*

It may seem a bit overwhelming to think of establishing a program to respond to domestic violence in your clinic or hospital, not to mention expensive, which in these times of cost-cutting and health care reorganization makes the prospect even more daunting. This section describes a model program which has been extensively field tested and has the added advantage of being inexpensive to implement. This prototype shows how to create a comprehensive program within an emergency department, primary care, ob/gyn, or other clinical setting. *(For help implementing the following model, call the FUND's Health Resource Center on Domestic Violence toll-free at 1-888-Rx-Abuse.)*

In 1992, the FUND and the Pennsylvania Coalition Against Domestic Violence designed a model program to strengthen a hospital's response to domestic violence; it was then pilot-tested and fine-tuned in 12 hospitals in two states, California and Pennsylvania. Over the next year, another 50 hospitals and clinics implemented the model. The FUND then worked with California's Department of Health Services to set up this program in 50 California clinics, and as part of this process, 800 clinic staff were trained.

This approach, applicable to an HMO, hospital, clinic, or group practice, enables the staff of a health care institution to respond in a comprehensive manner to domestic violence (i.e., through screening, identification/assessment, treatment, documentation, safety planning, referral, etc.) by:

- Creating an environment which *enhances* rather than discourages the identification of abuse
- Educating health care staff about how to *intervene* with patients who are victims of abuse
- Establishing an *integrated* and *institutionalized* response to domestic violence
- Developing referral and resource *materials*
- *Evaluating,* on an ongoing basis, the effectiveness of the program
- Becoming part of a *coordinated response* within the larger community through collaborative partnerships

A STEP-BY-STEP OVERVIEW OF HOW TO ESTABLISH A HEALTH CARE-BASED DOMESTIC VIOLENCE PROGRAM

1. Set Up a Collaborative Working Group

This means recruiting key people within the clinical setting plus representatives from local domestic violence service agencies, to ensure that training and referral are well coordinated. It is also essential to build support within the institution. To accomplish this, it may be helpful to obtain domestic violence prevalence data in the surrounding area, or to document the prevalence in this particular clinical setting; it may also be useful to survey provider knowledge, attitudes, and behavior about domestic violence. Administrators may be particularly receptive to the idea by being reminded of the requirements of the Joint Commission on Accreditation of Hospitals and Health Organizations (JCAHO) with regard to domestic violence, and being made aware of the guidelines developed by the American Medical Association, the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American Nurses Association.

Because of the different roles played by physicians, nurses, social workers, discharge planners, intake staff, and translators, it is also crucial for this Working Group to be multidisciplinary. It is also important to involve as many departments as possible, although this may not happen immediately but rather gradually, as awareness spreads throughout the institution. Before proceeding, an assessment should be made concerning what resources are available within the institution (existing protocols, administrative support, potential Working Group members) and in the community (domestic violence programs, other interested health care entities, technical assistance, etc.).

2. Develop Routine, Site-Specific Screening

What kind of response is best suited to this particular institution in this particular community? How can screening for violence be routinely incorporated into this setting? The answers vary by type of clinical setting and need to include the range of clinicians who are in a position to ask about abuse. The physical layout should be considered as well, so that private space can be identified.

It is essential that all identified victims of domestic violence leave the clinical setting with some basic intervention having been made, including an assessment and short discussion about domestic violence safety planning and referrals, even though many may not be ready to pursue a referral. Consequently, *all* primary care providers should be able to do basic interventions with patients. More in-depth interventions may be carried out by other staff (such as patient advocates, case managers, social workers, etc.), or an on-site domestic violence advocate may be hired to do this exclusively. The Working Group can decide which of these options is best suited to the institution and resources available.

3. Write Protocols

A protocol will minimally include a definition of domestic violence, screening questions and identification of who will ask them, interviewing strategies, safety assessment and planning guidelines, discharge instructions, clarification of legal requirements, procedures for collection of evidence (photographs, other evidence) and medical record documentation, referral information, and a plan for staff education. These protocols should be developed by a multidisciplinary team. Finalizing protocols is easier than it sounds, because there are so many good model protocols available that can be modified for specific settings.

4. Develop and Institutionalize a Staff Training Program

To enhance staff training, domestic violence advocates and survivors should be utilized as often as possible. Interactive exercises, role-plays, and other "learner-centered" techniques, which enable participants to practice screening and explore personal responses to abuse, are useful. Again, *all*

staff should receive this training (including physicians, nurses, social workers, clerical staff, security personnel, translators, clergy, and paramedics), and it should be *ongoing.* Often when health care providers receive training on domestic violence, it triggers their own personal experiences with abuse. Therefore, Employee Assistance Programs should also be trained, and services and resource materials should be developed, so that employees who are victims of domestic violence can receive the help they may need.

"I was an ICU nurse, my husband was a neurosurgeon, and at one point during my marriage we worked together. At the hospital, he would put me down in front of everybody. If I told him the condition of a patient, he would act like I was wrong and stupid. At home he was quite violent. When he got enraged, which was fairly often, he would punch me, throw me down, choke me, pull me by the hair, threaten to kill me. He kept on moving us around so I was totally isolated, and anyway he wouldn't let me see any friends. I wore scarves and long sleeved shirts even in summer to hide the bruises, but because he often punched me in the face the bruises were sometimes quite visible.

"No one at the hospital did anything. One physician asked me about the bruises on my face. I told him I ran into a cupboard, but I got tears in my eyes as I was answering him. He immediately got nervous and walked away. It was clear he didn't want to know. The inability of my co-workers to reach out to me just confirmed, for me, what my husband was telling me: that I was worthless, stupid, ugly, and deserved everything I was getting." — Julie S., Stockton, California

5. Develop Resource Materials for Clinicians and Patients

These can include informational materials for both providers (reminder stamps for screening, algorithms, referral lists, pocket reference cards, posters, etc.) and patients (posters, referral cards, brochures, booklets, etc.). Model materials can be easily obtained from the programs featured later in this publication and from the FUND's Health Resource Center on Domestic Violence (see p. 15).

Develop a referral network. In order to adequately respond to battered patients and assist them in addressing violence in their lives, providers need to be aware of services provided by local domestic violence shelters, legal assistance, counseling and support groups, mental health and substance abuse treatment, childcare, as well as resources which address language, culture, and disability needs in the surrounding community. This information should be collected into a referral list and made easily available to both clinicians and patients.

6. Establish Quality Assurance Mechanisms to Monitor the Response

Make appropriate responses to victims of domestic violence the target of quality assurance reviews. This notifies providers that responding to domestic violence is now a standard of care and no longer left to their "discretion." If a baseline needs assessment has been done, ongoing quality assurance reviews can be used to engage clinicians in setting goals and addressing obstacles that are identified.

7. Develop Collaborative Relationships with Community Domestic Violence Experts

Develop a close, working relationship with your local battered women's shelter or domestic violence program. These community experts are the best and most reliable source for information on local and state laws, civil and criminal justice responses, resource materials, referrals, etc. They also should be able to provide you with experienced trainers who can provide the "DV-101" portion of your training (i.e., dynamics of domestic violence, effects on children, prevalence, etc).

You may also want to participate in community-wide collaborative efforts to address domestic violence. This will help insure that all the necessary resources are available in the community to address the needs of battered patients, and that all the professionals involved — domestic violence advocates, law enforcement and prosecutors, the judiciary, health care, child protective services — are coordinating and supporting each other's efforts.

A Blueprint for Change in San Francisco:

How to Build a City-Wide Health Care Response to Domestic Violence

HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE

Family Violence Prevention Fund
383 Rhode Island St., Suite 304
San Francisco, CA 94103

Call Toll-Free: 1-888-Rx-Abuse
Mon-Fri 9am – 5pm PST

E-mail: health@fvpf.org

Website:
http://www.fvpf.org/health/

Funding: U.S. Department of Health and Human Services and Conrad N. Hilton Foundation

San Francisco is well on its way to becoming a model of how a locality can create a comprehensive, city-wide response to domestic violence, ensuring that every health care setting, whether public or private, asks every patient if they are experiencing violence at home, and that every provider knows the signs of abuse to look for and knows how to respond once the problem has been identified.

