

Implementing a Sexual and Domestic Violence Program: Things to Consider for Your Health Center



Primary Healthcare for All

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IMPLEMENTING A SEXUAL AND DOMESTIC VIOLENCE PROGRAM: THINGS TO CONSIDER FOR YOUR HEALTH CENTER

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IMPLEMENTING A SEXUAL AND DOMESTIC VIOLENCE PROGRAM: THINGS TO CONSIDER FOR YOUR HEALTH CENTER

Medical practitioners are often the first and sometimes the only professionals to come into contact with individuals in abusive situations. They have a unique responsibility and opportunity to intervene. Traditionally health care practitioners are not instructed in such intervention or in how to respond appropriately when domestic or sexual violence affects their patients' lives. The purpose of this document is to assist your clinic in being mindful of some considerations as you develop your screening and counseling policies and procedures for your sexual and domestic violence program.

BACKGROUND

The Affordable Care Act passed by Congress and signed into law by President Obama on March 23, 2010 helps make prevention affordable and accessible for all Americans by requiring health plans to cover preventive services. Preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a copayment, coinsurance, or deductible for these services when they are delivered by a network provider.

The U.S. Department of Health and Human Services commissioned an Institute of Medicine (IOM) study to review what preventive services are necessary for women's health and well-being and should be considered in the development of comprehensive guidelines for preventive services for women. The Health Resources and Services Administration (HRSA) is supporting the IOM's recommendations on preventive services that address health needs specific to women and fill gaps in existing guidelines. The focus of this document is the recommendation for screening/assessment and counseling for sexual and domestic violence.

"Assessment" is replacing the word "screening" as the concept of screening in the medical model usually involves the use of standardized clinical tests to detect disease in asymptomatic patients. Psychosocial health issues like domestic and sexual violence do not fit well into a disease-based approach, particularly when identification of the health concern relies primarily on the patient's response to questions. The U.S. Prevention Services Task Force uses the term "assessment" in their recommendations for many psychosocial issues such as tobacco use and alcohol consumption. Not all practice has moved to this terminology so you may see the words used interchangeably.

According to The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report, lifetime prevalence of rape among women is 18.3% men is 1.4% (rape is defined as completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration). This means in 2011, 31.2 million people in the United States were survivors of rape. 1 in 5 women and 1 in 71 men in the United States are survivors of rape. Domestic violence is pervasive, with 1 in 4 women experiencing abuse during their lifetimes. Women accounted for 85% of the victims of intimate

partner violence, men for approximately 15%. (Bureau of Justice Statistics Crime Data Brief, Intimate Partner Violence, 1993-2001, February 2003) In 2002, the World Health Organization identified domestic violence as a serious public health problem, with victims experiencing more operative procedures, visits to doctors, and hospital stays than non-victims. Domestic and sexual violence cause not only acute injuries, but have also been linked to serious and sometimes long-term health consequences such as chronic pain, abdominal complaints, sexually transmitted infections, unwanted pregnancies, depression, post-traumatic stress disorder, miscarriages, and premature labor.

Unfortunately, many victims suffer in silence and do not receive assistance that improves their safety or their health outcomes. Healthcare professionals play a crucial role in identifying victims because they have regular opportunities to ask patients about domestic and sexual violence, regardless of the reason for the medical visit. By routinely assessing patients for sexual and domestic violence, healthcare professionals can assist victims who may not seek assistance elsewhere. By directly asking patients about sexual and domestic violence, regardless of symptoms, injuries, or reason for the visit, there is an increased likelihood that victims will disclose abuse.

Given medical practitioners' specific roles and time constraints, assessing and responding to sexual and domestic violence can be challenging. This document identifies clinic concerns and explores methods of overcoming some of these challenges with the intention of assisting practitioners to efficiently identify sexual and domestic violence victims, intervene effectively, and provide meaningful referrals.

This document is an overview of items that were identified as the Arizona Alliance for Community Health Centers (AACHC) partnered with five rural health center sites to implement domestic and sexual violence advocacy programs. There are several national resources that have also developed guidelines for establishing programs, and those resources can be found at the end of this document.

