



IDENTIFYING AND RESPONDING TO

DOMESTIC VIOLENCE

CONSENSUS RECOMMENDATIONS

FOR CHILD AND ADOLESCENT HEALTH

Produced by
**Family Violence
Prevention Fund**

In partnership with
AMERICAN ACADEMY OF FAMILY PHYSICIANS
AMERICAN ACADEMY OF PEDIATRICS
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
CHILD WITNESS TO VIOLENCE PROJECT, BOSTON MEDICAL CENTER
NATIONAL ASSOCIATION OF PEDIATRIC NURSE PRACTITIONERS

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With support from
US DEPARTMENT OF HEALTH AND HUMAN
SERVICES, ADMINISTRATION FOR CHILDREN AND
FAMILIES AND THE CONRAD N. HILTON FOUNDATION

Family Violence Prevention Fund

For more than two decades, the **Family Violence Prevention Fund (FVPPF)** has worked to end violence against women and children around the world. Instrumental in developing the landmark Violence Against Women Act passed by Congress in 1994, the FVPPF has continued to break new ground by reaching new audiences including men and youth, promoting leadership within communities to ensure that violence prevention efforts become self-sustaining, and transforming the way health care providers, police, judges, employers and others address violence.

The FVPPF is a national non-profit organization committed to mobilizing concerned individuals, allied professionals, women's rights, civil rights, other social justice organizations and children's groups through public education/prevention campaigns, public policy reform, model training, advocacy programs and organizing.



Founded 1947, the **American Academy of Family Physicians** represents more than 93,500 physicians and medical students nationwide. It is the only medical specialty organization devoted solely to primary care. Family physicians, like other medical specialists, complete an extensive three-year residency program in the specialty after graduating from medical school. As part of their residency, family physicians receive training in six major medical areas: pediatrics, obstetrics and gynecology, internal medicine, psychiatry and neurology, surgery and community medicine. They also receive instruction in many areas including geriatrics, emergency medicine, ophthalmology, radiology, orthopedics, otolaryngology and urology. As a result, family physicians are the only specialists qualified to treat most ailments, and to provide comprehensive health care for people of all ages.



The American Academy of Pediatrics (AAP) is an organization of 57,000 primary care pediatricians, pediatric medical sub-specialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. The AAP's major activities include furthering the professional education of its members through continuing education courses, annual scientific meetings, seminars and publications. Our organization is committed to ensuring that children's health needs are taken into consideration as legislation and public policy are developed and implemented.



With over 43,000 members, the **American College of Obstetricians and Gynecologists (ACOG)** is the nation's leading group of professionals providing health care for women. ACOG is dedicated to the advancement of women's health through education, advocacy, practice, and research. It is a private, nonprofit organization. ACOG works in four primary areas: 1) serving as a strong advocate for quality health care for women; 2) maintaining high standards of clinical practice and continuing education for its members 3) Promoting patient education and stimulating patient understanding of, and involvement in, medical care; and 4) Increasing awareness among its members and the public of the changing issues facing women's health care. In fulfilling its purpose, ACOG develops and sponsors continuing medical education programs, creates guidelines to evaluate and improve medical practice, promotes access to the latest research through its publications and clinical gatherings, and supports programs for improved graduate medical education in obstetrics and gynecology.



The Child Witness to Violence Project, a program of the Department of Pediatrics at Boston Medical Center was established in 1992 to provide mental health and advocacy services to young children and their families who are affected by violence in the home or community. The project provides clinical services to children and conducts training and technical assistance to a wide range of professionals working with young children and families. The Project has been nationally recognized as an innovative and effective initiative for families affected by domestic violence.



National Association of Pediatric Nurse Practitioners (NAPNAP) was founded in 1973 as a non-profit specialty nursing organization devoted to improving the quality of infant and child health care. The pediatric nurse practitioner provides an advanced level of care to children and their families, including: counseling on normal development and behavioral problems, the prevention of illness and preventable injuries, and care of children with acute or chronic conditions. NAPNAP promotes high standards of child health care through education, research, and legislative action involving over 6,650 members in 50 chapters across the country.

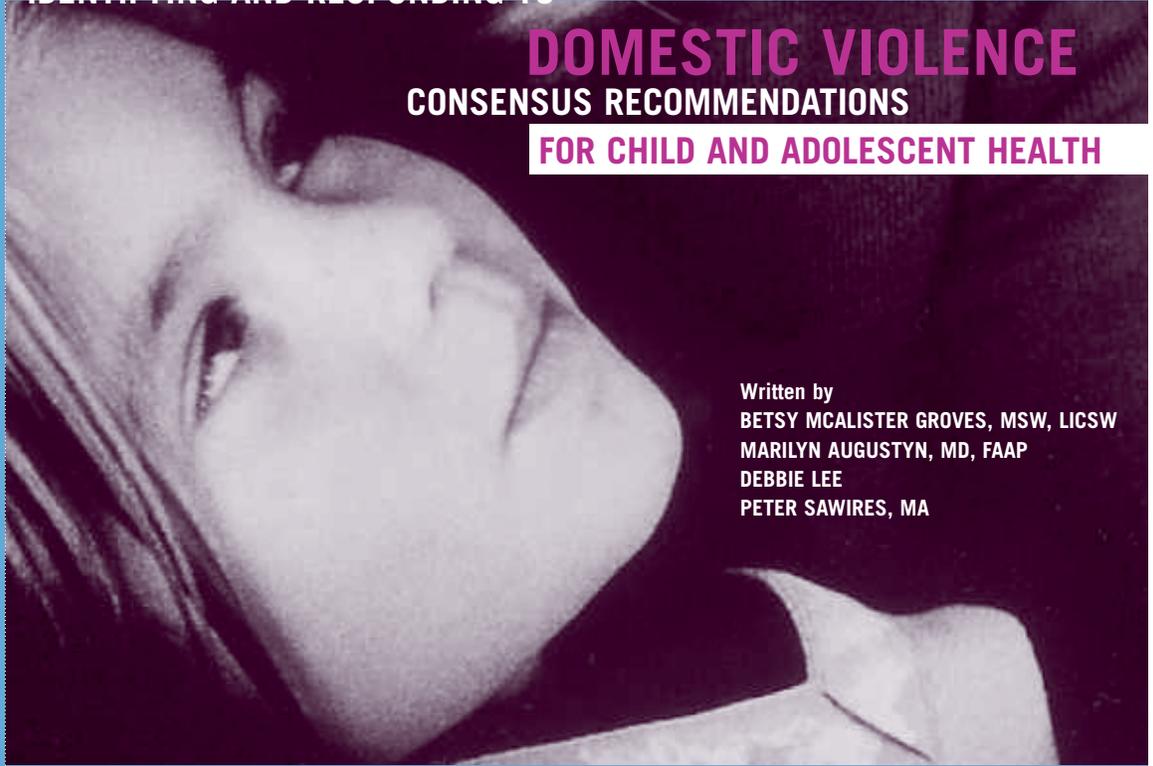


The Office for Victims of Crime (OVC) is a federal agency located within the Office of Justice Programs of the U.S. Department of Justice (DOJ) that Congress formally established in 1988 through an amendment to the 1984 Victims of Crime Act (VOCA). OVC provides leadership and federal funds to support victim compensation and assistance programs around the country and promotes victim services worldwide. OVC administers formula and discretionary grants designed to benefit victims, provides training for diverse professionals who work with victims, develops projects to enhance victims' rights and services, and undertakes public education and awareness activities on behalf of crime victims. The Office for Victims of Crime is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the National Institute of Justice, and the Office of Juvenile Justice and Delinquency Prevention.

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IDENTIFYING AND RESPONDING TO

DOMESTIC VIOLENCE CONSENSUS RECOMMENDATIONS FOR CHILD AND ADOLESCENT HEALTH



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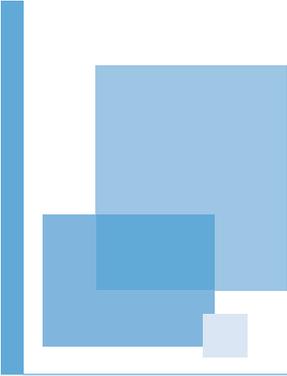
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CONTENTS

1	Part One: Overview
2	DEFINITIONS
3	PREVALENCE OF INTIMATE PARTNER VIOLENCE
4	HEALTH EFFECTS OF INTIMATE PARTNER VIOLENCE ON ADULTS AND TEEN VICTIMS
5	HEALTH EFFECTS OF INTIMATE PARTNER VIOLENCE ON CHILDREN
6	WORKING CROSS CULTURALLY
7	RECENT TRENDS
7	IDENTIFYING AND RESPONDING TO ABUSE CAN MAKE A DIFFERENCE
11	Part Two: Dilemmas Faced by Providers
11	WHEN DOES CHILD EXPOSURE TO DOMESTIC VIOLENCE BECOME CHILD ABUSE?
14	Intimate Partner Violence Victimization Reporting Requirements for Health Care Providers
15	Asking about Intimate Partner Violence with a Child in the Room
16	Documentation
17	Responding to a Child’s Disclosure of Intimate Partner Violence in the Home
21	Part Three: Consensus Recommendations
21	ASSESSING FOR INTIMATE PARTNER VIOLENCE WHEN YOUR PATIENT IS A CHILD OR ADOLESCENT
21	Who and How Often to Assess
22	How to Assess
22	What to Ask
24	Asking about Intimate Partner Violence with a Child in the Room
25	Who Should Assess
25	RESPONDING TO INTIMATE PARTNER VIOLENCE WHEN YOUR PATIENT IS A CHILD OR ADOLESCENT
25	Support the Victim
26	Provide Information on Intimate Partner Violence
26	What to Say to the Child Who has Witnessed Intimate Partner Violence For Adolescents Who are Victims of Violence
26	Assess and Address Safety Issues
27	Referrals for Adults and Adolescents
28	Referrals for Children
29	Reporting Requirements for Child Abuse and Intimate Partner Violence
29	How to Document Intimate Partner Violence
30	What to do if a Patient Says “No” or Will Not Discuss Abuse
33	Part Four: Preparing Your Child Health Practice

37

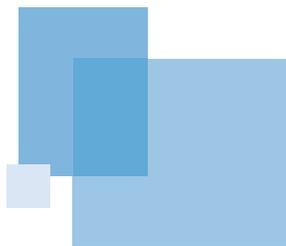
Appendices

- 37 I. Position Statements of Medical and Health Professional Associations
- 41 II. Bibliography
- 44 III. Abstracts of Selected Studies on Provider and Patient Attitudes Toward Screening for IPV in the Child Health Setting
- 49 IV. Dilemmas When Assessing All Patients for Victimization
- 53 V. Indicators of Abuse
- 54 VI. Expanded Assessment for Victims of Domestic Violence
- 56 VII. Safety Plan and Instructions
- 58 VIII. Intimate Partner Violence Victimization Reporting Requirements: How It Affects Child Health Settings
- 61 IX. State Codes on Intimate Partner Violence Victimization Reporting Requirements for Health Care Providers
- 63 X. Legislation Regarding Child Witnesses to Domestic Violence
- 67 XI. Child Abuse Reporting Laws
- 75 XII. Resources for Providers and Patients

81

Endnotes

Training and Education Materials Catalog



PART I

OVERVIEW



OVERVIEW

OVERVIEW



PART I | OVERVIEW

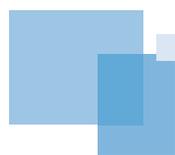
Over the past 15 years, there has been a growing recognition among health care professionals that domestic violence is a major health problem with devastating effects on individuals, families and communities. Health care professional associations have issued position statements or guidelines for their members that describe the impact of domestic violence on patients and suggest strategies for inquiring about domestic violence (See the [Appendix I](#) for position statements from several professional associations). Studies show that regular screening for domestic violence in medical settings has been effective in identifying women who are victims^{1,2,3} and that victims are not offended when asked about domestic violence.^{4,5,6,7,8}

In 1998, the American Academy of Pediatrics (AAP) issued a position statement declaring, “The abuse of women is a pediatric issue.”⁹ The statement made a strong case for recognizing domestic violence in child health care settings, but did not offer specific guidelines for inquiry and response or discuss the policy and practice dilemmas that arise when child health providers implement inquiry and response protocols.

The guidelines offered here provide specific recommendations for assessing and responding to domestic violence in child health settings, which provide a unique and important opportunity to inquire about for domestic violence and to educate parents about the impact of such violence on children. Virtually every child is seen at some point by a health provider. Thus, it is possible to assess every family that uses the health care system.

These guidelines also speak to the need for child health providers to engage in, model, and take leadership in delivering effective primary prevention of domestic violence, as well as other types of family and community violence, by highlighting violence prevention during well child and other routine visits, as a component of routine anticipatory guidance.

[Part One](#) of the guidelines presents an overview of the impact of domestic violence on children and adolescents, and the rationale for regular and universal assessment for domestic violence in child health settings. [Part Two](#) addresses dilemmas that providers may encounter in discussing domestic violence with parents of their patients and adolescents. [Part Three](#) contains the specific guidelines for inquiry and response. [Part Four](#) recommends elements to create a clinical environment that effectively responds to domestic violence. Several useful resources have been included in the Appendices.



DEFINITIONS

The term “**family violence**” and sometimes “**domestic violence**” has been used to describe acts of violence between family members, including adult partners, a parent against a child, caretakers or partners against elders and between siblings. While all forms of family violence can be devastating, this monograph focuses only on domestic violence or “intimate partner violence.” In this monograph, “intimate partner violence” will be used to more specifically define a range of behaviors between intimate or dating partners:

*Intimate partner violence is a pattern of purposeful coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was or wishes to be involved in an intimate or dating relationship with an adult or adolescent victim and are aimed at establishing control of one partner over the other.*¹⁰

Legal definitions of domestic violence or intimate partner violence are generally more restrictive and refer specifically to threats or acts of physical or sexual violence including forced rape, stalking, harassment, certain types of psychological abuse and other crimes where civil or criminal justice remedies apply. Laws vary from state to state. Since evidence exists that non-physical intimate partner violence has many devastating physical, psychological, behavioral and developmental effects, the definition used in these Guidelines is better suited for the identification and treatment of intimate partner violence in the health care setting.

*“Child exposure to domestic violence or intimate partner violence” is a term encompassing a wide range of experiences for children whose caregivers are being abused physically, sexually, or emotionally by an intimate partner. This term includes the child who actually observes his/her parents being harmed, threatened or murdered, who overhears this behavior from another part of the home or who is exposed to the short- or long-term physical or emotional aftermath of caregiver’s abuse without hearing or seeing a specific aggressive act. Children exposed to intimate partner violence may see their parents’ bruises or other visible injuries, or bear witness to the emotional consequences of violence such as fear or intimidation without having directly witnessed violent acts.*¹¹

Studies consistently show that the vast majority of victims of intimate partner violence are women. In fact, the latest United States Bureau of Justice Statistics report on intimate violence report found that 85 percent of victims are women.¹² The language in this monograph reflects this trend. However, it is important to note that some victims of intimate partner violence are men, and that violence exists in same sex relationships as well. All victims should be responded to appropriately.

Prevalence of Intimate Partner Violence

Intimate partner violence is a health problem of enormous proportions. It is estimated that 20 percent to 30 percent of all women and 7.5 percent of men in the United States have been physically and/or sexually abused by an intimate partner at some point in their adult lives.^{13,14,15} Heterosexual women are five to eight times more likely than heterosexual men to be victimized by an intimate partner.¹⁶ From 1993 to 1998, victimization by an intimate accounted for 22 percent of the violence experienced by females and three percent of the violent crime sustained by males.¹⁷ Females are also approximately ten times more likely to be killed by an intimate partner than males.

For adolescents, rates of experiencing some form of dating violence vary from 20 to 60 percent.^{19,20,21} Women age 16 to 24 experience the highest per capita rate of intimate partner violence with 15.6 victimizations per 1,000 females age 16 to 24, as opposed to 5.8 per 1,000 females in general.²² Teens are also at higher risk for abuse during pregnancy: 21.7 percent of pregnant teens experience abuse as opposed to 15.9 percent of pregnant adults.²³ While studies indicate that boys and girls may accept physical and sexual aggression as normal in dating and intimate partner relationships, female teens are more likely to receive more significant physical injuries and to be sexually victimized by their partners.²⁴ Finally, adolescent girls who have been sexually and physically hurt by dating partners are six to nine times more likely to attempt suicide or have suicidal ideation than those who reported no abuse.²⁵

Far less data exist on lesbian, gay, transgender, and bisexual (or LGTB) victimization, however available literature suggests similarly high rates for LGTB adolescents and adults.^{26,27} Intimate partner violence occurs in every community—urban, suburban or rural; in all social classes; and in all ethnic groups. Consequently, all health care settings and professionals are affected by intimate partner violence.

The estimates of numbers of children who are exposed to intimate partner violence vary from 3.3 million to ten million children per year, depending on the specific definitions of witnessing violence, the source of interview and the age of child included in the survey.²⁸

Children who are five and under are disproportionately represented in households in which there is intimate partner violence and a sizable number of these children are involved because they calling for help, are identified as the cause of the dispute that led to violence, are caught in the cross fire, or are directly physically abused by the perpetrator.²⁹ In a study conducted in an urban outpatient pediatric clinic, 40 percent of a sample of 160 mothers had filed a restraining order against a boyfriend or husband.³⁰ In another study conducted in an office-based pediatric practice, 2.5 percent of mothers reported current intimate partner abuse and 14.7 percent reported abuse in past relationships.³¹ In the Adverse Childhood Experiences (ACE) Study, conducted on a large sample of members

(30,000 adults) of the Kaiser Health Plan in California, 12.5 percent of respondents indicated childhood exposure to intimate partner violence and 10.8 percent indicated a history of child abuse, including physical, sexual and emotional abuse.³² Together these studies indicate that children who witness intimate partner violence are seen with both frequency and regularity in virtually all health settings and that young children are disproportionately represented in the population of children who live with intimate partner violence.

