Vermont Curriculum on Intimate Partner Violence for Health Care Professionals

Introduction:
Intimate Partner Violence and Health Care: Making the Connection

Vermont Network Against Domestic Violence and Sexual Assault 2004
In this training, we are going to focus on intimate partner violence, also commonly referred to as “Domestic Violence”. It is a subset of family violence, together with child abuse, elder abuse, and abuse of people with disabilities.
Domestic Violence results in immense costs to individuals and the community. Much of the measurable costs are health care related, because domestic violence results in so much morbidity. This data is from a 2003 report published by the CDC (Centers for Disease Control). The data were based on a large national survey. They found that the costs of intimate partner rape, physical assault and stalking in the U.S. totaled more than $5.8 billion annually, $4.1 billion of which went toward health care services.
If you have been screening for abuse in your practice, you should have approximately these numbers: Around 22% of your women patients should screen positive for lifetime abuse, between 1-3 out of every hundred women for current or recent abuse.

Data from other surveys indicate that the incidence is approximately 7% of men for lifetime abuse.

**Ask Question:** “Is this consistent with your data?”

If you are getting significantly smaller numbers, you may be missing an important piece of the health history of many of your patients.

We will talk about screening women and men in the second part of this seminar series.
Talking Points:

• The only specific domestic violence data we have in Vermont are the numbers of victims and their children served by the 16 local domestic and sexual violence programs in Vermont. In [name of your county/area] the local program(s) [name] served [# of victims and kids] in [year]. [please refer to the enclosed VT Network Against Domestic Violence and Sexual Assault 2003 Annual Report, or go online www.vtnetwork.org for an updated report]

• We know from isolated police statistics and from anecdotal evidence by police officers we work with that “domestics” as they call them, make up a large percentage of their cases

• This represents only the very tip of the iceberg, because only a small percentage of victims actually finds their way to one of these programs. And only a small number of violent incidents are reported to the police. The invisible part of the iceberg is represented by the thousands of Vermont victims who never reach out to the police or to domestic and sexual violence program. Most of these people access health care services. You may have many of these people in your patient files.

• From the VT Crime Report: “In 2002, rapes increased from 129 to 153 (19% increase) and aggravated assaults increased from 447 to 490 (10% increase). This is the third year in a row that reported aggravated assaults increased in Vermont. The typical victim of a violent crime in Vermont tends to be a white, female, in her early twenties. The victim and the assailant were known to each other in 87% of violent crime incidents. Assaults most frequently occurred on Sundays in the early evening at a private residence.” (www.dps.state.vt.us/cjs/crime_02) – This means that a majority of VT assault cases are intimate partner violence against women.
92% of battered women did not discuss violent incidents with their physicians; 57% did not discuss the violence with anyone. (Commonwealth Fund 1993)

Only an estimated 10% of primary care physicians routinely screened for intimate partner abuse in 1999 (JAMA 1999)

When health care providers educate themselves on domestic violence, screening and identification of victims of domestic violence improves. The Institute of Medicine found that 54% of evaluated domestic violence trainings for health care professionals resulted in significant increase in screening and identification rates (Institute of Medicine 2002)
This JAMA study and several others found that most domestic violence survivors would like to address this issue with their health care provider. But currently only a small number get the chance to do this.
Linda Chamberlain from the Alaska Department of Public Health surveyed the existing studies on the health impact of domestic violence and found that domestic violence has been shown to be correlated with 8 out of 10 leading health indicators of Healthy People 2010. Victims are at increased risk for health injurious behaviors like smoking, alcohol use, and poor nutritional behaviors. They are at greater risk for mental health problems. Battered women are more likely to enter prenatal care late and children of victims are less likely to get immunized. Finally, domestic violence is the leading cause of injuries and homicide for women. Units 1 and 2 of this training will give you more insight into how domestic violence influences your patients' health, health behaviors and access to health care.

For presenter's reference:
Indicator and Connection with Domestic Violence:
Tobacco Use: ↑ risk of smoking  (Hathaway et al, 2000)
Substance Abuse: ↑ risk of high risk alcohol use (Lemon et al, 2002)
Injury & Violence: Leading cause of injuries and homicide (Frye et al, 2001)
Mental Health: ↑ risk of mental health problems (Coker et al, 2002)
Responsible Sexual Behavior: ↑ sexual-risk taking and STIs (Coker, 2000); Less likely to use condoms consistently (Wingood et al, 2001)
Access to Health Care: ↑ risk of late entry into prenatal care  (McFarlane et al, 1992)
Immunizations: Children of battered women less likely to get immunizations (Attala et al, 1997; Webb et al, 2001)
Overweight & Obesity: Poor nutritional behaviors (McNutt et al, 2002; Bostwick & Baldo, 1996)
Because intimate partner violence is so common and has such a wide ranging impact on people’s health,
because victims say they would like to discuss it with their health care providers, but few health care providers screen routinely and effectively,
and because trainings have shown to improve screening and identification rates,
these and many other national health professional organizations recommend training on intimate partner violence for their members. Many of these organizations have also published statements or recommendations on intimate partner violence screening, assessment and intervention in health care settings. The AMA, for example, has published detailed Clinical Guidelines which you can access on their website. Some of these organizations also offer training materials or curricula on the topic (e.g. American Medical Women’s Association has an online curriculum on their website)
We do not have **enough high quality efficacy data** yet. Here are some **promising data from 2 studies.** *(read slide)* After the brief intervention, abused pregnant women reported increased safety behaviors and decreased physical violence at follow up visits. We will see more evidence in the coming years as many health care and domestic violence projects and studies are now being implemented throughout the U.S.

*If you have time you can mention other recent studies:*

Two other studies from 1999 and 2000 showed that abused women who were screened in health care settings and received wallet sized resource cards reported less violence at 6 and 12 month follow up. *(Parker B, McFarlane J, Soeken K, Silva C, Reel S. Testing an intervention to prevent further abuse to pregnant women. Res Nurs Health 1999;22(1):59-66; McFarlane J, Soeken K, Wiist W. An evaluation of interventions to decrease intimate partner violence to pregnant women. Public Health Nurs 2000;17(6):443-51.)*

Six telephone calls over eight weeks from nurses to women experiencing domestic violence can significantly increase their safety-promoting behaviors, with impact that lasts for at least 18 months. Average call lasted 9 minutes each. *(Judith McFarlane, DrPH, RN, FAAN; Ann Malecha, PhD; Julia Gist, PhD, RN; Kathy Watson, MS; Elizabeth Batten, BA; Iva Hall, PhD, RN; and Sheila Smith, PhD, RN. Increasing the Safety-Promoting Behaviors of Abused Women. American Journal of Nursing, March 2004. Vol 103, No 3, 40-50.)*

The goals of this training curriculum are:
To help build the attitudes, knowledge, clinical skills and relationships necessary to provide effective Screening, Diagnosis, Treatment and Referral for victims of intimate partner violence.
And here is the outline of the training. We just finished the **Introduction**. The next part is **Topic 1:** Understanding Intimate Partner Violence and Its Health Impact.

*(Please add information about the schedule of your training: how long will each unit last and when, where and by whom will it be offered)*

In **Unit 2**, “The Clinical Encounter”, we will cover practical steps and tools for responding to the health and safety needs of your patients in a clinical setting.

In **Unit 3**, we will look beyond the clinical encounter at institutional, legal and community contexts for clinicians and patients.

In **Unit 4**, we explore how health care providers can most effectively work as part of the community response to intimate partner violence. *(if you are planning to do a community panel, mention that they will meet and hear directly from important community referral resources)*
Vermont Curriculum on Intimate Partner Violence for Health Care Professionals

Topic 1:
Understanding Intimate Partner Violence and its Health Impact

VT Network Against Domestic Violence and Sexual Assault 2004
Talking Points:

- It is important to acknowledge that in a group of any size, there may be survivors and perpetrators. You may identify yourself or someone you know in one of these roles, and this may trigger many emotions.

- Everyone here should feel that it is o.k. for them to do whatever they need to take care of themselves. It’s o.k. to get up and leave in the middle of the presentation. If you would like to process your thoughts and feelings with someone right away, there is [an advocate? Phone to call hotline # ……] available [give details].

- We will be watching some video clips with survivor and perpetrator testimonies. There are no graphic scenes but if you find the descriptions upsetting, please take care of yourself.

- Confidentiality is the cornerstone to any discussion about intimate partner violence and we need to all agree on respecting this throughout the training. If personal things come up in this room, they should stay in this room. If emotions come up, please do not make assumptions about other people. There may be all kinds of different reasons why this may be a hard topic for any one of us. Please also respect the confidentiality of the people in the videos – in case you recognize the 2 Vermonters featured in the testimonies.

- In Unit 3 of this seminar series, we will talk more about how health care organizations can not only support patients but also health care providers, both in their roles as providers and as survivors.
Talking Points:

- This is the behavioral definition of intimate partner violence.

- The legal definition from the VT statutes focuses on incidents of physical or sexual violence or threats of imminent physical harm. If I hit my partner, VT law defines this as an act of domestic violence. However, the behavioral definition that focuses on the long-term abusive pattern is more reflective of the experience of survivors and also more relevant to clinical contexts.

Handout: Power and Control Wheel

- In your handouts you will find a Power and Control Wheel, a visual tool that was made to capture the experiences shared by battered women in support groups in Duluth, Minnesota in the 1970s and 80s. As the women shared their stories of the abuse they endured, a pattern of behaviors used against them emerged.

- It is very important that providers understand the full scope of intimate partner violence. Only some of the coercive and abusive strategies used against victims are against the law. [point at physical and sexual violence on the wheel] Isolated acts of physical violence may cause injuries. But it is the full pattern, which may be going on for many years, which victims are trying to survive and which may have such a powerfully negative impact on their health, well being and on their access to and compliance with health care.
Power and Control Wheel

Talking Points:

- At the center is the striving for power and control, that seemed to motivate the abuse.
- In the spokes of the wheel, you will see abusive behaviors that are for the most part not against the law, and do not involve physical violence, but that survivors reported experiencing as debilitating, painful, and powerfully contributing to their entrapment. [give some examples]
- Physical and sexual violence or the threats thereof, form the rim of the wheel. They are always in the background, as a memory of what happened or a threat of things to come, and they are what “makes the wheel turn”.

ASK QUESTION:

Given this definition of a pattern of abusive strategies, may I ask who among you has seen or suspected intimate partner violence in one or more of your patients? Would you mind raising your hands so we can get a sense ...? [show of hands] [if few hands are raised, you may ask whether they have seen it in their personal lives among friends, family, neighbors. You could comment on the number of hands, what does it signify to you? ..]

Thanks.

[Skip this if short on time:]

Would one of you be willing to share, very briefly, how your patient presented, how you found out about the abuse, and which forms of abuse you think they were trying to survive? [ask further questions if needed, or ask several people. Usually people like to talk about this because it makes them feel how relevant the material is, however you may be
The best way to find out about intimate partner violence and its health impact is to ask people who were directly affected. We say that the survivor is the expert on her situation, and as advocates, we see it as our role to make survivors’ voices heard. This is the first of a few testimonies that you will see and hear during this session.

We would ideally like to invite survivors as speakers to every training, but since we know that this is not always possible, we taped an interview with a Vermont woman survivor for this training series. We asked her to describe the situation she was in, and pay particular attention to health and health care issues.

(In the next unit of this training series, you will see the continuation of this interview, where Julie talks more specifically about her interactions with health care professionals and what was and wasn’t helpful.)

While you are listening to her, please focus on the following questions: [read slide]

Discuss briefly after the video clip. Some possible answers:

• Which abusive strategies were most effective in keeping her entrapped:
  - Isolating her from family and friends, ridiculing her in front of them. Emotional abuse that severely undermined her self-esteem. The relentless control and fear that kept her stress levels so high that she became exhausted and weak. Having 3 children. Occasional severe physical abuse that kept her in great fear of what he could do. Breaking the relief from abuse order to show her that she couldn’t protect herself that easily.