In San Francisco, training and implementation of domestic violence protocols are extending far beyond the public hospital in which these were initially based, and are branching out to include all the hospitals, all public and community clinics, and all physicians and nurses working in the city. Moreover, plans are in place to provide education to employees on domestic violence in all city government offices and to bring domestic violence training to all city-funded substance abuse treatment programs.

The end result is that all victims of domestic violence who interact with health care providers regardless of the setting, and not limited to those times when victims seek treatment for their domestic-violence related injuries, will be identified by their providers, and will be offered assistance for the violence they are suffering at the hands of their partners. At the very least, victims in San Francisco will know that someone cares, and that the abuse is not condoned or ignored by city health care providers. This is a major step toward ending the isolation of abused women and stopping the cycle of violence in which so many are trapped.

"The staff is now more informed and empowered; they are now more willing to intervene."

– Clinic Director, Mission Neighborhood Health Center

Every San Francisco clinic and hospital is being encouraged to document that screening for domestic violence took place. This can easily be accomplished through a simple notation on the chart, intake form, medical history or social history forms. The following screening notation can be printed onto charts as check-off boxes or added as stickers or via rubber stamps:

SCREENING: ❑ YES ❑ NO
❑ DV+ ❑ DV- ❑ DV?

Key: DV+ = positive identification
DV- = negative identification
DV? = suspected identification

To order the rubber stamp above, contact the Health Resource Center on Domestic Violence at 1-888-Rx-Abuse.

STEPS TO TAKE TO CREATE YOUR OWN CITY-WIDE HEALTH CARE RESPONSE PROGRAM

The following are examples taken from the San Francisco model of activities that you can adopt or adapt when creating your own city-wide health care response to domestic violence program.

San Francisco General Hospital ED Develops Program

In the pilot-test in California and Pennsylvania described in the previous section, the Family Violence Prevention Fund (FUND) worked with ED staff at San Francisco General Hospital, the city's Trauma Center, to create a domestic violence program. The staff at General added several unique components that enhanced the effectiveness of the program.

DOMESTIC VIOLENCE KIT

In a distinctively colored two-pocket folder, all the procedures and forms needed to help the clinician address domestic violence with a patient have been collected. This packet is pulled when a battered patient is identified and is a convenient way to get all the materials to those who may use them quickly, simply, and easily.

TRAINING ADDITIONAL STAFF

Recognizing the often crucial role played by non-medical, non-nursing staff, the decision was made to give domestic violence training to paramedics, ambulance drivers, translators, clergy, volunteers, and the ED clerical staff. As a result, everyone who comes in contact with patients, often in very close settings, knows the signs of possible domestic violence and are able to alert medical and nursing staff.

BLUE "ALERT" STICKER

Paramedics and ambulance drivers have been provided with a small blue sticker which they attach to the intake form to convey their suspicion that a patient they are bringing to the ED may be a victim of domestic violence. Clinicians are thereby alerted that they must probe carefully and thoroughly with these patients.

Clinic Training Conducted

Ten San Francisco clinics were then recruited: seven at S.F. General Hospital (Women's Health, General Medicine, Family Health, Employee Health, Family Planning, Rape Treatment, and Teen Clinic) and three in the community (one specializing in lesbian and women's health, one serving a primarily Latino population, and one Department of Public Health community health center). Each clinic assembled a multidisciplinary team, which included a domestic violence advocate from a local service agency, in order to craft a well-coordinated response with the community. The FUND provided extensive training to these teams, who then went back to their clinics to develop domestic violence protocols, train all of their clinic staff and expand resource materials for battered patients and clinicians.

Training Expands to All Public Health Clinics

At the one Department of Public Health (DPH) clinic in the pilot program, a staff physician decided it made sense to include the 10 other public health clinics in the city so there would be standardized treatment and response. The medical director, center director, and nurse manager at each clinic participated in finalizing the protocol, and staff at all 11 clinics were trained.

A City-Wide Protocol Approved

In San Francisco, domestic violence concerns are coordinated by a Family Violence Council, comprised of numerous professional and community representatives from many sectors of the city. This Council formed a Health Care Committee which has created a city-wide domestic violence screening protocol.

Recruited to the Committee were physicians (ED, private practice, public health, community clinic, prevention health education/injury prevention); social workers/health educators (hospitals, community clinics, public health); domestic violence advocates (shelters, legal services, counseling agencies); administrators (DPH and private sector planners and managers); and nurses (ED, public health center, hospital administrator, prenatal).

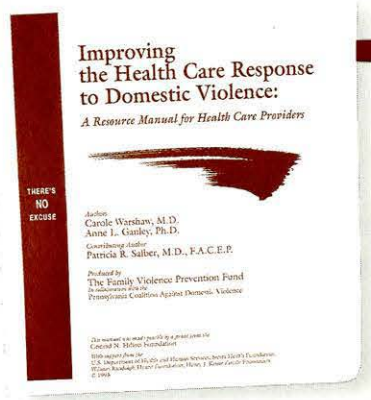
After developing the protocol, Committee members went back to their constituency organizations for approval. The protocol will be distributed throughout San Francisco to health care providers working in a diversity of settings including public clinics, private clinics, family practices, hospitals, private practices, etc.

Workplace Policies Developed for City Agencies

Another outcome of the FUND's initiative in San Francisco is the formation of a working group at the DPH to develop workplace policies for responding to employees within DPH who are victims of domestic violence. This is being accomplished by bringing together administrators, Employee Assistance Program staff, DPH planners, a community advocate, and a survivor of domestic violence (a nurse who worked with, and was beaten by, her surgeon-husband). After the policy has been developed and disseminated to all DPH agencies and workplaces, it will be replicated and distributed to all city departments throughout San Francisco.

Substance Abuse Treatment Programs Included

The Director of Substance Abuse for the City of San Francisco has requested assistance in developing domestic violence screening protocols so that every person coming into every city-funded substance abuse agency will be screened for domestic violence. Once these protocols are finalized and disseminated, efforts will be made to include the implementation of these protocols as part of city contract compliance.



FAMILY VIOLENCE PREVENTION FUND

Resource Manual

A comprehensive manual describing how to implement a hospital- or clinic-based domestic violence program and containing training hand-outs, sample resource materials, suggested protocols, screening tools and documentation forms is available from the FUND for $75.00. This Resource Manual also contains camera-ready copy for multi-lingual discharge instructions and patient information brochures which can be printed within most hospitals' resource education budgets.

Call the Health Resource Center on Domestic Violence's toll-free line 1-888-Rx-Abuse for ordering information.

We Can Help

THE HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE

A project of the Family Violence Prevention Fund, the Health Resource Center on Domestic Violence serves as the nation's clearinghouse for individuals wanting to strengthen their clinical response to domestic violence. Through its toll-free line — 1-888-Rx-ABUSE — and trained information specialists, the Health Resource Center provides information and referral, technical assistance and support to thousands of people every year interested in developing a comprehensive health care response to domestic violence. Our callers include health care professionals, domestic violence service providers, government agencies, researchers and policymakers.

THE HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE PROVIDES:

Resource & Training Materials

- *Improving the Health Care Response to Domestic Violence,* a resource manual providing the tools for an effective multidisciplinary health care response;
- Comprehensive information packets for a wide variety of health specialties (e.g., emergency medicine, primary care, nursing and obstetrics/gynecology);
- Multidisciplinary protocols emphasizing routine screening and identification of domestic violence;
- Research studies and other published materials on domestic violence and the health care response.

Technical Assistance

- Help with health care training program and protocol development;
- Models for local, state and national health policymaking.

Information & Referrals

- Information on model programs and materials for screening and intervention;
- A national network of experts for public speaking, training and consultation;
- Educational materials specifically developed for health care and domestic violence service providers.

