

Clinical Guidelines for
Assessment and Referral
for Victims of Domestic
Violence:
A Reference for Utah Health
Care Providers

3rd Edition

Utah Department of Health
Utah Domestic Violence Coalition



Utah Domestic Violence Coalition

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Peg Coleman, Executive Director

Dear Colleague,

Domestic violence (DV) is a widespread public health problem affecting the health and homes of millions of Americans. The effects of domestic violence are both devastating and far-reaching and impact men, women, and children in every socioeconomic level, race, religion, age group, and community. The financial impact of domestic violence on communities is huge, with much of the cost dedicated to health care services.

The prevalence and effects of domestic violence are devastating. It is imperative that we take action to decrease the enormity of the problem and to alleviate the suffering caused by abuse. Although domestic violence is not an issue that can be solved overnight or with one specific intervention, health care professionals play a critical role in identifying victims of domestic violence. Once identified, victims can then be offered services and interventions, beginning the process of healing.

However, to end the cycle of abuse, health care professionals must first overcome barriers and their own perceptions of victims. Even though health care providers may be the first or only professionals to see the injuries or other medical issues of the abused, many victims of domestic violence remain invisible, moving through the health care system without identification or referrals.

The most critical step health care professionals can take is to ASK about the occurrence of domestic violence. In fact, the U.S. Preventive Services Task Force now recommends that all clinicians routinely screen females of childbearing years for intimate partner violence. Even when victims do not disclose information about the violence they are experiencing, the simple act of asking may empower victims, making them realize there are people who care and are willing to help when they are ready to disclose.

The development and implementation of policies and procedures, reinforced by staff education, may increase the identification of DV victims and their children. By routinely using a screening tool such as the RADAR card or the assessment checklist included in this manual, health care providers can identify the risk factors associated with domestic violence, document any injuries, and refer victims for help.

We hope you find this resource manual useful in helping you to identify, treat, and refer victims of domestic violence. We encourage you to use the tools and resources in it. With your help, we can improve patients' health and well-being by helping to end this cycle of violence.

Sincerely,

A handwritten signature in cursive script that reads 'Peg Coleman'.

Peg Colmen
UDVC Executive Director

A handwritten signature in cursive script that reads 'Kathy Franchek MD'.

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This document can be downloaded at www.health.utah.gov/vipp/pdf/DomesticViolence/HmHlthTrngMnl.pdf

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Health Care Provider Algorithm

SCREEN ALL women between the ages of 14 and 46 years for IPV victimization
ASK any patient with risk factors (see **Page 17**)

I ask all my patients if they are in a relationship or in a home with someone who may be hurting or controlling them because it is important for your health (and the health of your children), and in some instances it may need to be reported.
Are you in a relationship with someone who physically hurts, threatens or emotionally abuses you?



RADAR

RADAR

R = ROUTINELY SCREEN WOMEN FOR ABUSE

Although many women who are victims of domestic violence will not volunteer any information, many will acknowledge that they are victims if asked. Intervening on behalf of battered women is an active form of preventing child abuse.

A = ASK DIRECT QUESTIONS

"Because violence is so common in many people's lives and witnessing violence can have negative effects on children, we've begun to ask all our families about their experience with violence." Sample questions include: "Have you ever been harmed by or felt afraid of your partner?" "Have you ever been hit, kicked, punched or otherwise hurt by your partner?" "Do you feel unsafe in your current or a previous relationship?" "Have your children witnessed anything violent or frightening in their home, school or community?" Inform patients of legal requirements.

D = DOCUMENT YOUR FINDINGS

Thoroughly document in the chart the patient's description of the violence and any injuries that are present. In the case of a pediatric chart, ask the victim if it is safe to document in the child's chart. Other ways to document in the child's chart include abbreviations such as DV+ or RADAR+. If further information about the violence needs to be documented, then place details in a 'restricted access' chart. Document what information was given to the victim and the referrals made.

A = ASSESS SAFETY OF VICTIM AND CHILDREN

Assess patient safety. Help the patient reduce the danger to herself and her children when the patient is discharged. A safety assessment includes some of the following questions: "Are you afraid to go home? Are there guns in the home? Are you planning on leaving? Do you need access to a shelter? Can you stay with family/friends? Has the violence increased? Have there been threats of suicide/homicide? Use of drugs or alcohol? Violence toward children? ARE YOUR CHILDREN SAFE?"

R = REVIEW OPTIONS AND REFERRALS

Refer the patient to specialists trained to help victims cope with all aspects of the abuse. Take time to talk about options available to the victim and her family. Give the victim written information if she feels that it is safe to do so. Call authorities; i.e. Law enforcement or DCFS, if appropriate. Find safe shelter for family if needed.

RADAR

DOMESTIC VIOLENCE (DV) GUIDE

Domestic violence is a pattern of assaultive and coercive behaviors that adults/adolescents use against their intimate partners. Children who witness domestic violence are at an increased risk for child abuse as well as behavioral, emotional, and psychological problems. In the state of Utah, a health care provider treating a patient for illness or injuries related to DV must report this to law enforcement. Commission of DV in the presence of a child is considered child abuse and must be reported to law enforcement or DCFS.

DV+ = ANSWERED 'YES' TO SCREENING QUESTION(S)

Send Supportive message

"You are not alone. You are not to blame. DV is a crime."