• How did the abuse affect her health:
  - Physical injuries (broken arm, black eyes, other contusions). Great stress that led to hair loss, weight loss, and health-injurious habits like heavy smoking. Mental health effects including depression, suicidal feelings. Etc.
  - Emphasize the long-term effects. She is still suffering from post-traumatic stress (she escaped 7 years ago and she still gets sick and anxious when she only hears he is in the same state). Say how typical this is, and that therefore screening for past abuse is a good idea, especially when people have unexplained lingering physical health problems, or any chronic mental health issues. (this will be discussed further in the second unit, so there is no need to get into a lengthy discussion here)
Typical Features of Violent Relationship

- Great beginning, “swept off my feet”
- Gradual onset of abuse
  - Undermining self-esteem
  - Erosion of social support network
- More severe abuse once victims are trapped emotionally, socially, financially
- Victims cannot find safe way to escape
- Abuse continues even after legal system is involved; even after victim has relocated
- Wide range of health effects, long-lasting

Just to summarize a few typical features that may be help you better understand the situation of your patients:

- Often the relationships have a great beginning, survivors report that they were “swept off their feet”, “dream come true” etc.
- There is the myth that battered women are somehow attracted to abuse, but this does not correspond with the many hundreds stories we have heard. They fell in love with someone who was wonderful to them, not someone who hit them on the first date.
- There is usually a gradual onset of abuse, often beginning with subtle emotional abuse and isolation strategies. Leading to:
  - Undermining of self-esteem
  - Erosion of social support network
- More severe abuse usually occurs only once victims are trapped emotionally, socially and/or financially, e.g. once they have moved in together, or the woman is pregnant.
- Victims cannot find a safe way to escape and thus come up with all kinds of coping strategies in order to survive the status quo.
- Abuse continues even after legal system is involved; even after victim has left the batterer or relocated
- Abuse can escalate after the victim attempts to leave or leaves.
- Victims suffer a wide range of health effects, often long-lasting.
Sexual Violence

48% of battered women reported sexual violence as one of the abusive strategies used against them.


Read Slide.

Sexual Violence is

• Any act in which sex is used as a weapon
• Physical or verbal
• Includes verbal humiliation, unwanted touching, sexual assault, rape
• As well as forcing the victim to perform sexual acts s/he is not comfortable with or that are against victim’s values

Many battered victims experience this form of abuse. It is often the hardest to talk about and the hardest to heal from. Julie, who talked to us in the interview, was regularly sexually abused by her batterer but you might not have guessed this since she did not mention it in the interview. This is something you should keep in mind when you talk to survivors about the abuse.

Sexual Violence can lead to a range of negative health effects, including STIs, unwanted pregnancies, injuries, pelvic pain, etc.

It may also affect the victim’s experience of any physical examinations you may do, especially gynecological exams.
Teens are another group who are affected by intimate partner violence, and often suffer tremendous health consequences. Here is a survivor quote from Joan, 16 years old:

"I listened to everything Jeff said when it came to sex because he was the first guy I was with. Wherever I asked him to use a condom, he refused. He said it 'ruined his pleasure'. He told me in a mean way that I couldn't satisfy him, and made me feel real ugly. I'd cry, He'd lie and say he had an AIDS test and I shouldn't worry. Or he'd say that his doctor told him he can't have children, so we didn't need birth control. I realized it wasn't true when I got pregnant. I had an abortion, which was the hardest thing I have ever had to do."

Joan, 16

quoted from Barrie Levy: In Love and In Danger, Seattle: Seal Press, 1993

**Impact on Reproductive Health**

Talking Points:

- **Sexual abuse is very frequent**, a big factor in teen pregnancy and STIs. This story is a **good example of how intimate partner violence can affect your patients' reproductive health** (and this is true for female survivors of all age groups, not only for teens!). **Your patients may not be able to protect themselves against STIs, unwanted pregnancies etc. Also consider how sexual abuse might affect their experiences of Ob/Gyn exams and care.**

- **An alarmingly high prevalence of teen dating violence** was recently confirmed in JAMA study: 20% of high school girls aged 14-18 reported being hit, slapped, shoved or forced into sexual activity by a dating partner. **Girls who are victims of dating violence are at increased risk of suicide, early pregnancy, unhealthy weight control, and substance abuse.**

  (Silverman, PhD; Raj, PhD; Mucci, MPH; Hathaway, MD, MPH. Journal of the American Medical Association, 2001.)

- **Teen dating violence:**
  - **Same power and control pattern** as adult intimate partner violence.
  - May not seek help from adults
  - Limited experience with relationships/life in general, makes them more vulnerable
  - Isolation interferes with social development, academic progress, life plans: high school drop outs, early marriages, early pregnancies, etc.

- **Recommend cited author (Barrie Levy) for further reading on teen dating violence. Books available both for practitioners and for teens themselves (self-help resource). A Healthy/Unhealthy Relationships Workbook for teens is available from the VT Network Against Domestic Violence and Sexual Assault.**
Talking Points:

- It’s important not to make assumptions about who can be a victim or a perpetrator. It really cuts across all lines and boundaries.

- This is important for us as service providers, because if you let yourself be guided by unexamined assumptions about who is likely to be a victim or perpetrator, then you may miss the problem in someone you deem unlikely to be affected, or you may not believe someone’s disclosure because you know their partner.
Patrick’s Story

Video: Survivor story

Questions:
- How does Patrick’s story compare to Julie’s story?
- What do we learn about escaping a batterer?
- How would this be relevant to you as Patrick’s Health Care Provider?

Include this if there is time – otherwise skip to next slide.

These clips are on the CD II (by the Massachusetts Medical Society).
- Pt Exp03 is about the cycle of abuse and apologies and how it kept him in the relationship. 1 minute 15 secs.
- PtExp05 is about how the batterer isolated him socially and how he controlled daily activities like shopping. 1 min 25 secs.
- PtExp06 is about how he stayed in the relationship at first for love and hope and in the end for different reasons: fear and desperation. How he felt he had no choices and would never be safe from him. 1 min 28 secs.
- PtEnd 07 is about how he tried to escape but that it took years to get free of the batterer. Deals with the myth of victims just needing to “leave”. 2 mins 25 secs
- All excerpts together approx 6-7 mins

Talking Points:
(Present or ask guided questions)
- Very similar story to that of Julie, typical power and control pattern evolving over time.
- A man can be victimized just as effectively, by the same strategies – however, a man is more likely to be victimized by a male intimate partner than by a female partner. This is because of gender roles and expectations in our society.
- It’s not about “leaving” an abuser, it is about escape. Escaping abuse is often a long process because abusers do anything to keep the victim under control.
- We may not assume that Patrick is a victim of intimate partner violence because of his gender, social class, physical strength, etc. We may not screen him because we may not pick up on red flags in a male patient. Patrick would need the same kind of long-term support and encouragement as Julie did. Patrick may need services that speak to him as a gay man, so referrals may be different (there is a program specializing in supporting GLBT survivors in Vermont, also a national hotline). [more details on resources/referrals and clinical interventions in Units 2-4]
Intimate Partner Violence happens in all relationships, both heterosexual and same sex. Anyone can become a victim. However, in heterosexual relationships, women are far more likely to be the victims and men the perpetrators.

Talking Points:
- Male violence against women is a social problem that has been **condoned and supported by customs and traditions** in our society.
- Men are **socialized to take control and use physical force** when necessary.
- As a result, in heterosexual relationships it is more often the male partner who feels a **sense of entitlement** to get what they want, if necessary by use of threats or force.
- Even if both male and female partners in a relationship use threats and physical force, there may be a significant **difference in impact**:
  - Violent acts by men are often more severe and more likely to produce **injuries**. They often also result in greater **fear** in the victim.
  - Abused women often suffer more severe **socio-economic consequences** than male victims. Female victims who leave their abusers very often face poverty, they may end up as socially stigmatized “single moms on welfare”.
- In **same sex relationships** the power balance and sense of entitlement is often determined by factors other than gender. The perpetrator may draw his or her sense of superiority from his/her class, racial, professional, religious or other identity.
- Although perpetrators may come from any socio-economic class, profession, sexual orientation, gender, ethnicity, etc., they often share certain characteristics. *will be explained in the next two slides*
We will now watch an interview with Fred, a Vermont man, who was convicted and jailed for abusing his female partner. After that, he successfully completed IDAP (Intensive Domestic Abuse Program) under supervision of VT Dept of Corrections. He talks about the abuse he committed through the lens of the concepts he learned in this domestic violence education program.

**Talking Points after video:**

- **Reiterate that** Fred presents this through the lens of what he learned at IDAP.

- Not many batterers get to this point in terms of attitude and interpretation of their actions, even after intensive education programs.

- **Highlight how** Fred used the medication/her mental health diagnosis against his partner and say that this is very typical. Victims often have psychoactive drugs prescribed to them to deal with the mental health impact of battering. Then the perpetrator uses this against them, convincing them they are crazy and telling everyone else that she is mentally ill, including police, courts, etc. Think about this when you prescribe antidepressants or anti-anxiety medications to victims. You may want to talk about this with the victim, as well.

*(more comments on this video are incorporated into talking points for next slide)*

After the video:

- The next slide shows a list of characteristics prepared by Lundy Bancroft, an expert who led batterer intervention programs for over 2 decades, and thus worked with 1000s of abusive men.
**Characteristics of Perpetrators**

- Controlling and possessive
- Feels entitled
- Twists things into opposites
- Disrespects partner and considers himself superior
- Confusion of love and abuse
- Manipulative
- Strives to have good public image
- Denies and minimizes abuse


[Go over slide:]

- Batterers are usually controlling and possessive. Jealousy for example is often the first sign that will be present in the relationship. Unfortunately, popular culture often celebrates jealousy as a part of romance, so this warning sign is usually overlooked.
- They feel entitled to have control/get their way. Fred felt that as a man he needed to control his family.
- They often twist things into the opposite, which can be extremely confusing to the victim. Many victims come to believe that they are the ones causing the problem in the relationship. An example is how Fred turned his partners legitimate complaints about housework into mental health issues (“have you taken your prozac?”)
- They usually disrespect their partner and consider themselves superior.
- They mix up love and abuse.
- They are often extremely manipulative. They don’t only manipulate their partners but also others around them, and this is very important for us as providers to understand, because we are one of their targets, once we try to help the victim.
- They usually strive to have a good public image. Most people may believe that they are the nicest persons – which of course makes it even more confusing and difficult for the victim: nobody may believe her. Fred talked about how he consciously played the role of the “good dad” in his neighborhood to make his partner look even worse.
- And batterers tend to minimize and deny the abuse, both in front of the victim and in to service providers or the public.

**IMPORTANT For Health Professionals Who Want to Make Effective Referrals:** Because of the characteristics of batterers and the dynamics of the power and control relationship, **couples therapy or counseling is usually not effective and often very unsafe for the victim.** If you want to explore this issue further, you can find Bancroft’s book on the resource list.

*If there is time: Ask:* Given these characteristics, how might an abuser affect the victim’s health care? Your therapeutic relationship? Your ability to intervene? Possible answers, offer some of these examples if participants don’t come up with them:

- Likely to control victim’s access and use of health care; May use victim’s health status against her e.g. especially mental health status/diagnosis (you know you are crazy, even the doctor says so”), the fact that she is on medication (“you must be hallucinating, have you forgotten to take your meds again), or any disability to make victim feel useless: Julie’s weight loss was used to make her feel ugly; May try to manipulate you or your relationship with victim; May try to appear as the responsible, caring person in the family (e.g. Fred made a point of taking the kids to doctor to prove he was the better parent); May identify himself as the victim (esp. if you screen all patients for abuse) So ... what causes this abusive behavior? *[next slide]*
Why is the batterer abusive?

- “Low Self-Esteem”
- “Anger Management Skills”
- “Substance Abuse”
- “Abused as a Child”
- “Witnessed abuse of parent”
- “Lost job, stress”
- Because he/she can be
- Because it works

[Note: this slide is animated so that reasons 1-6 appear first, then all disappear, and then reasons 7-8 appear] – if this does not work on your computer, make sure people get the idea that the first 6 reasons are not valid – they are myths and excuses)

Talking Points:
About the first 6 “reasons”:
- There are many myths about the causes of battering behaviors. All these factors may be related to the abuse, by complicating the relationship or exacerbating abuse. But they do not cause abuse.

About the last two reasons:
- A batterer like Fred was abusive because he could be, because it worked. It took years until he was held responsible by the community.
- Battering is learned behavior. An abuser may learn it by observation in their family, their peer group, or in the media.
- Battering is continued if it is reinforced: for example if a boy slaps his girlfriend around and his peers approve of the behavior or let it pass. If someone injures their partner, she goes to get health treatment for the injury and the cause of the injury is not addressed by the health care professional. If someone sexually assaults their partner but the state does not effectively prosecute marital rape. Etc

We need to realize that:
- Because substance abuse, anger issues, or stress do not CAUSE abuse, addressing them through treatment will not end the abuse. You can refer people for these issues separately, but make it clear that this is not addressing the violence.
- Battering will end when it is no longer tolerated in our society.
- If you as a health professionals see an obviously battered person and do not address this, you are reinforcing the batterer’s power and the reasons for his or her continued battering.