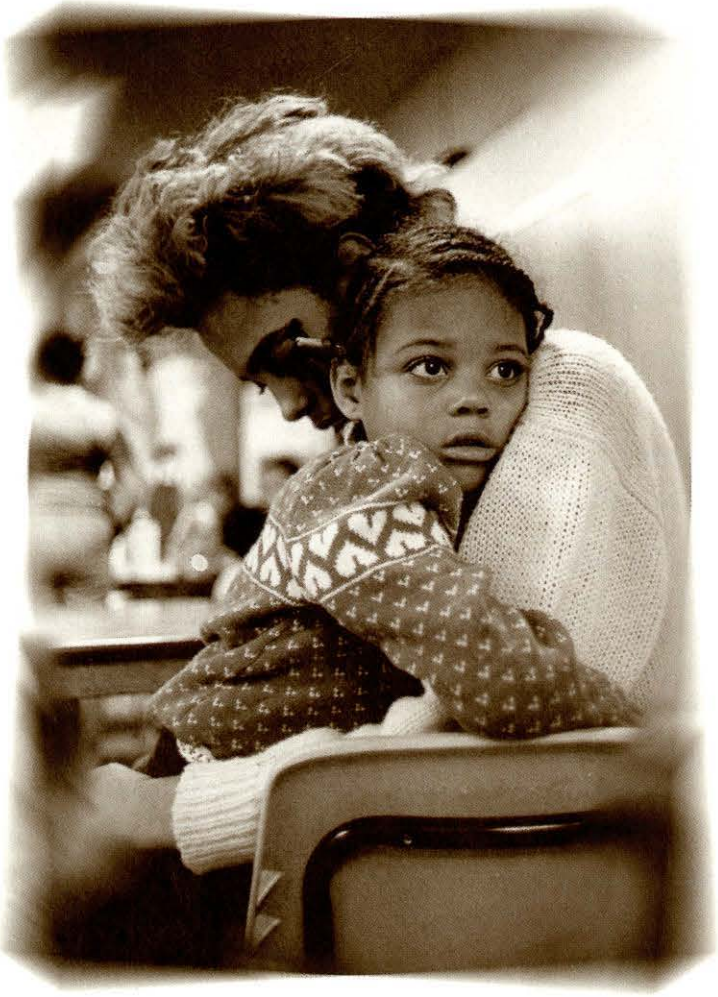
CALL TOLL-FREE 1-888-RX-ABUSE

M-F 9am-5pm, P.S.T.
health@fvpf.org
http: //www.fvpf.org/health/

A Sampling of Innovative

Health Care Domestic Violence Programs

From Around the Country



Hospital-Based Domestic Violence Programs

"It used to be that I would barely hear about a domestic violence case. Now the staff identify a lot more. The way it often happens is they get a hunch that the injury doesn't really match the explanation, but the patient denies it. So the nurses call me to come talk to the patient as a 'suspected' domestic violence victim. In every case I've been able to spend time establishing a rapport (because the nurses often don't have this kind of time) so I can penetrate her denial, and the suspicions always turn out to be right."

— Social worker Nancy von Bretzel, S.F. General Hospital

Several of the country's most comprehensive, innovative, and effective programs designed to assist abused women at hospitals and health clinics are described in this section. These specific programs were selected because they illustrate different service models, staffing patterns, or organizational structures, and/or because they have particularly unique features.

What is common to all these programs is that they are a result of collaborative efforts and that they all offer staff training in conjunction with services to victims. Experience confirms that, without ongoing training, a program will not endure effectively overtime.

The services provided by these programs vary, from advocacy to case management, and from short term crisis-oriented to long term, post-hospitalization support. Staffing configurations vary, and many programs include formerly battered women who provide validation and share stories from their own experience.

Structurally, a program may function as a department of the hospital, as a component of a community domestic violence agency, or as an independent nonprofit corporation set up specifically for this purpose. Some unique features are described, such as an apartment for emergency shelter established on hospital grounds, or a project which identifies abused mothers through a hospital-based child abuse program.

It is hoped that the range and variety of efforts explored here will enable interested staff members of hospitals, clinics, and domestic violence agencies to identify a model or combination of models that could meet their own particular needs, philosophy, structure, or community in developing health care-based services to domestic violence victims.

Chicago Creates One of the First Public Hospital Domestic Violence Programs

HOSPITAL CRISIS INTERVENTION PROJECT

Cook County Hospital
1835 W. Harrison, Room 3427
Chicago, IL 60612

Contact: Kim Riordan
(312) 433-2390

Annual Budget: $133,000

Funding: United Way; Victims of Crime Act; corporate, foundation and individual support; and honoraria

Number of clients served annually: 300

Number of individuals trained annually: 1,500

The Hospital Crisis Intervention Project (HCIP), one of the nation's first domestic violence programs established in a public hospital, is an on-site domestic violence advocacy and training program at Cook County Hospital in Chicago. A collaborative effort of the Chicago Abused Women Coalition and the Cook County Bureau of Health Services, HCIP provides immediate assistance to abused women at the hospital and trains hospital staff on identification, assessment, and referral of patients who are victims of domestic violence.

Linking the resources and expertise of both the medical and advocacy communities, HCIP was co-founded in 1992 by Vickii Coffey, then Executive Director of the Coalition, and Carole Warshaw, M.D., Director of Behavioral Science/Primary Care at the hospital. The Coalition opened Chicago's first shelter and started the area's first 24-hour domestic violence hotline. Cook County Hospital is the second largest public hospital in the country, providing health care services to approximately 650,000 patients annually, most of them medically indigent.

The staff is multicultural, offering services in seven languages

HCIP is staffed by three full-time domestic violence counselor/advocates, a full-time project coordinator, and Dr. Warshaw, who co-directs the project for the hospital. The staff is multicultural, offering services in seven languages. Advocates are available daily from 7:00 a.m. to 5:00 p.m. to provide crisis intervention, counseling, legal advocacy, information and support, and referrals. During the evenings, the hospital social worker is available on-call. Referrals to HCIP come from throughout the hospital, and staff work to reach out to all hospital departments. The program works most closely with the Trauma, Adult Emergency Services, Obstetrics and Gynecology, Social Work, Psychiatry, and Internal Medicine departments.

HCIP also trains health care providers within the hospital in several different ways. For example, every month a training is provided to Internal Medicine staff, and all Ob-Gyn residents rotate through HCIP. All new hospital staff hear a presentation about HCIP, and brown bag lunches are regularly scheduled to offer information about domestic violence. Training sessions include information on the dynamics of domestic violence, appropriate questions and responses to abuse victims, and barriers to identification. HCIP has also designed and taught a comprehensive 10-week course on improving the health system's response to domestic violence to students at the University of Chicago's Pritzker School of Medicine.

"If you don't know about it, you don't look for it," comments one hospital physician. "It's like illiteracy. If you can't read, you don't know a lot of what is happening."

UCLA Collaboration Provides Crisis Teams

Based in the Emergency Medicine Center, the UCLA Domestic Violence Consult Team is a low-cost, multidisciplinary crisis intervention and training program that involves a partnership between hospital staff, the University, and law enforcement. The program provides 24-hour crisis counseling and referral for domestic violence victims, and conducts training for all clinical staff on the identification, treatment and referral of abused women. The Consult Team consists of a rotating physician, nurse and social worker "on call" to help with iden-

On Site Advocate Available in Pittsburgh Hospital

Pittsburgh Mercy Health System

MEDICAL ADVOCACY PROJECT

Contact: Debbie Levenstein, Clinical Manager, Women's Center & Shelter of Greater Pittsburgh, 412-687-8017 x315

Address: P.O. Box 9024, Pittsburgh, PA 15224

Annual Budget: $80,000

Funding: Governor's Budget via the Pennsylvania Coalition Against Domestic Violence

Number of trainings/people trained annually: 12 trainings/yr; 1,200+ staff members trained over 3 years

Number of clients served annually: over 300

Note: *Three sister programs have been established: one in the Wyoming Valley Health Care System in Wilkes-Barre, one in Abington Memorial Hospital outside of Philadelphia, and one in Geisinger Medical Center in rural Danille. Information about these programs can be obtained from the Pennsylvania Coalition Against Domestic Violence at 800-537-2238.*

An apartment on hospital grounds for domestic violence victims when shelters are full is just one of the results of the long term collaboration between the Women's Center and Shelter of Greater Pittsburgh and Mercy Hospital, a large, inner-city teaching hospital. This collaboration produced the Medical Advocacy Project, which provides a full-time, on-site domestic violence advocate, numerous trainings for hospital staff, and a hospital-wide procedure manual.

Through the Medical Advocacy Project, each woman coming into Mercy's Emergency Department (ED) is screened for family violence by the intake nurse. Women identified as abuse victims are offered the services of the Medical Advocate: crisis intervention, counseling, identification of safety planning options, assistance in obtaining additional services, post-hospitalization support, and general case management services. (The Medical Advocate is an employee of the Women's Center and Shelter and is not a hospital employee; this means she does not have access to hospital records, nor does the hospital have access to the Women's Center records.)