Assess Safety (See reverse side)

Make Referrals

Involve social worker/advocate if needed/available. Schedule follow-up appt for victim/children. Encourage victim/children to see their physician. Consider mental health referral for victim/children. Notify DCFS if meets criteria of commission of DV in the presence of a child. Notify law enforcement if appropriate. Give DV Hotline Numbers.

Follow-up

Make f/up appt for victim/children. Ask about history of violence since last visit. Ask victim/children if they have seen their physician. Ask how children are functioning at home and at school. Ensure that children are safe. Ensure victim has resource numbers and information.

DV- = ANSWERED 'NO' TO ALL QUESTIONS

Accept the woman's response. Provide an open door to resources. "I am glad that you are in a safe situation. If you ever feel unsafe you can come to us for help." Rescreen yearly or if risk factors occur.

DV ? = UNABLE TO SCREEN OR CONCERNED

If the health care provider has a concern, then redirect the question. Provide open door to resources. "I am glad that you are in a safe situation. If you ever feel unsafe you can come to us for help." Rescreen at next visit if needed. Continue to be supportive.

DOMESTIC VIOLENCE INFORMATION

National Domestic Violence Number	800.799.SAFE
Utah DV Hotline Number	800.897.LINK
Utah Rape Crisis Number	888.421.1100
Child Protective Services (DCFS)	855.323.3237
Adult Protective Services	800.371.7897
Local Police	
Division of Safe and Healthy Families	801.662.3600

©2002 RADAR Pocket Card for Pediatricians developed by The Institute for Safe Families

I. Recognizing Patient Victimization

Domestic Violence Prevalence

Domestic violence (DV), also called intimate partner violence (IPV), is a serious problem plaguing the homes and health of millions of Americans. According to a national survey on sexual and intimate partner violence, 24 people per minute are victims of rape, physical violence or stalking by an intimate partner.¹ This national survey¹ found that more than 1 in 3 women (35.6%) and more than 1 in 4 men (28.5%) have been victims of DV at some point in their lives. The US lifetime prevalence of DV victimization is similar for Utah women, with studies finding that 37% of Utah women have been DV victims.^{1,2} These findings illustrate that domestic violence is an important and widespread public health problem not only in the US but also in Utah. In many cases the violence does not end with debilitating physical abuse, but escalates into homicide.

The effects of domestic violence are both devastating and far-reaching and impact men, women, children, and the elderly. Domestic violence can be found in every socioeconomic level, race, religion, age group, and community. The financial impact of domestic violence on communities is estimated to be more than \$8.3 billion per year, with the majority of costs going to health care services.³⁻⁴

Although the impact of domestic violence on the community continues to be explored, it is clear that women experiencing abuse, or who have experienced abuse, suffer physically and psychologically—beyond the actual episodes of violence. Health problems may persist even after the victim has left the abusive relationship. Female victims of domestic and sexual violence, when compared to women without a history of these forms of violence, report a higher prevalence of asthma, irritable bowel syndrome, diabetes, frequent headaches, chronic pain, difficulty sleeping, activity limitations, and having poorer physical and mental health.¹ Male victims of domestic violence also report a higher prevalence of frequent headaches, chronic pain, difficulty sleeping, activity limitations and poorer mental and physical health than men without a history of these types of victimizations.¹ Such health problems often are compounded by the use of alcohol and illicit drugs by the victims.⁵⁻⁹

The DV victim is not the only person who suffers from the negative health effects of victimization. Both children and the elderly in the home experience abuse, neglect, and exploitation. In approximately 60% of homes where DV takes place, child abuse also occurs.¹⁰ Whether the child is an actual victim of physical abuse or a witness to it, children in homes where domestic violence occurs are more likely to experience posttraumatic stress disorder, chronic somatic problems, depression, and anxiety. They are also more prone to exhibit violence toward peers, alcohol and drug abuse, suicide attempts, involvement in teenage prostitution, running away from home, and involvement in sexual assault crimes.¹¹

The childbearing years are the years of highest risk for domestic violence to occur or intensify.¹² A major predictor of whether a woman will be a victim of DV during her pregnancy is if she was a victim of DV before her pregnancy. Violence during pregnancy is an important issue because many women who were victimized before their pregnancy experience more frequent and severe violence during their pregnancy.¹³⁻¹⁷

Because of the devastating effects and prevalence of domestic violence, action must be taken to decrease the enormity of the problem and to alleviate the suffering caused by this type of victimization. Domestic violence is not an issue that can be solved overnight or with one specific intervention; it is a complicated health problem that must be addressed through a collaborative effort involving religious leaders, law enforcement, employers, health professionals, policy makers, legal professionals, educators, advocates, and friends of the abused.¹⁸

In Utah from 2003-2008, a current or former intimate partner perpetrated 64% of female homicides in Utah. These figures support previous reports that suggest "...violence against women is predominantly intimate partner violence".¹⁹ Nearly 8,000 (4%) Utah women who delivered a live birth in 2000-2003 reported physical abuse by a husband or partner during the year before her most recent pregnancy or during her most recent pregnancy.²⁰ In addition, this survey found that up to 23% of Utah women had experienced physical abuse, emotional abuse or partner stress during their pregnancy. The health impact of abuse on pregnant women and their offspring may be substantial. Utah women who were physically abused during pregnancy were more likely to receive late prenatal care, deliver a low birthweight infant, and experience postpartum depression.²⁰

Definitions

The term domestic violence (DV) or intimate partner violence (IPV) is defined as a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.²¹ This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.²²