SPECIAL NOTE

Most domestic violence victims are women, and most abusers are their current or previous male partners. While aspects of this document are applicable to prevention, detection, and intervention strategies for all domestic violence situations, the focus remains on screening female patients.

In this document, the victim is often referred to as female and the abuser as male. Please note that domestic abuse also occurs in gay and lesbian relationships, teen dating relationships, and among elders. In a minority of cases, the female partner abuses the male. No person deserves to be abused and every victim is entitled to resources and services to enhance safety.

ARIZONA LAWS

ARS 13-3620 Any Physician, physician's assistant...behavioral health professional, psychologist, counselor or social worker who develops the reasonable belief in the course of treating a patient or any domestic violence victim advocates who develop the reasonable belief in the course of their employment, or any other person who has responsibility for the care or treatment of the minor who reasonably believes that a minor is or has been the victim of abuse, child abuse, a reportable offense, or physical injury must immediately report this information to a peace officer of child protective services.

ARS 46-454A person who has responsibility for the care of an incapacitated or vulnerable adult and who has a reasonable basis to believe that abuse or neglect has occurred shall report to a peace officer or protective service worker in the same manner as child abuse report.

ARS 36-517.02. A mental health service provider shall release information when two tests have been met:

- If the patient has communicated to the mental health provider an explicit threat of serious harm or death to clearly identified or identifiable victims,
- And the patient has the apparent intent and ability to carry out the threat,

Then the provider shall tell the intended victim and anyone in a "reasonably foreseeable area of danger," and the police. The provider also must initiate voluntary or involuntary hospitalization of the client or other precautions

ARS 13-3806. Duty of physician or attendant upon treating certain wounds; classification:

A physician, surgeon, nurse or hospital attendant called upon to treat any person for gunshot wounds, knife wounds or other material injury which may have resulted from a fight, brawl, robbery or other illegal or unlawful act, shall immediately notify the nearest police officer, of the circumstances, together with the name and description of the patient, the character of the wound and other facts which may be of assistance to the police authorities in the event the condition of the patient may be due to any illegal transaction of circumstances.

Knowing the state laws regarding mandatory reporting and relating those laws to the client prior to her acknowledgment of violence is important in developing trustful communication.

DEFINITIONS OF KEY TERMS

Intimate Partner Violence AKA Domestic Violence

Intimate partner violence is a pattern of assaultive and coercive behaviors that may include inflicting physical injury, psychological abuse, sexual assault, progressive isolations, stalking, deprivations, intimidations, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.

Adolescent Relationship Abuse

Adolescent relationship abuse refers to a pattern of repeated acts in which a person physically, sexually, or emotionally abuses another person s/he is dating or in a relationship with, whether of the same or opposite sex, in which one or both partners is a minor. Similar to adult abuse, the repeated controlling and abusive behaviors distinguish relationship abuse from isolated events (e.g. a single experience of sexual assault occurring at a party where two people did not know each other). Sexual and physical assaults may occur in the context of relationship abuse, but the defining characteristic is a repetitive pattern of behaviors in which one person in the relationship engages to maintain power and control over the other person. For adolescents, examples of such behaviors include monitoring cell phone usage, telling a partner what s/he can or cannot wear, controlling whether the partner goes to school that day, or manipulating contraceptive use.

Reproductive Coercion

Reproductive coercion can be present in same sex or heterosexual relationships. Reproductive coercion involves behaviors that a partner uses to maintain power and control in a relationship related to reproductive health. Examples of reproductive coercion include:

- Explicit attempts to impregnate a female partner against her will
- Controlling the outcomes of a pregnancy
- Coercing a partner to engage in unwanted sexual acts
- Forced no condom use
- Threats or acts of violence if a person doesn't agree to have sex
- Intentionally exposing a partner to a STI/HIV

Birth Control Sabotage

Birth control sabotage is active interference with contraceptive methods by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. Examples of birth control sabotage include:

- Hiding, withholding, or destroying a partner's birth control pills
- Breaking a condom on purpose