We have talked about the victims and the perpetrators. Now we will look at the children who witness intimate partner violence.
Between 3.3 and 10 million children in the United States are exposed to intimate partner violence each year. Children under the age of 12 resided in 43% of the households where intimate partner violence occurred. In 30-60% of families experiencing either intimate partner violence or child maltreatment, the other form of violence is also present. Children of battered women are 12 to 14 times more likely to be sexually abused by their mother’s abuser.

We distinguish between children who are abused themselves, and children who witness the abuse of one of their parents. The latter are usually referred to as “child witnesses of domestic violence”.

Studies have shown that there is a huge overlap between intimate partner abuse and child abuse (read stats): In 30-60% of families experiencing either intimate partner violence or child maltreatment, the other form of violence is also present. Children of battered women are 12 to 14 times more likely to be sexually abused by their mother’s abuser (than children whose mothers are not battered). Therefore, if you find out about one form of abuse in one of the families you treat, it makes sense to also screen for the other. But make sure you make it clear that you are a mandated reporter for child abuse.
This little girl drew herself crying. She expressed that she feels sad when her mother gets hit.

Most child witnesses are affected emotionally in some way. They may experience
- fear,
- low self-esteem,
- guilt ,
- shame, embarrassment,
- stress,
- powerlessness,
- difficulties trusting
and a range of other difficult emotions.

They may exhibit symptoms of depression, suicide ideation, or anxiety.

This was confirmed by a range of studies using the child behavior checklist and other measures. You will find some references for recent research in your handouts. (e.g. Jeffrey L. Edleson, Problems associated with Children’s Witnessing of Domestic Violence, 2000. http://www.vaw.umn.edu/documents/vawnet/witness/witness.html )

In the shelters or support groups of the local domestic and sexual violence programs in Vermont we encourage children to identify their emotions and support them in dealing with them constructively.
This girl, Kristie, talks about the anger she feels when she witnesses the abuse. She directed most of her anger towards her mother, who was a survivor of severe emotional abuse by her husband. Children often interpret the emotional abuse as “mom getting in trouble because of things that she does wrong”. So, they often see it as her fault...projecting what children experience themselves (if you do something wrong, you get punished). Children are often angry at their mothers, which is very hard for the abused woman who is trying to cope with the abuse and to support her child.

Children may be affected behaviorally.

They may become nervous, cry a lot, withdraw, or show developmental regression.

Others may start acting out violently, become aggressive, get into trouble at school.

Others may take on a lot of responsibility, become overachievers, caretakers of younger siblings and/or parents, and start showing an adult affect.

Some studies have shown that child witnesses are at increased risk of becoming abusive in their dating relationships. (Sometimes referred to as the “intergenerational cycle of domestic violence”). The data are not conclusive as to whether this affects boys and girls differently and what the risk and protective factors are. However, it is important to remember that children who witness will not automatically become batterers or victims themselves.
This was drawn by a little boy, Billie, who lived in the shelter. He told the shelter worker that the title of this picture was “Billie is in the house with the monsters”. It speaks to the terror and nightmares that children may experience as a result of witnessing the violence.

Children often respond with great relief when they move to the shelter and feel safe. They also typically get a lot of attention from safe and respectful adults, which some of the children thrive on visibly.

Some study results about the impact of witnessing IPV on cognitive and social skills: Children from homes where their mothers were being abused have shown less skill in understanding how others feel and examining situations from others’ perspectives when compared to children from non-violent households. Peer relationships, autonomy, self-control, and overall competence were also reported significantly lower among boys who had experienced serious physical violence and been exposed to the use of weapons between adults living in their homes (Edleson, see slide 14)

If you are skipping the next two slides, ask: What physical and mental health effects would you expect to see in child witnesses of intimate partner violence who are your patients? – short brainstorming
Flashbulb Memories

Memories. Why do we sometimes remember the middle—
But not the beginning
Or end?
I’m hiding in the attic, alone. I know why I’m up here—
Mom has been hurt again. This time, she’s gone
To the hospital. How did I get up there? Where was
My sister? Where were my brothers?
I must have been up there for a long time because
I have to pee—real bad. I jump up and down
And race back and forth. Why
Was I alone?
I’d been hiding the knives for weeks because I’d had
a bad dream.
Sometimes my dreams came true. So I hid the
knives.
Mom would ask, “Where’s the butcher knife?” Did
she think
I’d tell her?
I hear his footsteps downstairs: The sound of his
steel-toed boots.
The boots he uses to kick her. I know it’s him

Didn’t anyone wonder
Where I was? Where were my sister and
brothers? How did I
Get up there? All I’m sure of is I have to pee
and I don’t want him
To find me. I pick my nails till they bleed.
One night he ate dinner at the coffee table.
Then he fell asleep
On the couch, his plate and utensils left
where she’d served him.
I tiptoed over, grabbed the steak knife, and
hid it.
Somewhere. I know I hid it.
His boots quit their ambling. I hear them
leave the front of the house
And head towards the back. They linger by
the attic door.
How did he figure out where I am? They
March up the wooden steps.
“Little Laurie!” His voice is playful. “What
Are you doing up here?”
He takes my hand.
It was a butter knife, she later told me. He
throw a butter knife
And it slit her wrist.
A butter knife.

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If Laurie were your patient …

how might you expect her health
and wellbeing to be affected?

(Only if you read the poem in slide 19 – otherwise skip this slide and question)

Ask the question on the slide and try to get a few answers, in order to keep encouraging participants to think about the relevance of the presented intimate partner violence facts for health and health care. No lengthy discussion needed here since a more comprehensive list of health sequelae will be offered in Unit 2.

A few possible answers:

▪ Stress related complaints (stomach aches, headaches etc)
▪ Nightmares, anxiety
▪ Behavioral patterns like nailbiting
▪ She might get injured if she gets too involved in the abuse
Children’s experiences of intimate partner violence lie on a continuum. (*Point at slide from left to right as you explain)*:

- They may never directly see the violence, but sense the tension.
- They may not see it but hear it at night from their bedroom.
- They may see the aftermath in the morning, e.g. the injuries, or damaged furniture etc.
- Or they may actually witness assaults against their parent. They may witness less severe forms of violence, or very severe forms, like rape or even murder.
- Some children may try to intervene thus becoming more than witnesses.
- Or they may also become victims of abuse themselves.

This visual was made by the Domestic Violence Unit of the VT Department of Children and Families (DCF). They were trying to illustrate that there is a range of exposure for child witnesses of intimate partner violence and that the left part of the range would not be considered child abuse, although the children may be negatively affected, whereas the right side of the spectrum might be considered child abuse. Depending on the severity and impact, SRS might consider stepping in.

However, the general guideline for trying to keep child witnesses safe is: *(show next slide)*
Increased safety and support for the battered parent usually translates into increased safety and support for the children.

- This is just a general rule, to remind us not to focus on the safety and wellbeing of children while forgetting the adult survivor, or working against the adult survivor (many battered women are in great fear of losing their children, a fear that is often manipulated by the batterer.)

- Unfortunately, batterers are often able to keep compromising the safety and well-being of their children and partners even after separation or divorce, often via shared custody or visitation arrangements (but we do not have time to discuss this more. There is a book in your resource list, “The Batterer as Parent”, by Lundy Bancroft and Jay Silverman, in which you can find out more about this topic)
Talking Points:

• As a service provider intimate partner violence can be painful and frustrating to deal with. We must guard ourselves and each other against slipping into victim blaming, which is all too easy and common.

• The stereotypical question "why doesn’t she leave" is an example of victim blaming. We do not ask other victims of crime this question. We normally hold the perpetrator accountable. Why does he do this? And we need to ask ourselves what we and the community can do to end the violence, both in individual cases and for the community as a whole.

• It is also very unfair to blame battered women for the harm that is done to the children by having them witness the violence. Avoid saying things like” Do you realize what you are doing to your children (by staying in the relationship)?”. Battered mothers often try their very best to keep the children safe. Again, we need to hold the batterer accountable for the harm done to the children. It can be helpful to explore with the victim how the children are affected, while placing the responsibility for this with the batterer, and then asking how you can support the victim in gaining and maintaining safety for herself and her children.

• The most important question for us as service providers is the last question on this slide [read]

• We will now do a quick experiential exercise to understand more accurately what your patient may be facing while trying to regain safety. The process we will witness is one that may have been triggered by your screening and referrals. Or you as a health care provider may come in somewhere in the middle, as one of the service providers involved.
For the Instructor: See → Exercise instructions and materials on the CD under Unit 1: Other Materials.

You should find:

- Instructions on how to set up the exercise
- A set of numbered cards with comments from service providers and helpers
- A script for the people impersonating the batterer and the victim
It is important for us to note that:

- **Anyone** can be a victim
- However: **Heterosexual Women** are at a higher risk
- **Younger women** are at higher risk than older women
- **Women with disabilities** are 2 – 10 times more likely to experience abuse. Elders and people with disabilities are perceived as vulnerable and therefore sought out by perpetrators

The **risk of being battered** and the **entrapment** when it happens **INCREASE** for

- Anyone who is more **isolated**
- Anyone who has **less access to resources**

The first picture shows a **non-white low income immigrant woman with young children** – this woman might be very isolated in the U.S. and have great barriers to accessing resources, especially if she doesn’t speak English.

Another example would be **women in remote rural areas**. There is often no neighbor within eyesight or ear shot, and access to resources can be very difficult (e.g.: in some areas in VT there isn’t even a taxi service after 6 p.m. – what if women have no access to transportation and need to flee their home, or get to the court to file for a relief from abuse order, or go to PATH to apply for emergency assistance?)
“Anyone who is more isolated or who has more difficulties accessing resources”, for example people from these groups: people with disabilities, elderly people, teens, same sex couples.

Many of the resources and options for intimate partner violence survivors are not very accessible to, for example, a person with a developmental or physical disability.

**ASK:** Who among you provides health care to people from these groups? (*show hands*)

Please keep in mind the special vulnerability and needs of survivors from these groups. (*more on this in the next video clip*)

*Photograph Credits: Elder Couple by Ben Garvin; Gay Couple by PDI;*
We will now see some video clips from an excellent documentary called “Voices Heard, Sisters Unseen”, a film by Grace Poore (on your resource list).

She interviewed female survivors from particularly marginalized groups, for example non-English speaking immigrants, women with disabilities, lesbian women, HIV-positive women, and sex workers.

I assume that you provide health care to women from these groups, and therefore may have to address intimate partner violence that is affecting their health. As you watch the video clips, please consider the following questions:

[read slide]
Before we close, I wanted to briefly address an issue whose connection with intimate partner violence is often misunderstood: **Substance abuse**.

[read as you have the bullets fade in one by one]:

Does substance abuse cause intimate partner violence?

NO.

“If he stops drinking, will he stop abusing me?”

NO.

**Talking Points:**

- Intoxication is often used as an excuse by the batterer and by the victim (who may be desperately looking for explanations why someone she loves would hurt her)
- Experience has shown that substance abuse can make abuse more intense and dangerous. However, a sober batterer is usually still a batterer, although he (she) may not act out as violently.
- Perpetrators have to address substance abuse and battering separately. As long as a batterer still holds the values and attitudes that are the basis of his behavior, the abuse will not stop.

Survivors of intimate partner violence may also abuse substances.

- [read first bullet] they may have started drinking or using as a way to cope or numb the pain.
- [read second bullet] They may have been pulled or coerced into the habit by the batterer.
- [read third bullet] Or they may have already been abusing substances.

**Talking Points**

- In any case, the **substance abuse makes them more vulnerable**. It may affect their judgment or safety planning, it may affect their legal status, it may affect their ability to gain economic independence, it may cause their social support to erode even more. Substance abuse by the victim often used as a weapon by the perpetrator. He may threaten to turn them in, he may use it to put them down, and he may use it to threaten loss of custody, job or other important supports.

- As a health care provider who screens and counsels patients for substance abuse, it is important that you are aware of how this issue can interact with the intimate partner violence. There may be a **precarious balance between the goals of safety and sobriety**. We will return to this issue in Unit 2.
A brief note on stalking, a form of abuse which we haven't talked about before:

In addition to physical and sexual violence, stalking is also a crime in Vermont (and all other states).

In Vermont Law, stalking is defined as following, lying in wait, and harassing, without legitimate purpose, causing fear and emotional distress in the victim.

This is another abusive strategy that is used by batterers, during the relationship or after the victim has tried to escape from the relationship.

The health impact of stalking can be severe, including anxiety, insomnia, and severe depression. Some victims seek psychological counseling or psychiatric health care.
I hope this session has enriched your understanding of intimate partner violence as a long-term, very complex issue that affects all parts of a survivor’s life and all family members.