Health Effects of Intimate Partner Violence on Adult and Teen Victims

In addition to injuries sustained by women during violent episodes, physical and psychological abuse are linked to a number of adverse physical health effects including arthritis, chronic neck or back pain, migraine and other frequent headaches, stammering, sexually transmitted infections, chronic pelvic pain, peptic ulcers, spastic colon, and frequent indigestion, diarrhea or constipation.³³ Additionally, optimal management of other chronic illnesses such as asthma, HIV/AIDS, seizure, diabetes and hypertension may be problematic in women who are being abused. Emerging research shows that women who are abused are less likely to engage in important preventive health care behaviors such as regular mammography.³⁴ Intimate partner violence is also linked with significant short- and long-term mental health consequences for victims.^{35,36,37,38,39}

Female adolescents who reported being sexually or physically abused are more than twice as likely to report smoking, drinking and using illegal drugs as non-abused teens.⁴⁰ In addition, 32 percent of teen victims report bingeing and purging, compared to 12 percent of non-abused teens. Adolescent women who are battered are also less likely to attend school and less likely to receive good grades if they are in school.⁴¹

Adolescents' experiences with sex are also associated with their history of dating violence. A study of adolescents found that those who experienced dating violence were more likely than their non-abused peers to have sexual intercourse before age 15 and to have had three or more sex partners in the past three months.⁴² Among young mothers on public assistance, half (51 percent) report birth control sabotage by a dating partner.⁴³ Additionally, high school girls reporting violence from dating partners are approximately four to six times more likely than their non-abused peers to have ever been pregnant.⁴⁴ The experience of interpersonal violence is correlated with rapid repeat pregnancy and higher incidences of miscarriage among low-income adolescents.⁴⁵ Finally, abused teens are more likely to enter prenatal care later in their pregnancy: 24 percent of teens identified as abused enter prenatal care in the third trimester compared to only nine percent of non-abused teens.⁴⁶

Health Effects of Intimate Partner Violence on Children

More than 100 studies have explored the effects of intimate partner violence on children. These studies enumerate both short and long term effects of intimate partner violence on children.⁴⁷ The most obvious and potentially dangerous risk for children who live in homes in which there is intimate partner violence is that they become direct victims of abuse. In 30 to 60 percent of families affected by intimate partner violence, children are also directly abused.⁴⁸ Young children and adolescents are more vulnerable to the abuse. Very young children cannot get out of harm's way, and adolescents more frequently intervene to stop the violence, thereby putting themselves at greater risk for injury.⁴⁹

Children who are exposed to intimate partner violence, particularly chronic episodes of violence, often show symptoms associated with posttraumatic stress disorder. One study found that exposure to intimate partner violence (without being directly victimized) was sufficiently traumatic to precipitate moderate to severe symptoms of posttraumatic stress in 85 percent of the children.⁵⁰

Children who are exposed to intimate partner violence are more likely to exhibit behavioral and physical health problems including chronic somatic complaints, depression, anxiety and violence towards peers.⁵¹ They are also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution and commit sexual assault crimes.⁵² Children who are exposed to intimate partner violence have increased difficulties with learning and school functioning.⁵³ Symptoms of trauma including sleep difficulties, hyper-vigilance, poor concentration and distractibility which interfere with a child's ability to focus and to complete academic tasks in a school setting.

Intimate partner violence also affects parenting. The emotional consequences of being injured, harassed or terrified may be significant for the parent who is victimized. That parent may be less attuned to children's needs or less emotionally available to the children. However this does not mean that victims of intimate partner violence are inherently abusive or neglectful of their children. Parents who batter are generally less involved with child rearing, more likely to use physical punishment and less able to distinguish or recognize the child's needs as separate from the parent's needs.

Children who grow up with violence in the home learn early and powerful lessons about the use of violence in interpersonal relationships. They learn that violence is an acceptable way to assert one's views, get one's way or to discharge stress. These children also learn that violence may be an inherent part of loving relationships. Exposure to violence thus provides justification for children to use violence in their own relationships. This may be particularly true for adolescents.⁵⁴

Studies demonstrate that children are not equally affected by exposure to intimate partner violence.^{55,56,57} Children react in different ways to trauma, and they have a range of strengths and vulnerabilities to cope with this stress. Some children appear to be more resilient; others may be deeply affected. Variables such as age, gender, proximity to the violence and the frequency and severity of the violence affect children's responses. In addition, the response of the caregiver and other characteristics of the family and community affect children's responses.

Working Cross Culturally

Intimate partner violence affects people regardless of race, ethnicity, class, sexual and gender identity, religious affiliation, age, immigration status and ability. The term culture is used in this context to refer to those axes of identification and other shared experiences. Because of the sensitive nature of abuse, providing culturally relevant care is critical when working with victims of abuse. In order to provide care that is accessible and tailored to each patient and their family, providers must consider the multiple issues that victims may deal with simultaneously (including language barriers, limited resources, homophobia, acculturation, accessibility issues and racism) and recognize that each victim of intimate partner violence will experience both the abuse and the health system in culturally specific ways.

Disparities in access to and quality of health care also have an impact on ability of providers to help victims of intimate partner violence. For example, women who are members of racial and ethnic minority groups are more likely than white women to experience difficulty communicating with their doctors, and often feel they are treated disrespectfully in the health care setting.⁵⁸ English-speaking Latinos, Asians and Blacks report not fully understanding their doctors and feeling like their doctors were not listening to them.⁵⁹ People with disabilities that affect cognitive or communication may be dependent on an abusive intimate partner and thus at especially high risk. In addition, some patients may experience abuse from the health care system itself and this may affect their approach to and utilization of the health care system.⁶⁰

Providers also enter health care encounters with their own cultural experiences and perspectives that may differ from those of the victim. In a successful health care interaction within a diverse client population, the provider communicates effectively with the patient, is aware of personal assumptions, asks questions in a culturally sensitive way and provides relevant interventions. Eliciting specific information about the patient's beliefs and experience with abuse, sharing general information about intimate partner violence relevant to that experience and providing culturally accessible resources in the community, improves the quality of care for victims of violence. In addition, having skilled interpreters who are trained to understand intimate partner violence (and not family members, caregivers or children) is crucial when helping non-English speaking patients⁶¹ and their families. Culturally sensitive inquiry questions for all caretakers and adolescent patients can facilitate discussion and help providers offer appropriate and effective interventions.

Recent Trends

These guidelines reflect an important shift in terminology. “Assessment” or “inquiry” has replaced the work “screening” throughout this document. The concept of screening in the medical model usually involved the use of a standardized clinical test to detect disease in asymptomatic patients. Psychosocial health issues like IPV do not fit well into a disease-based approach, particularly when identification of the health concern relies primarily on the patient’s response to a question. The U.S. Preventive Services Task Force (USPSTF) uses the term “assessment” in their recommendations for many psychosocial issues such as tobacco use and alcohol consumption. The USPSTF and other prominent medical organizations have identified the problems with fitting IPV into a traditional screening paradigm. The FVPF believes that using the term “assessment” will lead to a more appropriate evaluation of the importance of routine inquiry for IPV in the health care setting.

With growing recognition of the connection between IPV and other risk factors, there is a trend to integrate routine inquiry for IPV into assessment tools addressing a wide range of psychosocial issues associated with current or past victimization such as tobacco use, weight control, and access to preventive health care. This has led to innovative strategies for more comprehensive assessment and integrated service delivery. The Maternal and Child Health Bureau has funded several perinatal demonstration projects to develop an assessment tool for IPV, depression, and substance abuse. Another exciting initiative through the Substance Abuse and Mental Health Services Administration (SAMHSA) promotes coordinated services for women who experience violence, mental health problems, and have substance abuse issues.

Identifying and Responding to Abuse Can Make a Difference

The health care system plays an important role in identifying and preventing public health problems. Models developed to identify other chronic health problems may effectively be applied to intimate partner violence. **A primary starting point to improve the medical practice approach to intimate partner violence is routine assessment, with a focus on early identification of all families and victims of intimate partner violence whether or not symptoms are immediately apparent.**

Since nearly all young children and teens are seen at some point in a health care setting, these settings present a compelling opportunity to identify teens, mothers and children who may be living with intimate partner violence. A 2001 study in North Carolina found that only 23 percent of women injured by a partner shortly after pregnancy received treatment for their injuries. However, almost all of these women used health care services for their infants, indicating that child health settings are potentially important for identifying intimate partner violence.⁶²

Universal and regular face-to-face screening of women in adult health settings by skilled health care providers markedly increases the identification of victims of intimate partner violence, as well as those who are at risk for verbal, physical and sexual partner abuse.^{63,64} Expert opinion suggests that such interventions in adult health settings may lead to reduced morbidity and mortality.⁶⁵ Inquiry for IPV can assist clinicians in their diagnosis and assure more appropriate care for a victim's health symptoms by treating the underlying problems. Inquiry also gives victims a valuable opportunity to tell their providers about their experiences with abuse.⁶⁶ Battered women report that one of the most important parts of their interactions with their physicians is being listened to about the abuse. (See [Appendix III: Abstracts of selected studies on Provider and Patient Attitudes: Forward Screening for IPV in the Child Health Setting.](#))

Although there is no research as yet that proves the efficacy of assessment in child health settings, it is reasonable to assume that such inquiry would increase opportunities for identification and intervention within families, thereby enabling pediatric, family practice and primary care providers to assist both victims and their children. When child witnesses of intimate partner violence, victims or those at risk for intimate partner violence are identified early, providers may be able to intervene to help patients understand their options, live more safely within the relationship or safely leave the relationship. The child health care provider's direct discussion about safety at home tells the family that this is an important topic and one that belongs in the realm of pediatric and family practice care. Even if a woman denies that she is being abused, the provider can often lay the groundwork for the possibility of future disclosure or discussion of the issue.

PART II

DILEMMAS FACED BY PROVIDERS



DILEMMAS

DILEMMAS

A policy of universal and regular inquiry for intimate partner violence in child health settings presents dilemmas to the providers who assess that may not exist when assessing patients in an adult health setting. Perhaps the fundamental difference lies in the fact that adults are not the primary patients during pediatric visits. This section reviews several major dilemmas and provides specific recommendations for responding. Because these dilemmas present challenging practice and ethical questions for the provider, this panel strongly recommends that child health practices have access to legal consultation, as well as consultation from battered women's service providers, child protection and child mental health. These resources can be helpful in making decisions about how to intervene in ways that do not increase risk for the family or unnecessarily alienate the non-offending parent.

When Does Child Exposure to Intimate Partner Violence Become Child Maltreatment?

Because of the high rate of co-occurrence of intimate partner violence and child abuse, child health providers need to be concerned about the possibility of child abuse whenever intimate partner violence is disclosed. Whenever a child is abused, either intentionally or unintentionally, as a result of intimate partner violence, state law requires health care providers to report this abuse to child protection services. Mandated reporters would also report any high-risk situation of intimate partner violence in which children are at risk.

However, state laws are less clear about whether exposure to domestic violence in the absence of injury or serious risk of injury to the child would require a report to children's protective services.

- In some states, stringent rules/laws require mandated reporters to notify child protection services whenever a child is in the home and has been exposed to a parent's abuse, whether or not the child has been directly abused. Proponents of this definition point to the ample documentation of the overlap between adult intimate partner violence and child abuse and the adverse psychological effects on children who witness intimate partner violence. Opponents of this policy believe it penalizes women for abuse that they have no control over and may discourage women from seeking help.
- In other states, a child's exposure to intimate partner violence does not automatically require a mandatory child protection report. The provider has wider discretion to assess whether a child has been directly involved and what other factors may exist to put the child at risk. In these states, a provider would take into account the existence of direct injury to a child, the potential danger of the situation, and the capacity of the mother to keep her children safe in deciding whether to notify Child Protective Services (CPS).

Many victim advocates recommend having the victim place a phone call themselves to CPS from the practitioner’s office, thus protecting her from charges of “failure to protect” while simultaneously protecting the child and meeting statutory child abuse reporting laws.

Unless a child health care provider is legally required to report all incidences of intimate partner violence to CPS, it is preferable to make this decision based on the specifics of the case and the provider’s clinical judgment. In some instances, the children are not in danger; the victim has planned for their safety and is responding adequately to the child’s needs or emotional reactions. In these cases, a provider should offer voluntary services and support instead of simply submitting a report to CPS, especially if not mandated.

A policy that automatically defines child exposure to intimate partner violence as neglect or maltreatment assumes that victims are neglectful parents solely because their children witnessed the abuse, implying that somehow the victim could have stopped the abuse. This approach implies that not only are these parents victims of abuse, but that they also bear the responsibility for child neglect. This may be inaccurate and unfair. This policy also makes the assumption that all children are adversely affected by exposure to violence, no matter the circumstances. It ignores the fact that some children are more adversely affected than others and that some families and communities are more able to support children than others. Finally, opponents of this policy allege that mandatory reports also would increase the demands on protective services—a system that is already overburdened and under funded in most states.⁶⁷ In addition, the practice of routinely reporting intimate partner violence incidents that involve children to protective services discourages victims from seeking help with intimate partner violence. If a victim believes that children may be removed from her care, she will be less likely to seek help from medical professionals. A mandatory reporting policy also may discourage child health care providers from assessing for intimate partner violence because they do not want to involve protective services in their patient’s life.

RECOMMENDATIONS:

Know your state’s child abuse reporting laws (*see Appendix XI*) and its specific policies on defining child exposure to intimate partner violence as child maltreatment (*see Appendix X*). In a state that requires mandated reporting in all cases of intimate partner violence, the provider should inform the non-offending parent of the obligation to file a report to CPS, assess the safety needs of the victim, and inform CPS about the specifics of the perpetrator, his anticipated response and the potential for danger. In states where more discretion is left to the provider, the provider should assess the specifics of each situation as a means of making a decision about whether it is necessary to make a report. The assessment should include inquiries about injury or abuse to children, the current safety of the home, and whether the perpetrator has made threats to the children. Depending on the answers to these questions, the provider can make a decision about the imminent risk of harm to

the child and victim. If the situation is not currently dangerous, the provider can refer the victim to voluntary services: battered women’s services, counseling (preferably with a provider who has worked with victims of intimate partner violence), or child-focused services. If the situation is currently dangerous to the child, a report needs to be filed. Consider involving the mother in filing the report and follow the recommendations above to maximize the protection afforded to the mother during the CPS investigation.

BOX 1

In States with Mandatory Reporting Requirements for Child Exposure to Intimate Partner Violence

PROVIDERS SHOULD:

- Inform the non-offending parent of obligation to report to CPS
- Assess the safety needs of the victim
- Give CPS specific information about the perpetrator, the intimate partner violence, and the potential for danger
- Have resources available for the non-offending parent

In States with Less Specific Reporting Requirements for Child Exposure to Intimate Partner Violence

PROVIDERS SHOULD DECIDE WHETHER TO FILE A REPORT WITH CPS BASED ON:

- An inquiry about direct injury to child
- An assessment of potential for danger (threats, weapons, substance abuse)
- An assessment of mother’s ability to plan for children’s safety
- An assessment of support and connections to community

If provider decides not to report to CPS, he/she should offer referrals to voluntary services and provide follow-up care.

IF PROVIDER DOES DECIDE TO REPORT:

- Consider asking the mother to file a report herself to avoid charges of “failure to protect”
- Follow all the steps outlined above for reports in mandated states

Intimate Partner Violence Victimization Reporting Requirements for Health Care Providers

While all states mandate reporting of child abuse or neglect, most states have also enacted general mandatory reporting laws which require the reporting of specified injuries and wounds, suspected abuse or intimate partner violence for individuals being treated by a health care professional. These mandatory reporting laws are distinct from child abuse, elder abuse or vulnerable adult abuse reporting laws, in that the individuals to be protected are not limited to a specific class. These laws pertain to all individuals to whom the health care professional provides treatment or medical care, or who come before the health care facility.

The laws vary from state to state, but generally fall into four categories: 1) states that require reporting of injuries caused by weapons; 2) states that mandate reporting for injuries caused in violation of criminal laws, as a result of violence, or through non-accidental means; 3) states that specifically address reporting in intimate partner violence cases; and 4) states that have no general mandatory reporting laws. (See [Appendix IX](#) for state codes on Intimate Partner Violence Victimization Reporting Requirements for Health Care Providers).

In the majority of states, neither statutory nor case law specifies if a health care provider must report a parent's injuries if they are observed or discovered during a health care visit with that parent's child. Therefore, under a strict reading of most laws, if a child's health care provider is not providing treatment or medical care to the abused parent during the child's visit, the health care provider would not be required to make a report. In family practice situations where the child and parent are the provider's patients, and the current visit appointment is for the child, the same reasoning could be applied, although it is less clear-cut. That is, the health care provider would not be required to report since he or she is not treating the parent for the specified injuries during the appointment. This issue merits further discussion among health care providers, advocates, licensing authorities, and other professionals, as it is uncharted territory. There has been much debate about the benefit of mandatory reporting of intimate partner violence by health care providers. A more extensive discussion of these laws, their risks and benefits, and their application to pediatric and family practice providers can be found in [Appendix VIII](#).

RECOMMENDATIONS:

Providers should know their state's intimate partner violence reporting law, including who is required to report and under what conditions. ([Appendix IX](#) contains a chart listing state codes). In order to maximize patient input regarding law enforcement action, providers should also familiarize themselves with how their local law enforcement agency responds to such reports. Becoming familiar with such procedures will allow the

provider to better assist the patient in safety planning, and in knowing what to expect. Intimate partner violence reporting responsibilities should be carefully discussed with teens prior to assessing for dating violence or intimate partner violence in their homes. Additionally, recent federal privacy regulations require providers to inform patients of health information use and disclosure practices in general, and whenever a specific report has been made. Health care facilities should ensure that their intimate partner violence protocols and training materials address their state reporting laws and federal regulations.