- Not withdrawing when that was the agreed upon method of contraception
- Pulling out vaginal rings
- Tearing off contraceptive patches

Pregnancy Pressure

Pregnancy pressure involves behaviors that are intended to pressure a partner to become pregnant when she does not wish to be pregnant. These behaviors may be verbal or physical threats or a combination of both. Examples of pregnancy pressure include saying:

- “I’ll leave you if you don’t get pregnant”, or
- “I’ll have a baby with someone else if you don’t become pregnant”, or
- “I’ll hurt you if you don’t agree to become pregnant”

Pregnancy Coercion

Pregnancy coercion involves threats or acts of violence if a partner does not comply with the perpetrator’s wishes regarding the decision of whether to terminate or continue a pregnancy. Examples of pregnancy coercion include:

- Forcing a women to carry to term against her wishes through threats or acts of violence
- Forcing a partner to terminate a pregnancy when she does not want to
- Injuring a partner in a way that she may have a miscarriage

IMPLEMENTATION CONSIDERATIONS

System-wide changes in practices will only be implemented and sustained when there are tangible changes in policies and procedures and the infrastructure to support these changes. There are a number of important steps to take in preparing a health care setting or practice for identifying and responding to patients experiencing domestic/sexual violence. It is critical to develop or adapt protocols that assist and support staff. This approach enables the staff in any health care setting to respond to domestic and sexual violence in a comprehensive and institutionalized manner including: screening, identification/assessment, treatment, documentation, safety planning, discharge planning and referral. Clear and concise policies and procedures and training on them assist staff in accepting and implementing the new practices.

A clinic that has the opportunity to have an advocate on staff allows providers to transition the client to the advocate for continued support. While having an advocate on staff is optimum, it is important to remember it is not necessary to establishing a successful program.

Having an advocate on staff allows for the client to have a continuum of services at one location which increases the likelihood that s/he will receive support to identify her/his own needs and preferred outcomes.

Futures Without Violence has guidelines and sample protocols that are designed to provide you with a blueprint for preparing for and responding effectively and efficiently to patients experiencing domestic violence. Those documents can be found at:

http://www.futureswithoutviolence.org/section/our_work/health/health_material/dv_healthcare_protocols

TRAINING

The Institute of Medicine (IOM) 2002 report entitled *Confronting Chronic Neglect: The Education and training of Health Professionals on Family violence* (Cohn, et al, 2002) calls for health professional organizations to develop and provide guidance to their members, constituents, institutions, and stakeholders regarding violence and abuse education. While some progress has been made, training and education on intimate partner violence that is provided to healthcare practitioners often does not address the broad scope health impacts. Domestic and sexual violence are hard topics for many people to discuss, so providing training to providers helps them understand why they need to assess and become more comfortable with doing so.

In 2005 the Academy on Violence and Abuse (AVA) was founded to address the concerns and support the actions to achieve the IOM recommendations. The AVA developed core competencies for the Health Systems, Educational Institutions, and Individuals. While it is important that all three levels need to be implemented, a clinic would need to focus on the Health System and the Individual. The

document that outlines those competencies can be found at the Academy on Violence and Abuse website at http://www.avahealth.org/resources/ava_publications/.

There are a variety of sources available to gain the competencies recommended by the IOM. In Arizona, the Arizona Coalition to End Sexual and Domestic Violence provides The Sharing Experience: From Domestic Violence in Our Homes to Peace in Our Communities. It is a five day interactive basic Domestic Violence training. The training is designed for professionals working with people and communities impacted by domestic violence including staff and advocates at domestic violence shelters and safe homes, social workers, health care providers, faith based leaders, child welfare providers, law enforcement, attorneys, officers of the court, offender treatment providers, and others who interact with survivors, people who abuse or children exposed to domestic violence. The Coalition provides a variety of other trainings to meet the needs of their members and the state that develop knowledge and skills in the area of violence against women. The Arizona Coalition to End Sexual and Domestic Violence also provides educational trainings around the state on sexual violence.

Futures Without Violence is a national organization that provides trainings, research, sample policies and procedures, and technical assistance to meet the needs of providers of domestic violence services. This organization houses the National Health Resource Center on Domestic Violence, with resources and tools specifically designed to address the intersection of healthcare and domestic violence.