There are four main types of intimate partner violence:²²⁻²³

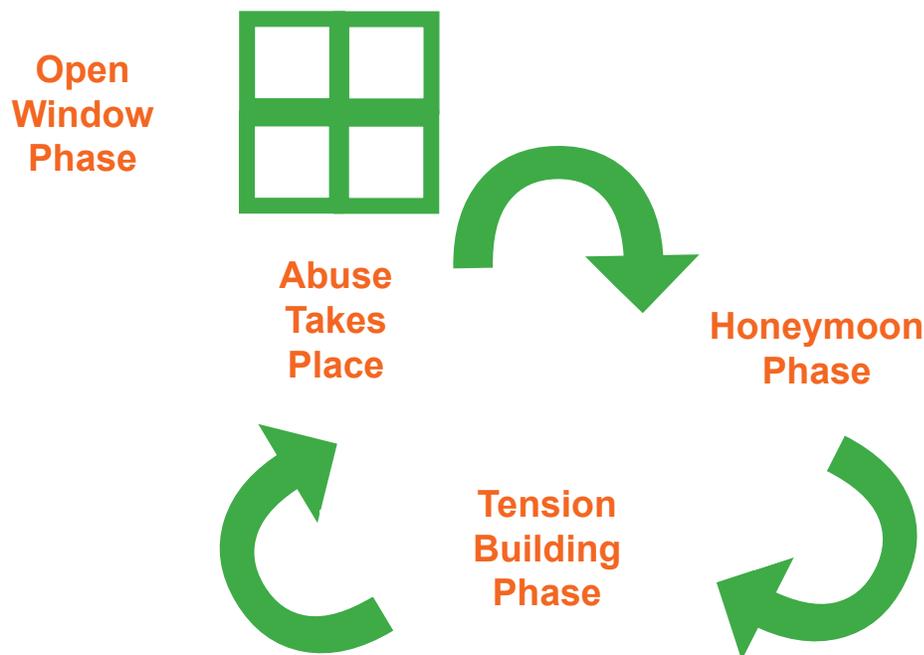
- 1. Physical violence** is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person.
- 2. Sexual violence** is divided into three categories:
 - Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed;
 - Attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and
 - Abusive sexual contact.
- 3. Threats of physical or sexual violence** use words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.
- 4. Psychological/emotional violence** involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately making the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence. In addition, stalking often is included among the types of DV. Stalking generally refers to "harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property."²⁴

I. Recognizing Patient Victimization

Cycle of Abuse

The Cycle of Abuse is a useful tool for educating patients about this abusive behavior. It does not apply to every couple's interactions, but it is very common. One of these phases may or may not occur every time. This can take place over any period of time, e.g., days, years, etc.

- **Tension Building Phase:** In this phase the abuser gets edgy and tense. Almost any subject, such as housework or money, may cause tension to build up. Verbal abuse, insults, and criticism increase. Shoving begins.
- **Abuse Takes Place Phase:** Violence erupts as the abuser throws objects at his or her partner, hits, slaps, kicks, strangles, abuses him or her sexually, or uses weapons. Once the attack starts, there's little the victim can do to stop it; there generally are no witnesses.
- **"Open Window" Phase:** The "open window" phase occurs just after the acute battering episode and just before the honeymoon phase. This is the time when women exhibit the most help-seeking behavior. This phase offers a crucial opportunity for successful intervention in the lives of victimized women and positive steps toward breaking the cycle of violence.
- **Honeymoon Phase:** The abuser apologizes and promises to change. This is known as the "honeymoon" phase. The abuser may be so charming that the victim believes that the violence will not happen again. The victim may think that the danger has passed and the relationship can be saved. From this point the cycle repeats. Usually the abuse will continue and get worse. The longer a victim stays in an abusive relationship, the greater his or her risk of being badly hurt.



Power and Control

The Power and Control Wheel was developed from the experience of DV victims in Duluth, Minnesota who had been abused by their male partners. The Wheel is available for download at <http://www.theduluthmodel.org/training/wheels.html>. These eight behaviors were the most common abusive behaviors or tactics used by perpetrators to control their partners. The Power and Control Wheel does not mention physical or sexual assault because most of the controlling behaviors are emotionally or psychologically damaging to victims.

Physical and sexual violence is used when the other controlling behaviors are no longer working on the victim. This is usually a time when the victim begins to seek help, learn about what is happening to her, and realizes that the only way to end the abuse is to leave the abuser. Therefore, the abuser resorts to violence to try to maintain control over the victim. Women and health care providers need to understand that the most dangerous time for a victim is usually when she decides to escape from the relationship.



I. Recognizing Patient Victimization

Victim and Perpetrator Dynamics

Although abusive relationships may differ in dynamics from one couple to another, research has shown that there are basic dynamics and certain high-risk behaviors or indicators of abuse.