You will be able to appreciate how intimate partner violence is likely to cause a wide range of health problems for your patients, some of them severe. It is also likely to interfere with the health care you are trying to provide.

Therefore, even if you do not address it in your practice, it will likely always be there right in the room with you and your patient.

So: how can you address it? [next slide]
Here are some key things that survivors need in order to regain their health and well-being. [read slide]

In the following units of this training series, you will explore strategies and tools that allow health care professionals to address intimate partner violence as part of their day to day routine.

- Thank participants for their attention and participation and
- Offer yourself (or someone else) as a resource if they have further questions about intimate partner violence.
- Encourage them to talk about intimate partner violence with a trusted friend or with a domestic violence advocate should this session have triggered difficult emotions for them, or should they ever need help for themselves or people close to them.
Welcome, introductions

In the last section of this training series, we covered what health care providers need to know about intimate partner violence in order to understand the issue and how it affects the health and health care of your patients.

Building on this, we will now explore the best ways to address intimate partner violence in the clinical encounter.
Our goals for this session are:
1. To clarify what is and what isn’t the role of the health care provider in addressing intimate partner violence;

2. To introduce and practice with strategies and tools for screening, assessment, documentation and intervention for patients who are victims of intimate partner violence; and

3. To address time management strategies for integrating all this into the brief clinical encounters you have with patients.

To summarize the situation: [next slide]
Your patient comes to you with health problems and hopes you can address them. Your patient is being battered, i.e. is being subjected to a pattern of abuse that may be emotional, physical, sexual and/or economic. This context affects your patient’s health. It may directly cause the health problems your patient is presenting with, or it may aggravate them. The context also affects the health care you can provide, and the therapeutic relationship between you and your patient. It may prevent the patient from giving you information, it may prevent adherence to treatment regimes you recommend, etc.

Therefore, even if you do not address the intimate partner violence, it is right there in the exam room with you.

**Question:** What are your fears/barriers in addressing intimate partner violence in your clinical encounters?

[Summarize responses and briefly say which ones will be addressed in this training session. Lead into the next slide which will probably start to address some of the fears/barriers mentioned.]

It may be helpful to start addressing some of the fears and barriers you mentioned by clarifying the role of the health care provider in intimate partner violence cases:
It is important to realize that intimate partner violence, although a crucial public health problem with many physical and mental health sequelae for your patient, is not a "medical" problem that can be solved with medical interventions.

- As health care providers, we are not supposed to solve it.
- We cannot fix the situation.
- We are not expected to get deeply involved in the issue or provide lengthy counseling.
- Our role is ...: [next slide]
(Our role is:)

- To acknowledge the violence as an issue that is seriously affecting the health, wellbeing and safety of our patients and their children.
- Our expertise is required to treat the physical and mental health sequelae of the battering.
- In our clinical encounter, we need to be able to identify, assess and record what is happening to the patient and how that affects their health.
- Like everyone dealing with intimate partner violence situations, we need to make safety a priority.
- And we need to help open doors for the affected patient so they are aware of options and resources and know how to access them.

The questions that come up regularly for health care providers are: [next slide]
Most of us have very limited time to spend with each patient.

In this and the next section of this training series we will explore tools, strategies and resources with you that will allow you to address intimate partner violence routinely in your brief clinical encounters and that will maximize your effectiveness.

These include screening and assessment tools you will work with today, also strategies like triage, team approach, using the practice environment, effective referrals and community collaboration, and patient outreach materials.
Remind people of Julie’s survivor testimony from Unit 1.

This is a continuation of the interview with Julie, but focusing more on her interaction with health care professionals and what was and was not helpful.

Julie had important experiences with the health care system as she was trying to survive abuse. While you are watching this clip, I would like you to consider what implications you see for your own role and practice.

Discuss briefly after the video.
If questions come up that have to do with the “how” of health care intervention, use this as a transition into the rest of the lecture and announce that you will give very concrete suggestions and tools and also show actual clinical scenarios.
These are the steps we will discuss today.

What we are presenting today is consistent with national consensus guidelines, for example those from the American Medical Association, and the new Consensus Guidelines published by the Family Violence Prevention Fund. They have guidelines for addressing intimate partner violence with regard to adult patients, and another set specific to children and youth. [hold up the two copies] These can be ordered for $5/each or you can print them as a PDF file from the website, if you are interested in having this as a resource for your practice or clinic. You can find references and ordering information for these and all other materials we are using today in your training packet.

In the next hour, we will watch 3 clinical scenarios from a new video called “Screening to End Abuse”. The health care providers featured in these scenarios are real health professionals, in their actual clinical settings, although the situations are acted.

The first scenario will show a fairly thorough screening for abuse with a teenager who comes for her first visit to a Planned Parenthood clinic. Notice how the practitioner screens the teen both for child abuse and dating violence.
Post-Video Discussion (keep brief):
What is your reaction to this? What do you think the provider accomplished?

[possible answers:
provider accomplished a lot in this brief encounter:
• screening for both dating violence and child abuse, but not child witnessing
• Asked about physical, emotional and sexual abuse
• Educating on health relationship and resources -> prevention
• Opening the door for future disclosures should patient ever need it
• Presenting clinic/clinician as resource]

ASK: Does this seem like something you could realistically integrate into your practice?
Screening and Identification

Who:
- Health Care professional trained on the issue

Whom:
- All adolescent and adult women;
- Any patient if indicators present

If you screen, be prepared to intervene!

- Screening and initial response should be conducted by a health care provider who
  - has been educated on dynamics of intimate partner violence and on issues of patient safety and autonomy.
  - has been trained how to screen, assess, document the abuse and to provide information and referrals to community resources.
  - is authorized to write in medical records (documentation is important)

- Screening should not be done if you cannot ensure an appropriate response to patients who may disclose abuse. (“if you screen, be prepared to intervene!”)

- It is generally recommended that all female patients are screened routinely and that male patients are screened if indicators of victimization are present.
  - The new consensus guidelines recommend routine screening of all patients, male or female, but caution that this will increase the likelihood of batterers perpetrators screening positive for victimization. They recommend extra precautions to ensure safety for victims and careful training for providers on perpetrator dynamics. This may go beyond realistic possibilities for a clinic that is only starting to tackle the issue and where providers have only received basic training.
  - We would only recommend routine screening of men if the health care team has a high level of training in the issue, has clear protocols, and safety measures are built into the protocol.
  - However, men should be screened when red flags for intimate partner violence victimization are present.
  - We will talk briefly about dealing with perpetrators later in the lecture.
It is recommended practice to screen

- All new patients
- Annual visits
- New chief complaint
- New intimate relationship
- First prenatal visit and at least once/trimester; post partum check up
- When signs or symptoms raise concerns
How to screen

- **In private!**
- Confidentially
- Routinely
- Questionnaire and face-to-face
- Appropriate language

- You must ask in private, never within ear shot of other people.
- Screening must be done confidentially. **Address confidentiality (and its limits) explicitly** with the person you are screening. This will allow them to make more informed choices about whether it is safe to disclose intimate partner violence to you.
- Screening is best done **routinely** (and presented to patients as routine, so they don’t feel singled out)
- You can use a questionnaire but without your **asking face to face**, many patients may not be able to share this information with you
- The appropriate language to use is language that is easily accessible and feels comfortable to the survivor. Most survivors do not identify with terms like “intimate partner violence”, “battered woman” etc. and don’t want to be labeled. **Listen for the language they use** to talk about what’s happening to them. This becomes particularly important when you are working with patients whose culture you do not share.

If you remember one thing about this lecture, it should be that **screening must be done confidentially and in private, in a situation that feels safe**. We hear stories again and again about providers screening patients when their partners, family members or other people are in the same room or within ear shot. This is not only **ineffective**, since they obviously cannot safely disclose, but is also detrimental and even **dangerous** to the victim.

- For example she or he may more keenly feel the isolation and hopelessness of the situation and her or his powerlessness as she or he is forced to lie in front of you and family,
- or she or he may actually have to bear the abusive repercussions if the partner witnessed the screening and takes offense at the way she or he responded.
Both current and past abuse can be affecting the patient’s health.  
- Screening for current abuse should always be done.  
- Screen for lifetime abuse only when an extensive social history is taken, or when special concerns arise. Post-traumatic stress symptoms can affect someone’s health for many years after a relationship has ended.  
- Always screen for the different types of abuse. It is important that you acknowledge not only physical violence but also emotional and sexual violence and their potentially debilitating effects. Some patients may not have named what’s happening to them as “violence”, this can be a powerful (validating, educational) step.
[Step-by-step handout]

Your handout gives examples for effective screening questions.

Usually you would use a **framing statement**, like “Because so many people are impacted by violence, I have begun to ask all my patients about it.”

Or, if you are reacting to specific indicators of abuse: “I am concerned that your symptoms may have been caused by someone hurting you.”

Then you would ask very **direct and specific questions** “has someone close to you hit you or pushed you or otherwise hurt you over the past 6 months (or: since you got pregnant; or: in the past)?”

**Brief Activity**: Please take a minute and do the following: pick a couple of questions you may want to use in your screening. Then turn to your neighbor, and try out the questions or statements – just so that you see how it might feel to say these things, and maybe find a way to formulate these questions that feels most comfortable to you. Give each other feedback – how did this question feel to you as the person who is asked?

[Keep this very brief. Just enough to get participants actively engaged with the screening questions]
Physical violence may result in visible injuries. When you are treating a patient for an injury or you are reviewing the past medical record, watch for the following:

- If there is a history of frequent injuries (the apparently “clumsy” patient who breaks her arm, walks into a door, slips on the stairs etc all within one year)
- If the cause of the injury is unexplained or the history is inconsistent with the presentation.
- If there is an unexplained delay in the patient's seeking treatment (they may have been too embarrassed or they may have been prevented by the batterer from seeking treatment).
- If you see several injuries in different stages of healing. For example a burn scar, an old bruise, and a fresh bruise.
- If the injuries are injuries one would receive when using a defensive posture to protect oneself from physical assault [demonstrate putting arms up to protect face, or curling up to protect head and abdomen]
- Many things leave a distinctive pattern when they are used to injure someone, for example finger tip imprints from being grabbed and shaken, an imprint of the shape of the object that was used as a weapon, e.g. shoe tread, belt buckle, burn in the shape of an iron or cigarette butt, etc.
- Batterers are often quite controlled about where they cause injuries. They may try to leave visible marks only in places that are normally covered by clothing, leading to the so-called bathing suit pattern of injuries.
- Injuries in the genital area should be a red flag for sexual abuse.
In some cases, a serious assault may leave behind very little visible injury. Such may be the case with victims who have been choked or strangled.

- In the case of choking or strangulation, the victim’s visible injury may include only redness around the throat.

- Keep in mind that although choking or strangulation injuries may appear mild initially, they can kill the victim within 36 hours because internal neck swelling can occur, leading to airway compromise.

- The patient may experience neck pain, a sore throat, hoarseness, loss of voice, difficulty swallowing, light-headedness or head rush, fainting or unconsciousness, nausea or vomiting.
Identifying Strangulation Injuries

- Rope or cord burns
- Neck swelling
- Petechiae
  (face, neck or sclerae)

- Look for vertical or horizontal marks on the neck, rope or cord burns, contusions, petechiae (due to capillary breakage during the choke-hold).

- Also check for scratches around the neck — these may be from either the assailant or the victim who was trying to release the choke-hold.

- Look for neck swelling, which may range from subtle to severe.

- Check the victim’s sclerae for ruptured capillaries as well.

- Bruises may be delayed in presentation. If the patient is discharged, be sure to have her or him return in 24 hours for a follow-up photo if it is safe for her or him.
“This patient is so frustrating…!”

You may have said this in exasperation about one of your patients, when what you were reacting to were really **indicators of intimate partner violence**

Your patient may:

- miss appointments
- not follow the treatment regime you prescribed
- start prenatal care late
- delay seeking treatment for injuries or acute conditions
- abuse substances
- show a flat affect, be uncommunicative

If your patient is not taking care of her(or him)self or not cooperating with you – consider whether someone may be preventing them from doing so.

The **partner’s behavior** may also give you clues. Very controlling batterers often accompany their partners to the health care visit. They may be **reluctant to leave the room**, they may **hover, or answer questions for the patient, act controlling** etc

You need to find **strategies to get time alone with the patient** if you want to address intimate partner violence. This can be quite challenging because this is what batterers want to prevent.