The National Center for Domestic and Sexual Violence has a list of trainings around the country on both sexual and domestic violence.

CLINIC ENVIRONMENT

Displaying educational posters addressing domestic violence, sexual violence, reproductive coercion, and healthy relationships that are multicultural and multilingual in bathrooms, waiting rooms, exam rooms, hallways, and other high visibility areas and having information including hotline numbers, safety cards, and resource cards on display in common areas and in private locations for victims/survivors such as bathroom and exam rooms demonstrates that the clinic is concerned about and available to help address these issues.

ASSESSMENT AND SCREENING

On August 1, 2012 the women's health provision that is part of the new health care law, the Affordable Care Act, took effect. It ensures that women and adolescent girls receive annual preventive health services with no co-pays. Among the services that are covered by new insurance plans (and eventually, existing plans), are screening and counseling for domestic and interpersonal violence. This means that women and girls who have been hurt by violence and abuse will be far more likely to get help and also receive better health care.

Importantly, assessment/screening and counseling by a health provider has been shown to make a difference in health outcomes for women. Assessment/screening coupled with education, harm reduction, and referrals to domestic and sexual assault services, can reduce violence and improve the health status of women. Research has also shown that there are no harmful effects of screening and that women usually appreciate being asked and given the chance to get help as long as it's done in a supportive way. Regular face-to-face screening of women by skilled health care professionals increases the identification of victims of domestic violence as well as those that are at risk of verbal, physical, and sexual abuse.

Universal routine inquiry of all patients, as opposed to indicator-based screenings increases opportunities for both identification and effective interventions. Universal screening means that the same questions are asked of women despite demographics, such as socioeconomic status, ethnic group, or educational attainment. Indicator-based screening is subjective and done when the practitioner feels there is an indication to do so. Only asking patients who “seem” like victims about their experiences should be avoided. When victims exposed to domestic violence are identified early, providers may be able to break the isolation that occurs and coordinate with advocates to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Even if a patient chooses not to disclose being abused, the provider's inquiry can often communicate support and increase the likelihood of future discussion of the issue.

Best practice indicates that routine assessment is the most comprehensive way to identify and educate clients about domestic and sexual violence. Conducting routine face-to-face assessment regardless of the presence or absence of indicators is recommended. It is important prior to inquiry that patients are informed of any reporting requirements or other limits to provider/patient confidentiality. To make it most comfortable for both the provider and the patient, the provider can indicate that because violence is so common in many people's lives, they have begun to ask all patients about it. S/he can indicate that some are too afraid or uncomfortable to bring it up by themselves, so they have started asking about it routinely.

Some of the questions might include:

- Are you in a relationship with a person who physically hurts or threatens you?
- Have you ever been emotionally or physically abused by your partner or someone important to you?
- Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
- Within the last year, has anyone forced you to have sex when you did not want to?
- Have you ever been touched sexually against your will or without your consent?
- Have you ever been forced or pressured to have sex?

Despite time constraints and patient overload, medical professionals play a key role in addressing and ending domestic violence. In many cases, the health care provider may be the only person who can provide help to the victim. Not asking about abuse can result in adverse health consequences, leading to costly testing and misdiagnosis or death for patients. Medical organizations such as the American Medical Association and American College of Obstetricians recommend screening for domestic violence.

Domestic/Intimate Partner Violence is a health problem of enormous proportions. It is estimated that between 20 and 30% of women and 7.5% of men in the United States have been physically and/or sexually abused by an intimate partner at some point in their adult lives.¹ In addition to injuries sustained by women during violent episodes, physical and psychological abuse are linked to a number of adverse medical health effects including arthritis, chronic neck or back pain, migraine or other types of headaches, sexually transmitted infections (including HIV/AIDS), chronic pelvic pain, peptic ulcers, chronic irritable bowel syndrome, and frequent indigestion, diarrhea, or constipation.² Six percent of all pregnant women are battered and pregnancy complications, including low weight gain, anemia, infections, and first and second trimester bleeding, are significantly higher for abused women, as are maternal rates of depression, suicide attempts, and substance abuse.³

Optimal management of other chronic illnesses such as asthma, HIV/AIDS, seizures, diabetes, gastrointestinal disorders, and hypertension can be problematic in women who are being abused or have been abused in the past. Often times the perpetrator controls the victim's access to and compliance with health protocols. Practitioners must also remember that health consequences of abuse can continue for years after the abuse has ended.