Victim Dynamics²¹

- Fearful of partner
- Not allowed access to family, friends, or other support networks
- Experiences reduced autonomy and/or, when the victim exercises autonomy, he/she may suffer negative or abusive consequences
- Feels guilty or wonders if he/she is to blame for his/her partner's violence
- May suffer physical injuries and/or psychological problems
- Expressed concern by others about the victim's safety
- Takes blame for the violent episode(s)

Perpetrator Dynamics²¹

- Controls access to money, property, and other shared commodities
- Notably jealous of friends, family, coworkers, and others
- Scornful of partner's perspective
- Uses various forms of status to claim authority, knowledge, or power
- Minimizes or explains his/her behavior, makes excuses, or becomes defensive
- Vague about violent incidents
- May have a documented prior use of violence
- Can have defensive wounds caused by the victim (e.g., scratches or bite marks)
- Uses physical force against people or property

Vulnerable Adult Abuse Prevalence

According to the 2012 U.S. Census, ²⁵ the elderly, defined as persons age 65 and older, numbered 40.3 million in 2010. This represents approximately 13% of the U.S. population or one in every eight Americans. Utah has one of the fastest-growing older populations in the country. It is forecast that Utah's 65+ population will increase 165 percent by 2030 and the 85+ population is expected to increase from 19,569 in 2000 to 43,566 in 2030, an increase of 123 percent.²⁶

Federal and state statutes require that vulnerable adults, who include the elderly and mentally or physically impaired, be protected from abuse, neglect, and exploitation. Utah statute includes a mandatory reporting law that requires anyone who suspects abuse, neglect, or exploitation of a vulnerable adult to report it to either law enforcement or Utah Adult Protective Services (APS). Adult Protective Services within the Utah Division of Aging and Adult Services is in turn mandated to investigate allegations of abuse against any vulnerable adult.

In the U.S. it is estimated that over 500,000 older adults are believed to be abused or neglected each year.²⁷ Incidents of elder abuse are largely underreported to authorities. It is estimated that only one in 10 cases of elder abuse is ever reported to the proper authorities. In addition, elders can also be victims of abuse by their intimate partners.

In Utah in 2008, Utah APS investigated 2,435 referrals of abuse of vulnerable adults.²⁸ Of the substantiated cases, 29% were for exploitation, 19% emotional abuse, 17% caregiver neglect, 16% self-neglect, 14% physical abuse, 4% sexual abuse, and 1% unlawful restraint. Of these cases, 58% of the victims were female and 56% were between the ages of 60-89. In most cases (56% percent), the perpetrator was a relative or family member of the victim.

Definition

Accepted referrals require an adult to be at risk due to an allegation of abuse, neglect, or exploitation and contain one of the following elements:

1. A person 65 years of age or older
2. A person who is 18 years of age or older and has a mental or physical impairment that substantially affects that person's ability to:
 - Provide personal protection
 - Provide necessities such as food, shelter, clothing, or mental or other health care

- Obtain services necessary for health, safety, or welfare
- Carry out the activities of daily living
- Manage his/her resources
- Comprehend the nature and consequences of remaining in a situation of abuse, neglect, or exploitation.

Physical Abuse is any forceful, physical behavior, which may include:

- Physical injury/harm
- Unlawful restraint
- Sexual abuse
- Deprivation of life-sustaining treatment

Caregiver Neglect is the failure or refusal of a caregiver to provide for a vulnerable adult's basic physical, emotional, or social needs or failure to protect them from harm and can include:

- Failure to provide adequate nutrition, hygiene, clothing, shelter, or access to necessary health care
- Failure to prevent exposure to unsafe activities and environment

Self-neglect is the failure of the elderly or disabled person to provide his/her own basic needs.

Exploitation is the unauthorized or improper use of the resources of a vulnerable adult for monetary or personal benefit, profit, or gain and includes:

- Forgery
- Misuse or theft of money or possessions
- Use of coercion or deception to surrender finances or property
- Improper use of guardianship or power of attorney

Children Witnessing Domestic Violence Prevalence

An estimated one in three children in the U.S. live in a violent home and is a witness to the violence.²⁹⁻³¹ Surveys indicate that at least 50 percent of female victims of domestic violence have children less than 12 years of age in the home.³² Living in violent homes not only places children at risk of being witnesses to violence, but also of being victims of violence. The co-occurrence of domestic violence and child maltreatment is well documented. A growing amount of literature finds, that in 30-60% of homes where DV or child maltreatment occurs, other forms of violence are also present.^{10,33-34}

In the state of Utah, witnessing domestic violence is also considered a form of child maltreatment. As such, witnessing domestic violence accounts for 16% of confirmed cases of child abuse.³⁵

Definition

Child witness to domestic violence or intimate partner violence is defined by the national advocacy organization Futures Without Violence as, "...a term encompassing a wide range of experiences for children whose caregivers are being abused physically, sexually, or emotionally by an intimate partner. This term includes the child who actually observes his/her parents being harmed, threatened or murdered, who overhears this behavior from another part of the home, or who is exposed to the short- or long-term physical or emotional aftermath of caregiver's abuse without hearing or seeing a specific aggressive act. Children exposed to intimate partner violence may see their parents' bruises or other visible injuries, or bear witness to the emotional consequences of violence such as fear or intimidation without having directly witnessed violent acts."³⁶

The Health Care Provider's Role

Health care providers are mandated to report to a law enforcement agency the facts of an injury or wound inflicted by the person's own act or by the act of another by means of a knife, gun, pistol, explosive, infernal device, or deadly weapon, or by violation of any criminal statute of this state (Utah Health Code Chapter 26-23a-2). The Adult Abuse Statute, Utah Health Code Chapter 26-23a-1, defines "health care provider" as any person, firm, corporation, or association which furnishes treatment or care to persons who have suffered bodily injury, and includes hospitals, clinics, podiatrists, dentists and dental hygienists, nurses, nurse practitioners, physicians and physician assistants, osteopathic physicians, naturopathic practitioners, chiropractors, acupuncturists, paramedics, and emergency medical technicians.