Batterers also often strive for a **good public image**. Remember Fred’s story from Unit 1? They may present themselves as the perfect concerned family member. They may **try to manipulate you**, for example by trying to tell you things about their partner that will undermine her or his credibility.
Here is a list of health conditions that may be related to intimate partner violence.

Obviously, patients presenting with depression, anxiety, Post Traumatic Stress Disorder (PTSD), or suicidal ideation should always be screened for intimate partner violence, both for current and past abuse.

Other possible indicators include [read slide].

For last bullet: We talked in Unit 1 about the impact that intimate partner violence can have on reproductive health (remember the story of the teenage girl who became pregnant). Batterers often prevent their partners from protecting themselves against pregnancies and STIs. They may also force their partners to seek an abortion or prevent them from doing so. Abuse during pregnancy may lead to complications.
If the patient discloses abuse: Validation

- Listen non-judgmentally
- “I am sorry this happened to you”
- “It is not your fault”
- “Nobody deserves to be abused”
- “I am concerned for your safety”

If the patient discloses abuse take the time to listen and make these statements. [read statements on slide]

Most survivors are afraid of being judged.
They may be ashamed.
They may have had bad experiences when they disclosed before. They may have heard statements like: “why don’t you just leave?” “I can’t believe Bill would do something like this to you.” “What did you do to provoke Jane?” etc. Or they may have just elicited embarrassed silence and a change of topic. They are used to being invisible and isolated.
They have likely been told again and again by the abuser that it is they who are responsible for the abuse, that it is their fault, that they deserve it.

In countering these destructive messages, these simple validating statements can be your most powerful intervention with a survivor.
You may also have planted an important seed that will bear fruit in the future.
If you ask about abuse and the patient says no, this would be a helpful response from you:

[read slide]

With this response, you have opened doors both for people who are being abused and for those who aren’t.

- **People who are being abused** but cannot disclose to you, will know that this is an issue that you are concerned about and that they can bring it up with you in the future. They are also encouraged to pick up information material in a confidential space (the restroom), so they can self-refer to an domestic violence hotline without ever talking to you about the abuse.

- **People who are not being abused** are alerted to the fact that this is a health issue, and that they can use you or the clinic as a resource if they ever need to. They may also think of someone else who needs help, and they may pick up information for them.
If you strongly suspect that your patient is surviving abuse, **don’t try to force a disclosure.** This is not your goal and not your role. People may have very good reasons why they don’t choose to talk about this with you. Or at least not at this time.

You could, however, **discuss some risk factors and offer resources** in a purely informational way, again, opening doors for the patient.

For example: “Young women who start dating are often hurt by their dating partners and it can be quite confusing. That’s why I talk to all my patients about this. For example, several of the young women I have seen were isolated from their friends and families, or they were forced to have sex, or they were constantly put down by their boyfriends [if you know she is dating male partners]. So I just want to make sure that you know that you don’t deserve to be treated like this and should this ever happen to you, there are people you can talk to and who may be able to help. We always keep safety cards and […] in the restrooms, so if you want to pick up information for yourself or for anyone else you know who might need it, feel free to do that.”
If you have screened a patient and she or he has disclosed that she is being battered by an intimate partner, the next step is to assess the situation.

The assessment covers

1. The abuse pattern: What’s happening to your patient – who is doing what to them, how often, since when?

2. How is this impacting her health, and how might it be connected with the chief complaint that they are presenting?

3. How safe are they? Are they or their children in danger of injury or death?
Safety assessments are based on current knowledge about risk factors for lethal danger.

A batterer’s unemployment, access to guns, use of illicit drugs (but not alcohol use) and threats of deadly violence are the strongest predictors of female homicide in abusive relationships, according to a study published in the American Journal of Public Health (July 2003, Vol. 93, No. 7. Risk Factors for Femicide in Abusive Relationships: Results From a Multisite Case Control Study.) Victims who try to leave or ask him to leave are also at greater risk of being killed.

The study was based on interviews with family members and other acquaintances of 220 female victims of intimate partner homicide from eleven cities across the country, as well as a control group of 343 women who reported being the victims of physical abuse in the past two years.

Safety assessment tools have been made based on results from this and similar studies. It’s very important to note that a safety assessment is only a guiding tool. Of course we cannot reliably predict human behavior. But it will allow you and your patient to assess the situation and identify red flags.

We have included an assessment and documentation tool specifically designed for health care settings in your course handouts (so you can use it in your further practice if you find it helpful).
Introduce the Video:

We will now show a clinical scenario where the provider screens and the patient discloses abuse. You can see:

1. Gender-neutral screening for same-sex abuse,
2. How you may deal with a partner who doesn’t want to leave the room,
3. And some of the validation intervention that we talked about earlier.

The provider here does not get to do an assessment of the abuse pattern and its health impact, although she addresses safety briefly. After the video, we will use this case as a case study and fill in what she didn’t do, using our assessment tool.

After Video, introduce role play exercise:

- Ask participants to pick a neighbor as role play partner and to decide who will play the patient and who will play the provider. [wait briefly]
- Hand out separate ⇒ role play instructions for the “patients” and the “clinicians” (⇒ see “Unit 2: Handouts”)
- Ask participants to read their role play instructions and take 5-7 minutes to do assessment of abuse pattern, health impact and safety risks, using the relevant portions of their assessment tool and filling in the information as they go along.
- After role play do brief check in: how did the tool work for you? Would this be useful in your practice? How did it feel to the person playing the patient role?
In documenting your findings it is important that you create an entry that will:

- Feel accurate and respectful to the patient if s/he ever requests to see her/his chart
- Not hurt the patient should the chart ever be used as evidence in a possible court case

Use verbatim quotes from the patient whenever possible. Use the verb "patient states", not verbs like "alleges" or "claims" which could be turned against her in court by the defense attorney. Never use pejorative language like “patient is hysterical” or “patient failed to do xyz”.

Another mistake that is often made is to use the passive voice to describe what happened to the patient and eliminate the perpetrator: "patient struck by blunt object". Or the perpetrator is not identified: "patient struck by boyfriend". This may be used by the defense attorney to argue that this is not necessarily about the defendant. Always include who did what, and add the full name if possible.

We have prepared a handout with sample documentation, bad and good examples.

[point to handout on documentation, give them time to read it]

Activity: In order to familiarize yourself with the documentation tools, I suggest everyone write a chart entry and complete the body map for our case with Peter. [the man from the clinical scenario]

- You know his story from the assessment you just did. Here are two slides with his injuries.
- [show next two slides]
- [allow a few minutes for charting]
Bruising of the ulnar aspect of the forearm can indicate a defensive injury.
Here we see a circular pattern injury caused by fingertip pressure. Fingertip contusions are typically 1.0 – 1.5 cm in diameter, but may be larger if the victim struggled and pulled away while the perpetrator was still grabbing her or him.

(when participants have finished their chart entries:)

**Can one of you share your chart entry?**

[have one read; if good, proceed to next slide; if problematic, discuss in group and get better version]
We already mentioned that screening in itself is already an intervention. We also talked about the importance of the simple intervention of validating the survivor’s experiences.

Other important brief interventions include:

Education – this can be done verbally or in written form through brochures.

Safety Planning – you may not have time for extensive safety planning. However, you can strategize with the patient around immediate safety issues, should they be in immediate danger (for example asking whether you should call the police, whether they need emergency shelter, or can they safely take information home, come back for a follow up visit, see a counselor at your clinic, etc.). The important thing is that you keep safety issues in the forefront of your mind and raise them with your patient. If needed, you can refer for more extensive safety planning, either in-house if you have a social worker trained in this, or to the local domestic and sexual violence program.

HANDOUT: Safety Plan

Referrals are a key intervention, since you will not be able to meet many of the needs the survivor may have. We will talk more about effective referrals later in this section, and also in the next part of this curriculum.

Follow-up – schedule a follow up visit. This will give you opportunities for building a relationship, checking in about emerging issues, reiterating important messages, and ongoing medical support of the survivor.

We will now watch a clinical scenario in a pediatric office.
While you are watching this scenario, please note which interventions this provider offers.

[show video clip]

Which interventions did you think were done effectively?
[screening, validation, educating about effects of witnessing intimate partner violence on children, offering to be ongoing resource, offering referral material]

What else could the provider have done?
[assessing abuse/danger, safety planning for future violent episodes, talking about possible interventions/referrals for child, other ..?]
• Studies have found that between 4-8% of pregnant women are abused during pregnancy.
• In public prenatal clinics, studies found a prevalence of 16% or more pregnant women abused.
• National data indicate 11% more homicides in pregnant women than in non-pregnant women.
• Given the data we have, pregnant women are more likely to die from intimate partner violence than from eclampsia, clotting disorders, or diabetes.

• We have seen earlier that battering often interferes with reproductive choices.

• It can also have a direct or indirect effect on the fetus,
  • through injuries,
  • through the stress that battered pregnant women are experiencing,
  • through their possibly limited access to prenatal care,
  • or through coping behaviors of the survivor (like smoking, alcohol consumption, use of sedatives, etc.)

• Pregnancy is often a great window of opportunity to address intimate partner violence in a health care context:
  • Women often have very frequent and sustained contact with their health care providers, and
  • they may be highly motivated to think about their child’s future, to be a good parent, etc.
  • All pregnant women should be screened and all perinatal health care providers should be trained to offer interventions.
Substance abuse of the survivor may, as we discussed in the previous lecture, be directly connected to the intimate partner violence. Survivors may use substances as part of coping strategies, or they may have been coerced into substance abuse by the batterer. They may also have started using substances without direct connection to the abuse. In any case, substance abuse makes the survivor more vulnerable, both in physical and in legal terms.

Most domestic and sexual violence programs in Vermont do not provide substance abuse counseling or services, and substance abuse programs don’t usually provide domestic/sexual violence services. Survivors need to use different services for their problems. In referring and counseling your patient on this, you need to assess and discuss with the patient what timing and sequence might be best in her case. Safety should always be the first consideration, even if this delays addressing the substance abuse. Addressing both issues at the same time may also feel overwhelming. Sometimes survivors may need to get out of the reach of their violent and controlling partner before they can follow a substance abuse treatment program successfully. On the other hand, other survivors may feel they need to solve their substance abuse problem first, before they can successfully escape the battering.

Another issue providers should be aware of is that substance abuse services and domestic/sexual violence advocates may be giving messages to the survivor that can seem contradictory and confusing. For example, in 12 step programs participants learn that substance abuse is a disease that is stronger than they are. If they attend support groups for battered women at the same time, they will likely discuss that domestic abuse is not related to disease or disorders, either of the survivor or the batterer. If they see a mental health counselor, they maybe encouraged to see the abuse and substance abuse in terms of mental health problems (co-dependency, enabling, battered women’s syndrome etc). This may be confusing. The health care provider can help by clearly distinguishing between the two issues, and reiterating that intimate partner violence is a crime and not a disease and that nothing the survivor does causes the abuse.

Another thing to keep in mind when documenting, educating or making referrals for the patient is that substance abuse makes the survivor more vulnerable. The survivor whose substance abuse is known in court risks not being believed or, worse, losing custody of the children.
If patients are accompanied by their abusive partner, or if the abusive person is also your patient, you may have to deal with the perpetrator directly and this may feel quite difficult.

- Everything you do should be guided by the priority of survivor safety and confidentiality.
- Never, ever discuss intimate partner violence with both people in the room, even if you have a good relationship with them.
- Also never let any of them know what the other one said, unless there is a threat of homicide and you have the duty to warn [get legal advice on this].
- However, if batterers self-disclose: (e.g. “I broke my knuckle when I slapped her around. She went berserk that night and I had to stop her for her own safety and the kids”) you must respond, because silence would communicate tacit approval or tolerance, which is the message that enables batterers to keep battering. You can treat it as a health and safety issue, for example say that this makes you very concerned for the safety and health of the whole family. Offer some brief education on effects of violence on adults and children, and offer a referral to a domestic violence education group for batterers.
- If a batterer discloses and the victim is also your patient and has not screened positive for abuse, make a note in the victim’s chart to make sure screening and interventions happen at the next visit.
- Make sure you have safety protocols in place that address how to deal with a batterer who threatens the victim or a health care professional at your clinic.
Are you serving people from groups who identify with cultural norms significantly different from yours or from the dominant culture?

It is important that we do not make assumptions about who is more or less likely to be abused or who would be more or less responsive to interventions. We sometimes hear sweeping statements about other cultures and violence, for example that “domestic violence is the norm in [Muslim/South East Asian/West African] families”. It is very important that we remember that:

- Intimate partner violence is a crime by U.S. Law.
- It also violates the Universal Declaration of Human Rights.
- Nobody likes to be abused, no matter what the culture.
- None of the major religions endorses family violence.