A Domestic Abuse Team has been formed and meets monthly to discuss policy and procedures. Members include the medical advocate, Women's Center and Shelter Clinical Manager, the Medical Facilitator, the ED chair, an ED nurse, a second physician, the assistant to the chair of the Obstetrics/Gynecology Department, a pastoral care counselor, a Trauma Department physician, and a social worker.

The hope and belief of the Project staff is that abused women are getting help earlier

Interestingly, the vast majority of abused women who are being identified at Mercy Hospital have never been involved with the Women's Center and Shelter, yet have extensive histories of domestic violence. The hope and belief of the Project staff is that abused women are getting help earlier in the cycle of violence.

tification, counseling, and referral. A relationship has been established with the UCLA police department, which provides protection, referrals, and emergency protective orders as needed. Educational and training materials are being developed.

Kelly Hubbell, Domestic Violence Consult Team, UCLA Emergency Medicine Center, Box 951744, Los Angeles, CA 90095-1744; 310-825-2126.

Nonprofit Formed to Provide Hospital Domestic Violence Services in Kenosha, Wisconsin

DOMESTIC VIOLENCE PROJECT

Contact: Amanda Cosgrove, 414-656-8502

Address: 6308 8th Avenue, Kenosha, WI 53143

Annual Budget: $100,000

Funding: Hospital, Victim of Crime Act, Community Development Block Grant, private contributions, annual fundraisers

Number of women served annually: 200

Number of trainings/people trained annually: 1,200 people

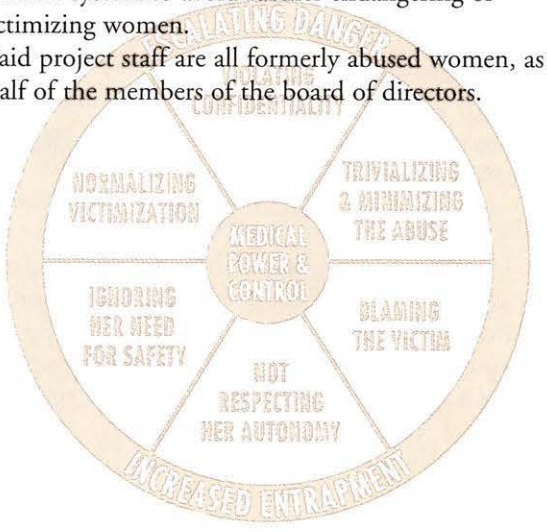
Round-the-clock domestic violence advocacy services are provided to two hospitals in Kenosha, Wisconsin, by a private nonprofit organization created for that purpose. The effort grew out of a collaboration between a cardiologist, a nurse, and the local shelter director.

Created in 1991, the project offers 24-hour on-site advocacy, support groups, and followup contact and ongoing support. The women (70% of whom have not previously sought community-based services) are offered safety planning, advocacy, information and referral, and legal protections and options. Long term individual support is available for a year or more. Group support is also provided, including two groups which meet at the hospital: one for women over 50, and one for women of any age. Because it was noted that few African-American women were attending support groups at the hospital, the Project now offers a support group at a local neighborhood center. Another support group is held for teens at a local high school.

The Project also offers a support group for teens at a local high school

The Project also provides trainings to both the general public and to health care providers, specifically the staff at both hospitals, through a variety of inservices and workshops. A Medical Power and Control Wheel (see illustration) was adapted from the Duluth Intervention Project's Power and Control Wheel, and is used in conjunction with an Advocacy Wheel which suggests different responses for providers to consider. In addition to building skills, the trainings help the participants identify the attitudinal and institutional changes that need to be made in the health care system to avoid further endangering or re-victimizing women.

Paid project staff are all formerly abused women, as are half of the members of the board of directors.



Volunteers Utilized in Low-Cost Illinois Program

This program, Hospital Advocacy for Victims of Domestic Violence, offers three hospitals 24-hour advocacy services for any adult victim of family violence (including elder abuse). Support, counseling, and informational/referrals are provided by volunteer advocates at the emergency departments; the advocates are paged when needed and are able to respond within 45 minutes. They also offer shelter at the Crisis Center to female victims and their children; male victims are offered motel-shelter for one to three nights. The volunteer advocates

"AWAKE" Addresses Domestic Violence Through Child Abuse

AWAKE

Contact: Jennifer Robertson, Project Director, 617-355-4760

Address: Children's Hospital, 300 Longwood Ave, Boston, MA 02115

Annual Budget: $220,435

Funding: 34% Healthy Start, 27% Victims of Crime Act, 13% Children's Hospitals, 4% Honoraria (trainings and case consultations), 2% Mass. Dept. of Social Services (CPS); 20% private foundations

Number of women served annually: 531 (281 new plus 250 ongoing)

Number of trainings annually: 30-40

Number of individuals trained annually: more than 1,000

A number of years ago, the Family Development Clinic at Children's Hospital in Boston was involved in an incident that made the staff question its response to family violence. During an evaluation ordered by the Boston Juvenile Court to explore allegations of child abuse, they were confronted with a terrifying yet undisputable connection between child abuse and woman abuse. During the initial interview with the child's parents, the father started to pace around the room and then unexpectedly lunched for his wife's throat. Pulling him away, the stunned staff had little idea of what to do next. "What," they later wondered, "should be done to protect the mother?"

This case and other similar ones stimulated the creation, in 1986, of the country's first hospital-based program that offers advocacy and support to abused mothers at the same time that the hospital is providing protection to abused children. AWAKE (Advocacy for Women and Kids in Emergencies) was formed to broaden child abuse programming to include intervention on behalf of battered women and to unite services which are often offered separately, and in conflict, to women and children. AWAKE staff have found that a hospital is one of the best places to discover domestic violence, and provides one of the best opportunities to talk to a mother about the negative effects of domestic violence on both her and her children. This realization can often serve as a major motivation for a woman to accept ongoing help.

In the AWAKE program, battered women with abused children are paired with an advocate experienced in family violence. The advocate devises an immediate safety plan which is updated during each subsequent contact and is designed to keep mothers and children together and safe. Input is sought from a multidisciplinary team (Child Protection Team, District Attorney, Department of Social Services, outside agencies). Long term supportive services are also offered to these families.

In AWAKE, battered women with abused children are paired with an advocate

In 1994, AWAKE expanded its program. Its two bilingual/bi-cultural advocates began offering services at a health center located in a Jamaica Plains public housing development. Because 40 percent of pre- and post-natal patients there indicated that they were battered, aggressive intervention is being targeted to pregnant battered women served at the center. AWAKE also trains medical staff at Children's Hospital and the Martha Eliot Health Center, as well as across the state and the nation, on the dynamics of domestic violence, its overlap with child abuse, its effects on children, signs/symptoms, interviewing techniques, assessment, response, documentation, and referral.

receive 50 hours of training, and ED staff are also trained to identify and respond to victims of domestic violence. The program's only expenses are the coordinator's salary, educational materials, and incidental training costs. The project is operated by the Community Crisis Center, Elgin's domestic violence shelter. ***Sharon Burner or Wendy DePatie, Community Crisis Center, P.O. Box 1390, Elgin, IL 60121. 847-697-2380.***

Comprehensive, Integrated Model Offered in Minnesota

WOMANKIND

Support Systems for Battered Women

WOMANKIND

Contact: Susan M. Hadley, MPH 612-924-5774

Address: Fairview Health System, 3400 W. 66th Street, Suite 128, Minneapolis MN 55435

Annual Budget: $250,000

Funding: Fairview Foundation, Fairview Hospitals Auxiliary, and Fairview Health System

Number of women served annually: 1300 with over 2800 ongoing contacts

Number of trainings: 100

On-site case management combined with ongoing staff education are key to the WomanKind program serving three hospitals, related clinics, and medical offices in Minneapolis, Minnesota. WomanKind's ultimate goal is "to integrate domestic violence into the total health care of each patient resulting in overall system change," says founder and Director Susan M. Hadley, MPH. Early intervention and prevention are the cornerstones of the program's philosophy.