While assessment is important for the health and safety of the client and the ability of the provider to treat clients, there are barriers that may arise. The majority of the barriers can be diminished or prevented by a number of measures, including intensive education and information provided to the providers in your organization.

¹ National Institute of Justice and Centers for Disease Control and Prevention. (1998). *Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey*. Washington, D.C.: National Institute of Justice and Centers for Disease Control and Prevention, 1998.

McCauley J, Kern DE, Kolodner K, Dill L, Schroeder AF, DeChant HK, Ryden J, Bass EB, Derogatic LR. (1995). The "battering syndrome": prevalence and clinical characteristics of domestic violence in primary care internal medicine practices." *Annals of Internal Medicine*;123:737-746

Dearwater SR, Coben JH, Campbell JC, Nah G, Glass N, McLouglin E, Bekemeier B. (1998). Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *Journal of the American medical Association*: 280:433-438

² Coker, A., Smith, P., Bethea, L., King, M., McKeown, R. (2000). "Physical Health Consequences of Physical and Psychological Intimate Partner Violence," *Archives of Family Medicine*, Vol. 9

³ Centers for Disease Control and Prevention, (1994). Abuse During Pregnancy: Effects on Maternal Complications and Infant Birth weight in Adults and Teen Women, *Obstetrics & Gynecology*, 84:1 323-328.; McFarlane, J. Parker B., & Soeken, K. (1996). Abuse during Pregnancy: Association with Maternal Health and Infant Birth weight. *Nursing Research* 45, 32-37.

The tangible cost of implementing a screening and advocacy program varies depending on the extent of the program your organization desires. Health centers can have a simple program that includes assessment and a brief intervention and then refers clients to community-based advocate services when available. Alternately, if funding is available, health centers may choose to have an advocate on site that can be available immediately to assist clients while they are safe in the clinic setting.

Potential costs might include but are not limited to cost for initial and ongoing training for providers, advocates, medical assistants, and other staff who are involved in the screening process, loss of clinic income or cost of contract staff on days practitioners are being trained, salary and related office costs for an advocate. Costs might also include adding screening tools/prompts to Electronic Medical Record (EMR) systems.

To assist with screening time include screening questions as part of the medical assessment and/or a general health status questionnaire, which could be completed by the patient within the waiting room. Ask follow-up questions on domestic violence during the medical examination. Ensure that no partner, child, family member or other patients are present during this time. Establishing clear policies and procedures on what will happen when a client screens positive for sexual or domestic violence will assist with clinic flow. Take into consideration your staffing level, who is trained, client safety, and confidentiality.

Electronic Medical Record systems without key domestic and sexual violence prompts may be a challenge in completing assessments. It is key to build in prompts that will alert the practitioner to assess at every visit. Documentation in the records regarding the screening is also fundamental. If the electronic medical record used by your agency does not include these prompts, the agency should budget for costs necessary to build these prompts to fully integrate a successful program.

Comprehensive training for all clinic staff is key for several reasons. Providing training for all staff shows that Administration is supportive of making sure that implementation of domestic and sexual violence screening is successful. Having all staff trained will allow create an environment where staff can support one another and promote appropriate clinic flow. With comprehensive knowledge staff will feel more comfortable when conducting the screenings the process will be more efficient, and take less time overall. It is important to note there will be staff that have been victims of domestic and or sexual violence themselves, and it is necessary to ensure any training allows these staff members the space needed to address their feelings and practice self-care.

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

DOCUMENTATION

Documentation should be conducted by a health care provider who is authorized to record in the patient's record. Providers should document the patient's statements and avoid pejorative or judgmental documentation (e.g. write "patient declines services rather than "patient refused services," "patient states" rather than "patient alleges"). The provider should document the relevant history, results of physical examination, laboratory and other diagnostic procedures and their relationship to the current or past abuse, and results of intervention and referral.