But ways to address and talk about the abuse may differ widely.

Options and resources also differ widely. An immigrant woman who speaks little English, has no family here, may risk her immigration status if she gets divorced and is completely dependent on her husband, obviously has extremely difficult choices to make.

If you are working with a patient who does not share your language enough to communicate effectively, do get an [professional interpreter](http://www.example.com). **Never use children or family members** to interpret when you address intimate partner violence. If you can’t access an interpreter immediately, schedule one for the follow up visit.

Your resource list should include resources that meet the needs of specific groups. These may be scant in your local area, but there may be statewide or national resources, some of them with 1-800 numbers. Examples include VT Refugee Resettlement, SafeSpace, a VT LGBTQ anti-violence program; or DVAS: Deaf Victims’ Advocacy Service.

If you have time, engage participants:

Thinking back to the survivor testimonies from Unit 1, what might this look like in your practice with a patient/survivor like

1. Elsa, the Central American non-English speaking immigrant woman?
2. Cindy, the tall lesbian woman who couldn’t disclose her status at work?
3. Beverly, the deaf woman?
### How can I do this during a 15 minute office visit?

- Team approach
- Protocols
- Tools
- Patient packet
- Practice environment
- Community collaboration
- Referrals

How can you do this in 15 minutes?

You can accomplish this best if you use triage and a team approach, have efficient tools at hand, have patient information materials available, and create a practice environment that facilitates addressing intimate partner violence. Effective referral protocols with in-house and community resources are also crucial. You can find resources and materials on these topics online. (Point out their [handout on Resources for Clinicians. The Domestic Violence page of the VT Medical Society has materials and links on all of these topics](#))

We’ll talk more about protocols and using the team approach in the next unit.
In order for you to respond to intimate partner violence, your practice environment needs to allow for private and confidential screening. If patients cannot be in the room alone with you they will likely not be able to disclose current abuse.

Outreach and educational materials can greatly facilitate your response. You reach out to patients while they are waiting or using the rest rooms. You have things to share with them even though you may not have the time to talk to them much.

Imagine a survivor coming into your clinic. There is a poster on intimate partner violence reaching out to her in the waiting area. Then the intake questionnaire asks her about victimization. While you see her, you have a button on your coat that says: “It’s o.k. to talk to me about domestic violence”. You ask her directly about it but she decides not to disclose. You let her know that there are safety cards and brochures in the restroom, a safe and confidential place for her to pick them up. She goes to the restroom, picks up a safety card, and slips it into her shoe. She leaves it under her sole for a few weeks, then takes it out to call the hotline number to talk to an advocate. She also knows that she can bring it up with you at a future visit.

In this case you would have implemented quite an effective response to intimate partner violence, without taking much time at all.

It is absolutely crucial to think about safe ways for survivors to access the outreach material. It may not be safe for them to take brochures home. If you put the brochures in the waiting room within public view, they will likely gather dust on the shelves. Handouts and large brochures may be too big to take home safely. Small safety cards or coins may work better. You can offer patients access to more extensive materials in your clinic, if there is a space where they can read it.
You are the expert on health sequelae of intimate partner violence.

Who are experts on other things a patient may need?

It is crucial that you know your local resources.

Build relationships, have updated resource lists and referral protocols. Just giving the patient a phone number may not result in an effective referral. Patients may have many barriers to making this phone call. Tell them exactly what these places have to offer and what they can expect when they call. It is also helpful to refer the patient to a service provider whom you know personally. These steps can greatly increase the effectiveness of referrals.
Addressing intimate partner violence in the health care setting starts with you, that is health care professionals trained to screen, assess and respond appropriately and effectively.

But you alone cannot and should not have to carry the sole responsibility for implementing the health care response to intimate partner violence. This graphic illustrates the **different layers of institutional support that are required to create an effective and sustainable response.**

We have talked about the practice environment. In the next units, we will discuss the other layers. You will have the opportunity to talk to people from key community resources, the other players in a response network that survivors of intimate partner violence may need to escape the violence.
VT Curriculum on Intimate Partner Violence for Health Care Providers

TOPIC 3:
Beyond the Clinical Encounter: Institutional, Legal and Community Contexts for Providers and Patients

Vermont Network Against Domestic Violence And Sexual Assault, 2004
Commissioned by the VT Department of Health
In this presentation we will go beyond the clinical encounter to discuss how the health care response to intimate partner violence can be institutionalized so it becomes an automatic part of your daily practice.

We will also go over legal responsibilities and liability issues that may arise for you as a health care professional dealing with intimate partner violence.

Finally we will give a brief overview over legal options for your patients. This is important background knowledge for you as someone who will educate and refer patients who are victims/survivors of intimate partner violence.
Addressing intimate partner violence in the health care setting starts with you as a health care professional trained to screen, assess and respond appropriately and effectively.

But you alone cannot and should not have to carry the sole responsibility for implementing the health care response to intimate partner violence. This graphic illustrates the different layers of institutional support that are required to create an effective and sustainable response.

One thing that can help you and your response greatly is a practice environment that supports the central messages through outreach materials and also allows you to screen in private.

Another important factor is a team approach. Different people at your facility can have designated roles and all work together to implement the response efficiently.

Trained health care providers, a conducive practice environment and an effective team approach are sustained through administrative support from your facility.

- Administrative support can provide resources like outreach materials, and implement regular training on domestic and sexual violence (for example for all new staff).
- A really important administrative step is to create effective protocols and make sure they are accessible, people are trained on them, and have someone oversee their implementation. Since intimate partner violence is part of JCAHO’s accreditation guidelines, there would be an incentive for the administration to do this. Another issue is a little different: personnel policies.
- Part of an effective response is also to acknowledge that this is an issue that affects staff as well as clients. Personnel policies should be in place that support victims and hold perpetrators responsible. This is not only the right thing to do for any employer but it will also emphasize that the facility is taking intimate partner violence seriously as a health issue.

Finally, the health care response takes place in the context of a community with many potential resources. In order to offer effective interventions to your patients, your facility and you as providers need to take advantage of these resources, collaborate with other key players and ensure effective referrals.
It is much more **efficient and effective** to use a team approach. This can save you a lot of time.

- For example, the screening could be done by a nurse, the health assessment by the doctor, and the safety assessment and referrals by the social worker.

This will also **serve the survivor better**.

And it is important for **safety's sake** to have everyone on your team clued in and aware of their respective role.

**For example:**

- A **receptionist** needs to know that there may be safety issues in calling the survivor at home. Or she could pick up on the fact that several appointments for one woman were canceled by a man, not herself. If she reports this to the nurse, the nurse may be able to screen more specifically for intimate partner violence. Receptionists should also know that survivors sometimes can not comply with the administrative procedures, because they have to be home at a certain time, or they don't have access to certain information.

- **Security personnel** definitely need to be trained on intervening in intimate partner violence situations, and the staff may need to have a code word for initiating certain safety procedures, for example making up excuses for taking the victim in a room alone (taking for x-rays or urine sample) or calling security or the police.

**Activity:**

- Take a few minutes to determine an effective response team at your facility. What might be an effective and efficient division of labor?

  Depending on the composition of the training participants, this can be done by each participant alone, or in small groups, if it would make sense for people from the same facility/department/practice to work to get her.

  It might be helpful for participants to look at the materials from Topic 2 (steps of clinical management) while they are working on this.
Designating roles for everyone on a health care team is best done through protocols. These are also indispensable for training new staff.

Here are the minimal requirements for an effective IPV protocol, as recommended by the Family Violence Prevention Fund.

If you are interested in more information on this or in obtaining sample protocols from other facilities across the country, contact the Fund. They will send you everything you need.

**ASK:**

- Who of you has an intimate partner violence protocol in your facility?
- Does it meet the minimum requirements?
- Is it helpful to you in your practice?

**Information:** JCAHO requires IPV protocols for all JCAHO accredited institutions (this will be mentioned again in more detail)
Any institution that addresses intimate partner violence amongst its clients should **also address intimate partner violence amongst its members or employees**. Nurses or doctors who are encouraged by their work place to address the violence-related health and safety issues of their patients, also need to know that their own work environment is safe and supportive, allowing victims to come forward and holding perpetrators responsible.

**Sample issues that may come up for you as an employee:**

- If you are being abused and you need to take time off repeatedly to go to court, will your employer accommodate you?
- What if you have a relief from abuse order against your partner and are fearful that he or she will turn up at work and threaten you? Whom can you notify and how will your workplace help to keep you safe?
- Will you have easy access to an Employee Assistance Program and are the counselors trained on intimate partner violence issues?

**ASK:** Is anyone aware of personnel policies that address IPV in your facility? How important is this in your perspective?

If your institution wants to pursue this, there are both **statewide and national resources** that offer help with setting up the appropriate workplace response:

- **The Vermont Attorney General’s Office** runs a “Domestic Violence and the Workplace Initiative”. Your institution can request training or materials free of charge. Contact: Amy S. Fitzgerald, Assistant Attorney General, 109 State St, Montpelier, VT 05609, 828-5520 or afitzgerald@atg.state vt.us
- **The Family Violence Prevention Fund** runs a national workplace campaign. You can order or download materials from their website www.endabuse.org. They have a resource manual, sample policies and a training video.
This checklist was made for self-monitoring purposes. It is from the national Health Care and Domestic Violence Initiative coordinated by the Family Violence Prevention Fund. It is really for hospitals that commit to institutionalizing a proper intimate partner violence response program, so not all items will apply to you and your facility. However, it can give us a good overview of what it would look like if the health care intimate partner violence response were fully institutionalized in a large health care facility.

The following activity can be expanded (30 min including report-out time), depending on your group of participants and their interest. They could form small work groups and start making a list of next steps for their facility, including who does what and the timeline. This might be an important step toward facilitating institutional change.

Activity: Take 10 minutes to get a sense of recommended institutional changes. See how your facility compares.

- Identify a few areas where you think institutional change in your facility would be particularly helpful to you as an individual practitioner who wants to address intimate partner violence with your patients.
- Do you see areas where change would be relatively easy to implement in your facility?
- Who would have to bring suggestions from this list to which forum in order to facilitate the changes you would like to see?

Take a few minutes to have people share some of their results. Encourage them to form or identify an intimate partner violence “taskforce” group and use/adapt this tool to work on changes in their health care facility.
We will now go over some of the legal responsibilities of Health Care Professionals in Vermont, including:

- Any reporting requirements related to intimate partner violence
- Your possible role as an expert witness
- And some general liability issues
There is no mandatory reporting requirement for adult intimate partner violence in Vermont.

Some states, for example California, have mandatory reporting laws for adult intimate partner violence. These laws are very controversial and it remains to be seen whether they can improve safety outcomes for victims.

Regarding Vermont reporting requirements there are two exceptions

1. **Vulnerable Adults** – refers to people who are elderly or persons with disabilities (will be discussed in a slide coming up soon)

2. **Gunshot injuries** 13 VSA §4012: Any injury resulting from discharge of firearm, must be reported to local or state police

**Tip:** You can read the statutes online at www.leg.state.vt.us/statutes

FYI: The statute reads:

§ 4012. Reporting treatment of firearm wounds

(a) Every physician attending or treating a case of bullet wound, gunshot wound, powder burn, or any other injury arising from or caused by the discharge of a gun, pistol, or other firearm, or whenever such case is treated in a hospital, sanitarium or other institution, the manager, superintendent or other person in charge shall report such case at once to local law enforcement officials or the state police. The provisions of this section shall not apply to such wounds, burns or injuries received by a member of the armed forces of the United States or state of Vermont while engaged in the actual performance of duty.

(b) A person violating the provisions of this section shall be fined not more than $100.00.
III. CHILD ABUSE

Reporting Requirement: Yes. 33 VSA §4912-14 (chapter 49)

NOTE: Department of Children and Families usually focuses on abuse of children or youth by caretakers. They do not usually take on dating violence cases except in cases of sexual abuse.

Report to: Department of Children and Families (formerly Social and Rehabilitation Services – SRS).

Contact: Call your closest district office for making a verbal report. Ask for fax number and fax written report. Form available at district office or write informally (include name of caretakers and names, ages, schools/daycare of kids. Also your name, title, and contact info with mailing address).

What to expect: If the case meets legal definitions, the Department of Children and Families will start investigation within 72 hours of report. You may get notified whether an investigation was started and, eventually, about the outcome. You can request notification. Investigators may call you for more information. The Department of Children and Families may contact VNÄ, Healthy Babies program etc. to coordinate investigation and services. They may also involve schools/daycare. Call your local district office for more information on their practices.