Asking about Intimate Partner Violence with a Child in the Room

Providers differ in their practice of asking sensitive questions to the mother when the child is present. Generally, if the child is under age three, most providers assume that asking a mother about safety or other sensitive issues is appropriate. However, there is not consensus about whether to require that an older child not be present in the room when screening the mother for intimate partner violence. Some providers are concerned about asking questions when older children are present. They assert that having the child in the room will be a barrier to disclosure because parents will avoid discussing it in front of their children. Some say that it would be upsetting for children to hear such conversation or that children may reveal the conversation to the batterer which may endanger the mother and child. Other providers believe that the assessment questions about intimate partner violence should be asked regardless of the age of the child. They assert that children generally are aware of the intimate partner violence and that mothers will indicate if they are uncomfortable with the subject, thus giving the provider the opportunity to schedule a more private conversation with the parent.

RECOMMENDATIONS:

It is best to conduct assessment without children in the room and should occur regardless of the age of the child. In some practices it is possible to have the child wait in a supervised waiting area or under the supervision of another staff member. In other practice settings, it is not possible to have children leave the exam room. In these situations, providers can ask general questions and should always be sensitive to the comfort level of the parent. If the parent seems uncomfortable, the provider can offer other options for talking more privately, either by telephone or in a follow-up visit. Providers should be aware of the impact of a disclosure on a child, and should ask follow-up questions about the child and family's safety.

BOX 2**Asking about Intimate Partner Violence with a Child in the Room****Child in the Room****PRACTICAL POINTS:**

1. Ask general questions first.
2. Be sensitive to comfort level of parent.
3. If parent is uncomfortable, schedule a time to talk without the child present.

Child not in the Room**PRACTICAL POINTS:**

1. Ask during routine parts of visit when child is not in the room: vision screening, immunizations, laboratory work.
2. Have the child wait briefly in a supervised waiting area if possible.

Documentation

There is no consensus over the procedure for documenting the presence of intimate partner violence in a family in a child's chart. If the batterer is the biological or custodial parent, he may have access to the chart and the information about the victim would thus not be confidential. Therefore, putting information about intimate partner violence disclosures in the child's chart may not be advisable. On the other hand, the information is important and other providers who work with the family should know about this risk factor if they read the child's chart. Charting can also be helpful to the victim should custody disputes arise.

RECOMMENDATIONS:

A review of the literature and current practice reveals that recommendations for documentation are contradictory and inconsistent. One recommendation is for the provider to document all screenings for intimate partner violence in the child's chart. The suggested notation, perhaps in the section on anticipatory guidance, is: "The parent was routinely asked about verbal abuse, threats, physical violence in the home and community. If so, the parent was offered information about community resources for safety planning and counseling." This type of routine documentation is recommended for tracking and quality assurance. If possible, the documentation for the outcome of the inquiry (if positive for abuse) should be placed in the woman's health chart or in social work notes where there is more protection of confidentiality. Some practices use non-specific terms or a code word to indicate the presence of intimate partner violence in a child's chart: for example, "family problems," "difficult home situation" or "+ wtv." Some practices maintain a section of the child's chart that is confidential and is not released when there is a request for medical records. A brief notation of intimate partner violence in this section is appropriate. Intimate partner violence should not be listed as a discharge diagnosis or billing information that is sent home or can be viewed by the perpetrator.

If the provider is unsure about documentation and its confidentiality from the battering parent, he/she should consult with medical records experts, billing personnel, risk management professionals or attorneys.

BOX 3**Options for Documentation**

- Document that inquiry has occurred.
- Document results of inquiry by using non-specific terms or code works: “family problems,” “difficult home situation,” or “wtv.”
- Maintain a section of the child’s chart that is confidential (not released with a request for medical records). Document finding of intimate partner violence in this section.
- If possible, document the existence of intimate partner violence in the woman’s health chart or in social work notes where there is more confidentiality.

Responding to a Child’s Disclosure of Intimate Partner Violence in the Home

Direct disclosures of intimate partner violence occur more frequently with older children or teenagers who see child health providers without their parents. If the parents are unaware of the disclosure, the provider must decide how to inform the parents in a way that protects the child and does not create an unsafe situation in the home. The provider may feel uncomfortable about how to handle this disclosure. Should the provider notify child protective services? What are the consequences for the child of telling someone outside the family about the violence? What are the issues and laws related to confidentiality?

RECOMMENDATIONS:

Find out as much specific information as possible about the abuse and the extent of risk for the child and the adult victim. If the situation is dangerous, notify protective services. Inform the child of your concern about his/her safety and tell the child that you would like to speak to the non-offending parent about the situation. Inform the non-offending parent of the child’s concerns, taking care to stress that you are concerned and that you want to be helpful and supportive. Ask if the parent is safe and what types of supports would be helpful. If possible, make a referral to an intimate partner violence support agency or to counseling/social services/mental health. Schedule a follow-up appointment for the next week.

BOX 4

Responding to Child Disclosure of Intimate Partner Violence

PRACTICAL POINTS:

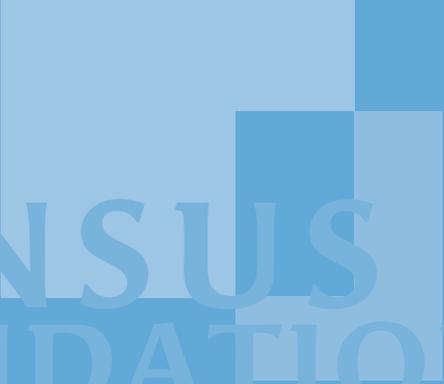
- Inform the child of your concern about her/his safety and that you intend to speak to the non-offending parent about the situation.
- Inform the non-offending parent of the child's concerns.
- Ask if the parent is safe and what types of supports would be helpful.
- If possible make a referral to an intimate partner violence support agency or to counseling/social services/mental health for the adult or adolescent victim and their children.
- Schedule a follow-up appointment for the next week.
- Notify protective services if there are safety concerns about the child.

PART III

CONSENSUS
RECOMMENDATIONS

CONSENSUS
RECOMMENDATIONS





CONSENSUS RECOMMENDATIONS

ASSESSING FOR INTIMATE PARTNER VIOLENCE WHEN YOUR PATIENT IS A CHILD OR ADOLESCENT

All health care providers seeing children and adolescents should provide intimate partner violence assessment as part of routine patient care in public health, private practice and managed care settings.

Who and How Often to Assess:

- Assess female caregivers/parents who accompany their children during new patient visits; at least once per year at well child visits; and, thereafter, whenever they disclose a new intimate relationship.
- Assess female and male caregivers/parents known to be in same-sex relationships who accompany their children during new patient visits; at least once per year at well-child visits; and, thereafter; whenever they disclose a new intimate relationship.
- Assess adolescents during new patient visits; at health maintenance visits once per year; or whenever they disclose a new intimate relationship.
- Ask pregnant teens at first pre-natal visit; at least once per trimester; and at the postpartum visit.ⁱ
- Also ask whenever signs and symptoms raise concerns:ⁱⁱ
 - Specifically, assess when the child or adolescent has:
 - Obvious physical signs of physical or sexual abuse;
 - Behavioral or emotional problems, such as increased aggression, increased fear or anxiety, difficulty sleeping or eating, or other signs of emotional distress; or
 - Chronic somatic complaints.
 - When adults present with obvious physical injuries or a history of intimate partner violence.

(See [Appendix IV: Dilemmas When Assessing All Patients for Victimization.](#))

ⁱ Recommended by the American College of Obstetricians and Gynecologists

ⁱⁱ See Appendix V: Indicators of Abuse.

BOX 5

Who and How Often to Assess:

TYPE OF VISIT	WHO TO ASSESS	WHEN TO ASSESS
New Born	Caregiver	At postpartum visit
New Patient	Caregiver & Adolescent	At first visit
Well Child:		
Child	Caregiver	At 2, 6 and 12 months, then yearly
Adolescent	Adolescent	Yearly
Prenatal	Adolescent Mother	Once per trimester
Mental Health	Caregiver & Adolescent	At initial visit
Emergency	Caregiver & Adolescent	At every visit
Other Visits	Caregiver or Adolescent	Whenever there are physical or behavioral indicators or chronic somatic complaints

How to Assess:

- Direct questions should be asked, whether or not signs or symptoms are present and whether or not the provider suspects abuse has occurred.
- Inform patient about the limits of practitioner/patient confidentiality related to intimate partner violence prior to assessing.
- Use language that is direct, specific and easy to understand.
- Conduct assessment in a private room.
- For a parent, it should take place without the intimate partner or other adult family members present.
- For adolescents, it should take place without the parent (or partner) in the room.
- Can be included as part of a written health questionnaire or health history, but this should not replace face-to-face assessment.
- Should be conducted in a patient’s primary language.
- If an interpreter is used, it should not be an acquaintance or relative of the family. Children should never be used as interpreters.

What to Ask:ⁱⁱⁱ

Intimate partner violence questions can be framed within discussion of other safety issues such as car and bicycle helmet safety, and assessing for guns at home or community violence.

ⁱⁱⁱ There are no controlled studies of the efficacy of screening questions in pediatric or family practice settings. The questions we propose are drawn from three sources: Family Violence Prevention Fund, Preventing Domestic Violence: Clinical Guidelines on Routine Screening. San Francisco, October, 1999. Groves, B. (1994). Children who Witness Violence, in Developmental and Behavioral Pediatrics: A Handbook for Primary Care. Parker, S. and Zuckerman, B., eds. Boston, Little Brown & Co. 334-336. McNamara M. (2001). “Clinical guidelines for screening and responding to child and youth exposure to domestic violence for healthcare providers”. LINC (Living in a Nonviolent Community), UCSF Department of Pediatrics, November 2001.

For adults who accompany their children:

INTRODUCTORY STATEMENTS OR QUESTIONS:

- “I have begun to ask all of the women/parents/caregivers in my practice about their family life as it affects their health and safety, and that of their children. May I ask you a few questions?”
- “Violence is an issue that unfortunately effects everyone today and thus I have begun to ask all families in my practice about exposure to violence. May I ask you a few questions?”

INDIRECT QUESTIONS:

- “What happens when there is a disagreement with your partner/husband/boyfriend or other adults in your home?”
- “Do you feel safe in your home and in your relationship?”

DIRECT QUESTIONS:

- “Have you ever been hurt or threatened by your partner/husband or boyfriend?”
- “Do you ever feel afraid of (or controlled or isolated by) your partner/husband/boyfriend?”^{iv}
- “Has your child witnessed a violent or frightening event in your neighborhood or home?”

For adolescents:

INTRODUCTORY STATEMENTS OR QUESTIONS:

- “Many teens your age experience threats, name calling, uninvited touching, sex or violence, so I ask all my teen patients about it. May I ask you a few questions?”
- “I don’t know if this is a concern for you, but many teens I see are dealing with violence or bullying issues, so I’ve started asking questions about violence routinely.”
- “Sometimes when I see an injury like yours, it’s because somebody got hit. How did you get this injury/bruise?”
- “Now I am going to ask you confidential questions. The answers are confidential, unless your health is in immediate danger.”
- “How are disagreements handled in your family?”

INDIRECT QUESTIONS:

- “Are you in a relationship or seeing anyone?” or “Do you have a boyfriend or girlfriend? What happens when you disagree with them?”
- “How are your parents getting along?”

^{iv} In case of same sex relationships we recommend using “partner” or mirroring the language of the adult being screened. For example, if a parent refers to her same sex partner as “roommate,” use “roommate.” If the sexual orientation is unknown, we recommend “partner.”

- “How often do you have yelling or screaming fights? Do any of them involve pushing or slapping?”

DIRECT QUESTIONS:

- “Sometimes if someone is being hurt in her/his own relationship, they may have seen it happen in their own family. Have you seen anyone get hurt in your home?”
- “Teens see a lot of violence these days. Seeing parents or other adults fight can feel as bad as being hit yourself. Has this happened to you?”
- “We all have disagreements sometimes with family members or friends. Have you ever been hurt or threatened by anyone?”
- “Have you ever been hurt – hit, kicked, slapped, shoved, pushed by a friend or person you know?”
- “Have you ever been forced to do something sexual that you didn’t want to do?” —as part of sexual history.
- “Do you ever feel afraid of or controlled by someone you’re dating or a friend?”
- “Has anyone hit you at home in the last year?”

QUESTIONS BASED ON INDICATORS:

- “I noticed that you have an injury. Sometimes injuries like that come from someone hurting you. What happened to you?”

Asking about Intimate Partner Violence with a Child in the Room

There are different opinions about whether inquiry about sensitive issues such as intimate partner violence should take place with the child in the room or whether the questions should be asked without the child’s presence. For further discussion of this issue, see page 10.

- If it is possible to see the parent without the child, (e.g. the child is old enough to wait alone; the child is in a supervised waiting area; the child is having laboratory work or vision /hearing screening done), questions can be asked in the manner mentioned in the section “What to Ask” above.
- For children under age three, asking the mother questions about safety and relationships in the presence of the child is generally not an issue.

IF THE CHILD IS IN THE ROOM:

- Begin inquiry with an indirect question (see section “What to Ask” above).
- If parent appears uncomfortable or upset and it is not possible to see the parent alone in this visit, ask if there is another time to speak by telephone or to follow-up.
- If parent appears comfortable with the questions, proceed to ask more specific questions about intimate partner violence.

Who Should Assess:

QUESTIONS CAN BE ASKED BY ANY HEALTH CARE PROVIDER WHO IS:

- Educated about the dynamics of intimate partner violence, how children are affected and how to assess safety of children and/or know what resources are available for further assessment and counseling services;
- Trained on how to ask about abuse, how to assess the safety needs of an abuse victim, and how to assist the victim, and who recognizes her autonomy and right to make her own decision or is trained to refer the patient to someone who can assess safety needs and further assist her;
- Sensitive to issues of culture and class in interactions with patients; and
- Knowledgeable about community resources.

RESPONDING TO INTIMATE PARTNER VIOLENCE WHEN YOUR PATIENT IS A CHILD OR ADOLESCENT

If the patient or his/her mother tells you that s/he has been abused, you become an important part of her/his support system. Living with intimate partner violence or making the decision to leave a relationship are ongoing issues for both patient and family that affect their health care. Providers need to respect the integrity and authority of victims of intimate partner violence to make decisions about their own relationships, even if the provider does not agree with those decisions. The health care provider can play an important role in the victim's decision making process by asking the right questions, providing information about the nature of intimate partner violence, giving messages of support, and letting her know about resources available to her. At times it will be appropriate for the health care provider to make recommendations about what to do, but only after understanding the reality of the victim's situation and only with the understanding that, ultimately, the victim must and will make her own choices, not withstanding child abuse laws.

Support the Victim:

- Express concern for the patient's or parent's safety.
- If the victim is comfortable, encourage her/him to talk about what has happened.
- Listen without making judgments.
- Tell victims that they are not alone and that you and other people can help them.
- Tell her/him that the violence is not their fault, s/he does not deserve to be abused and that only her/his abuser can stop the abuse, and that there is no excuse for intimate partner violence.
- Make sure s/he knows that there is help available and that there are people s/he can turn to for support.
- Remind the victim that you are a resource, should s/he need further assistance.

- Inform the attending parent or adolescent of any reporting laws and requirements.

Provide Information on Intimate Partner Violence:

- Intimate partner violence is common (among all social strata, educational levels and ethnic groups).
- Most violence continues for a long time and often gets more frequent and more severe.
- Violence happens in all kinds of relationships – including teen relationships and lesbian and gay relationships.
- Violence in the home can harm all family members including children, both physically and emotionally
- There are resources for families, and this clinic/practice/provider can help find them.
- Intimate partner violence affects victim health and the health of the family.

What to Say to the Child Who has Witnessed Intimate Partner Violence:

If a parent discloses intimate partner violence, the provider with the parent's permission can specifically acknowledge the disclosure with the child by saying:

- “What are your worries about the fighting at home?”
- “I am concerned about the safety of people in your home and I am glad your mother told me about this.”
- “What is going on in your house is not your fault.”
- “You are not responsible for solving these problems. I am going to work with your mother (father, caretaker, etc.) to try to make things better.”

The way in which the provider discusses these issues with children will vary by their age and level of cognitive development. For a four-year-old, it is probably sufficient to provide simple acknowledgment and reassurance about safety. For an eight-year-old, it may be appropriate to add more specific reassurances about what steps the parent is taking to handle the situation. For an older child or an adolescent, it may be important to offer the opportunity to talk about their perspectives of the situation at home.

For Adolescents Who are Victims of Violence:

- Address the health issues by obtaining a complete history.
- If possible, conduct a complete, unclothed, physical exam. Look for – and document – evidence of current or previous injuries and of sexual abuse.
- Ask about medical and psychological effects resulting from abuse, such as chronic pain, worsening of existing medical conditions, psychological distress, anxiety, sleeping and eating disorders, miscarriages or substance abuse.
- Schedule a follow-up appointment, encourage your patient to return and make other

appropriate referrals.

- Encourage the patient to talk to his/her parents or trusted adult about dating violence.
- For severe violence, inform adolescents that you must inform their parents or guardian to keep them safe. In this case, you may need to inform state protective service if the caretaker will not protect the child.

Assess and Address Safety Issues:

Before your adolescent patient or a parent leaves, talk with her/him about immediate and future safety. These questions can also be asked over time and during subsequent visits.