ESTABLISHING A COMMUNITY REFERRAL SYSTEM

Shelters, social services support, transportation, courts and law enforcement are all part of the circle of providers that can assist victims. The primary responsibility is the client's safety. Whether you have an advocate on site or not, it is important to have the ability to make a warm connection with an advocate in your community. At a minimum the client should leave with a safety plan, a list of referrals, and a safety/shoe card with emergency contacts.

Developing a relationship with the local shelter advocates is key to a successful agency program, especially one that does not have an advocate on staff. Being able to pick up the phone and know who you are talking to will build trust with the client that you are not asking her to speak to a person that is not known to the provider. Most shelter staff will be happy to attend a staff meeting to provide education on the services they provide and meet your practitioners. If there is no shelter in your community, investigate where the shelter is that serves your area and contact them. For example the shelter in Winslow provides services for clients in Holbrook.

If there are no local resources there are hotlines that are available to help. It is helpful for the providers to call the hotlines in advance to determine what information they provide and what they ask when a person calls so that they can share that information with a patient. The following hotlines are familiar with resources and services available in all areas and will provide information to you or the survivor 24 hours a day.

- National Domestic Violence Hotline at 1-800-799-7233, www.thehotline.org
- Sexual Assault Hotline at 1-800-656-4673, www.rainn.org
- Teen Domestic Violence Hotline at 1-800-331-9474, www.loveisrespect.org

There is a legal advocacy hotline in Arizona that provides information and answers questions relating to navigating the legal system, legal rights, resource and referral, and safety planning. The can be contacted at 1- 800-782-6400 - TTY 602-279-7270 - legaladvocacy@azcadv.org.

The Legal Advocacy Hotline provides services to:

- Survivors of domestic violence
- Concerned friends, family, neighbors, and other individuals who are calling on behalf of survivors of domestic violence
- Professionals working with survivors of domestic violence such as case managers, advocates, attorneys, medical personnel, teachers, counselors, and law enforcement

The Hotline is open Monday – Friday 8:30 a.m. to 5:00 p.m.

Crime victim compensation programs are often able to provide financial support to victims of violence for medical expenses and other costs that arise as a result of the crime. A directory of these programs is available online at <http://azcjc.gov/ACJC.Web/victim/VictComp.aspx>

CLINIC SAFETY

Because safety of clients and staff is of utmost concern, it is important that an internal safety assessment is conducted. This can be done with the help of local law enforcement. Things to consider are where doors are located. Do they lock? Where is the advocate located? You never want to locate the advocate's office in a place where she and/or a victim could be cornered by a batterer.

Clinics also need to develop a policy and train employees on what is to be done if there is someone hostile at the health center. This policy has a much broader application that solely to address perpetrators of domestic or sexual violence and can help a health center be prepared for a variety of situations.

Written policy and procedures for clinic safety and security and guidelines for handling hostile individuals are optimal for staff safety. Safety policies should be included for all clinics, however with the implementation of domestic violence/sexual violence screening and/or advocacy services these policies and procedures are very important. Staff should be involved in development of policies and procedures around safety and should receive comprehensive training. Guidelines for the development of policies and procedures can be found on the Occupational Health and Safety website.

The Policy and Procedures that are developed also need to include how your agency will assist employee victims who disclose concerns or request for help. The purpose is to promote the health and safety of agency employees, create a supportive workplace in which employees feel comfortable discussing and seeking assistance for domestic violence, provide responsive guidelines and procedures to assist employees who are affected by domestic violence, and provide support and assistance to employees who are victims. This may include allowing the employee to come and go from a different door, work adjusted hours, and/or work in a different office space. Keep in mind that domestic and sexual violence can and do affect every level of employee, not just those at the lower end of the pay scale.