FYI: The Statute reads: § 4913. Suspected child abuse and neglect; remedial action

(a) Any physician, surgeon, osteopath, chiropractor, or physician's assistant licensed, certified, or registered under the provisions of Title 26, any resident physician, intern, or any hospital administrator in any hospital in this state, whether or not so registered, and any registered nurse, licensed practical nurse, medical examiner, dentist, psychologist, any other health care provider, [...] mental health professional, social worker, [...] who has reasonable cause to believe that any child has been abused or neglected shall report or cause a report to be made in accordance with the provisions of section 4914 of this title within 24 hours. As used in this subsection, "camp" includes any residential or nonresidential recreational program.

(c) Any person enumerated in subsections (a) or (b) of this section, other than a person suspected of child abuse, who in good faith makes a report to the department of social and rehabilitation services shall be immune from any civil or criminal liability which might otherwise be incurred or imposed as a result of making a report.

(d) The name of the person making the report, or any person mentioned in the report shall be confidential unless the person making the report specifically requests disclosure or unless a judicial proceeding results therefrom or unless a court, after a hearing, finds probable cause to believe that the report was not made in good faith and orders the department to make the name available.

(e)(1) A person who violates subsection (a) of this section shall be fined not more than $500.00.

(2) A person who violates subsection (a) of this section with the intent to conceal abuse or neglect of a child shall be imprisoned not more than six months or fined not more than $1,000.00, or both.
The Department of Children and Families investigates any case of sexual violence against a minor, regardless of who the perpetrator is. However, if a minor is being physically or emotionally abused by a dating partner (rather than a parent or caretaker) this is usually beyond their purview.

If you have a teenager who is the victim of physical or emotional dating violence, refer her or him to the local domestic and sexual violence program and any local resources that support teens.

If you report sexual violence by a dating partner against a teen, also refer the teenager to the local sexual violence program and any local resources that support teens.

As we discussed in an earlier part of this training series, witnessing adult intimate partner violence in itself does not constitute child abuse, unless the child is severely harmed. Educate your adult patient about the effects of witnessing intimate partner violence on children and try to help the adult victim to regain safety together with the child(ren).

You are a mandated reporter of child abuse. When you are reporting child abuse to protect the child in cases where both adult and child abuse are present, consider how you can make this least harmful for the adult survivor. Battered women are often very afraid of losing their children and have often been threatened with this possibility by the batterer.

Identify your concerns for the adult victim to the intake worker. Strategize with them about safest way to investigate.

You can encourage the adult victim to make the report her(him)self first.

You could also refer her or him to the Domestic Violence Unit of the Department of Children and Families – they can talk to them even anonymously and explore their options. The Domestic Violence specialists at the Department of Children and Families would be happy to help.
II. ABUSE OF VULNERABLE ADULTS (ELDER OR DISABLED):

Reporting Requirement: Yes. 33 VSA §6902-6904. (Chapter 69). Report within 48 hours.

Definition: physical, sexual or emotional abuse, neglect or economic exploitation of an individual who has impaired ability to protect her/himself. People who don’t provide their own personal care. People who are in a residential treatment setting (nursing home, group home, psych unit) – check detailed definitions in the statutes. (www.leg.state.vt.us/statutes)

Report to: Adult Protective Services (APS)

Contact: For questions or to obtain a reporting form: 802-241-2345 (Mon-Fri 7:45 – 4:00) - they can also write an informal report. Reporting: 1-800-564-1612; Fax written report to: 241-2358; questions about whether a case meets criteria: 241-3924.

What to expect:

- APS Field Investigator may contact you with further questions.
- If they start investigation, they may ask you or other health care professionals (e.g. Home Health Care) to coordinate setting up confidential interview with victim, if victim cannot be safely contacted.
- Due to confidentiality rules, you may not hear about investigation or any actions taken.
- Victim has right to refuse giving information or accepting services.
- If victim is interested in services, they will try to refer and coordinate, also help with abuse protection orders etc.
- APS will refer to police if they believe crime has occurred.
- APS refers any case involving a Medicaid client to Medicaid Fraud unit. In contrast to APS, Medicaid can take the case to court, and can also follow the case around the country.
Partnering with the Patient

- Don’t report without patient’s (or parent’s) knowledge
- Open dialogue
- Discuss self-reporting
- Safety Planning

(the picture shows a home health nurse visiting an elderly person)

We know that batterers deprive their victims of control over their own lives. **If you have to report abuse to the authorities, you are also doing something that bypasses the victim and takes things out of her or his control. This is your legal responsibility. However, try to mitigate the effects of this loss of control by partnering with the patient (or an abused child’s parent/caretaker) around reporting:**

- **Don’t report without the patient’s (or their parent’s) knowledge**
  Let the patient know that you will report, that you have to do this by law, to whom you are reporting and what they can expect to happen as a result of the report.

- **Open dialogue**
  Allow the patient to respond to your words and hear possible concerns. Ask how you can make it least detrimental to the patient.

- **Discuss self-reporting**
  Discuss the option of self-reporting. *(You will have to report in any case, but patient could make self-report first or concurrently).* Some people feel that this allows them more agency and dignity.

- **Safety Planning**
  Always discuss safety concerns around reporting. How can the authorities (police, The Department of Children and Families, APS) contact the victim most safely. Does she or he need more safety planning to protect her/himself from possible repercussions of the report. *(As we discussed in Topic 2, you can refer for more in-depth safety planning).*

If the patient can not participate in a dialogue or safety planning about reporting due to her/his condition (lost consciousness, dementia, severe developmental disability etc.), contact Adult Protective Services and consult with them.
• JCAHO
• AMA Guidelines
• Other professional recommendations
• Landmark Case

(point out that information on JCAHO and AMA are on the back of their Resources handout. You can read the following JCAHO standards or just refer participants to their handouts)

The Joint Commission on Accreditation of Health Care Organizations included identification and assessment of intimate partner violence in their accreditation criteria:

• Additional Standards for Victims of Abuse Standard PC.3.10 (Hospital Version)
• Patients who may be victims of abuse or neglect are assessed. (See RI.2.150.)

• Rationale for PC.3.10 Victims of abuse or neglect may come to a hospital in a variety of ways. The patient may be unable or reluctant to speak of the abuse, and it may not be obvious to the casual observer. Staff needs to be able to identify abuse and neglect as well as the extent and circumstances of the abuse or neglect to give the patient appropriate care. Criteria for identifying and assessing victims of abuse or neglect should be used throughout the organization. The assessment of the patient must be conducted within the context of the requirements of the law to preserve evidentiary materials and support future legal actions.

• Elements of Performance for PC.3.10 adopting criteria for identifying victims, educating staff, providing referral lists, identification of victims at entry into the system and on an ongoing basis, referring for or conducting assessment, reporting according to laws and policies.

(The American Medical Association published excellent Diagnostic and Treatment Guidelines on http://www.ama-assn.org/ama/pub/category/3242.html)

• Landmark Case: Kringen v. Boslough and St. Vincent Hospital, 1994
• Allegations:
  • no careful hx had been taken;
  • failure to discharge duties in violation of applicable standards of care;
  • failure to comply with policies and protocols for the appropriate management of DV situations;
  • failure to diagnose & assess the DV situation & risk of future injury;
  • failure to intervene to ensure safety.
• The case ended in an out-of-court settlement. A confidentiality clause contained in the agreement prevents us from knowing the details but we know that the hospital had to pay. Court approval was likely due to 1992 AMA and JCAHO protocols
Since JCAHO and professional organizations have, through their recommendations and statements, established screening, assessment and referral of intimate partner violence victims as standards of care, the issue of provider civil liability arises.

[This slide is borrowed with permission from Physicians for A Violence Free Society Abuse Response Course]

You may be liable if you fail to recognize and intervene in cases of intimate partner violence. “Intervene” means: screen, assess, address safety, refer and document what you did – i.e. the steps we covered in the previous session of this training series.

You potentially can be sued for negligence based on your failure to diagnose IPV, assess safety, or to refer victims of IPV.

Consider this case:
- A woman enters an ER and on exam is found to have a broken nose, a black eye, and bruises on her left forearm.
- She tells you she fell down the stairs.
- No one questions her version of the events, yet you strongly suspect she has been abused.
- No one offers her information about IPV. No one assesses if it is safe for her to go home, no one refers her to shelters or other resources.
- No one documents in the medical records that any attempt at intervention was made.
- The patient is discharged.
- When the patient returns home, she is killed by her husband. Her family sues the hospital for negligence because of their failure to diagnose IPV.

- There have been similar cases involving failure to screen and intervene in the health care setting, which have been settled in the plaintiff’s favor.

- This case is to remind you of the importance of routine screening for IPV which - first and foremost - is the right thing to do, but will also help protect you from medical malpractice liability.
Intimate partner violence crimes often occur behind closed doors without witnesses. Medical evidence or testimony can therefore sometimes make or break a case.

**Good documentation can keep you out of court**
The prosecutor can use documentary evidence (patient medical record), photographic evidence (photos of injury, taken as part of documentation procedures at health care site) and physical evidence (e.g. torn clothes, bullets retrieved from body, other samples collected in forensic exam) to achieve a plea agreement before the case goes to trial, if you follow the recommended documentation guidelines (covered in Unit 2)

**Expert or other witness**
The prosecutor could call on you to testify if
- You were an eyewitness of the assault
- The perpetrator had accompanied victim to health care visit and you heard incriminating statements
- You handled physical evidence (e.g. recovered a bullet from patient’s body)
- You are an expert who can give an expert opinion on the medical facts involved in the crime
- You have diagnosed and treated victim for the health sequelae of the abuse and are asked to testify on the nature and location of the injuries – this should not be necessary if the documentation is complete and there is nothing unusual about the injury or treatment the patient received.
- Another staff person – the “custodian of records” – may be called to testify in order to establish the authenticity of records.

**You hope to support the victim and the prosecution with your medical documentation but the defense may try to use medical records to impeach or discredit the victim.**
- If the patient statement in the medical chart as to what caused the injury is different from the victim’s testimony in court. For example the medical chart says Patient states “I walked into a door.”, but in the trial the victim states her boyfriend punched her in the eye.
- **Note:** despite this risk, you cannot counsel a patient on telling the truth in order to help herself in court. A statement elicited in this way would not be admissible in court.
- Another example: If the medical chart omits crucial details “Patient reports being hit in the eye”. The defense could argue that there is no clear connection with the defendant because the defendants name is not mentioned as the agent in the reported assault.

**In general:** the court and the jury are more likely to believe the medical records than the victim’s testimony, so try to make detailed, objective records that hold up in court.

**If you receive a summons to testify in court**, review the medical record of the patient and call the prosecutor to discuss whether your in-person testimony would add something relevant to the case. If the prosecutor continues to think of you as a necessary witness, ask for a pretrial conference with the prosecutor and discuss all relevant facts and ask all questions you may have. Then ask to be placed on call for the trial so that you only have to appear for your testimony (you need to be reachable by phone and at the court within 30 min)

**For more information on your role in legal cases, refer to the book by Sherri L. Schornstein, Domestic Violence and Health Care (in your resource handouts).**
Physical and sexual intimate partner violence is a crime in all jurisdictions in the United States. Isolated emotional abuse, however, is not a crime.

A victim can initiate criminal action against the batterer reporting an incident to law enforcement. Law enforcement and the prosecutor decide whether the batterer will be arrested and charged.

In Vermont, spousal and partner abuse can be prosecuted as:

- Simple or aggravated assault
- Domestic assault
- Harassment
- Disturbing the peace
- Stalking
- Violation of an abuse protection order
- Attempted murder
Legal Options for Victims of Intimate Partner Violence

There are both criminal and civil legal options for victims of intimate partner violence.

If a victim decides against reporting a crime and seeking criminal prosecution, the victim has other legal options.

The victim may take civil actions against the batterer and seek:
- temporary or permanent protective orders
- legal separation or divorce
- child custody
- securing property
- compensation through the Victims of Crime Act (VOCA) - only eligible if crime was reported to police. In Vermont crime victim’s comp is handled by the Center for Crime Victim services (contact is on your handout)
- civil suit for damages

Local Domestic and Sexual Violence organizations can help the victim to obtain protective orders.
A civil attorney can help her with legal separation, divorce, and custody of her children as needed.
Who Controls the Process?

- **Civil options**: Victims have more control
- **Criminal options**: victims have less control
  - the State (not the victim) prosecutes the perpetrator
  - only State/judge (not victim) can drop the case

Very generally speaking,

- **civil legal options** allow the victim more control of the process.

For example an intimate partner violence victim who received a protection order against the batterer can ask that the order be dropped.