In addition, Utah Administrative Rule R432-100 on General Hospital Standards mandates that (1) hospital emergency departments have policies and procedures that address the evaluation and handling of alleged or suspected child or adult abuse cases; (2) hospitals providing pediatric care shall have orientation and in-service training of staff on child abuse and neglect; and (3) all direct care and housekeeping staff shall receive annual documented in-service training in the requirements for reporting abuse, neglect, or exploitation of children or adults.

Health care providers have the unique opportunity and responsibility to identify victims of domestic violence and to refer and intervene on their behalf. Often health care providers are the first or only professionals to see the injuries or other medical issues of the victims, yet many victims of domestic violence move in and out of the health care system without identification or referrals.³⁷ The development and implementation of policies and procedures, reinforced by staff education, may increase the rate of identification of DV victims and their children.³⁸ As domestic violence recurs, emergency department or other health care facility identification may interrupt the cycle of violence and help prevent further incidents of abuse and violence.³⁹

Health providers have a reputation as sources of comfort and care. Generally, patients trust their providers to make suggestions that will benefit their physical and mental well-being. Such a relationship can open up avenues of communication that may otherwise have remained closed. This is why it is important for health care providers to ASK about the occurrence of domestic violence in the homes of their patients. Many medical professional organizations, including the American Academy of Family Physicians,⁴⁰ American Academy of Neurology,⁴¹ American Academy of Pediatrics,⁴² American Association of the Colleges of Nursing,⁴³ American College of Emergency Physicians,⁴⁴ American College of Obstetricians and Gynecologists,⁴⁵ American Medical Association,⁴⁶ American Psychiatric Association,⁴⁷ National Association of Social Workers,⁴⁸ and U.S. Preventive Services Task Force⁴⁹⁻⁵⁰ recommend that all clinicians screen females of childbearing years for intimate partner violence and victimization.

When health care providers fail to question patients about DV victimization, it is usually not because they do not care about their patient's safety, but because of existing or perceived barriers. Such barriers include:⁵¹

- Cultural differences
- Lack of privacy
- Language differences
- Lack of training on domestic violence
- Lack of time
- Lack of resources/referrals
- Fear or discomfort in asking questions about domestic violence
- Desire not to become involved in the issue with the patient

It is hoped that, with the realization that many of these barriers are due to perceived misconceptions and can be overcome, health care providers will make screening a routine practice and will recognize the benefits of identifying and referring domestic violence victims. Even when victims do not disclose information about the violence they are experiencing, it is empowering for the victims to know there are people who care and are willing to help when they are ready to disclose. In this small way, the simple act of asking can have a positive effect on the lives of patients. At other times, the process of asking sometimes can even save the life of the patient.⁵²

Bias

Before dealing with victims of domestic violence, it is important for the health care provider to evaluate his or her own feelings and prejudices. Victims of domestic violence have endured much – both physically and psychologically – and any indication of disbelief about the abuse may have a devastating effect on the patient's morale and confidence in divulging the truth about the violence he/she experiences.

When faced with the knowledge that any patient is being abused, it is important that providers understand that, even though the victims may feel responsible, the acts of violence are not their fault. The violence is the action and responsibility of the abuser. Domestic violence, elder abuse, and child maltreatment are crimes and no one deserves to be abused.

There are many obstacles that victims face when trying to leave their abusers and health care providers need to be patient and supportive when working with victims.⁵³ Victims stay for many reasons, including but not limited to: the lethality of the situation, the love they feel for their partners, the need to protect their children, and socioeconomic circumstances. The provider should continue to support the victim regardless of his or her decision to leave or stay with the abuser. The provider should also continue to document any occurrences of injury and report those cases the health care provider is mandated to report.

The provider can empower victims by helping them realize that they are strong, resourceful, and clever to have gotten as far as they have under the circumstances. It is important that these compliments be honest and reasonable. The provider may want to suggest that patients keep a journal about the violence they experience. Victims will know if they would be able to do this safely. It is natural for providers to want to present a solution to the problem; however, by empowering patients to make their own choices, the provider will be helping patients realize their potential for taking control of their own lives. It is important for the health care provider to be realistic and honest with the patient.

Recommending that patients leave their abusers without considering the dangerousness of this act could increase the patients' risk for lethality.⁵² Health care providers should advise patients to contact the crisis hotline number so that patients are fully aware of their situation and can have experts help them develop a safety plan. Health care providers should inform the patient that there is risk in any decision they make.

II. Screening Guidelines

Compelling Reasons for Routine Screening

Domestic violence is a major health care issue affecting millions of patients every year. It is a significant threat to the health and well-being of victims, as well as to other family members, including children. More females are killed by their intimate partners than by other family members, acquaintances, or strangers.⁵⁶ In 2011, more than half (53.5%) of the homicides in Utah were DV-related.⁵⁶ In addition, homicide is a leading cause of death for pregnant and postpartum women in this country.^{9,57}

In addition to injuries and death, the health consequences of and co-morbid conditions associated with domestic violence victimization include the following:^{9,58-71}

Physical Health Consequences

- Arthritis
- Asthma exacerbations
- Chronic pain syndromes including fibromyalgia, headache, pelvic pain
- Diabetes
- Gastrointestinal disorders including irritable bowel syndrome and other functional gastrointestinal disorders
- Heart and circulatory problems including stroke, high cholesterol, and heart disease
- Injury
- Neurologic disorders including traumatic brain injury, syncope, and psychogenic nonepileptic seizures
- Children can physically suffer the direct impact of DV by becoming injured during a DV incident and by becoming victims of other forms of child maltreatment