CULTURAL ISSUES

Culture is a complex, multidimensional, deeply rooted system of beliefs. It is a dynamic process which involves shared experiences or commonalities that have developed in relation to changing social and political contexts. Culture is based upon race, ethnicity, gender, religion, sexual orientation, socioeconomic status, country of origin, level of assimilation and acculturation, tradition, disability status, level of privilege in society and language. Culture influences an individual's attitudes, beliefs, emotional expression, choices, and consequent behavior.

Maintaining an awareness of different cultural norms can help a medical practitioner or clinical staff member establish trust and communicate effectively with patients from diverse backgrounds.

Remember, however, that these cultural norms are guidelines, not determinants of a patient's response. Establishing a relationship with the patient and developing trust are essential for effective communication with the patient. It is important to remember that while culture plays a significant role in shaping personal behavior, it should not be viewed as an automatic predictor of how a person will respond during a domestic violence assessment. Each patient should be assessed as a unique case, with aspects of culture utilized as relevant factors.

Listed below are a few key elements to keep in mind when assessing for domestic or sexual violence.

- When applicable, it is useful for the practitioner to acknowledge that he/she does not know much about the patient's culture, and wants to learn from the patient, rather than operating from a false sense of familiarity
- Culture is a complex and multidimensional concept that is deeply embedded in daily life
- It is useful to understand norms but not to generalize, as culture is personalized
- Consider each individual in his/her context, acknowledging that choices are made and based on each person's "world view"
- Establishing a relationship with the patient and developing communication skills are essential for effective intervention
- It is useful to put yourself "in the shoes" of others in order to gain perspective on your patient's decision process, choices and behavior
- It is important for the practitioner to interact with patients from different cultures in a non-judgmental manner, so that he/she can facilitate the process of comfortable communication about the abuse

CONFIDENTIALITY

Confidentiality is a multi-faceted issue. While health centers have specific guidelines for patient confidentiality as a result of the Health Insurance Portability and Accountability Act (HIPAA), they must also have a confidentiality policy specific to sexual and domestic violence. Many factors need to be taken into account to provide a safe and confidential environment. Key items to be considered in policy and procedure development include: the need to speak to each patient privately; access to a professional interpreter, if needed; informing clients of the reporting laws; confidentiality within small communities; and process to secure client permission to refer to an advocate or other services that will be of assistance in securing her safety. Before receiving services, a patient must be thoroughly informed of the confidential nature of interactions with advocate. If the patient wants any information released to other agencies for assistance in her case, the patient must complete a very specific release form (which expires after a period of time) to allow the provider or advocate to work with other agencies on her case.

All health center staff must be made aware of the confidentiality policy specific to domestic and sexual violence. This is especially important in smaller communities where people at the health center may know the victim from the community or may know members of the victim's and/or abuser's family.

A member of the victim's family (such as her mother), the abuser, or his family member (such as his mother or sister), may frequently accompany the victim to her medical appointments. These family or extended family members may contribute to an environment that tolerates the abuse, complicating the victim's ability to seek help. If these people are present during the screening, it will decrease the likelihood of disclosure. It is crucial to speak to each patient privately in order to effectively screen her for domestic violence.

The patient is unlikely to disclose her abuse in the absence of an objective interpreter. Also, lack of a professional interpreter violates the entitlement to confidentiality, as well as increasing her risk of negative consequences, such as being harmed by the abuser. Using a family member, friend, or another client is not acceptable. The practitioner should follow the procedures for interpretation that are in place for all medical interpretation.

ADDITIONAL CONSIDERATIONS WITH AN ON-SITE ADVOCATE

ADVOCATE COST

When a facility is able to have an on-site advocate there are additional budgetary details that need to be considered. In addition to the salary cost for an additional staff person, and an office space that will allow the advocate to have safe, confidential discussions, there will also likely be cost for initial and on-going training.