One of the earliest programs in the country, WomanKind was started by Hadley in 1986 as a private nonprofit organization providing services at a suburban hospital which was part of the Fairview Health System. The program grew to include two other hospitals, offices and clinics within the Health System, and in 1992 WomanKind joined Fairview Health System and became a hospital department.

This case management approach for victims of abuse in the hospital, the first of its kind in the country, encompasses three phases. The first phase is Crisis Intervention, Assessment, and Evaluation, which addresses the presenting domestic violence issues, immediate safety needs and identifies mental health concerns such as suicidal thoughts or feelings. Phase II, Education and Information, entails listening, providing support and short term counseling, and discussing the dynamics and myths about domestic violence and its short- and long-term effects on the woman and her family. In Phase III, Action and Protection Plans and Resource Referral, WomanKind staff work with the woman to explore options, identify resources, develop goals, create plans, and take small steps. Typically these services are provided over a 4-6 month period, but sporadic contacts may continue over 3-5 years.

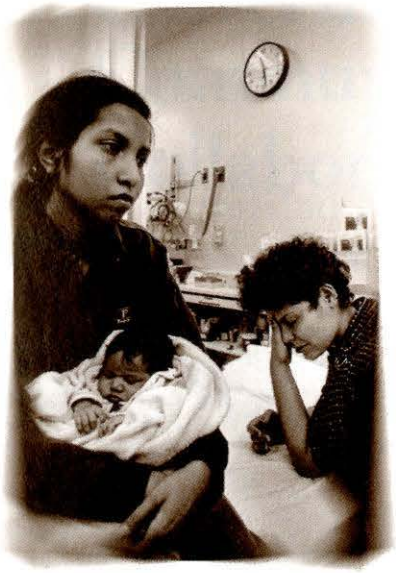
These comprehensive case management services are available 24 hours a day by paid WomanKind staff. More than 75 volunteers, half of whom are formerly abused women, provide advocacy services in the ED. Providing respectful, nonjudgmental support is fundamental to this program; the process emphasizes respect for the patient's process, timetable, and decisions.

A unique aspect of WomanKind is its comprehensive integration into the health care system. WomanKind's staff sit on hospital committees and domestic abuse policies and procedures requiring routine assessment have been fully institutionalized. Many referrals now come from the perinatal department, medical/surgical and intensive care units, the chemical dependency and mental health units, employee health services, and the surrounding communities.

Early intervention and prevention are cornerstones of the program's philosophy

"The crux of the model," says Hadley, "is that we provide case management services in conjunction with staff education." Part of this training is geared toward sensitizing hospital staff that recovery for an abused woman is often a long-term process, in contrast to the traditional medical focus on being able to "fix" a problem quickly. Regular workshops, a monthly column in hospital newsletters, and specialized training-case study analysis with specific departments are also provided.

As a result of WomanKind's work, every patient who comes to one of the Fairview hospitals is now automatically screened for domestic violence and abuse, with the following question added to the standard admission form: "Are you now or have you ever been in a relationship where you have been abused physically, emotionally, or sexually?"



Training Programs

"Before this training, we would consider our work a failure if an abused woman went back to the batterer and not to a shelter. And this was really a 'no win' situation, since four out of five shelter requests are turned away due to a lack of space! The whole experience was discouraging. Now, the way we look at it is, we just want to find out what step she'd like to take next, or feels ready to take next, understanding that it's disempowering for us to believe that she must leave ***today****.*

It's been important for us to learn that some women get killed when they leave, that the abuser can find her if she doesn't take the time she needs to escape... That she's the expert on him, and on what is he likely to do next. That's what we've come to know.

We now have much more reality-based interactions with her. Her leaving when she hasn't been prepared to leave may result in her having to go back and then he's more brutal. So she experiences flight to freedom as a failure. Now, instead of us being one more force saying, 'Don't go back there, you're sick,' we're much more likely to say, 'What have you tried in the past? What's worked? Let us facilitate what you want to do.'"

— Social worker Nancy von Bretzel, S.F. General Hospital

Several different models for training health care providers about domestic violence are described in this section. Without thorough, effective and institutionalized training programs in place, screening protocols will lay unused and domestic violence interventions will not take place consistently. Developing policies and protocols but not incorporating regular training sessions will likely doom the effort to failure.

Traditionally, trainings in health care settings were limited to physicians, nurses, and social workers. As can be seen by the following descriptions, the effectiveness of the training and the buy-in of a health care setting is enhanced when a multidisciplinary group is included in the training.

The trainings described here vary according to who sponsors them, who is being targeted for training, how the training has been designed, what type of training is provided, and how trainees are being reached. The venues vary as well, ranging from department-specific, to hospital-wide, to encompass an entire community, and to reach out over a state. Again, all of these variations are delineated so that those interested in creating their own training programs have a wide range of models to draw from.

Alabama Trains Public Health Department Staff Statewide

ALABAMA COALITION AGAINST DOMESTIC VIOLENCE

Contact: Carol Gundlach, 334-832-4842

Address: P.O. Box 4762, Montgomery, AL 36101

Annual Budget: start-up funds of $59,000; no "formal" ongoing budget

Funding: Alabama Medical Association, Law Enforcement Planning Division of the Alabama Dept of Economic and Community Affairs, Frost Foundation; in-kind from Department of Public Health

Number of trainings/people trained annually: 1,951

This training program for health care providers throughout the state of Alabama was developed in 1993 through a strong partnership between the Alabama Coalition Against Domestic Violence and the Alabama Department of Public Health. This Public Health Department, unlike most other state health departments, provides extensive patient care and a wide variety of services in every county in Alabama through a vast network of public health clinics. In fact, the Department serves over one-half of the pregnant women in the state. This means that training Alabama Public Health Department workers has the potential to reach a large segment of the state's female patients.

After minimal funding had been obtained, a protocol on the identification and treatment of domestic violence victims was developed and distributed to every hospital in Alabama. A series of hospital-based workshops on domestic violence, regional mini-conferences for the Alabama Nurses Association, and workshops for professional medical and social work associations throughout the state were then offered.

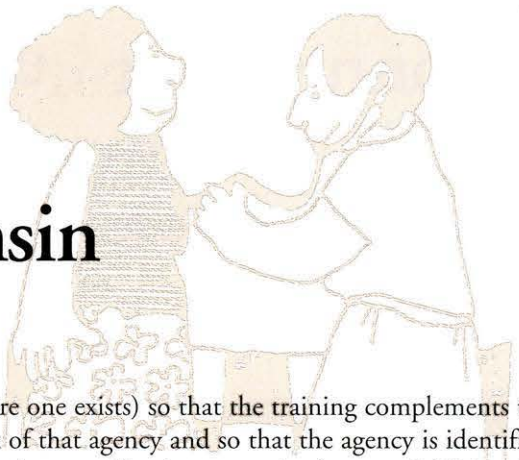
A television talk-show format was the innovative design of a teleconference that was developed on domestic violence identification and treatment in a public health clinic environment. This interactive teleconference was viewed at 13 Extension Service sites by 244 Health Department employees from 66 counties. An Alabama newsman was "host," and a physician, shelter director, attorney, and three survivors played the parts of "talk show guests." A toll-free number was obtained to enable viewers to call in their questions. A second session was scheduled for local health departments and shelters to discuss local resources, role-play patient interviews, and coordinate services. The program was taped and copies have been made available for continuing training. A protocol for health clinics has also been developed and distributed statewide.

A television talk-show format was the innovative design of a teleconference developed on domestic violence identification and treatment in a public health clinic environment

Colorado Pioneers Joint Effort

In 1989, the Colorado Domestic Violence Coalition became one of the first groups in the country to recognize the need for an organized, collaborative, institutionalized health care response to domestic violence. In one of the nation's first health department-state coalition collaborations, the Coalition worked with the Colorado Department of Health to produce a comprehensive training manual, *Domestic Violence: A Guide for Health Care Providers.* The Coalition and the Department also organized a Domestic Violence Protocol Development Task Force which produced a 60-page document, *Suggested Protocols for Victims of Spousal and Elder Abuse,* designed for use by hospitals. ***Laine Gibbes, Colorado Coalition Against Domestic Violence, P.O. Box 18902, Denver, CO 80218; 303-831-9632.***

University and Community Agencies Collaborate in Wisconsin



DOMESTIC VIOLENCE TRAINING PROJECT

Contact: Nancy Worcester, Distinguished Women's Studies Outreach Specialist, 608-262-3635

Address: University of Wisconsin Madison, Women's Studies Outreach, 623 Lowell Hall, 610 Langdon Street, Madison, WI 53703-1195

Annual Budget: $36,800

Funding: Wisconsin Dept of Health and Human Services, fees, in-kind support from the University

Number of trainings annually: 50

Number of people trained annually: 2,000

This project shows what can be done when a university joins with grassroots community organizations to create and deliver trainings on domestic violence. Credibility is gained by the involvement of the university which also enables professional advancement credit to be offered while the consistent and central participation of the domestic violence agencies ensures that the needs of abused women are primary.