Reproductive Health Consequences

- Miscarriage
- Unwanted/unintended pregnancy
- Sexual assault/rape
- Spontaneous abortion
- Pregnancy complications including preeclampsia, vaginal bleeding, preterm labor
- Fetal complications including prematurity or fetal death
- Cervical cancer
- Sexually transmitted infections, including HIV
- Sexual disorders

Emotional and Mental Health Consequences

- Depression
- Anxiety
- Insomnia or other sleep disturbances
- Posttraumatic stress disorder
- Suicidal ideations/attempts

Behavioral Health Consequences

- Engaging in high-risk sexual behavior
- Alcohol/substance abuse
- Smoking
- Unhealthy diet practices

Research shows that children's health can be adversely impacted by living in a home where domestic violence occurs. It is important to note that many symptoms of violence exposure are common pediatric complaints.⁷²⁻⁷⁵

Infants can present with

- Disrupted feeding routines
- Disrupted sleep patterns
- Failure to thrive
- Excessive screaming that the physician may diagnose as colic
- Developmental delays

Preschoolers can have

- Regression of developmental behaviors such as thumb-sucking or bed-wetting
- Changes in behavior by becoming more clingy or anxious
- Decreased willingness to explore their environment and exert their independence

School-aged children can have

- Problems with being aggressive
- Poor school performance
- Behavior problems
- Chronic somatic complaints, such as chronic headache or chronic abdominal pain

Adolescents may

- Feel shame, betrayal
- Become aggressive
- Exhibit high risk behaviors; e.g., drug use, sexual promiscuity
- Run away from home
- Exhibit truancy
- Lose impulse control, which can be deadly if there are lethal weapons available

Another important finding is that up to 50% of children who witness assaults against their mother have clinical criteria consistent with posttraumatic stress disorder.⁷⁶⁻⁷⁶ Many of these children are incorrectly diagnosed with anxiety disorder, conduct disorder, mood disorders, and attention deficit/hyperactivity disorder (ADHD). However, one of the most devastating outcomes of violence exposure is the perpetuation of the cycle of violence. Children who grow up in violent homes are more likely to be involved in violent relationships in their adult lives than children who are not exposed to DV.

Medical professionals are often the only professionals to see a victim of domestic violence or her children. Failing to diagnose abuse increases the patient's health risk. Recent research has linked DV to all of the 12 leading health indicators defined in the federal Healthy People 2020 Initiative, including overweight and obesity, tobacco use, substance abuse, risky sexual behavior, infant deaths and preterm births, mental illness, injury and violence, lack of current immunizations, and poor access to health care.⁷⁸ Recent recognition of the significant negative health impact of violence victimization has prompted recommendations for screening women of childbearing years for intimate partner violence by the Institute of Medicine³⁹ and the U.S. Preventive Services Task Force.⁵⁰⁻⁵¹ Domestic violence screening is included as a no-cost shared preventive health service for women in the Affordable Care Act.⁷⁹ By identifying and acknowledging the abuse, the health care provider may help to end the generational cycle of violence and increase the health and welfare of the patient and her children. This simple intervention may begin a process whereby the victim may seek the necessary assistance to help her become safe and free from violence.

II. Screening Guidelines

Indicators of Abuse

Although abusive relationships may differ from one couple to another, research has shown that there are basic dynamics and certain risk factors associated with domestic violence victimization. Listed below are historical indicators and injuries that should raise suspicion of abuse:^{22,80-81}

Historical Indicators (or Red Flags) for Domestic Violence Victimization

- Women between the ages of 20 and 34
- Men in same sex relationships
- Having a disability
- Recent trauma history
- Unexplained injuries
- Injuries inconsistent with the story
- Delay in seeking medical care
- Physical injury during pregnancy
- Direct or indirect reference to abuse
- Alcohol/substance abuse
- History of depression, anxiety, suicidality
- Overly protective or controlling partner
- Having a child with alleged or confirmed child maltreatment
- Not following through with recommended treatments
- Chronically “no-showing” for appointments

Symptoms/Injuries Concerning for Domestic Violence Victimization^{1,57-58,71,82-83}

- Injury to head, neck, torso, breasts, abdomen or genitals
- Defensive wounds (e.g., bruises/lacerations on back of forearms or hands)
- Strangulation injury
- Mental illness
- Sexually transmitted infections
- Obstetric complications
- Chronic pain syndromes (e.g., headaches, irritable bowel syndrome, fibromyalgia, pelvic pain)
- Chronic fatigue
- Sleep disorders

Separating the Patient from Visitors

The health care provider's primary concern should be for the safety of the staff and the victim. Never inquire about abuse in the presence of any person who accompanies the patient. Appearances can be deceiving. Do not assume that the person who accompanies the patient has the patient's best interest at heart.

Perpetrators of domestic violence are often very controlling and may not allow the victim to be alone for fear of disclosure. Providers should be prepared and have a plan for separating the perpetrator and the victim in a non-confrontational way that ensures the safety of the victim and the staff.