VICARIOUS TRAUMA

Most simply put, vicarious trauma can be thought of as the negative changes that happen to humanitarian workers (advocates) over time as they witness other people's suffering and need. While many advocates are changed positively by their experiences, vicarious trauma focuses on the negatives. These negative changes are the cost of caring for and caring about others who have been hurt. We could therefore define vicarious trauma this way: Vicarious trauma is the process of change that happens because one cares about other people who have been hurt, and feel committed or responsible to help them. Over time this process can lead to changes in one's psychological, physical, and spiritual well-being. Advocates who work with organizations that don't support their staff well enough may also be at greater risk for more problematic vicarious trauma. The following are some agency-related risk factors for worker vicarious trauma:

- Agencies that work as top-down hierarchies (with little opportunity for those at lower levels to communicate their concerns, get the latest accurate information on the agency's priorities and policies, or influence important decisions);
- Agencies that ignore the demanding nature of this work and do not work to create a supportive organizational culture; and
- Agencies that don't provide adequate time off and/or that overwork staff chronically.
- Organizations that do not have policies and practices that foster an organizational culture of effective management, open communication, and good staff care, increase staff risk of vicarious trauma.

WORK HOURS

Advocacy cannot always happen during regular business hours. Domestic and Sexual Violence Advocates are in the business of helping women and families be safe. While the client may have come to the clinic during business hours, the time it takes to develop and begin implementation of a safety plan may take long after regular hours. Advocates often work to help build some self-determination in the clients, empowering them to make decisions for themselves, and this can take a significant amount of time as well. Depending on a client's situation, Advocates may not be able to say "we are closed now please come back at 8:00 a.m. and we will continue to help you." Safety looks different to every victim/survivor, and it is the Advocate who helps the client navigate the system to gain increased safety. This may mean that an advocate is working into the evening trying to secure housing or transportation to a safe location.

The agency must support this commitment of the Advocate and the work s/he is doing by having processes in place such as allowing the Advocate to work flexible hours when needed. This support is tied to decreasing possibility of vicarious trauma.

The advocate may not always be in the office. The advocate may accompany the client to court, or/he may meet regularly with the local shelter(s), law enforcement, and other social service providers so they can be kept well informed of the services they can assist clients in securing to help them with their safety.

FINAL THOUGHTS

Developing sexual and domestic violence assessment and intervention standards and protocols in your clinical setting will enhance the quality of care you provide in your clinic. The information provided in this document gives you an overview of the elements that need to be considered to develop standards and readiness for your facility. There is no one way to implement a program, merely guidelines on identifying and responding to sexual and domestic violence in the health care setting. We hope that this document will help your clinic begin the conversation about the development of protocols for domestic and sexual violence assessment and intervention as a standard for every woman at every visit. The Resources listed will provide more specifics for your consideration, and the staff at the Arizona Alliance for Community Health Centers are available to provide assistance.

RESOURCES

Futures Without Violence - www.futureswithoutviolence.org

Academy on Violence & Abuse – www.avahealth.org

OSHA – www.osha.gov

Arizona Coalition Against Domestic Violence – www.acesdv.org

American Medical Association

National Advisory Council on Violence and Abuse <http://www.ama-assn.org/ama/category/3248.html>

Violence Prevention <http://www.ama-assn.org/ama/pub/category/3242.html>

Centers for Disease Control and Prevention

Child Maltreatment Prevention <http://www.cdc.gov/ncipc/dvp/CMP/default.htm>

Intimate Partner Violence Prevention <http://www.cdc.gov/ncipc/dvp/ipv/default.htm>

Sexual Violence Prevention <http://www.cdc.gov/ncipc/dvp/SV/default.htm>

Child Welfare Information Gateway <http://www.childwelfare.gov/>

Family Violence Prevention Fund

<http://www.endabuse.org>

Health Materials Catalog and Technical Assistance

<http://www.endabuse.org/programs/display.php3?DocID=100200>

Health Cares About Domestic Violence Day

<http://www.endabuse.org/hcadvd/>

The National Center on Elder Abuse

http://www.ncea.aoa.gov/ncearoot/Main_Site/index.aspx

http://www.ncea.aoa.gov/NCEAroot/Main_Site/Find_Help/State_Resources.aspx

National Coalition Against Domestic Violence

<http://www.ncadv.org/>

Domestic Violence State Laws http://www.ncadv.org/publicpolicy/StateLaws_216.html

Prevent Child Abuse America

<http://www.preventchildabuse>