- Ask her/him about her/his immediate plans. Is s/he going home to the person who hurt her/him? Does s/he have a friend or relative s/he can talk to? If s/he is going to leave, where is s/he going to go?
- Depending on the amount of time the clinician has, the following issues can be pursued to assess current danger:
 - What happened during the latest incident? Is the abuse increasing in frequency or severity?
 - Were weapons involved?
 - Have there been prior incidents?
 - Have you sought any kind of assistance for previous battering? Have you ever left before?
 - Has the abuser ever threatened or physically injured the children?
- Assess for suicidal ideation and risk of homicide:
 - Have you ever considered, threatened or attempted suicide?
 - What injuries did you sustain during the worst incident of violence?
 - Has the violence increased in frequency and/or severity?
 - Has the abuser ever threatened to kill you? Do you believe s/he is capable of killing you? Has the abuser used a weapon or threatened you with a weapon before?
 - Are you planning to leave/divorce him in the near future?
 - Are there firearms or other weapons in the house?
- Help parents think about safety issues for their children. For example:
 - Do the kids usually get involved when a violent incident occurs?
 - What do they do when violence erupts?
 - Do you talk with them about it? What do you say?
 - Children should be taught that their job in a violent situation is to stay safe, not to protect their parents or stop the fighting. They should be taught now to call 911 (where age appropriate).
 - Help the victim think about options and their implications.
- Inquire about the possibility of referring a victim to appropriate services from a battered women's shelter or support network and/or other culturally relevant agency such as a

community center, church or other organization serving the victim's community.
(See [Appendix VII](#) for a *Safety Plan and Instructions*).

Referrals for Adult Parents and Adolescents:

Help your patient find culturally appropriate support from a hospital or community-based social worker or advocate who can help the victim with:

- Emergency shelter or permanent housing
- Emergency financial assistance or transportation
- Counseling and/or support groups for victims and their children
- Child care, visitation centers
- Legal assistance
- Mental health and substance abuse treatment
- Social services
- Batterer intervention programs
- Independent living centers

Note: Couples treatment and mediation are not usually recommended^v

When possible, refer patients to organizations that reflect their cultural background or address their special needs such as organizations with multiple language capacity and those who specialize in working with teen, disabled or LGBT (lesbian, gay, bisexual, or transgender) clients.

Allow her/him to use your phone to make calls. If you don't have information about intimate partner violence programs in your area, call the National Domestic Violence Hotline at 800-799-SAFE (800-799-7233 or TDD: 800-787-3224).

^v Mediation and couples counseling imply that both parties are responsible for the perpetrator's violent behavior, a message that blames victims and fails to hold offenders accountable for their crimes. Mediation also presumes that both parties have equal power and can negotiate a mutually agreeable settlement. Where there is domestic violence, sexual assault, or stalking behavior, however, one party has controlled the other through sexual, physical, emotional and/or economic abuse. Even the most skilled mediator or therapist cannot shift the balance of power when one party has abused or assaulted the other, making mediation and joint counseling dangerous and ineffective in such cases.

Referrals For Children:

Children react to witnessing intimate partner violence in many different ways. The family's capacity to support these children also varies, as do their beliefs or ways of seeking help. If the parent is concerned about her child, options for help should be discussed, including a counseling referral, mental health assessment or other support services (such as Big Brother/Big Sister). A referral would be strongly recommended in the following circumstances:

- If the child has witnessed severe violence resulting in injury or hospitalization of either the child, sibling or the parent.
- If the child's symptoms have persisted for more than three months.
- If there has been a change in behavior or an increase in aggression or depression.
- If the caretaker is unable to be emotionally attuned to the child's needs.
- If the violence has resulted in the death of a parent.

Reporting Requirements for Child Abuse and Intimate Partner Violence:

Know your state's child abuse and intimate partner violence reporting laws. (*Discussion of the complexity of these issues can be found in [Appendices VIII, IX & X](#)*). Contact your local prosecutor or state attorney general, and local law enforcement to interpret the law.

- Before asking about intimate partner violence, you may want to disclose any limits of confidentiality. Since many adolescents who are victimized by an intimate partner do not want their family to know about an intimate relationship, it is important that you understand and explain the limits of confidentiality of both their medical record and reporting before screening.^{vi}
- If the child has been injured, or if your state requires mandated reporting in all cases of a child's exposure to intimate partner violence, you must:
- Follow the state guidelines for completing a report.
- Encourage the victim to place a call to CPS themselves from the practitioners office, thus protecting her from charges of "failure to protect" while simultaneously protecting the child and meeting statutory child abuse reporting laws.
- If possible, when making the report yourself, tell the attending parent what you will say in the report and/or allow her to read/hear what you will say.
- When making the report to CPS, inform the screener or intake worker about the specifics of the domestic abuse and give as much information as possible about the risks for safety of the mother and child, the perpetrator, his current location, the anticipated response and the potential for subsequent violence.

^{vi} Federal health privacy regulations allow parents of teens to access health information unless the teen is emancipated or legally seeking care without parental consent such as services offered in Title XX, family planning clinics or STD clinics.

How to Document Intimate Partner Violence:

Documentation provides information on the effects of intimate partner violence over time and improves continuity of care. Make sure you are following your institution, state and federal privacy policies.

- Documentation is recommended. However, use caution in documenting intimate partner violence in a child's chart if the abuser is the biological or custodial parent. It may be advantageous to document on a separate form.
- For adolescents, documentation should be handled consistently with documentation of other sensitive issues, such as sexual activity, alcohol or drug use.^{vi}
- When documenting, use direct quotes like "Mother/Patient states...". Avoid judgmental terms such as "patient alleges" or "patient claims."
- With permission, photograph or draw picture of any injuries.

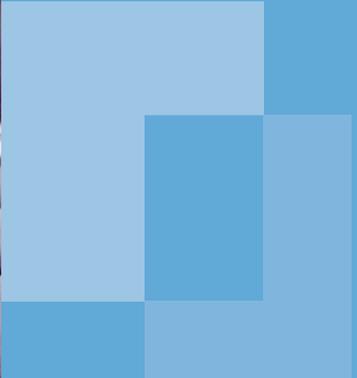
What to Do if a Patient Says "No" or Will Not Discuss Abuse:

Many victims of intimate partner violence will talk about their experiences if asked to do so in a sensitive and empathetic way. However, some victims may be reluctant to talk about their experiences regardless, because they are embarrassed or ashamed, or afraid that if they tell anyone they may face more severe abuse. There may be financial issues and or immigration concerns. Patients need to decide for themselves about whether they wish to disclose. If you suspect intimate partner violence and the victim remains reluctant to discuss or disclose, let her/him know that should s/he need your assistance in the future, you are available. The goal is not to get the victim to admit to the problem, but to let her/him know that you are a resource should intimate partner violence ever be an issue for them.

PART IV

PREPARING YOUR CHILD HEALTH PRACTICE

PREPARING
YOUR PRACTICE





PREPARING YOUR PRACTICE

PART IV | PREPARING YOUR CHILD HEALTH PRACTICE

It is important that the practice or clinic setting be set up to support the staff in responding effectively and efficiently to disclosures of intimate partner violence. In preparing your practice to begin routine inquiry for and response to intimate partner violence, it is advisable to obtain support from the leadership and administration, as well as to solicit staff input.

Physical environment should:

- Allow for confidential interviewing
- Have posters on intimate partner violence that are multicultural and multilingual; that present available resources; and that include information about victims, perpetrators, and/or other family and community members affected by family violence
- Have brochures/pocket cards for victims and perpetrators and resources that describe the impact of intimate partners violence on children.
- Have brochures placed in exam rooms and private places such as bathrooms
- Patient materials should include: brochures, discharge instructions, safety planning handouts and referral information on services for on-site or off-site advocacy, counseling, and legal and other community-based services for child witnesses, victims, perpetrators and others affected by intimate partner violence

(See [Appendix XII](#) for resources or www@endabuse.org/health for materials.)

Training for staff should include:

- Short- and long-term developmental and behavioral effects of childhood exposure to domestic violence and child abuse
- Survivors' perspectives
- Cultural competency
- Dynamics of victimization and perpetration
- Skills building—how to assess, intervene supportively and document appropriately
- Interactive role playing and modeling of inquiry and response techniques
- Information on where employees in abusive relationships can access help

Training should be part of staff orientation; ongoing, repeated and institutionalized; and mandatory for all employees. Providers who will be assessing and documenting in the medical record should receive training on dynamics and clinical response. Other staff—including allied health professionals, receptionists and security, who can play an essential role in identifying and protecting victims and their children—should receive general awareness training on intimate partner violence. Interpreters in particular should be trained in advance about the dynamics of intimate partner violence, childhood exposure to violence, the importance of confidentiality and non-judgmental interpretation, and appropriate word choices for translation of routine assessment.

Protocols should include:

- Definitions, guiding principles, routine assessment, intervention and documentation strategies, reporting policies and confidentiality rules
- Roles and responsibilities of staff

All staff should receive an orientation on the protocol. It should also be updated regularly and informed by new knowledge, laws and policies regarding intimate partner violence. It should be accessible to all staff.

Continuous Quality Improvement (CQI) Program:

- Scheduled audits of medical records to review compliance with the protocol
- Patient satisfaction surveys
- Regular discussions during staff meetings regarding functioning of intimate partner violence program
- Links to other quality improvement efforts
- Links to medical information system developments
- CQI goals publicized

Provider resources should include:

- Chart prompts in the medical record
- Documentation and assessment forms
- Posters and practitioner pocket cards
- Materials that are easily accessible to providers and regularly updated
- Consultation with on-site or off-site domestic violence advocates, legal and forensic experts, counselors with expertise in trauma treatment, and community experts from diverse communities (LGBT, disability, elder, teen, and ethnic-specific, immigrant, and others)
- Feedback mechanisms for providers

Employee assistance or human resources programs (for large facilities) should:

- Address intimate partner violence victimization and perpetration
- Be confidential (within legal limits), easily accessible and well publicized
- Be incorporated into managerial training
- Include intimate partners violence information in employee publications and alerts

APPENDICES



APPENDICES

APPENDICES

37	I. POSITION STATEMENTS OF MEDICAL AND HEALTH PROFESSIONAL ASSOCIATIONS
41	II. BIBLIOGRAPHY
44	III. ABSTRACTS OF SELECTED STUDIES ON PROVIDER AND PATIENT ATTITUDES
49	IV. DILEMMAS WHEN ASSESSING ALL PATIENTS FOR VICTIMIZATION
53	V. INDICATORS OF ABUSE
54	VI. EXPANDED ASSESSMENT FOR VICTIMS OF DOMESTIC VIOLENCE
56	VII. SAFETY PLAN AND INSTRUCTIONS
58	VIII. INTIMATE PARTNER VIOLENCE VICTIMIZATION REPORTING REQUIREMENTS: HOW IT AFFECTS CHILD HEALTH SETTINGS
61	IX. STATE CODES ON INTIMATE PARTNER VIOLENCE VICTIMIZATION REPORTING REQUIREMENTS FOR HEALTH CARE PROVIDERS
63	X. LEGISLATION REGARDING CHILD WITNESSES TO DOMESTIC VIOLENCE
67	XI. CHILD ABUSE REPORTING LAWS
75	XII. RESOURCES FOR PROVIDERS AND PATIENTS
81	ENDNOTES
	TRAINING AND EDUCATION MATERIALS CATALOG

APPENDIX I

POSITION STATEMENTS FROM HEALTH PROFESSIONAL ASSOCIATIONS —EXCERPTS—

AMERICAN ACADEMY OF PEDIATRICS

COMMITTEE ON CHILD ABUSE AND NEGLECT

The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women (RE9748)

ABSTRACT. Pediatricians are in a position to recognize abused women in pediatric settings. Intervening on behalf of battered women is an active form of child abuse prevention. Knowledge of local resources and state laws for reporting abuse are emphasized.

The abuse of women is a pediatric issue. The American Academy of Pediatrics (AAP) and its membership recognize the importance of improving the physician's ability to recognize partner violence as well as child abuse and other forms of family violence.¹ Intervention is crucial because children whose mothers are being assaulted are also likely to be victims. Identifying and intervening on behalf of battered women may be one of the most effective means of preventing child abuse.⁷

Abuse of spouses and intimate partners is a pediatric issue even when children are not being physically assaulted. Pediatricians should be aware of the profound effects family violence has on children who witness it or even overhear it. Witnessing violence in the home can be as traumatic for children as being the victim of physical or sexual abuse. Children whose mothers are abused may experience serious emotional distress and manifest severe behavioral problems as a result.^{6,8} Adolescents who observe abusive relationships at home may repeat that dynamic in dating or other relationships. (Men and older persons of both genders also can be victims of partner and intimate violence, but they are less likely to be seen in pediatric settings.)

Abused women are unlikely to seek care for their injuries from pediatricians. However, mothers of children seen by pediatricians may show signs of injury such as facial bruising. They may have other less obvious signs of abuse such as depression, anxiety, failure to keep medical appointments, reluctance to answer questions about discipline in the home, or frequent office visits for complaints not borne out by the medical evaluation of their child. Women may reveal the abuse to the pediatrician if they are questioned in a sympathetic and sensitive manner, in a confidential setting, away from the abuser, and provided some assurance of safety.

Questions about family violence should become part of anticipatory guidance. Pediatricians must understand the dynamics of abusive relationships. Excellent guidelines for managing situations of abuse have been published,⁹⁻¹³ and pediatricians need to become familiar with them. There also are increasing numbers of continuing education opportunities available to learn intervention techniques.

Pediatricians should have a protocol or action plan that has been reviewed with local authorities on domestic violence. Because of time constraints in a busy office practice or emergency room setting, an interdisciplinary approach to family violence may be most appropriate. Pediatricians can call on nurses, social workers or advocacy groups with expertise in assisting and counseling victims. The AMA's 1996 Diagnostic and Treatment Guidelines on Domestic Violence state that optimal care for the woman in an abusive relationship depends on the physician's working knowledge of community resources that can provide safety, advocacy, and support. The AMA and many state medical associations provide directories of agencies that provide services or information about all forms of family violence.

Pediatricians can provide education to agencies that deal with battered women about the risk of primary and secondary abuse to children whose mothers are abused. Every effort should be made to secure counseling for children who have been exposed to family violence. Such treatment may be provided in groups or individually, but the focus should be on understanding violence and how to avoid it. There is increasing evidence that children who grow up with violence are prone to violent behavior themselves, and pediatricians are in a position to break the cycle.

THE AAP RECOGNIZES THAT FAMILY AND INTIMATE PARTNER VIOLENCE IS HARMFUL TO CHILDREN. THE AAP RECOMMENDS THAT:

1. Residency training programs and continuing medical education (CME) program leaders incorporate education on family and intimate partner violence and its implications for child health into the curricula of pediatricians and pediatric emergency department physicians;
2. Pediatricians should attempt to recognize evidence of family or intimate partner violence in the office setting;
3. Pediatricians should intervene in a sensitive and skillful manner that maximizes the safety of women and children victims; and
4. Pediatricians should support local and national multidisciplinary efforts to recognize, treat and prevent family and intimate partner violence.

American Academy of Child and Adolescent Psychiatry

This statement has been approved by the Council on Child and Adolescent Health.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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AMERICAN ACADEMY OF FAMILY PHYSICIANS-Violence (Position Paper)

Family violence permeates our society. It affects us as individuals, family physicians, parents, spouses, educators and citizens. The breadth of the problem is staggering. Public health officials identify family violence as a public health issue of epidemic proportions.

THE FAMILY PHYSICIAN'S ROLE

Family violence will affect at least one third of the patients cared for by family physicians, and the impact of family violence may become evident in the one-on-one relationship of the family physician and the patient. It is imperative that physicians be aware of the prevalence of violence in all sectors of society and be alert for its effects in their encounters with virtually every patient.

Violence against women will be the form of family violence most frequently seen in family practice. Physicians need to recognize that women who are victims of domestic violence will be patients in every family practice in this country because one in every four women has been a victim of domestic violence at some point in her life, and one in seven women has been victimized in the past year. Pregnancy confers no protection. In fact, abuse often begins or escalates during pregnancy. One in six pregnant women is abused during pregnancy and 17 percent of physical or sexual abuse of women occurs during pregnancy. One study reported abuse in 37 percent of obstetric patients and showed that class, race and educational level made no difference.

THE ROLE OF THE FAMILY PHYSICIAN IN THE IDENTIFICATION AND TREATMENT OF FAMILY VIOLENCE

Despite barriers to the diagnosis and treatment of victims of family violence, family physicians are in an ideal position to take on this challenge and are compelled to do so by the sheer magnitude of the problem. Family physicians are better able to identify those at risk because they are trained to care for the whole family and for the individual as a part of the larger community. Because of the continuity of care family physicians provide, they can gain patient confidence over time and can serve as sympathetic listeners and patient advocates. Family physicians can provide early intervention to break the cycle of violence through routine screening and the identification of abuse. They can help by teaching parenting skills and counseling patients on the stress of caring for children or elderly parents. Physicians can talk with women and men about their experiences of previous abuse and can be a central referral source for other resources in the community.

AAFP INITIATIVES TO DECREASE FAMILY VIOLENCE

Among activities for the American Academy of Family Physicians (AAFP) to consider are the following:

1. Developing or adapting teaching modules for members to present to medical students, residents, hospital staff and community groups;
2. Creating an ongoing education program for members on screening, recognition and treatment of violence, including distribution of the American Medical Association's guidelines for history-taking around issues of violence and abuse;
3. Supporting or developing university-, hospital- or office-based protocols and policies about family violence;
4. Publicizing to members the hot-line numbers for organizations that help physicians and

- patients deal with abuse;
5. Offering continuing medical education for members to increase their skills in screening for, identifying and treating cases of domestic violence;
 6. Participating in public policy initiatives and legislative reform to protect victims and rehabilitate batterers and partnering with other organizations committed to decreasing family violence;
 7. Promoting reasonable and responsible control of firearms and other weapons.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

*Division of Women's Health Issues, ACOG Educational Bulletin, No. 257, December 1999
Domestic Violence –*

SCREENING AND IDENTIFICATION

Specific measures can be taken to improve identification and facilitate disclosure of domestic violence. A prefacing statement followed by a few simple, direct questions will identify most women with a history of abuse or assault. The introduction or preface should establish that screening is universal. The screening assessment should follow with direct questioning.