In 1991, a group of abused women, domestic violence advocates, and health care providers met together to discuss how health care providers should, and should not, be trained on domestic violence. The next year, a conference was held to celebrate health care providers nominated by domestic violence programs around the state in recognition of the leadership they had demonstrated in addressing domestic violence. Exemplary projects were showcased, and media coverage was generated.

In ensuing years, 200 trainings have reached more than 10,000 people. For each training, the intent is to build connections in the local community between health care providers and domestic violence programs. This lays the groundwork to generate a community response to domestic violence. Each training is organized in conjunction with the local domestic violence agency (where one exists) so that the training complements the work of that agency and so that the agency is identified as the key coordinating group in the area. Additionally, since domestic violence agencies throughout the state are offered free slots in every public training session, representatives from these organizations are able to become trainers themselves. Survivors often participate in the trainings as well.

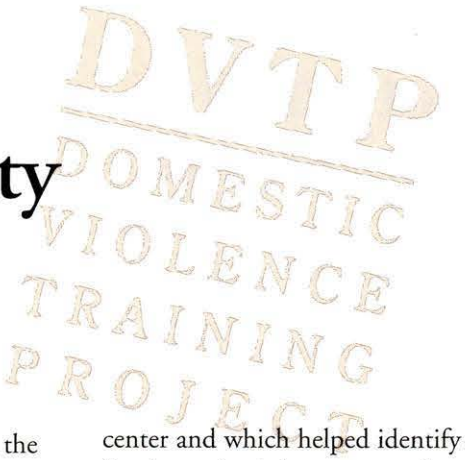
This project also trains school personnel.

200 trainings have reached more than 10,000 people, building connections in the local community between health care providers and domestic violence programs

Manual Available for Nurse-Midwives

The American College of Nurse-Midwives has developed a comprehensive manual, "Domestic Violence Education Module" by Patricia A. Paluzzi and Charlotte Houde Quimby. Its purpose is to help nurse-midwifery faculty teach their students about domestic violence. Information includes screening for abuse, safety assessments and documentation, as well as extensive appendices. The manual is adaptable to a variety of health care settings and professionals, and costs $23.00. ***Patricia A. Paluzzi, American College of Nurse-Midwives, Special Projects Section, 818 Connecticut Avenue, NW, Suite 900, Washington, D.C. 20006; 202-728-9864. To order the manual, contact Shannon Perry, Publications Coordinator, at 202-728-9879.***

Connecticut Trains Community Health Centers



DOMESTIC VIOLENCE TRAINING PROJECT: A Program for Health Professionals

Address: 900 State Street, New Haven, CT 06511

Contact: Robin Tousey Ayers, 203-865-3699

Annual Budget: $120,000

Funding: The Commonwealth Fund

Number of trainings/people trained annually: 400 community health center staff

"We work with the community health centers in a way that is very similar to how we work with survivors of domestic violence: by validating their experience, helping them to identify their hopes and goals, supporting them, and helping them implement a program through a series of small steps over time," explains Anne Flitcraft, M.D., in describing the approach of the Connecticut Community Health Centers' Domestic Violence Initiative. A product of a partnership between the Connecticut Primary Care Association and the University of Connecticut Health Center Domestic Violence Training Project, this initiative focuses on training nine community health centers in underserved areas of Connecticut. These centers serve medically indigent and culturally diverse women and children with a community-oriented, primary care approach.

To develop a curriculum that would work well in these centers, staff convened a working group of representatives from the community health centers which "taught" staff about the workings of a typical health center and which helped identify specific opportunities for domestic violence prevention and intervention in that setting.

The training curricula include a clinic-wide curriculum on domestic violence, a continuing medical education curriculum accredited for clinical practitioners, and a train-the-trainers curriculum to develop a base of experienced trainers in the state and to leave behind free-standing expertise for the community health centers following the training. Community awareness and patient informational materials are provided as well.

These centers serve medically indigent and culturally diverse women and children with a community oriented, primary care approach

Earliest Manual Developed in New Jersey

In 1983, New Jersey's Division on Women published of the first manual of its kind, "Domestic Violence: A Guide for Health Care Professionals." Included are protocols, questioning techniques, instructions on how to photograph injuries, and information on legal rights. It has been distributed to every hospital in New Jersey, and two-day trainings have been conducted in every county. The manual is currently in its third revision, and now includes information on sexual assault. ***Office on the Prevention of Violence Against Women, Division on Women, New Jersey Department of Community Affairs, 101 South Broad Street, CN 801, Trenton, NJ 08625; 609-292-8840. Manual costs approximately $10.***

Maryland Joint Venture Develops Materials, Trains Hospitals Statewide

MARYLAND ALLIANCE AGAINST FAMILY VIOLENCE

Contact: Joanne Tulouen, 410-243-9075

Address: 2220 North Charles Street, Baltimore, MD 21218

Annual Budget: $100,000 plus in-kind

Funding: Maryland State Dept of Human Resources and Dept of Health and Mental Hygiene, and U.S. Dept of Health and Human Services

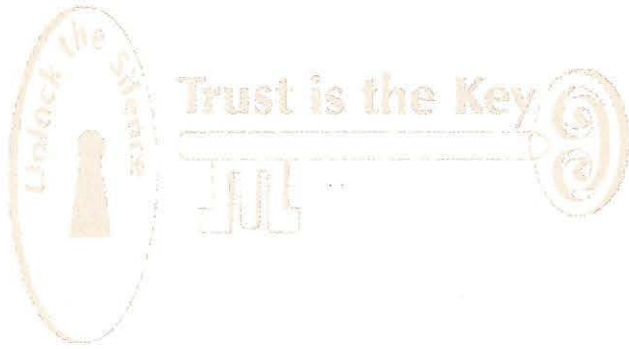
Number of trainings conducted annually/people trained annually: (see text at right)

This highly effective education program is a joint venture between the Maryland Alliance Against Family Violence and the Medical and Chirurgical Faculty of Maryland (the state medical society). With seed funding and in-kind contributions from the medical society, the Maryland Physicians' Campaign Against Family Violence was launched with the formation of a 25-member task force. This Task Force represented state government, medical and health organizations, and domestic violence advocacy groups. With additional resources, the Task Force developed comprehensive training materials including a physicians' manual on domestic violence; training curriculum guide; slides; posters; bus placards; clergy information packet; hospital information packet; victim information brochures in English, Spanish, and Korean; and a brochure specifically for African American women. Manuals were designed to offer Continuing Medical Education Credits to physicians through self-study guides included with the manuals. Similar materials for child abuse have been developed and an elder abuse manual is in process.

The *Maryland Medical Journal* launched the campaign with a journal issue devoted entirely to domestic violence. Next, Maryland counties were invited to send teams of health care providers and domestic violence advocates to trainings who, in turn, conducted trainings for their local hospitals and health departments. To date, over 4,000 health professionals at 40 of Maryland's 65 hospitals and all of the 24 local health departments have been trained.

The MARYLAND MEDICAL JOURNAL launched the campaign with a journal issue devoted to domestic violence

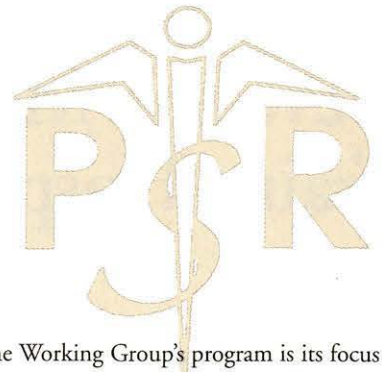
Because the Task Force was chaired by a physician who later became Maryland's Secretary of Health, all materials were distributed to the Maryland legislature, which stimulated legislation to develop on-site victim advocacy programs at four diverse hospitals.