Steps for Health Care Providers

- When possible, hang a sign in a specific area that indicates "patients only beyond this point."
- Take advantage of the privacy of the bathroom: Go into the bathroom with the patient when a urine sample is needed, or simply use the collection of the sample as an excuse to get the patient alone.
- Assure private time with the patient during tests (e.g., x-rays, MRIs, CT scans).
- If it is safe, provide the patient with educational information and other resources. Ask the patient what would happen if her partner found the resource materials, such as phone numbers and pamphlets.
- Identify code phrases that alert staff to call for security or law enforcement (e.g., "We need A, B, or C").

Steps for Home Health Care Providers

- There may be an occasion when the patient is home alone. Use this opportunity to discuss abuse in the home. Keep in mind that the abuser may be someone you least expect (e.g., daughter, niece, grandchild).
- Phone the patient ahead of time to set up an appointment when the patient will be home alone (e.g., when other household members are at work, shopping, running errands).
- Use the framing questions to preface the reason for a private visit.
- Be creative. As a home health care provider, you often know your patients and the dynamics of their home lives.

Remember, if your patient is a "vulnerable adult" you are mandated to report all suspected abuse, neglect, and exploitation. Your reporting rights **ARE NOT** limited to the existence of an injury caused by another person in this circumstance.

As part of your routine practice, ask every female patient between the ages of 14 and 46 about domestic violence victimization, or any patient when there are possible signs of domestic violence. Normalize your questioning by explaining to the patient that the questions are a new personal standard or agency policy (if applicable). Most patients will not be offended if they know the questioning is policy or standard practice and the screening is done in an empathetic, nonjudgmental manner.

Before asking any questions regarding violence or abuse, separate the patient from any visitors. If the mother is accompanied by children older than 2 years of age, separate the mother from the children so that she can be questioned in private if needed; otherwise, use a more general, open-ended approach (see Open-Ended Approach). If you are unable to do this, questioning may have to wait for a safer, more private situation.

Never ask accompanying family or friends to act as interpreters. This includes interpreting for the deaf and/or for non-English-speaking patients. Always use a professional interpreter.

Respect the decision of the patient to discuss the problem or to remain silent about the issue. Victims of domestic violence will discuss the problem when they are ready. If you suspect violence or abuse but your patient denies being abused, you may want to pose more than one question about the issue. When asking questions, remember that the manner in which you ask the question is just as important as the question itself. Domestic violence is a very personal, sensitive subject and should be dealt with in a respectful, non-judgmental way. How you ask the question will depend on your patient. Some people may respond better to direct questions, while others may need a question framed in such a way that will not make them defensive.

II. Screening Guidelines

Recommended Screening Frequency

Listed below is the recommended frequency for screening women for domestic violence victimization in the various health care settings:^{22,84}

- Screen routinely at **EVERY VISIT** and ensure referral to the patient's primary care provider in the following health care settings:
 - Emergency departments
 - Urgent care clinics
 - Same day visits
 - Episodic visits
 - Inpatient care
 - Orthopedic surgery clinics
 - Other specialty clinics
- Screen routinely at **INITIAL VISIT, ANNUALLY, OR WHENEVER RISK FACTORS ARE PRESENT** in the following health care settings:
 - Adult/teen primary care
 - Family practice
 - Public health clinics
 - School health settings
- Screen routinely at **INITIAL VISIT, ANNUALLY, WHENEVER RISK FACTORS ARE PRESENT, AND PRENATAL AND POSTPARTUM VISITS** in the following health care settings:
 - Obstetrics/Gynecology clinics
 - Family planning clinics
 - STI clinics
 - Geriatric clinics
 - Prenatal clinics
 - Women's health clinics
 - Dental clinics
- Screen routinely at **INITIAL VISIT, ANNUALLY, AND DURING PERIODIC HEALTH ASSESSMENTS** in the following health care settings:
 - Mental health clinics
 - Substance abuse clinics

A direct question approach (see below) is more appropriate in urgent care settings, such as emergency departments, urgent care clinics, mental health, and substance abuse clinics. In primary care settings, an open-ended invitation to the patient to offer information about abuse may be a more appropriate way of screening.

What to Ask

Direct questioning is particularly important for patients who have risk factors for DV victimization and present to certain health care settings such as emergency departments, urgent care, specialty, mental health and substance abuse clinics, and inpatient settings.

An opening statement such as...“I ask all my patients if they are in a relationship or in a home with someone who may be hurting or controlling them because it is important for your health (and the health of your children), and in some cases it needs to be reported. Are you in a relationship with someone who physically hurts, threatens, or emotionally abuses you?”

Other suggested questions include

- Have you ever been hit, kicked, punched, shoved or otherwise hurt by someone you are or were in a relationship with?
- Has a partner ever forced you to have sex?
- Has a partner ever verbally threatened or abused you?
- Are you afraid of your partner or anyone else?
- I am concerned that your symptoms may have been caused by someone hurting you. Is anyone hurting you?
- Have your children witnessed anything violent or frightening in your home, school, or community (neighborhood)?

If a patient denies abuse, but the health care provider has a concern, then the question can be redirected. For example you can say, “Other patients I see with an injury/symptom/complaint like yours have this because someone is hurting them. Is anyone hurting you?” If the patient continues to deny victimization, then acknowledge and reaffirm that if the patient ever needs help that you are a resource.