Children in violent homes should be evaluated by a professional who can assess the child's behavioral patterns and help the child address the emotional impact of the violence. Referrals to such resources are essential, because the victim may not be willing or able to do so on her own, especially if she fears removal of the child more than the violence.

Physicians or other health care workers who provide acute or chronic medical care to the older adult may see the older adult on a regular basis and have unique opportunities for screening and assessment. Additionally, an opportunity for screening and recognition exists during all health-related encounters of older individuals, such as routine gynecologic examinations.

SUMMARY

Many physicians, especially in the current managed care environment, are concerned that abuse screening and disclosure will require inordinate amounts of time, but with an established protocol and referral system this important problem can be managed. Screening all patients is the key to identifying abuse. With disclosure of ongoing domestic violence, the physician's responsibility should include acknowledgement of abuse, making a safety assessment, assisting with a safety plan, providing appropriate referrals, documentation, and continued support. For disclosure of past violence, the responsibilities are similar but generally do not require immediate intervention. Women with a history of past victimization need to have that history identified and acknowledged and may need referral to other professionals to assist with the resolution of their trauma-related issues. Regardless of the types of victimization a woman has experienced, providing a safe setting in which she can discuss the problem and receive support is an important part of her recovery. Through these measures, the health care team can help abused women take the first steps toward ending the violence and achieving a healthy recovery.

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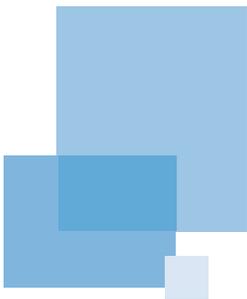
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Knocking Down Walls: Barrier Myths to Screening for Violence in Primary Care

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BACKGROUND: In 1998 the AAP in a policy statement recommended that “questions about domestic violence(DV) should become part of anticipatory guidance”. Since that time, studies have shown that providers are hesitant to follow the recommendation. Barriers have been sited from child presence in the room to fear of offending parents.

OBJECTIVE: This study explored how frequently providers in an urban practice screened for DV, whether children’s age and/presence in the room, length of time providers knew the family and how providers perceived parents response influenced screening.

DESIGN/METHODS: At baseline, 24 providers in an urban pediatric practice completed an interview about their current practices of screening for a child’s exposure to violence. Over the following 4 weeks, they completed a form at the conclusion of well child care visits(children birth to 12 years) which covered several areas including whether they screened for DV and a Likert scale rating provider perceptions of parents’ response to being asked these questions.

RESULTS: The providers were 16 residents, 6 attending pediatricians, 1 Nurse practitioner and 1 fellow. 84% reported they asked screening questions with the child in the room. During the 4 week period of the study, 60% of the providers reported that they screened for DV with 60% also reporting screening for community violence (CV). 93% of the time, providers asked these questions with the child in the room. Of these encounters, 78% were first visits with the family. Of the 22% that were repeat visits, 80% had known the family more than 6 months. 70% of the providers rated parent response as an 8 or higher on a 10 point scale (10 being most receptive). Controlling for child age and how long the provider knew the family, providers were more likely to screen when the child was older whether or not they had known the family previously.

CONCLUSIONS: Over 3 years after the statement was issued recommending universal screening for DV, providers continue to struggle with several barriers. In this pilot data of an urban practice, only 60% of visits were screened and these primarily were visits among older children. Interestingly, child presence in the room did not appear to be a barrier nor did parent response to the questions. Since the greatest risk for DV is often when children are less than 5 years of age, providers perhaps need to consider alternative methods to screen more effectively.

Maternal Screening for Domestic Violence during Pediatric Visits: Physicians' Practices and Perspectives

Linda Chamberlain, Ph.D. MPH

OBJECTIVES: Very little is known about how physicians respond to domestic violence in the pediatric setting. Our objectives were to examine physicians' maternal screening and intervention practices for domestic violence and to investigate perceived barriers to screening during child health care visits.

METHODS/DESIGN: A 17-question survey about current screening and intervention practices, training and perspectives on perceived screening barriers was conducted by mail.

SAMPLE STUDIED: All physicians practicing in Alaska who provided health care to children, age 18 or younger.

PRELIMINARY RESULTS: Surveys were completed by 393 (73%) of the 540 eligible physicians, including 208 family practitioners and general practitioners; 70 pediatricians and 48 emergency medicine physicians. Forty-nine percent of physicians had specific training on the effects of domestic violence on children. More than one-quarter (29%) estimated that 1 in 10 children in their practices had lived in a household with domestic violence. The majority of physicians screened often or always for domestic violence when the mother had signs of injury (88%) or when they suspected child abuse (95%). Routine screening was less common at initial pediatric visits (16%), well-child visits (11%), urgent care visits (31%), and when providing counseling/anticipatory guidance to mothers of newborn infants (16%). Commonly reported intervention strategies included providing information on victim services (87%), talking to the mother about safety concerns (81%), and talking to the child alone when appropriate (51%). The majority of physicians did not consider commonly perceived barriers such as inadequate training and concerns about child witness reporting requirements as major barriers to screening. Nearly all (98%) respondents agreed that witnessing domestic violence in an important health issue for children. Eighty-five percent of physicians agreed that they have a responsibility as part of their practice to screen mothers for domestic violence when providing health care to children. There was nearly total agreement (99.5%) among respondents that helping a mother who is being battered can make a difference in the lives of her children.

CONCLUSION: While physicians frequently screen mothers for domestic violence when there is evidence of maternal injury or suspected child abuse, opportunities to screen at other child health care visits are being missed. Most physicians agreed that domestic violence is an important children's health care issue that should be addressed in the pediatric setting. Many commonly perceived barriers to screening may not be predictive of physicians' maternal screening practices

ABSTRACTS OF SELECTED STUDIES ON PROVIDER AND PATIENT ATTITUDES

Mothers' and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department

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OBJECTIVE: To determine the attitudes, feelings and beliefs of mothers and pediatric emergency department health care providers toward routine intimate partner violence screening.

METHODS: This qualitative project employed focus groups of mothers who brought their children to a children's hospital emergency department for care and physicians and nurses who staffed the same department. We held six ethnically homogeneous mother groups: two Caucasian, two African-American, two Latina and four provider groups: two predominately female nurse groups and two physician groups: one male and one female. Professional moderators conducted the sessions using a semi-structured discussion guide. All groups were audio- and videotaped and tapes were reviewed for reoccurring themes.

RESULTS: A total of 59 mothers, 21 nurses and 17 physicians participated. Mothers identified intimate partner violence as a common problem in their communities and most remarked that routine screening for adult intimate partner violence is an appropriate activity for a pediatric emergency department. However, many expressed concern that willingness to disclose might be affected by a fear of being reported to child protective services. They stressed the importance of addressing the child's health problem first, that screening be done in an empathetic way and that immediate assistance be available if needed. Themes identified in the provider groups included concerns about time constraints, fear of offending and concerns that unless immediate intervention was available the victim could be placed in jeopardy. Many said they would feel obligated to notify child protective services upon disclosure of intimate partner violence.

CONCLUSIONS: Intimate partner violence screening protocols in the pediatric emergency department should take into consideration the beliefs and attitudes of both those doing the screening and those being screened. Those developing screening protocols for a pediatric emergency department should consider: 1) Those assigned to screen must demonstrate empathy, warmth and a helping attitude. 2) The importance of addressing the child's medical needs first and a screening process that is minimally disruptive to the emergency department. 3) A defined, organized approach to assessing danger to the child and how and when it is appropriate to notify CPS when a caregiver screens positive. 4) Resources must be available immediately to a victim who requests them.

Pediatrician's views on the treatment and preventions of violent injuries to children

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(PERIODIC SURVEY OF FELLOWS, American Academy of Pediatrics, Division of Health Policy Research from PEDIATRIC ACADEMIC SOCIETIES , May 2001)

OBJECTIVE: To assess the portion of pediatricians treating violent injuries and their perceived capacity to address violence in the office setting.

DESIGN: National random sample, mailed survey.

PARTICIPANTS: 574 U.S. members of the American Academy of Pediatrics who provide direct patient care.

RESULTS: Many pediatricians report they treated (in the past 12 months) injuries due to child abuse (61%), domestic violence (43%) or community violence (45%). Substantial numbers of respondents believe that pediatricians should address, in the community and in practice, violence against children. However, while pediatricians generally feel confident about their skills in treating child abuse, they are less likely to feel adequately prepared to treat children at risk for domestic violence.

Proportion of Pediatricians Indicating Agreement (%)

	CHILD ABUSE	DOMESTIC VIOL.	COMMUNITY VIOL.
Are confident in ability to identify children at risk for.....	63.7	35.1	32.6
Are confident in ability to manage cases of.....	62.6	43.1	46.4
Have received adequate training in the area of.....	48.5	19.7	15.8

CONCLUSION: Injury from violence is a problem confronting large numbers of pediatric practices. The identified gaps can help shape new training programs and interventions to help practitioners address this critical risk to children.

**ABSTRACTS OF SELECTED STUDIES ON PROVIDER AND
PATIENT ATTITUDES****Should Children Be in the Room When the Mother Is Screened for Partner Violence?**

Zink, Therese MD, MPH

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BACKGROUND: The goal of our study was to understand the important issues to consider when screening women for intimate partner violence in front of their children.

METHODS: Interviews and focus groups were conducted with experienced family physicians and pediatricians and family violence experts (child psychologists, social workers, and domestic violence agency directors). Session transcripts were coded and categorized.

RESULTS: Experts disagreed on the appropriateness of general screening for intimate partner violence in front of children older than 2 to 3 years. The majority thought that general questions were appropriate, if the in-depth questioning of the abused parent was done in private. Screening for child abuse when domestic violence is identified (and for domestic violence when child abuse is discovered) was recommended. Documentation about intimate partner violence in the child's medical chart raises questions about confidentiality, since the person committing the abuse may have access, if he or she is a legal guardian. Physicians need more education on the symptoms of children who are exposed to violence between adults.

CONCLUSIONS: More research is needed to understand appropriate questions and methods of screening for intimate partner violence in front of children. The tension is between practical recommendations for routine screening and preserving the safety of the parent and the children. Intimate partner violence screening by physicians is important. Interrupting the cycle of violence may give a child a better chance at maturing into a healthy adult.

Routinely assessing all parents and caretakers (both female and male) for IPV victimization raises additional policy and practice issues for providers and there is debate in the field about appropriate responses. Those opposed to these policies assert that the risks of alerting perpetrators to protocols identifying and assessing IPV outweigh the benefits. The concerns are that perpetrators may limit their partners' access to health care, may threaten victims who disclose, or may learn about safety planning materials which could ultimately undermine victim safety. Proponents of policies to assess men and women assert that, because men in same sex relationships experience DV at equal rates as women in heterosexual relationships, and some men in heterosexual couples experience abuse, it is critical to identify and assist as many victims as possible. Proponents also argue that determined perpetrators can already access safety planning materials and that assessing all patients offers unparalleled opportunities for abuse prevention. Still others maintain that because the majority of IPV victims are women, providers should begin by assessing all female patients and integrate inquiries for men as a second step, after gaining more experience in screening for victimization and developing policies to address some of the difficult practical concerns that are raised when assessing all parents and caretakers. Providers and health facilities should consider the dilemmas and recommendations listed below as they develop their unique protocols.

DILEMMAS:

It may be difficult to assess who the victim is. The accounts of one or both parties may lead to significant confusion about the incident.

- Male perpetrators often claim victimization to avoid consequences or as a tactic to further control victims.⁶⁹ Because the majority of IPV perpetrators are male, assessing men increases the likelihood of assessing perpetrators who may claim they are victims. There is not sufficient experience with female perpetrators of violence to know if this is also true in with female batterers.
- Victims may take the blame for the abuse because they have been told repeatedly by their partners that the problems in the relationship are their fault or because they used violence or other tactics in self-defense.
- Both parties may use physical force in an incident.

Whether the patient is viewed as a victim or perpetrator will influence the health care providers' response and may lead to inappropriate treatment.

- A victim who takes the blame for the abuse might prevent providers from offering them support and information about IPV
- Perpetrators who falsely claim they are victims might lead providers to sharing safety-planning strategies with perpetrators, inadvertently colluding with them and

DILEMMAS WHEN SCREENING ALL PATIENTS FOR VICTIMIZATION

undermining victims' safety planning efforts.

- What is recorded in the medical record by the health care provider can have legal ramifications for the victim particularly in divorce, custody or other legal cases.

While it is not the role of the health care provider to determine if the patient is telling the truth, the provider should take care in evaluating the patient's information and in identifying whether or not she/he is a victim of IPV, just as they take care in evaluating other patient's reports of health concerns. Understanding the definition of IPV and being skilled in behavioral inquiry assists providers in making accurate identification of victimization.

RECOMMENDATIONS FOR POLICY IMPLEMENTATION:

The Family Violence Prevention Fund recommends that providers implement policies to assess all male and female parents for victimization only after taking precautions to protect victims whose perpetrators claim to be abused. Training providers on perpetrator dynamics and responses to gay, lesbian and straight victims is critical for all IPV programs, including those that target women only. When implementing a policy to assess all patients, first:

- Contact local DV programs (and batterer's intervention programs that they recommend) and explain that you are considering a plan to assess all patients for victimization. This will prepare them for referrals and will give them an opportunity to inform the development of your protocol.
- Inform all patients that you assess men and women for victimization and make safety planning materials available to both, so that victims who are concerned about perpetrators sabotaging their safety plan efforts can plan accordingly. Make information available about advocates on-site or in the community that can help the victim with these plans, regardless of whether the victim discloses abuse.
- Understand and conduct training on the IPV prevalence studies. Emerging research demonstrates that IPV occurs at similar rates in LGTB adolescent and adult populations⁷⁰ with higher rates in male same sex relationships than female.⁷¹ Most studies indicate that about 5-10%⁷² of all victims are men (an unknown percentage of whom are gay). Because of this, you should expect to see a fairly small percentage of heterosexual male victims in your practice – but should be prepared to respond to all victims.
- Understand and conduct training on the dynamics of IPV: IPV serves the purpose of establishing power and control through various tactics. This establishment of an abusive imbalance of power and control is fundamentally what distinguishes IPV perpetrators from victims. There are multiple indicators of abusive behavior (denying access to friends/family, intimidation, etc) not just physical abuse, and victims' lives generally become more limited and controlled.

Recommendations for Clinical Practice:

- Do not blame patients or force them to prove their “victimhood.”
- Assessments should be handled sensitively and without bias.
- Even if you are unsure if your patient is a victim, document that you inquired, the patients’ response, and note the details of the abuse and health consequences. Offer the patient educational materials about IPV and referrals.

**HEALTH CARE PROVIDER RESPONSE TO GAY, LESBIAN AND
HETEROSEXUAL MALE VICTIMS****Lesbian, Gay Bisexual and Transgendered victims of abuse:**

Emerging research demonstrates that IPV occurs at similar rates in LGTB adolescent and adult populations as in heterosexual populations^{vii} with higher rates in male same sex relationships than female^{viii}. However, it is important to realize that the statistics may be low because those in a same sex relationships may not be comfortable stating their sexual preference. A policy to assess all patients should include specific recommendations for responding to lesbian, gay bisexual, and transgendered (LGBT) victims. Specialized services may be limited in your area so, when unavailable, refer patients to national organizations or the National Domestic Violence Hotline.

**PRIOR TO IMPLEMENTING A PROGRAM TO ASSESS ALL PATIENTS,
IT IS IMPORTANT TO:**

- Beware of your own bias and/or homophobia
- Call your local IPV program and determine what resources are available for lesbian, gay, bisexual and transgendered clients
- Call any local programs for LGBT communities and determine what resources they offer for victims of IPV
- In addition (or if no programs exist in your area), provide LGBT victims with the national DV hotline number for more information or materials.
- Have educational and safety materials available that are appropriate for LGBT victims (for materials, go to the FVPF website www.endabuse.org/health)
- Refer gay male victims of IPV to Community United Against Violence (San Francisco), Gay Men’s Domestic Violence Project (Boston) or other organizations for information and support (See [Appendix XII](#)).

^{vii} Bureau of Justice Statistics Special Report, Intimate Partner Violence and Age of Victim, 1993-99, United States Department of Justice, October 2001.

^{viii} Morrow, Jeanie (April 1994). Identifying and treating battered lesbians. San Francisco Medicine/Letellier, Patrick (April 1994). Identifying and treating battered gay men in a medical setting. San Francisco Medicine. Goodenow, Carol. (1998). 1997 Massachusetts Youth Risk Behavior Survey. Malden, MA: Massachusetts Department of Education. Renzetti, C. Violent Betrayal: Partner Abuse in Lesbian Relationships. Sage Publications. 1992, 18.

DILEMMAS WHEN SCREENING ALL PATIENTS FOR VICTIMIZATION

- Refer lesbian victims to the Network for Battered Lesbians and Bisexual Women (Boston), Anti-Violence Project and/or other local organizations for information and support (See [Appendix XII](#)).

Heterosexual Male Victims

There is limited research on male victims of IPV in heterosexual relationships. Most major studies on male victimization do not clarify if male victims are in gay or heterosexual relationships. However, a policy to assess all patients should include specific recommendations for responding to heterosexual male victims. Services for male victims may be very limited in your area, so be prepared to refer patients to national or international programs and the National Domestic Violence Hotline. Prior to implementing a program it is important to:

- Be aware of your own bias regarding heterosexual male victims of abuse.
- Call your local DV program and learn about their policy on heterosexual male victims
- Refer patients to any local programs available, the National Domestic Violence Hotline or other resources including: www.vix.com/menmag/batamen.htm.
- Have gender neutral educational materials available about abuse or refer patients to the websites listed in Appendix VIII for more educational materials for battered men.

APPENDIX V

INDICATORS OF ABUSE

Many victims of IPV will talk about their experiences if asked to do so in a sensitive and empathetic way. However, other victims may be reluctant to disclose. They may be embarrassed, ashamed, or afraid that if they tell anyone they may be at risk for more severe abuse. There may be financial issues and/or concerns about immigration status, or they may lack trust in people because trust was violated in their intimate relationship. Below are some of the reasons one might suspect IPV and might ask follow-up questions.