State Office Effective in New York

The New York State Office for the Prevention of Domestic Violence (OPDV) has been active in developing and improving services for domestic violence victims since 1979. In 1984, the OPDV and the NY Department of Health (DOH) drafted the state's first domestic violence protocol. In 1990, state regulatory codes were amended to require domestic violence protocols, staff training, and referrals in all state-regulated hospitals and outpatient care facilities. The office trains DOH staff and, since its inception, has also trained over 25,000 health care practitioners. ***Alison Unger Clifford, R.N., New York State Office for the Prevention of Domestic Violence, Capitol View Office Park, 52 Washington St., Room 366, Rensselaer, NY 12144; 518-486-6262.***

Multidisciplinary Group Trains Health Centers in Philadelphia



THE RADAR DOMESTIC VIOLENCE TRAINING PROJECT

Contact: Sandy Dempsey, 215-765-8703

Address: Physicians for Social Responsibility, 704 North 23rd Street, Philadelphia, PA 19130

Annual Budget: $141,300

Funding: The William Penn Foundation

Number of trainings: 5 initial overview trainings and 23 followup trainings for health centers; 14 trainings for medical/legal groups; and 2 HMO trainings

The Philadelphia Family Violence Working Group, a city-wide alliance of nurses, physicians, health policy professionals, medical students, domestic violence program staff, and survivors, has been the key to the success of a city-wide health center training program. In 1994, this multidisciplinary Working Group, under the auspices of Physicians for Social Responsibility, was awarded a three-year grant to train 14 federally qualified community health centers that serve approximately 40,000 women.

RADAR, an acronym created by the Massachusetts Medical Society, was adapted by the Working Group into a comprehensive training program for health care providers on the identification, treatment, and referral of victims of domestic violence. RADAR stands for ***R**outine screening, **A**sk direct questions, **D**ocument your findings, **A**ssess patient safety, and **R**eview patient options and referrals.* Several tools have been developed for this training program:

- A **RADAR Laminated Pocket Card** offers a step-by-step guide on what to say and do in screening for domestic violence; it fits into a provider's lab coat pocket.
- A **Domestic Violence Assessment Form** outlines information to be documented and included in the medical record.
- A plain **RADAR Stamp** indicates whether a patient has been screened for domestic violence: Screening performed? Abuse confirmed? Abuse suspected?
- A **Where to Turn for Help** card has major local resources for interpersonal violence and safety tips; it can fit into a patient's shoe.

Unique to the Working Group's program is its focus on **Trauma Theory**, which derives from studies on the effects of violence on, for example, child abuse and domestic violence victims and combat veterans. This theory offers a framework for understanding what violence actually does to the body, mind, soul, and social group of those involved. This approach enables providers to see how deep and long-lasting the effects of interpersonal violence are, which in turn makes comprehensible and meaningful much of the victim's behavior that has been seen as "crazy." As Holocaust survivor and psychologist Dr. Victor Frankl said, "An abnormal reaction to an abnormal situation is normal behavior." The Working Group developed a one-hour video to explain the link between trauma theory and interpersonal violence.

The goals of the Working Group are to increase health care providers' awareness about interpersonal violence generally, to institutionalize routine screening for domestic violence, and to help providers feel comfortable with their ability to do this. To accomplish these goals, the project has two special aspects: first, everyone in the health center is trained in the belief that all staff can play a role in detecting and treating domestic violence. Second, follow-up trainings to the health center staff are offered for two and a half years after the initial overview training.

This initial overview training, 3-6 hours long, is provided by a multidisciplinary team consisting of a physician, health care advocate, domestic violence survivor, police domestic violence response team member, and representatives from each of the four Philadelphia domestic violence agencies. In addition to learning about Trauma Theory and viewing a video which opens participants to the emotional impact of the issue, trainees learn how to use the RADAR approach, listen to a survivor's story, and hear about how the police and domestic violence providers can work with them to assist victims. The followup training is customized to the needs of the particular center and staff and has presented, for example, information on batterers, the needs of abused Latinas, the intersection of child abuse and domestic violence, and case presentations.

Florida Governor Makes A Difference

A strong commitment to ending violence against women on the part of Florida's governor Lawton Chiles has had dramatic results. First, a Governor's Task Force on Domestic and Sexual Violence, comprised of legislators, experts, and providers, was convened. The Task Force conducted an assessment of resources for abused women in 1993-94, and made 31 recommendations on improving the health care response to battering. Consequently, Florida passed legislation requiring a one-hour instruction on domestic violence as a condition of licensure and re-licensure for health care providers. ***Robin Hassler, Executive Director, Governor's Task Force on Domestic and Sexual Violence, The Capitol, Tallahassee, FL 32399-0001; 904-921-2168.***

Public Education

In this section, an ambitious and successful statewide public education campaign is presented. Such a campaign will reinforce domestic violence policies developed at institutions, and can make a major contribution to changing the values and norms of the health care profession. Public education campaigns can also be designed to encourage victims to talk to their providers about the violence in their lives.

Minnesota Medical Association Launches Public Education Campaign

MINNESOTA MEDICAL ASSOCIATION
"Stop the Violence" Campaign

Contact: Mark Vukelich, 612-378-1875

Address: 3433 Broadway St, NE, Suite 300, Minneapolis, MN 55413

Annual Budget: $20,000

Funding Source: Minnesota Medical Society

"It's OK to talk to me about family violence and abuse," the doctor's button proclaims, one of the products of the Minnesota Medical Association's statewide public education campaign launched in 1992. The campaign has produced PSAs featuring a star of the Minnesota Timberwolves (a professional basketball team) and billboards that say, "Doctors can't cure family violence. But they can help!" Treatment guidelines have also been distributed to all Minnesota physicians, health clinics, and hospitals.

Uniquely seed-funded by physician membership dues to the Medical Association, the campaign was designed to "educate the docs first, and then the public," according to Mark Vukelich, Minnesota Medical Association (MMA) spokesperson. Collaboration was key. Three domestic violence agencies: the Minnesota Coalition Against Domestic Violence, the Domestic Abuse Project of Duluth, and WomanKind, Inc., were instrumental from the beginning, assisting in the project design and materials development. Soon the MMA enlisted the Minnesota Nurses Association for support, and other professional associations were also enrolled.

To reach the most physicians, treatment guidelines were published in the MMA's monthly medical journal, Minnesota Medicine. The MMA also worked with the Minnesota Coalition for Battered Women in disseminating the Coalition's "Hands Are Not For Hitting" campaign aimed at children. The MMA created posters and brochures for doctors' offices, hospitals, and clinics encouraging victims to seek help from their health care providers. Recently, the MMA passed a resolution opposing the denial of insurance claims to victims of domestic violence and is seeking legislation to prohibit such insurance discrimination. Future plans include developing a series of articles on domestic violence, possibly accompanied by quizzes that could enable physicians to receive Continuing Medical Education credit.

A small staff of two has been able to carry out this project because significant support and staff time have been donated by the three domestic violence organizations and because 50 volunteers are involved, many of whom are spouses and partners of physicians.

"One of the best things to come out of our campaign is that it brought doctors back into the role as advocates for good public health . . . I've never seen physicians get as involved in any issue as much as they are in domestic violence prevention," concludes Vukelich enthusiastically.

Community-Based Organizing Efforts

Every successful social change movement requires a commitment to get involved not just from individuals but also from the collective community of which they are a part. Community-based projects serve to expand the constituency of people concerned about and active in addressing domestic violence. Individuals tend to define the "community" they are a part of in a myriad of ways — including their professional affiliation; religious or spiritual community; racial, ethnic or cultural identification; activist or political affiliations, etc.

Therefore, successful community-based efforts need to develop spokespeople and leadership on the issue from the health, justice, education, entertainment, sports, media, political, corporate and civil rights fields, as well as within diverse racial, ethnic, women's rights and domestic violence communities. Encouraging spokespeople from many different "communities" to speak out against domestic violence creates an environment in which domestic violence victims see themselves reflected on the face of the speaker and begin to understand they are not alone.