- **If a crime is reported**, this will set a machinery in motion that the victim cannot control.

For example, an intimate partner violence victim cannot ask that the criminal case against the batterer be dropped, even if the victim may want to for example to avoid negative repercussions (threats by batterer, economic worries – e.g. losing perpetrator’s income may leave family destitute etc).

The intention behind this is that it protects victims of crimes (they are not responsible for the prosecution, they can’t be forced by the perpetrator to drop the case) and makes it more likely that perpetrators are brought to justice.

However, this can also result in loss of control for a victim and may increase her difficulties in surviving.
Obtaining protection orders may be part of the safety planning for victims of IPV so Health Care Professionals should have a basic understanding of them. Patients may ask you for help in obtaining protection orders. Or you may want to mention them as part of your patient education/referral interventions.

The order can impose **conditions on the perpetrator** like:
- not to commit further abuse
- to stay away from victim’s residence and/or work place
- not to contact the victim
- to pay child support and return stolen property

**Can grant victims**
- Temporary custody of the children
- Temporary sole use of residence (even if jointly owned)

It can also **grant the victim** certain protective **privileges** like:
- Temporary custody of the children
- Temporary sole use of residence (even if jointly owned)

These are just examples; **victims can also ask for many other provisions** (which may or may not be granted).

Most Orders of Protection will be honored by jurisdictions other than the one in which it was issued (this principle is called “full faith and credit.”)

Orders of Protection are obtained through the **civil legal system** (family court), however, a **violation of the order** can be prosecuted by the **criminal justice system**.

It is important to keep in mind that your local domestic and sexual violence advocates can help your patients apply for protection orders and be there for them during the court hearing.
Protection Orders

- Can be obtained on an emergency basis 24/7 (Temporary Relief from Abuse Order)
- Can be made permanent after court hearing (Permanent Relief from Abuse Order)
- Make violation of order a felony
- Are “just a piece of paper” (Julie, survivor of intimate partner violence)
- Victims may be manipulated into dropping the order

▪Survivors can obtain orders anytime, either at the family court or after hours at the police department.

Process:
▪The victim has to file an affidavit detailing the abuse, the after hours worker then calls the judge and the judge decides whether an order is granted. The order is valid only once the police have served the perpetrator with the order.
▪A hearing is scheduled within ten days. The victim has to appear in court. The perpetrator is advised of his/her right to appear. After the hearing the judge decides whether a permanent order is granted and what conditions the order will entail.
▪Domestic violence advocates from local DV/SV programs are available to give information and to support victims through the process.

▪Protection orders step up the disincentives for the perpetrator. With the order in place, any violation of the conditions becomes a felony. This means the police can enforce the order and criminal charges can be brought against the perpetrator if he or she violates it.

▪Another great advantage is that the order can give the victim temporary control of the residence and the children, rather than forcing the victim to leave and be homeless.

▪HOWEVER: this only works if the perpetrator abides by the order and if the police department can effectively enforce the order. As Julie, the survivor whose story accompanied us through Topic 1 and 2, said: “it’s just a piece of paper”. It can be very unsafe for the survivor to get the order. It may be the last straw that pushes the batterer into lethal violence. Survivors usually have a good sense whether the order would work or not, so they should not be pushed into using this protection strategy.

▪Victims are also often coerced or manipulated by the batterer into dropping the order before its expiration date. If a victim drops an order, this doesn’t look great to law enforcement and the court and it may decrease the survivor’s chances to get another order when the situation turns dangerous again.
The Victim's Compensation program in Vermont is run by the VT Center for Crime Victim Services in Waterbury. (contact info is on your resource handouts)

If victims sustain losses as a direct result of a crime perpetrated against them, they may be eligible for compensation of the following expenses:

- Medical/dental expenses (incl. eyeglasses, etc.)
- Counseling costs for self or family
- Transportation to medical/counseling/court appointments
- Other expenses: relocation, loss of earnings, funeral, security devices

Note: People can only access victim's comp if:
- The crime was reported to the police, and
- The police have found probable cause that a crime was committed

Many people are not aware of this option. You should mention it to any patient who discloses intimate partner violence victimization. Mention it again if you are referring for counseling, other medical treatments or other services that could represent a financial burden on the victim.
If acts of physical or sexual violence (or stalking) were committed against your patient then a crime has occurred according to VT statutes.

If the crime is reported to law enforcement, they will have to investigate. This may happen at your health care facility or the police may contact the victim later. If a report is done from your facility make sure you know how the victim can be contacted without increasing her/his risks.

Battering is a crime and perpetrators should be brought to justice. However, the process includes some risks for the victim which you should be aware of so you understand that victims who decide against taking the criminal legal route may have very good reasons:

• The perpetrator may be charged with a crime, they may be taken into custody, but it is likely that they will be released immediately (with criminal conditions of release). This means they may be back knocking at the victim’s door within a couple of hours. In general, few perpetrators serve time in jail for battering. Usually it takes a long time for them to be convicted and they will walk free in the meantime. Even when sentenced, they may serve their sentence in the community (under supervision of the Dept. of Corrections). This means that many victims are not effectively protected from further assaults.

• Perpetrators may retaliate against victims for reporting the violence. This may increase risk of injury or death for the victim or other family members or friends. Victims may also have been threatened with abduction of the children or other punishments.

• There are other reasons why victims may decide not to report, for example dependency on the perpetrator for housing/income, personal care (if they have a disability) or residency status (if they are immigrants). Do not urge victims to report a crime if it doesn’t feel safe or helpful to them. As we said earlier, once the crime is reported the process is out of the control of the victim.

Again: perpetrators should be brought to justice, and the police can be a great resource. All police officers in Vermont receive training on intimate partner violence. Some departments in Chittenden County have victim advocates. The VT Department of Corrections has also added some victim advocates to their staff. These victim advocates are also potential collaborators for health care professionals.
What we just talked about is meant as background knowledge for you so you understand the options for your patients and their limitations. You do not have to become a legal expert. So what is your role?

A recent article in the American Journal of Preventive Medicine addressed this question (Pollitz W. “Criminal Justice Response to Violence Against Women” Am J Prev Med 2000;19(4)). Important points from this article are that:

Health Care Providers should clarify that abuse is a crime. Some victims may be uncertain that abusive behavior constitutes a crime. The article states, “Uncertainty may be reinforced when Health Care Providers remain silent about discussing violence in terms of it being a crime.”

Following the clarification that abuse is a crime, the health care professional should:

• mention that there are legal options for victims and
• be ready to refer the patient to places where she or he can obtain more information and assistance regarding accessing the legal options
• If emergency access to legal help is needed, the health care facility should support the patient in doing this (use of their phones, offering to contact law enforcement, can she/he meet domestic violence advocate at the clinic? Etc)

Good documentation in medical records can also be helpful to a victim whose case is going to court. In Unit 2, we talked about how to document intimate partner violence in your medical records. The following slide summarizes what makes documentation valid in court.
Medical records may be useless in court unless they contain:

- Full identity of patient (DOB, SSN, full name)
- Date and time of treatment
- Full name of attending physician
- Nature and location of all injuries
- Victim/patient’s statements regarding who caused injuries, how injuries were caused, preceding history of violence
- Full name of perpetrator and relationship with victim
- Diagnosis and treatment
- Photographs of all injuries
- Injury location chart (body map)
- Documentation concerning all physical evidence recovered by health care professionals and the disposition of the evidence

-Documentation is very important. Medical records may be useless in court unless they contain:
  - Full identity of patient (DOB, SSN, full name)
  - Date and time of treatment
  - Full name of attending physician
  - Nature and location of all injuries
  - Victim/patient’s statements regarding who caused injuries, how injuries were caused, preceding history of violence
  - Full name of perpetrator and relationship with victim
  - Diagnosis and treatment
  - Photographs of all injuries
  - Injury location chart (body map)
  - Documentation concerning all physical evidence recovered by health care professionals and the disposition of the evidence

•NOTE: Well-meaning health care providers may ask patient to consider how a false statement may hurt her or him in court. HOWEVER: DO NOT elicit patient statements about cause of injuries by telling patient about how these statements could help/hurt them in court. Statements made in such a context will be inadmissible in court. Only statements elicited for the expressed purpose of diagnosis and treatment will be admissible.

•Good resource for learning more about legal options and health care professionals role in reporting and court cases (on your handout):
  - Sherri L. Schornstein, Domestic Violence and Health Care: What Every Professional Needs to Know,
Reporting and legal issues can be overwhelming. However, you do not need to be the expert on this. Here is a summary of the community resources you and your patient can use to address legal issues. (read slide)

A regularly updated resource contact list for your local area will serve both you and your patients well. It is also helpful to think about how to make referrals most effectively. Just handing out a phone number may not lead to successful referrals. Patients may have many barriers to reaching out to these organizations. Some ideas for lowering these barriers are
• Describe the services that you are referring to and tell your patient what to expect when s/he calls
• Ask whether the patient will have the opportunity to make a phone call safely and privately during business hours
• Refer the patient to someone in-house, e.g. a social worker, who can do more in-depth needs assessment and referrals
• Offer to make the first phonecall for them and then hand the phone to them.
• Explore arrangements with your local domestic and sexual violence program or the DCF Domestic Violence Unit to have advocates/workers meet patients at your office

During the last session of this training series, you will have the opportunity to meet and work with representatives of some of these organizations.
Survivors who choose to pursue legal remedies are facing a long and often confusing and very stressful process.

Local D/SV programs can help support someone through this process, both on the phone and in person. An added benefit is that all services are free and confidential (unless the advocate is a mandated reporter and suspects child abuse). Survivors can safely explore their options.

Most other resources have legal mandates that may force them to go against the wishes and interests of the survivor at times. For example: the Victim Advocates at the State’s Attorney’s offices around the state are wonderful resources to help and support victims through the criminal court process (N.B. this does not include protection orders, which are civil legal remedies). However, they do not have crisis worker privilege and they have to share information with the prosecution. It is important that victims are clear about the difference, so they can make informed choices and maintain some control.

- Point out that this slide only lists the services related to legal issues. The DV/SV programs offer many more services (see handout Program List)
- Thank the participants and let them know that they will learn more about community resources and the best ways to refer/collaborate in the next unit.
- Refer them to the information resources listed in their “Further Resources” handout for further questions on the topics that were discussed today.
VT Curriculum on Domestic Violence for Health Care Providers

Topic 4:
Health Care as Part of the Community Response

VT Network Against Domestic Violence and Sexual Assault 2004
Many people trying to survive partner abuse feel as if they are completely alone in their predicament, a situation that is fostered by the isolation strategies used by most batterers.

Once you reach out to a survivor, you are making an important statement: You are not alone. This is a public issue. I am here to help.
Intimate Partner Violence, as we have seen, is a very complex problem. Your patient who is trying to survive intimate partner violence needs you to address the health problems resulting from the abuse. However, she or he may have many other needs. You may not be able to address her health and safety needs effectively as long as the other needs are not addressed.

Health care providers are not alone and they don't have to do it all. They are only one piece of the puzzle.
Collaborative responses are the most effective way to address intimate partner violence. The more coordinated the responses of these resources are, the better the outcome for your patient.

Today you will be able to talk to and work with some of your potential key collaborators in your community. Our guests today are [briefly introduce panelists by name, title and organization and thank them for being there].

[USE THE FOLLOWING SLIDE ONLY IF YOU HAVE DECIDED TO DO THE

1. NEEDS ASSESSMENT EXERCISE, or/and
2. THE COMMUNITY RESOURCE PANEL FORMAT THAT ASKS PANELISTS TO RESPOND TO THE CASE STUDIES]

We will start with some case studies to identify the variety of needs your patients may be bringing to the health care encounter. After this we will hear from the panelists how they can help your patients and how you can refer to or collaborate with them most effectively.
How could you help these patients?

[USE THIS SLIDE ONLY IF YOU HAVE DECIDED TO DO
1. NEEDS ASSESSMENT EXERCISE, or/and
2. THE COMMUNITY RESOURCE PANEL FORMAT THAT ASKS PANELISTS TO RESPOND TO THE CASE STUDIES]

For our case scenarios today, we have chosen some of the survivors whom you encountered in the previous sessions. You remember Julie from the Survivor video. We also have Peter and Alex, the gay couple. Kara, the 16 year old survivor, and Nguyen (“Nyen”), the Vietnamese immigrant to the U.S. whom you encountered in the Slide Lecture for Topic 1.

[refer to case scenarios handout.]

[Start group exercise (needs assessment) – see facilitation notes and “case scenarios with needs assessment” handout]

[Or start community resource panel (see panel facilitation materials) ]