For Adults

- Failure to keep medical appointments, or comply with medical protocols
- Secrecy or obvious discomfort when interviewed about relationship
- The presence of a partner who comes into the examining room with the patient and controls or dominates the interview, is overly solicitous and will not leave the patient alone with her/his provider
- The patient returns repeatedly with vague complaints
- A patient who presents with health problems associated with abuse
- Unexplained injuries or injuries inconsistent with the history given
- Somatic complaints
- Delay between an injury and seeking medical treatment
- Injury to the head, neck, chest, breasts, abdomen, or genitals
- Bilateral or multiple injuries, especially if in different stages of healing
- Physical injury during pregnancy, especially on the breasts and abdomen
- Chronic pain without apparent etiology
- An unusually high number of visits to health care providers
- High number of STI's, pregnancies, miscarriages, and abortions repeat vaginal and urinary tract infections.

(See [Appendix VI](#) for others)

For Children and Adolescents

All of the applicable health problems listed above as well as:

- Age inappropriate injuries, burns, injuries to the genital areas
- Developmental & behavioral problems
- Psychological distress such as depression, suicidal ideation or attempts, attachment problems, anxiety, sleeping and/or eating disorders, panic attacks, symptoms of PTSD, and substance use/abuse problems

If you see any of these indicators, or if you suspect abuse, yet the patient remains reluctant to discuss or disclose, provide the patient with a hotline number and other resources in case they need them in the future. Let the patient know that should s/he ever need it, you are available as a resource. Bring the issue up during the next visit. The goal is not to force the victim to admit to a problem, but to try and anticipate his/her concerns about disclosure and to let her/him know that you can be a resource should this ever be a problem. Encourage her/him to return and schedule a follow-up visit within a short time.

Assessment time will vary with the severity of the abuse, the readiness of the domestic violence victims to discuss it and time available with the provider. Unless the patient is in crisis, the assessment can be conducted over time. Expanded health assessments can include assessment of associated health problems and/or expanded assessment of the abuse. Provide the victim an opportunity to talk with someone else from the community who is trained on IPV if they are uncomfortable speaking with the provider. These assessments can occur in primary care, ob/gyn, mental health settings or in any setting where a trained health care provider, social worker, or advocate can conduct the assessment in private.

Expanded Assessment of Related Health Problems

A positive identification for lifetime or current exposure to IPV should trigger expanded health assessment (either by the provider who identified the patient or a specialist to whom the patient is referred). Consider and address the following areas:

- Health issues related to IPV: injuries, chronic pain (neck, back, pelvic migraines) peptic ulcers, irritable bowel syndrome, STI's (including HIV/AIDS), insomnia, vaginal and urinary tract infections, multiple pregnancies, miscarriages and abortions
- Substance abuse by the patient: (such as tobacco, alcohol, or others)
- Ability to manage other illnesses (such as hypertension, diabetes, asthma, HIV/AIDS)
- Mental health problems: depression, PTSD, anxiety, stress, suicide risk
- If pregnant: pregnancy complications such as miscarriages, low weight gain, anemia, infections, first and second trimester bleeding, and low birth weight babies
- If forced sex occurred: assess for gynecological problems including STI's, anal/vaginal tearing, sexual dysfunction, and ask about safe sex practices and family planning
- If choking/head injury and the patient was unconscious: conduct a neurological exam
- Particularly for teens: Assessment of exposure to dating violence or forced use of drugs such as Rohypnol (RH) "rophies", GHB (Gama Hydroxybutyric acid) etc.
- Preventive health behaviors: encourage and help facilitate preventive health behaviors: such as regular mammography, pap smears, early pre-natal care, etc.

Expanded assessment of the history and extent of the abuse

- Discussion of childhood history of abuse in family of origin
- Discussion about whether abuser is limiting access to friends, family or co-workers
- Assessment of supports in place including friends, family, community, church, etc.
- Discussion of separation, divorce, or seeking shelter
- Assessment of the victim's community's response to abuse, marriage, divorce, health and healing, and find out how the victim responds to cultural expectations
- Assessment of how the abuse has affected the children (physically, emotionally, etc.)
- Assessment of how abuse affected her/his life, work, school, and relationships
- Assessment of whether threats have been made, or violence has been carried out against the family pet(s).

Questions about the batterer

- Does the batterer use illicit drugs and/or alcohol? How much? How often?
- Does batterer increase his/her violent behavior when under the influence?
- Does the batterer have any mental health problems?
- Is the batterer taking medications, if so what?
- Does the batterer have a criminal record?

Suicide and Homicide Assessment Questions

To assess the risk for victim's homicidal and suicidal ideation follow:

RISK OF SUICIDE BY THE VICTIM

- Have you ever felt so bad that you didn't want to go on living?
- Have you ever attempted or thought about suicide in the past?
- Are you thinking about killing yourself? Do you have a plan?
- Do you feel this way now?

RISK OF HOMICIDAL THOUGHT BY THE VICTIM

- How do you perceive your options for safety?
- Have you ever attempted or thought about homicide in the past?
- Have you thought about how you would do it? Do you have a homicide plan?
- Assess if the patient is expressing anger or a genuine intent to kill.

If there is significant risk of suicide or homicidal ideation the patient should be kept safe until emergency psychiatric evaluation can be obtained.

APPENDIX VII | SAFETY PLAN AND INSTRUCTIONS

SAFETY PLAN FOR ADULT VICTIMS LIVING WITH THEIR ABUSERS

STEP 1:

Safety during a violent incident. I can use some or all of the following strategies:

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

STEP 2:

Safety when preparing to leave. I can use some or all of the following safety strategies:

- A. I will keep copies important documents, keys, clothes and money at _____.
- B. I will open a savings account by _____, to increase my independence.
- C. Other things I can do to increase my independence include: _____.
- D. I can keep change for my phone calls on me at all times. I understand that if I use my telephone credit card, the telephone bill will show my partner those numbers that I called after I left.
- E. I will check with _____ to see who would be able to let me stay with them or lend me some money.
- F. If I plan to leave, I won't tell my abuser in advance face-to-face, but I will call or leave a note from a safe place.

STEP 3:

Safety in my own residence. Safety measures I can use include:

- A. I can change the locks on my doors and windows as soon as possible.
- B. I can replace wooden doors with steel/metal doors.
- C. I can install additional locks, window bars, poles to wedge against doors, and electronic systems etc.
- D. I can install motion lights outside.
- E. I will teach my children how to make a collect call to _____ if my partner takes the children.
- F. I will tell people who take care of my children that my partner is not permitted to pick up my children.
- G. I can inform _____ (neighbor) that my partner no longer resides with me and they should call the police if he is observed near my residence.

STEP 4:

Safety with a protection order. The following are steps that help the enforcement of my protection order.

- A. Always carry a certified copy with me and keep a photocopy.
- B. I will give my protection order to police departments in the community where I work and live.
- C. I can get my protection order to specify and describe all guns my partner may own and authorize a search for removal.

SAFETY INSTRUCTIONS

If you are currently being abused...

Are you here as a result of someone hitting or threatening you—a spouse, boyfriend, lover, relative or someone you know? Have you been sexually abused by someone you know? As you read this, you may be feeling confused, frightened, sad, angry or ashamed. **You are not alone!** Unfortunately, what happened to you is very common. Domestic violence does not go away on its own. It tends to get worse and more frequent with time. There are people who can help you. If you want to begin talking about the problem, need a safe place to stay or want legal advice—call one of the agencies listed on the back of this instruction sheet today.

While still at the clinic...

- Think about whether it is safe to return home. If not, call one of the resources listed on the back of this instruction sheet or stay with a friend or relative.
- You have received instructions on caring for your injuries and taking medications prescribed. Remember, if you have received tranquilizers they may help you rest but they won't solve the problem of battering.
- Battering is a crime and you have the right to legal intervention. You should consider calling the police for assistance (see information on back of this sheet). You may also obtain a court order prohibiting your partner from contacting you in any way (including in person or by phone). Contact a local DV program or an attorney for more information.
- Ask the doctor or nurse to take photos of your injuries to become part of your medical record.

When you get home...

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

Most states have enacted mandatory reporting laws, which require the reporting of specified injuries and wounds, suspected abuse or domestic violence for individuals being treated by a health care professional, or who come before the health care facility.^{ix} Mandatory reporting laws are distinct from elder abuse or vulnerable adult abuse reporting laws,^x in that the individuals to be protected are not limited to a specific class, but pertain to all individuals^{xi} whom the health care professional provides treatment or medical care to, or who come before the health care facility.

The elements that trigger these reports vary, from specific injuries such as gunshot and stab wounds to more broadly described “wounds indicating violence.” With few exceptions, these reporting laws were not passed with domestic violence in mind. However, as the health care community became more aware of domestic violence, many asked how mandatory reporting laws should be applied in cases of domestic violence.

THE LAWS VARY FROM STATE TO STATE, BUT GENERALLY FALL INTO FOUR CATEGORIES:

1. States that require reporting of injuries caused by weapons;
2. States that mandate reporting for injuries caused in violation of criminal laws, as a result of violence, or through non-accidental means;
3. States that specifically address reporting in domestic violence cases;
4. States that have no general mandatory reporting laws.

In a majority of states, existing laws would most likely not apply in those cases when a child health provider is treating a child and screening the child’s parent for domestic violence. In the pediatric visit where the parent is not the patient and not seeking treatment, the clinician is generally under no legal obligation to report because the parent does not fall within the purview of the reporting law. However, for family physician visits, the case may be more complicated. The parent may be a patient of the provider, even though she is not seeking treatment during the particular visit. Additionally, if the child is also presenting with injuries, child abuse reporting laws may require the physician to report.

(See page 13: When does child exposure to intimate partner violence become child abuse?)

^{ix} Different states have different reporting requirements of various health care professionals, and various health care facilities. Because the differences vary widely, we do not include them in this paper. Please be sure to consult your state law and/or local expert for further information on reporting requirements in your state. A list of the specific codes can be found in Appendix VII.

^x Elder abuse or vulnerable adult abuse reporting laws seek to protect a specific class of individuals being treated, i.e. the elderly, or mentally or physically incapacitated individuals.

^{xi} Please note that all states with general mandatory reporting laws except for California, Georgia, Kentucky, and Wisconsin use the term “person(s)” in the text of the law. Georgia, California, and Wisconsin use the term “patient.” Kentucky’s general mandatory reporting law is an exception, as it uses the term “adult,” rather than “person(s)” or “patient.”

There has been much debate about the benefit of mandatory reporting of domestic violence by health care providers. Most advocates and providers support state laws that require reports to law enforcement only in the case of gunshot or other potentially life-threatening assault. However, several laws require reports of any domestic violence assault, regardless of severity or victim preference. The intended goals of these laws include assisting officers in solving crimes, enhancing patient safety, holding batterers accountable, and improving domestic violence data collection and documentation. Opponents argue that there are serious risks created by these laws, including unintentionally endangering victims, deterring victims who do not want or need police involvement from seeking medical care, and reducing victim autonomy, control, and ability to plan for safety for herself and her children.

Providers should know their state's domestic violence reporting law, including who is required to report, and under what conditions. ([Appendix IX](#) contains a chart listing state codes). In order to maximize patient input regarding law enforcement action, providers should also familiarize themselves with how their local law enforcement agency responds to such reports. Becoming familiar with such procedures will also allow the provider to better assist the patient in safety planning, and in knowing what to expect. Additionally, recent federal privacy regulations require providers to inform patients of health information use and disclosure practices in general, and whenever a specific report has been made. Health care facilities should also ensure that their domestic violence protocols and training materials address their state reporting laws and federal regulations.

How do mandatory reporting laws apply to the pediatric and family practice setting?

In the vast majority of states, neither statutory nor case law specifies when or if a health care provider must report a parent's injuries if they are observed or discovered during a health care visit with that parent's child. Therefore, under a strict reading of most laws, if a child's health care provider is not providing treatment or medical care to the abused parent during the child's visit, the health care provider would not be required to make a report. In family practice situations where the child and parent are the provider's patients, and the current visit appointment is for the child, the same reasoning could be applied, although it is less clear-cut. That is, the health care provider would not be required to report since he or she is not treating the parent for the specified injuries during the appointment. This issue merits further discussion among health care providers, advocates, licensing authorities, and other professionals, as it is uncharted territory.

INTIMATE PARTNER VIOLENCE VICTIMIZATION REPORTING REQUIREMENTS

Georgia, Kentucky, and Ohio^{xii} require reports when a provider believes that an individual has suffered certain injuries, or observes such injuries, but is not necessarily providing treatment or medical care. Since these laws do not specifically require that the individual must be seeking treatment or medical care in order to trigger the reporting requirement, a parent with visible injuries accompanying a child to a child health appointment may fall within the class of individuals the statutes apply to, and reporting would be required.

There are also two states that do not fit either category of laws: Michigan and Pennsylvania. In both of these states, the laws do not mention whether the physician must be providing treatment or medical care in order to trigger the reporting requirement. Additionally, the laws do not contain any language regarding a physician's belief or observance of the specified injuries. Thus, practitioners in these states should consult a local expert regarding further interpretation of these laws.

^{xii} The Family Violence Prevention Fund opposes laws that specifically mandate health care providers to report all injuries, including those that may not be serious, to law enforcement or to any other authorities. See the paper entitled Mandatory Reporting of Domestic Violence by Health Care Providers: A Policy Paper (November, 1997), prepared by Ariella Hyman for the Family Violence Prevention Fund (FVPF), published by the FVPF: (415) 252-8900.

APPENDIX IX

STATE CODES ON INTIMATE PARTNER VIOLENCE VICTIMIZATION REPORTING REQUIREMENTS FOR HEALTH CARE PROVIDERS^{xiii} Current through March 8, 2002

Code Number	States with General Mandatory Reporting Laws	IF ANY OF THE FOLLOWING TYPES OF INJURIES ARE PRESENT, PRACTITIONERS IN THE STATE MUST MAKE A REPORT:										Treatment of Specified Injuries Requires Practitioners to Report ^{xiv}					
		Injuries Resulting from Domestic Violence or Abuse	Injuries Resulting from Criminal Activity	Injuries Resulting from General Violence	Intentionally Inflicted Injuries	Injuries Inflicted by Gun or Firearm	Injuries Inflicted by Knife or Other Sharp Object	Burn Injuries	Injuries Likely to Cause Death								
AL																	
AK	Alaska Stat. §08.64.369																
AZ	A.R.S. §13-3806																
AR	A.C.A. §12-12-602																
CA	Cal. Pen. Code §11160																
CO	C.R.S. §12-36-135																
CT	Conn. Gen. Stat §19a-490f																
DC	D.C. Code §7-2601																
DE	24 Del. C. §1762																
FL	Fla. Stat. §790.24																
GA	O.C.G.A. §31-7-9																
HA	HRS §453-14																
ID	Idaho Code §39-1390																
IL	20 ILCS 2630/3.2																
IN	Ind. Code Ann. §35-47-7-1																
IA	Iowa Code §147.111																
KS	K.S.A. §21 – 4213																
KY	KRS §209.030																
LA	La. R.S. §14:403.4 to 3.5																
ME	17-A M.R.S. §512																
MD	Md. Ann. Code art. 27, §336A																
MA	Ma. Ann. Laws ch. 112, §12A																
MI	MCLS §750.411																
MIN	Minn. Stat. §626.52																
MS	Miss. Code Ann. §45-9-31																
MO	§578.350 R.S.Mo.																
MT	Mont. Code Anno. §37-2-302																

● ● ● ● Identifying and Responding to Domestic Violence:
 Consensus Recommendations for Child and Adolescent Health

^{xiii} This document is intended to provide a cursory overview of mandatory reporting laws. Please be sure to consult the complete set of mandatory reporting laws in your state for further information. If you note any changes or errors on this document, please contact the FVPF at 415-252-8900.

^{xiv} Under a strict reading of these laws, practitioners must be providing treatment or medical care to the person with specified injuries in order to trigger the reporting requirement. Therefore, in a pediatric or family practice setting, if an attending parent with injuries is bringing her child in for a health care appointment, the attending parent is not actually receiving treatment or medical care from the practitioner, and thus the practitioner in the state would not be required to report. Further discussion is merited, given the lack of statutory or case law that have been developed around this area.

^{xv} The law provides an exception to reporting if the patient is over the age of 18, did not suffer a gunshot wound, and does not consent to reporting.

^{xvi} Report is made for medical data collection purposes only, and does not contain identification information.
 Prepared by Josephine Yeh, J.D., for the Family Violence Prevention Fund

APPENDIX IX

STATE CODES ON INTIMATE PARTNER VIOLENCE VICTIMIZATION REPORTING REQUIREMENTS FOR HEALTH CARE PROVIDERS^{xiii} *Current through March 8, 2002*

Code Number	States with General Mandatory Reporting Laws	IF ANY OF THE FOLLOWING TYPES OF INJURIES ARE PRESENT, PRACTITIONERS IN THE STATE MUST MAKE A REPORT:										Treatment of Specified Injuries Requires Practitioners to Report ^{xiv}			
		Injuries Resulting from Domestic Violence or Abuse	Injuries Resulting from Criminal Activity	Injuries Resulting from General Violence	Intentionally Inflicted Injuries	Injuries Inflicted by Gun or Firearm	Injuries Inflicted by Knife or Other Sharp Object	Burn Injuries	Injuries Likely to Cause Death.						
NE	R.R.S. Neb. §28-902		•	•											•
NV	Nev. Rev. Stat. Ann. §629.041, §629.045				•										•
NH	RSA §631:6	• ^{xv}	•												•
NJ	N.J. Stat. §2C:58-8														•
NM															
NY	NY CLS Penal §265.25 to .26														•
NC	N.C. Gen. Stat. §90-21.20														•
ND	N.D. Cent. Code, §43-17-41														•
OH	ORC Ann. 2921.22														•
OK	10 Okl. St. §7104														•
OR	ORS §146.750														•
PA	18 P.A.C.S. §5106														•
RI	R.I. Gen. Laws §11-47-48, §12-29-9														•
SC	S.C. Code Ann. §16-3-1072														•
SD	S.D. Codified Laws §23-13-10														•
TN	Tenn. Code Ann. §38-1-101														•
TX	Texas Health & Safety Code §161.041														•
UT	Utah Code Ann. §26-23a-2														•
VT	13 V.S.A. §4012														•
VA	Va. Code Ann. §54.1-2967														•
WA															
WV	W. Va. Code §61-2-27														•
WI	Wis. Stat. §146.995														•
WY															

● ● ● ● Family Violence Prevention Fund

^{xiii} This document is intended to provide a cursory overview of mandatory reporting laws. Please be sure to consult the complete set of mandatory reporting laws in your state for further information. If you note any changes or errors on this document, please contact the FVPF at 415-252-8900.