The following domestic violence programs take place in the community, are based on grassroots organizing strategies, and target hard to reach populations. Such strategies are important to ensure that specific ethnic and racial groups, those isolated by transience, severe poverty, or language barriers, or groups with different cultural values or practices, are able to learn about domestic violence and access services. Extensive public health literature documents that major public education efforts to change behavior have been successful in part because messages and actions have grown out of a target community. Research on AIDS prevention in low-income housing projects in Chicago found, for example, that African-American women were significantly more likely to adapt desired behaviors (i.e. request condoms) when culturally sensitive messages about AIDS are employed.

Moreover, because these are *grassroots organizing* efforts that develop from the "bottom" up, they are designed to be grounded in the real life experiences and perspectives of these often-marginalized groups, and therefore are more likely to be able to address their needs and concerns, and communicate more effectively to them.

National Black Women's Health Project Holds "Community Conversations"

The National Black Women's Health Project has developed a plan to address domestic violence within the black community. This approach is being piloted in the Mechanicsville area of Atlanta, Georgia. A local coalition will be convened, comprised of numerous "stakeholders" — representatives from the police, courts, domestic violence agencies, churches, and schools. Focus groups will be conducted to identify attitudes and beliefs about domestic violence, and domestic violence agencies will be surveyed to determine how accessible they are. The coalition will then meet with community members to design strategies to reduce domestic violence, focusing on consensus building, education, and the activation of community members. "Community conversations" may be held, in which events such as community picnics will invite campaign spokespeople to discuss domestic violence in the community. Self-help groups for women may also be started. ***Julia R. Scott, National Black Women's Health Project, 1211 Connecticut Avenue, N.W., Suite 310, Washington, D.C. 20036; 203-833-0117.***

Women Farmworkers Empowered as Advocates

Throughout rural California, Organización en California de Líderes Campesinas (the Farmworker Women's Leadership Project), under the California Rural Legal Assistance Foundation, promotes the empowerment of low-income Latina farmworker women to become advocates for abused women. They are trained in leadership and organizing skills as well as in the dynamics of domestic violence in order to break the silence about domestic violence and to assist victims. A culturally sensitive model developed in accordance with the value system of the Latino community is employed. Thirty-six farmworker women have been trained and they have, in turn, reached more than 15,000 farmworker women. In the project's next stage, intervention teams will be set up to link each farmworker advocate with a local health care provider and a domestic violence agency to work with abused women. ***Mily Trevino-Sauceda, Organización en California de Líderes Campesinas (Farmworker Women's Leadership Project), 611 S. Rebecca Street, Pomona, CA 91766; 909-865-7776.***

Projects Emerge Around the Globe

Projects are emerging, not only in America, but throughout the world to help health care providers identify and treat abused women. The Women's Program of Uraco Pueblo in Honduras uses socio-dramas, discussions, and role playing in its "health promoter" training. The promoters then convene community meetings, in which lawyers offer women legal advice and joint meetings are held with husbands and other men from the village. In Gujarat, India, women working at the SARTHI (Social Action for Rural and Tribal Inhabitants of India) project provide individual and community support to victims of violence, and may accompany women to the police station to press charges or work with family members to uphold women's decisions about their abusive spouse. In Brazil, Dr. Ana Flavia d'Oliveira, a public health physician, has set up an abuse screening program for her prenatal care patients.

Regional efforts are underway as well. The Pan-American Health Organization sponsored a regional conference on "Violence Against Women as a Public Health Issue" in Managua, Nicaragua, and is developing several four-year pilot intervention projects in Central America and in Peru, Bolivia, Ecuador, and Mexico. The projects work with existing health care facilities to develop culturally appropriate means for identifying and treating victims in areas where there are few health care resources. On the research end, the World Health Organization has embarked on a cross-cultural study of the impact of violence on women's health. ***For further information about international projects: Lori Heise, co-director of the Health and Development Policy Project, 301-270-1182.***

Programs of the Family Violence Prevention Fund

The FUND's highly successful **NATIONAL HEALTH INITIATIVE ON DOMESTIC VIOLENCE** trains health care providers throughout the nation to recognize signs of abuse and to intervene effectively to help battered women. The FUND's Health Resource Center on Domestic Violence acts as the nation's clearinghouse for information in this field and provides technical assistance to thousands of health care and domestic violence professionals each year.

The FUND's **THERE'S NO EXCUSE FOR DOMESTIC VIOLENCE** public education campaign is a collaborative effort with the Advertising Council designed to educate the public about the seriousness of the epidemic of domestic violence and to mobilize community members to be part of the solution; the campaign includes powerful television, radio and print public service announcements that reach millions with the campaign's key message that domestic violence is "everybody's business."

The **JUDICIAL EDUCATION PROJECT** helps abused women and their children in court by teaching judges to better understand how their decisions can play a critical role in preventing domestic violence injuries and deaths; the project has developed and distributed a series of highly respected training curricula for family and criminal court judges.

The **CHILD WELFARE PROJECT** is raising awareness of the integral links between child abuse and spouse abuse in order to improve the child welfare system's handling of families with domestic abuse, develop innovative strategies aimed at preventing both forms of violence, and improve the courts' handling of child custody cases where the mother is being abused.

The **NATIONAL WORKPLACE RESOURCE CENTER ON DOMESTIC VIOLENCE** is a historic collaboration in which employers and unions disseminate helpful, easy-to-follow information to employees and members on preventing and reducing domestic violence, develop workplace policies on domestic violence, and support employees who are victims of domestic violence.

The **BATTERED IMMIGRANT WOMEN'S RIGHTS PROJECT** seeks to improve the legal rights of battered immigrant women by building public awareness, affecting public policy, making resources accessible to the women, and strengthening networking efforts to assist and protect them through the Violence Against Women Act (VAWA) provisions.

The **LATINO COMMUNITY PROJECT,** a community-based effort in San Francisco, includes a Latina Leadership Training Group to train women as "promotoras," educating their community about domestic violence; and outreach to bring social services agencies and community organizations together to raise awareness and develop action plans for prevention.

Through culturally and linguistically appropriate outreach and public education, the **FILIPINO COMMUNITY PROJECT** reframes cultural norms to educate and mobilize community members about domestic violence with a Speakers Bureau and a poster campaign in the San Francisco Bay Area.

Order These Materials to Strengthen Your Clinical Response to Domestic Violence

Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers

by Carole Warshaw, M.D. and Anne L. Ganley, Ph.D.

This 250-page, 8.5" x 11" binder is designed to help health care providers develop and implement a comprehensive response to domestic violence in emergency department, primary care and ob/gyn settings. It includes information about the dynamics of domestic violence, identification, screening, assessment and intervention with victims of domestic violence, responding to batterers and developing and implementing response strategies. It also contains resource materials for patients and clinicians, model protocols, screening and discharge materials, and other clinical tools. ($75.00)

Information Packets

The Health Resource Center publishes free information packets that include fact sheets, referral lists, and background articles on health care and domestic violence. Subjects include the primary care and emergency department responses, screening patients for domestic violence, and mandatory reporting. (Free)

Practitioner Reference Card

This laminated, 3" x 5" pocket reference card outlines the steps providers can take to help battered patients, including screening, messages of support, safety assessment, referral and documentation of findings ($1.00 each)

Safety Information Card

This pocket-sized card, entitled, "If you are being abused at home...You are not alone," outlines ways battered women can protect themselves and their children. It can be distributed in person or in the privacy of restrooms where battered women can discreetly slip them into a pocket. Available in English, Spanish and Tagalog. ($0.20 each)

Working with Battered Immigrant Women: A Handbook to Make Services Accessible

Written for all service providers who help battered immigrant women, this handbook contains information about what battered immigrant women experience, options available to assist them in dealing with violence at home, information on how to effectively advocate for their needs and how to work with them on their immigration status, and information about relief contained within the Violence Against Women Act. ($8.00; $5.00 for non-profits)

Public Education and Mobilization Materials

The Family Violence Prevention Fund has produced an extensive catalog of public mobilization materials for its "There's No Excuse for Domestic Violence" campaign, including posters, public service announcements, bumper stickers, banners, t-shirts, coffee mugs, buttons and lapel stickers. Contact the Health Resource Center for prices and more information.

FOR ORDERING INFORMATION CALL TOLL-FREE: 1-888-RX-ABUSE.
PRICES ARE CURRENT AS OF FEBRUARY 1997, AND ARE SUBJECT TO CHANGE.

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