^{xiv} Under a strict reading of these laws, practitioners must be providing treatment or medical care to the person with specified injuries in order to trigger the reporting requirement. Therefore, in a pediatric or family practice setting, if an attending parent with injuries is bringing her child in for a health care appointment, the attending parent is not actually receiving treatment or medical care from the practitioner, and thus the practitioner in the state would not be required to report. Further discussion is merited, given the lack of statutory or case law that have been developed around this area.

^{xv} The law provides an exception to reporting if the patient is over the age of 18, did not suffer a gunshot wound, and does not consent to reporting.

^{xvi} Report is made for medical data collection purposes only, and does not contain identification information.

Prepared by Josephine Yeh, J.D., for the Family Violence Prevention Fund

APPENDIX X

LEGISLATION REGARDING CHILD WITNESSES TO DOMESTIC VIOLENCE

The following introduction was taken in part from Child Abuse and Neglect State Statutes Series Compendium of Laws:

CHILD WITNESS TO DOMESTIC VIOLENCE, 2002

Approximately 20 States and Puerto Rico have enacted legislation that specifically includes children who witness acts of domestic violence as a class of persons in need of legal protection. The majority of these States provide enhanced criminal penalties for the commission of domestic violence offenses in the presence of a child. Other States mandate counseling for child witnesses, allow courts to find a child witness in need of aide, require supervised visitation for such behavior, presume that a child witness may have sustained physical injury for purposes of restitution and consider such conduct an aggravating factor for courts to consider in sentencing. Although there is great variation across States as to the particular requirements imposed by this legislation, these statutes share common elements. The Statutes generally define which particular children are protected under the legislation, the meaning of “in the presence of a child,” those actions that constitute domestic violence and whether one witnessing incident is sufficient or exposure to repeated incidents is required.

STATE BY STATE CIVIL AND CRIMINAL LEGISLATIVE REFERENCES

The following list was compiled and updated May, 2004 by the National Clearinghouse on Child Abuse and Neglect Information 330 C Street, SW, Washington, DC 20447 Website: <http://nccanch.acf.hhs.gov/general/legal/statutes/index.cfm>

Alabama	Not addressed in statutes reviewed
Alaska	Alaska Stat. § 47.10.011 (Lexis, WESTLAW through 2000 3rd Spec. Sess.) Alaska Stat. § 12.55.155 (LexisNexis through 2003 Sess.)
Arizona	Ariz. Rev. Stat. Ann. § 13-702 (LexisNexis through Ariz. 2004 Legis. Serv., Ch. 174)
Arkansas	Ark. Code Ann. § 5-4-701(2) (WESTLAW through 2001 Reg. Sess.) Ark. Code Ann. § 5-4-702 (WESTLAW through 2001 Reg. Sess.)
California	Cal. Penal Code § 1170.76 (West, WESTLAW through 1999-2000 Reg. Sess. & 1st Ex. Sess. & 11/7/00)
Colorado	Not addressed in statutes reviewed

**LEGISLATION REGARDING CHILD WITNESSES
TO DOMESTIC VIOLENCE**

Connecticut	Not addressed in statutes reviewed
Delaware	Del. Code Ann. tit. 11, § 1102 (WESTLAW through 2001 Reg. Sess.)
District of Columbia	Not addressed in statutes reviewed
Florida	Fla. Stat. Ann. § 921.0024 (LexisNexis through 2003 Sess.)
Georgia	Ga. Code Ann. § 16-5-70 (LexisNexis through Ga. 2004 Legis. Serv., Act 439)
Hawaii	Haw. Rev. Stat. Ann. § 706-606.4 (LexisNexis through 2003 Reg. & Spec. Sess.)
Idaho	Idaho Code § 18-918 (LexisNexis through Idaho 2004 Legis. Serv., Ch. 118)
Illinois	720 Ill. Comp. Stat. Ann. 5/12-3.2 (LexisNexis through 3/20/04)
Indiana	Ind. Code Ann. § 31-14-14-5 (LexisNexis through 2004 Spec. Sess.)
Iowa	Not addressed in statutes reviewed
Kansas	Not addressed in statutes reviewed
Kentucky	Not addressed in statutes reviewed
Louisiana	Not addressed in statutes reviewed
Maine	Not addressed in statutes reviewed
Maryland	Not addressed in statutes reviewed
Massachusetts	Not addressed in statutes reviewed
Michigan	Not addressed in statutes reviewed
Minnesota	Minn. Stat. Ann. § 626.5552 (West, WESTLAW through 2000 Reg. Sess.)

Appendix X

LEGISLATION REGARDING CHILD WITNESSES
TO DOMESTIC VIOLENCE

Mississippi	Miss. Code Ann. § 97-3-7(3)-(4) (LexisNexis through Miss. 2004 Legis. Serv., H.B. 816)
Missouri	Not addressed in statutes reviewed
Montana	Mont. Code Ann. § 45-5-206(1), (2), (3)(a) (LexisNexis through 2003 Reg. Sess.)
Nebraska	Not addressed in statutes reviewed
Nevada	Nev. Rev. Stat. Ann. § 200.485 (LexisNexis through End of 2003 Sess.)
New Hampshire	Not addressed in statutes reviewed
New Jersey	Not addressed in statutes reviewed
New Mexico	Not addressed in statutes reviewed
New York	Not addressed in statutes reviewed
North Carolina	N.C. Gen. Stat. § 14-33 (LexisNexis through 2003 Reg. & 2nd Ex. Sess.)
North Dakota	Not addressed in statutes reviewed
Ohio	Ohio Rev. Code Ann. § 2929.01(MM), (NN) (LexisNexis through 3/29/04) Ohio Rev. Code Ann. § 2929.12 (LexisNexis through 3/29/04) Ohio Rev. Code Ann. § 2929.17 (LexisNexis through 3/29/04)
Oklahoma	Okla. Stat. Ann. tit. 21, § 644 (West, WESTLAW through 2000 1st Ex. Sess.)
Oregon	Or. Rev. Stat. § 163.160 (WESTLAW through 1999 Reg. Sess.)
Pennsylvania	Not addressed in statutes reviewed
Rhode Island	Not addressed in statutes reviewed
South Carolina	Not addressed in statutes reviewed
South Dakota	Not addressed in statutes reviewed
Tennessee	Not addressed in statutes reviewed

**LEGISLATION REGARDING CHILD WITNESSES
TO DOMESTIC VIOLENCE**

Texas	Not addressed in statutes reviewed
Utah	Utah Code § 76-5-109.1(1), (2) (LexisNexis through 2003 Sp. Sess.)
Vermont	Not addressed in statutes reviewed
Virginia	Not addressed in statutes reviewed
Washington	Wash. Rev. Code Ann. § 9.94A.535 (LexisNexis through 3/18/04)
West Virginia	Not addressed in statutes reviewed
Wisconsin	Not addressed in statutes reviewed
Wyoming	Not addressed in statutes reviewed

Please be advised that this list contains dated information and is intended for educational and research purposes only. It is the responsibility of each party receiving this information to verify the laws for accuracy and currency of legislation.

APPENDIX XI

CHILD ABUSE AND NEGLECT REPORTING LAWS

WHO MUST REPORT	Mental Health			Social Standard for Nurse Worker		Reporting?	Report What?	Report to Whom?	Report How?
	Dentist	Doctor	Health	Nurse	Worker				
Alabama Ala. Code § 26-14-3 (2000)	Y	Y	Y	Y	Y	Knowledge or suspicion	Child Abuse or Neglect	Law enforcement Department of Human resources	Oral and written
Alaska Alaska Stat. § 47.17.020 (Michie 2000)	Y	Y	Y	Y	Y	Reasonable cause to suspect	Harm as a result of child abuse or neglect	Department of Health and Social Services	Not Specified
Arizona Ariz. Rev. Stat. § 13-3620 (2000)	Y	Y	Y	Y	Y	Resonable grounds to believe	Injury, commercial sexual exploitation of a minor, sexual exploitation of a minor, incest, child prostitution, death, abuse, or nonaccidental physical neglect	Law enforcement or Child Protective Services	Oral and written
Arkansas Ark. Code Ann. § 12-12-507 (Michie 1999)	Y	Y	Y	Y	Y	Reasonable cause to suspect	Child maltreatment or conditions that will result in child maltreatment	Child abuse hotline	Oral
California Cal. [Penal] Code § 11166 (West 2000)	Y	Y	Y	Y	Y	Knowledge or reasonable suspicion	Child abuse	Child protective agency	Oral and written
Colorado Colo. Rev. Stat. § 19-3-304 (1999)	Y	Y	Y	Y	Y	Reasonable cause to know or suspect	Child abuse or neglect	County Department of Human Services or law enforcement	Not Specified
Connecticut Conn. Gen. Stat. §§ 17a-101 to - 101b (1999)	Y	Y	Y	Y	Y	Reasonable cause to suspect or believe	Abuse, nonaccidental physical injury, or neglect	Commissioner of Children and families or law enforcement agency	Oral

● ● ● ● Identifying and Responding to Domestic Violence:
Consensus Recommendations for Child and Adolescent Health

APPENDIX XI

CHILD ABUSE AND NEGLECT REPORTING LAWS

WHO MUST REPORT	Mental Health			Social Standard for Nurse Worker		Reporting?	Report What?	Report to Whom?	Report How?
	Dentist	Doctor	Health	Nurse	Worker				
Delaware Del. Code Ann. Tit. 16, §§ 903-904 (1999)	Y	Y	Y	Y	Y	Knowledge or good faith suspicion	Child abuse or neglect	Division of Child Protective Services of Department of Services for Children Youth, and Their Families	Oral and written (if requested)
District of Columbia D.C. Code Ann. § 2-1352 (1999)	Y	Y	Y	Y	Y	Knowledge or reasonable cause to suspect	Immediate danger of physical or mental avuse or neglect	Law enforcement or Child Protective Services	Not Specified
Florida Fla. Stat. ch. 39.201 (1999)	Y	Y	Y	Y	Y	Knowledge or reasonable cause to suspect	Abuse, abandonment, or neglect	Department of Children and Family Services	Oral
Georgia Ga. Code Ann. § 19-7-5 (1999)	Y	Y	Y	Y	Y	Reasonable cause	Abuse	Child welfare agency designated by the Department of Human Resources or law enforcement Commissioner of Children and families or law enforcement agency	Oral and written (if requested)
Hawaii Haw. Rev. Stat. § 350-1.1 (1999)	Y	Y	Y	Y	Y	Reason to believe	Child abuse or neglect or substantial risk of above in reasonably foreseeable future	Department of Human Services and law enforcement	Oral and written
Idaho Idaho Code § 16-1619 (1999)	Y	Y	Y	Y	Y	Reason to believe	Abuse, abandonment, or neglect or conditions that would reasonably result in any of above	Law enforcement or Department of Health and Welfare	Not specified

APPENDIX XI

CHILD ABUSE AND NEGLECT REPORTING LAWS

WHO MUST REPORT	Mental Health			Social Standard for Nurse Worker		Reporting?	Report What?	Report to Whom?	Report How?
	Dentist	Doctor	Health Worker	Nurse	Worker				
Illinois 325 Ill. Comp. Stat. 5/4 (West 2000)	Y	Y	Y	Y	Y	Reasonable cause to believe	Abuse or neglect	Department of Children and Family Services	Not specified
Indiana Ind. Code §§ 31-33-5-1 to -2, -4 (1999)	Y	Y	Y	Y	Y	Reason to believe	Abuse or neglect	Child protective services or law enforcement	Oral
Iowa Iowa Code § 232.69 (1999)	Y	Y	Y	Y	Y	Reasonable belief	Child abuse	Department of Human Services	Oral and written
Kansas Kan. Stat. Ann. § 38-1522 (1999)	Y	Y	Y	Y	Y	Reason to suspect	Injury resulting from physical, mental, or emotional, neglect, or sexual abuse	Department of Social and Rehabilitation Services	Oral and written (if requested)
Kentucky Ky. Rev. Stat. Ann. § 620.030 (Michie 1998)	Y	Y	Y	Y	Y	Knows or has reasonable cause to believe	Dependency, neglect or abuse	Law enforcement, Cabinet for Families and Children, or county attorney	Oral or written
Louisiana La. Civ. Stat. Ann. Art. 603, 609-610 (West 2000)	Y	Y	Y	Y	Y	Cause to believe	Endangerment of child's physical or mental health or welfare due to neglect or abuse	Child Protection Unit of Department of Social Services	Written
Maine Me. Rev. Stat. Ann. Tit. 22 § 4011 (West 1999)	Y	Y	Y	Y	Y	Knowledge or reasonable cause to suspect	Child likely to be or has been abused or neglected	Department of Human Services	Not Specified
Maryland Md. Code. Ann., [Fam. Law] § 5-704 (1999)	Y	Y	Y	Y	Y	Reason to believe	Abuse or neglect	Department of Social Services or law enforcement	Oral and written

APPENDIX XI

CHILD ABUSE AND NEGLECT REPORTING LAWS

WHO MUST REPORT	Mental Health			Social Standard for Nurse Worker		Reporting?	Report What?	Report to Whom?	Report How?
	Dentist	Doctor	Health	Nurse	Worker				
Massachusetts Mass. Gen. Laws ch. 119, § 51A (2000)	Y	Y	Y	Y	Y	Reasonable cause to believe	Physical or emotional injury resulting from abuse which causes harm or substantial risk of harm to child's health or welfare;	Juvenile Court	Oral and written
Michigan Mich. Comp. Laws § 722.623 (1999)	Y	Y	Y	Y	Y	Reasonable cause to suspect	Abuse or neglect	Department of Social Services	Oral and written
Minnesota Minn. Stat. § 626.556 (1999)	Y	Y	Y	Y	Y	Knows or has reason to believe	Neglect, or physical or sexual abuse, currently or within past three years	Welfare agency or law enforcement	Not specified
Mississippi Miss. Code Ann. § 43-21-353 (2000)	Y	Y	Y	Y	Y	Reasonable cause to suspect	Neglect or abuse	Department of Human Services	Oral and written
Missouri Mo. Rev. Stat. § 210.115 (1999)	Y	Y	Y	Y	Y	Reasonable cause to suspect	Child has been or may be subjected to abuse or neglect or is being subjected to conditions that would reasonably result in abuse or neglect	Division of Family Services	Not specified
Montana Mont. Code Ann. § 41-3-201 (1999)	Y	Y	Y	Y	Y	Knows or has reasonable cause to suspect	Abuse or neglect	Department of public Health and Human Services	Not specified
Nebraska Neb. Rev. Stat. § 28-711 (2000)	Y	Y	Y	Y	Y	Reasonable cause to believe	Abuse or neglect or conditions that reasonably would result in abuse or neglect	Law enforcement or Department of Health and Human Services	Oral and written

APPENDIX XI

CHILD ABUSE AND NEGLECT REPORTING LAWS

WHO MUST REPORT	Mental Health		Social Standard for Nurse Worker		Reporting?	Report What?	Report to Whom?	Report How?	
	Dentist	Doctor	Health	Nurse					Worker
Nevada Nev. Rev. Stat. § 432B.220 (2000)	Y	Y	Y	Y	Y	Knowledge or reasonable cause to believe	Abuse or neglect	Law enforcement or protective services	Not specified
New Hampshire N.H. Rev. Stat. Ann. §§ 169-C:29 to -C:30 (1999)	Y	Y	Y	Y	Y	Reason to suspect	Abuse or neglect	Department of Health and Human Services	Oral and written (if requested)
New Jersey N.J. Stat. Ann. § 9:6-8.10 (west 2000)	Y	Y	Y	Y	Y	Reasonable cause to believe	Abuse	Division of Youth and Family Services	Oral or written
New Mexico N.M. Stat. Ann. § 32A-4-3 (Michie)	Y	Y	Y	Y	Y	Knowledge or reasonable suspicion	Abuse or Neglect	Law enforcement or Department of Children, Youth, and Families or tribal law enforcement (if child resides in Indian country)	Not specified
New York N.Y. [Soc. Serv.] Law § 413 (McKinney 1999)	Y	Y	Y	Y	Y	Reasonable cause to suspect	Abuse or maltreatment	Central register of child abuse and maltreatment	Oral and written
North Carolina N.C. Gen. Stat. § 7B-301 (1999)	Y	Y	Y	Y	Y	Cause to suspect	Abuse, neglect, dependency, or death resulting from maltreatment	Department of Social Services	Oral or written
North Dakota N.D. Cent. Code § 50-25.1-03 (2000)	Y	Y	Y	Y	Y	Knowledge or reasonable cause to suspect	Abuse, neglect, or death resulting from abuse or neglect	Department of Human Services	Not specified

APPENDIX XI

CHILD ABUSE AND NEGLECT REPORTING LAWS

WHO MUST REPORT	Mental Health				Reporting?	Report What?	Report to Whom?	Report How?
	Dentist	Doctor	Nurse	Social Standard for Worker				
Ohio Ohio Rev. Code. Ann. § 2151.421 (Anderson 1999)	Y	Y	Y	Y	Knowledge or suspicion	Suffers or faces threat of suffering abuse, neglect, physical or mental wound, injury or disability that reasonably indicates abuse or neglect	Public Children Services Agency or law enforcement	Oral and written (if requested)
Oklahoma Okla. Stat. Tit. 10, § 7103 (1999)	Y	Y	Y	Y	Reason to believe	Abuse or neglect	Department of Human Services	Oral or written
Oregon Or. Rev. Stat. §§ 419B.005, .010-.015 (1997)	Y	Y	Y	Y	Reasonable cause to believe	Abuse	Office for Services to Children and Families or law enforcement	Oral
Pennsylvania 23 Pa. Cons. Stat. § 6311 (1999)	Y	Y	Y	Y	Reasonable cause to suspect	Abuse	Department or appropriate county agency	Oral and written
Rhode Island R.I. Gen. Laws § 40-11-3 (2000)	Y	Y	Y	Y	Reasonable cause to know or suspect	Abuse, neglect, or sexual abuse perpetrated by another child	Department for Children and Their Families	Oral
South Carolina S.C. Code Ann. § 20-7-510 (Law. Co-op. 1999)	Y	Y	Y	Y	Reason to believe	Physical or mental health or welfare has been or may be adversely affected by abuse or neglect	Department of Social Services or law enforcement	Oral
South Dakota S.D. Codified Laws §§ 26-8A-3, -6	Y	Y	Y	Y	Reasonable cause to suspect	Abuse or neglect	State's attorney, Department of Social Services, or law enforcement	Oral

WHO MUST REPORT	Mental Health		Social Standard for Nurse Worker		Reporting?	Report What?	Report to Whom?	Report How?
	Dentist	Doctor	Nurse	Worker				
Tennessee Tenn. Code Ann. § 37-1-403 (1999)	Y	Y	Y	Y	Knowledge or reasonable indication or reasonable appearance	Wound, injury, disability, physical or mental condition caused by brutality, abuse, or neglect	Juvenile court judge, Department of Children's Services, or law enforcement	Oral or written
Texas Tex. [Fam.] Code Ann. §§ 261.101-103 (West 2000)	Y	Y	Y	Y	Cause to believe	Physical or mental health or welfare adversely affected by abuse or neglect	Law enforcement or Department of Protective and Regulatory Services	Not specified
Utah Utah Code Ann. § 62A-4a-403 (1999)	Y	Y	Y	Y	Observation or has reason to believe	Incest, molestation, sexual exploitation, physical abuse, neglect, or circumstances reasonably resulting in any of above	Law enforcement or Division of Child and Family Services	Not specified
Vermont Vt. Stat. Ann. Tit. 33, §§ 4913-4914 (2000)	Y	Y	Y	Y	Reasonable cause to believe	Abuse or neglect	Commissioner of Social And Rehabilitation Services	Oral and written
Virginia Va. Code Ann. § 63.1-248.3 (Michie 1999)	Y	Y	Y	Y	Reason to suspect	Abuse or neglect	Department of Social Services	Oral
Washington Wash. Rev. Code § 26.44.030 (2000)	Y	Y	Y	Y	Observation or reasonable cause to believe	Abuse or neglect or conditions likely to result in neglect or abuse	Law enforcement or Department of Social and Health Services	Not specified
West Virginia W. Va. Code § 49-6A-2 (2000)	Y	Y	Y	Y	Reasonable cause to suspect	Neglect or abuse, or conditions likely to result in neglect or abuse	State Department of Human Services and Division of Public Safety and law enforcement (if serious)	Not specified

APPENDIX XI

CHILD ABUSE AND NEGLECT REPORTING LAWS

WHO MUST REPORT	Dentist	Doctor	Mental Health	Nurse	Social Worker	Standard for Reporting?	Report What?	Report to Whom?	Report How?
Wisconsin Wis. Stat. § 48.981 (1999)	Y	Y	Y	Y	Y	Reasonable cause to suspect or reason to believe	Abuse or neglect, or threat of abuse or neglect	Department of Health and Family Services	Oral and written (if requested)
Wyoming Wyo. Stat. Ann. § 14-3-205 (Michie 1999)	Y	Y	Y	Y	Y	Knowledge or reasonable cause to believe or suspect	Abuse or neglect or subjection to conditions that would reasonably result in abuse or neglect	Child protective agency or law enforcement	Not specified

NOTE: Because the term allied health professional is defined variably among different states, this Chart cannot accurately summarize the duties of all persons who might be included in this broad category

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HOTLINES FOR VICTIMS OF IPV/DOMESTIC VIOLENCE

NATIONAL DOMESTIC VIOLENCE HOTLINE, 24 hours, 1-800-799-SAFE (7233), 1-800-787-3224 (TTY) Links individuals to help in their area using a nationwide database that includes detailed information on DV shelters, other emergency shelters, legal advocacy and assistance programs, and social service programs. website: www.ndvh.org

RAPE ABUSE & INCEST NATIONAL NETWORK (RAINN), 24 hours, 1-800-656-HOPE Will automatically transfer the caller to the nearest rape crisis center, anywhere in the nation. It can be used as a last resort if people cannot find a DV shelter. 635-B Pennsylvania Ave SE, Washington, DC 20003 Phone: 1.800.656.HOPE (4673) ext. 3 Fax: (202) 544-3556 e-mail: rainnmail@aol.com website: www.rainn.org

LOCAL DV PROGRAMS (numbers are listed in the front of your telephone book). Or go to the list of State Domestic Violence or Sexual Assault Coalitions website: www.ojp.usdoj.gov/vawo/state.htm

DOMESTIC VIOLENCE (IPV) ORGANIZATIONS

FAMILY VIOLENCE PREVENTION FUND (FVPF) is a national non-profit organization that focuses on domestic violence education, prevention and public policy reform; and provides health care specific materials and information. 383 Rhode Island St., Suite 304, San Francisco, CA 94103-5133 phone: (415) 252-8900 fax: (415) 252-8991 e-mail: fund@endabuse.org website: www.endabuse.org

PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE (PCADV) AND NATIONAL RESOURCE CENTER ON DOMESTIC VIOLENCE is a private, nonprofit membership organization and is dedicated to ending domestic violence and helping battered women and their children re-establish physical, social, and economic dignity; PCADV has established health care advocacy programs throughout the state. 6400 Flank Drive, Suite 1300, Harrisburg, PA 17112 phone: (800) 932-4632 fax: (717) 671-8149 website: www.pcadv.org

NATIONAL COALITION AGAINST DOMESTIC VIOLENCE (NCADV) is dedicated to the empowerment of battered women and their children and is committed to the elimination of personal and societal violence in the lives of battered women and their children. PO Box 18749, Denver, CO 80218 phone: (303) 839-1852 fax: (303) 831-9251 website: www.ncadv.org

NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, FAMILY VIOLENCE DEPARTMENT provides technical assistance to those working in the field of domestic violence and child protection and custody. The Resource Center identifies and develops model policies, protocols, and programs that are sensitive to the legal, cultural and

RESOURCES AND REFERRALS

psychological dynamics of child protection and custody cases involving family violence. P.O. Box 8970, Reno, Nevada 89507 phone: (800)527-3223 email: www.ncjfcj.org/dept/fvd

NATIONAL NETWORK TO END DOMESTIC VIOLENCE THE NATIONAL NETWORK TO END DOMESTIC VIOLENCE is a membership and advocacy organization of state domestic violence coalitions, allied organizations and supportive individuals and is a leading voice among domestic violence advocates in public policy. website: www.nnedv.org

SACRED CIRCLE: THE NATIONAL RESOURCE CENTER TO END VIOLENCE AGAINST NATIVE WOMEN. Dedicated to the Actions that promote the Sovereignty and Safety of Women. 722 St. Joseph St. Rapid City, SD 57701 (605) 341-2050. 1 (877) RED-ROAD (733-7623)

ASIAN & PACIFIC ISLAND INSTITUTE ON DOMESTIC VIOLENCE: Strives to eliminate domestic violence in Asian and Pacific Islander communities by increasing awareness about the extent and depth of the problem making culturally specific issues visible; strengthening community models of prevention and intervention; identifying and expanding resources; informing and promoting research and policy and deepening understanding and analysis of the issues surrounding violence against women. 942 Market Street, Suite 200, San Francisco, CA 94102 (415) 954-9964 (p) (415) 954-9999 (f) website: www.apiahf.org

INSTITUTE ON DOMESTIC VIOLENCE IN THE AFRICAN AMERICAN COMMUNITY: Provides an interdisciplinary vehicle and forum by which scholars, practitioners, and observers of family violence within the African American community will have the continual opportunity to articulate their perspectives on family violence through research findings, the examination of service delivery and intervention mechanisms, and the identification of appropriate and effective responses to prevent/reduce family violence in the African American community. 290 Peters Hall 1404 Gortner Avenue St. Paul, MN 55108-6142 (p) (877) NID-VAAC (643-8222) Fax (612) 624-9201 website: www.dvinstitute.org

NATIONAL LATINO ALLIANCE FOR THE ELIMINATION OF DOMESTIC VIOLENCE
A network of nationally recognized Latina and Latino advocates, community activists, practitioners, researchers, and survivors of domestic violence working together to promote understand, sustain dialogue, and generate solutions to move toward the elimination of domestic violence in Latino communities, with an understanding of the sacredness of all relations and communities. P.O. Box 322086 Fort Washington New York, NY 10032 Tel (800) 342-9903 Fax (800) 216-2404. website: www.dvalianza.org

CLINICAL MATERIALS FOR THE HEALTH CARE SETTING

THE NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE a project of the FVPPF, provides support to thousands of health care professionals, policy makers and domestic violence advocates through its four main program areas: model training strategies,

practical tools, technical assistance, and public policy. phone: (888) Rx-ABUSE fax: (415) 252-8991 e-mail: health@endabuse.org website: www.endabuse.org/health

THE CHILD WITNESS TO VIOLENCE PROJECT AT BOSTON MEDICAL CENTER provides mental health services to young children exposed to violence. Staff also provide training and technical assistance to a wide range of professionals working with young children and families affected by violence and have published a training curriculum for mental health professionals and victim advocates: “Shelter from the Storm: Clinical Intervention with Young Children Affected by Domestic Violence”. For more information, call (617) 414-4244. The project website is www.bostonchildhealth.org/special/CWTV/overview.html

ALASKA FAMILY VIOLENCE PREVENTION PROJECT specializes in training for health care and service providers, have articles, curricula in PowerPoint that can be downloaded, run a clearinghouse of education materials. website: <http://www.hss.state.ak.us/dph/chems>

HOWARD S. KING, MD, MPH AND MELINDA STRAUSS, ACSW, LISCW authors of Routine Screen for Domestic Violence in Pediatric Practice written to help pediatricians and family practitioners become aware of the problem of domestic violence and to consider screening for it during the routine office visit. View or download this publication at www.drkingsoffice.com

THE INSTITUTE FOR SAFE FAMILIES' (ISF) mission is to prevent family violence and to offer an alternative vision for wholeness, healing, family health, and personalempowerment. ISF is conducting a Philadelphia area initiative to address domestic violence within the pediatric setting and has developed a pocket card on what to do, with a variety of materials in development. ISF, 3502 Scotts Lane, Philadelphia, PA 19129, (215) 843-2046, website: ISF2002@aol.com

Websites of Interest for Adolescents

THE EMPOWER PROGRAM works with youth to end the culture of violence. 1312 8th Street, Washington, DC 20001 phone: (202) 882-2800 fax: (202) 234-1901 e-mail: empower@empowered.org website: www.empowered.org

GIRLS INCORPORATED NATIONAL RESOURCE CENTER is a national youth organization dedicated to inspiring all girls to be strong, smart and bold. 441 West Michigan Street, Indianapolis, IN 46202 phone: (317) 634-7546 fax: (317) 634-3024 e-mail: girlsinc@girls-inc.org website: www.girlsinc.org

LIZ CLAIBORNE INC. produces “A Teen’s Handbook” and web pages to help teens learn about dating violence by providing facts, guidance and resources. To order a free handbook, phone: (800) 449-STOP (7867) website: www.lizclaiborne.com/lizinc/lizworks/women/handbook.asp#teen

RESOURCES AND REFERRALS

LESBIAN, GAY, BISEXUAL, TRANSGENDERED, QUEER (LGBTQ)

COMMUNITY UNITED AGAINST VIOLENCE (CUAV) is a 20-year old multicultural organization working to end violence against and within lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) communities. 973 Market St., #500, San Francisco, CA 94103 phone: (415)777-5500 Fax: (415)777-5565 24 Hr. Support Line: (415) 333-HELP (4357) e-mail: cuav@aol.com website: www.cuav.org

PARENTS, FAMILIES, AND FRIENDS OF LESBIANS AND GAYS (PFLAG) is a national organization that promotes the health and well-being of gay, lesbian, bisexual and transgendered persons, their families and friends. Their Web site provides users with information on local chapters, advocacy and support information and other resources that support the family and friends of gays and lesbians. 1726 M Street, NW, Suite 400, Washington, DC 20036 phone: (202) 467-8180 fax: (202) 467-8194 e-mail: info@pflag.org website: www.pflag.org

GAY MEN'S DOMESTIC VIOLENCE PROJECT is a grassroots, non-profit organization in Boston providing community education and direct services for clients. GMDVP offers shelter, guidance, and resources to allow gay, bisexual, and transgender men in crisis to remove themselves from violent situations and relationships GMDVP, PMB 131, 955 Mass Ave. Cambridge, MA 02139 Fax: 617 354 6072, Bus: (617) 354-6056 Crisis: (800) 832-1901 website: www.gmdvp.org 1-800-832-1901.

NETWORK FOR BATTERED LESBIANS AND BISEXUAL WOMEN. The Network/La Red was formed to address battering in lesbian, bisexual women's, and transgender communities. Through a) the formation of a community-based multi-cultural organization in which battered/formerly battered lesbians, bisexual women, and transgender folks hold leadership roles; b) community organizing, education, and the provision of support services, we seek to create a culture in which domination, coercion, and control are no longer accepted and operative social norms. The Network POB 6011 Boston, MA 02114. Office (v/tty) (617) 695-0877. Hotline (v/tty)(617) 423-7233. website: www.thenetworklared.org

TEEN PREGNANCY

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG) has a membership of 40,000 physicians and is the nation's leading group of professionals providing health care for women. ACOG's website provides adolescent sexual assault screening tools as well as other teen pregnancy materials. To request free copies of their educational bulletins, call: (202) 638-5577 or e-mail: violence@acog.org. ACOG, 409 12th Street, SW, PO Box 96920 Washington, DC 20024. phone: (202) 863-2487 fax: (202) 484-3917 e-mail: adolhlth@acog.org website: www.acog.org

SEXUAL ASSAULT

CENTER FOR THE PREVENTION OF SEXUAL AND DOMESTIC VIOLENCE is an interreligious educational resource addressing issues of sexual and domestic violence whose goal is to engage religious leaders in the task of ending abuse, and to serve as a bridge between religious and secular communities. 936 North 34th St., Suite 200, Seattle, WA 98103 phone: (206) 634-1903 fax: (206) 634-0115
e-mail: cpsdv@cpsdv.org website: www.cpsdv.org

RAPE ABUSE & INCEST NATIONAL NETWORK (RAINN) (see “Hotlines” for further info)

SEXUAL ASSAULT RESOURCE SERVICE (SARS) is designed for nursing professionals involved in providing evaluations of sexually abused victims. SARS’ website provides information and technical assistance to individuals and institutions interested in developing new SANE-SART programs or improving existing ones. website: www.sane-sart.com

ANIMAL CRUELTY AND FAMILY VIOLENCE

THE HUMANE SOCIETY OF THE UNITED STATES, through its First Strike campaign, is dedicated to raising public and professional awareness about the connection between animal cruelty and family violence. 2100 L Street, NW, Washington, DC 20037 phone: (301) 258-3076; toll-free (888) 213-0956 fax: (301) 258-3074 e-mail: firststrike@hsus.org website: www.hsus.org/firststrike

OTHER WEBSITES OF INTEREST WITH DOMESTIC VIOLENCE-SPECIFIC HEALTH CARE RESOURCES

AMERICAN ACADEMY OF PEDIATRICS: www.aap.org

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS: www.acep.org

AMERICAN COLLEGE OF NURSE MIDWIVES: www.acnm.org

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS: www.acog.org

AMERICAN MEDICAL ASSOCIATION: www.ama-assn.org

AMERICAN MEDICAL WOMEN’S ASSOCIATION: www.amwa-doc.org

AMERICAN PSYCHOLOGICAL ASSOCIATION: www.apa.org

ASSOCIATION OF TRAUMATIC STRESS SPECIALISTS: www.atss-hq.com

BATTERED WOMEN AND THEIR CHILDREN: <http://hosting.uaa.alaska.edu/afrhm1/wacan/>

CHILD WITNESS TO VIOLENCE PROJECT AT BOSTON MEDICAL CENTER:
www.childwitnessstoviolence.org

FAMILY VIOLENCE AND SEXUAL ASSAULT INSTITUTE: www.fvsai.org

INTERNATIONAL ASSOCIATION OF FORENSIC NURSES: www.forensicnurse.org

RESOURCES AND REFERRALS

JOHNS HOPKINS UNIVERSITY SCHOOL OF NURSING: www.son.jhmi.edu

MASSACHUSETTS MEDICAL SOCIETY: www.massmed.org

MEN STOPPING VIOLENCE: www.menstoppingviolence.org

NURSING NETWORK TO END VIOLENCE AGAINST WOMEN INTERNATIONAL:
www.nnvawi.org

NATIONAL SEXUAL VIOLENCE RESOURCE CENTER: www.nsvrc.org

SOCIETY OF ACADEMIC EMERGENCY MEDICINE: www.saem.org

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