Instead of direct questions, the health care provider who has an ongoing relationship with a patient (such as in primary care, family medicine, pediatrics, or obstetrics-gynecology) may want to let the patient know that their clinic is a safe place for patients. This can be done by:

- Making statements about DV victimization such as, “Because violence is so common in many people’s lives and witnessing violence can have negative effects on children, we want to make sure that all our patients in our clinic are safe. If you feel you are not safe or if you are afraid someone is going to harm you or someone has harmed you, you can come to us for help.”
- Wearing buttons saying “Tell me if someone is hurting you.”
- Displaying posters or having tear-off cards in the bathrooms with the crisis hotline number. (Contact Utah Domestic Violence Coalition for patient materials at www.udvc.org.)

If a health care provider has no concerns about abuse with a particular patient, this provides an open door for the patient to discuss this with the health care provider when the patient feels ready to disclose. This statement sends the message to the patient that the health care provider is a resource for the patient when and if he/she needs it.

The above are offered as examples for approaching screening for DV in the health care setting. For a more extensive review of DV screening questions see <http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf>.

To maintain open communication and prevent patient defensiveness, avoid questions such as:

- Are you a battered woman?
- Does your husband beat you?
- You’re not being hurt by your boyfriend, are you?
- Your child isn’t witnessing the abuse, is she?

Danger Review

A review of safety is a difficult and uncertain task and it cannot predict if a domestic violence perpetrator will or will not seriously harm or kill his/her partner or others. Remember that the most dangerous time for a DV victim is when she tries to leave her abuser. Provide the patient with the crisis hotline number (1.800.897.LINK) so that the experts can discuss safety planning with the victim. Among the concerning characteristics for future lethality are:

- Has the perpetrator verbally threatened to kill or harm the victim, children, or others?
- Has the perpetrator threatened to harm or kill himself/herself or has he/she exhibited fantasies or detailed plans of suicide and/or homicide?
- Does the perpetrator possess weapons and has he/she threatened the victim or actually used them in abusing the victim or others?
- Has the perpetrator injured the victim, children, or others seriously enough to require medical treatment?
- Does the perpetrator have a criminal history of violence or stalking behaviors?
- Is the perpetrator intoxicated on a daily or weekly basis or does he/she heavily or regularly use amphetamines, heroin, or other street drugs, and/or does the perpetrator become violent when abusing substances?
- Has the perpetrator violated a protective order in the past?
- Has the domestic violence increased in severity and frequency over the past year?
- Has the perpetrator forced sexual activities upon the spouse or children?
- Has the perpetrator ever prevented the victim or children from leaving by threatening physical harm to self or others if they leave?
- Has the victim recently separated from or terminated the relationship with the perpetrator?
- Has the perpetrator harmed or killed family pets or threatened to do so?
- Has the perpetrator destroyed the victim’s personal property?
- Has the perpetrator dropped out of treatment or been non-compliant in a domestic violence treatment program?
- Does the perpetrator exhibit excessive jealousy?

Adapted from Lethality Review by Dan Greene, LCSW, and the Treatment Sub-committee of the Salt Lake Domestic Violence Advisory Committee.

II. Screening Guidelines

Use the following checklist to document findings to the **Danger Review questions**.

Interview the victim separately from the partner or other family members.

Risk Factors: (check all that apply)

- Financial problems, unemployment
- Divorce or separation (especially during pregnancy)
- Substance abuse by victim or abuser
- Victim or abuser physically abused as a child
- Overly protective or controlling abuser (refuses to leave room)
- Suicide attempts by victim or abuser
- Mental illness of victim or abuser

Signs of Physical Abuse: (check all that apply)

- Self-induced or attempted abortions; multiple therapeutic abortions
- Multiple miscarriages
- Abdominal or pelvic injuries, back or spinal injuries (not from fall or motor vehicle accident)
- Injuries to face, neck, throat, chest, breasts
- Injuries during pregnancy
- Increased drug/alcohol abuse during pregnancy
- Multiple injuries in various stages of healing
- Injury inconsistent with history
- Delay in seeking medical treatment
- Minimizes frequency and seriousness of injuries
- Repeated emergency department visits
- Sexual assault by partner
- Suicide attempt
- Single car crash
- Fractures in various stages of healing
- Burn (cigarette, friction, splash, chemical)
- Head injuries
- Low self-esteem, sense of apprehension or hopelessness, depression (laughing inappropriately, crying, no eye contact, angry, defensive)

Homicidal Risk: (check all that apply)

- Presence of gun in home
- Threats of homicide or suicide
- Overly jealous
- Violent behavior by abuser toward non-family members
- Use of alcohol or drugs by abuser
- Increasing severity of injuries
- Abuser has killed pets
- Abuser objectifies victim

Documenting Abusive Injuries

For medical records to provide evidence and patterns of violence for legal proceedings, chart documentation must be accurate, legible, and thorough. Medical records can provide crucial evidence in support of the victim in court. Documentation should include:⁸⁵

- Date and time of arrival
- Name, address, and phone number of anyone accompanying the patient
- Primary complaint
- Description of injury-causing event, including patient's own statements of how the injuries occurred (direct quotes)
- Patient's statements of past battering incidents (direct quotes)
- A detailed description of the injuries, including type, number, and location, (record injuries on body charts)
- Complete medical history
- Relevant social history
- Laboratory and radiological results
- Name of health care professional who provided treatment
- Documentation that the patient was asked about DV and the patient's response
- Documentation that injuries were reported to law enforcement
- Documentation of resource information given for aftercare (e.g., shelters, counseling, victim advocates, etc.)
- Consent forms for any photographs taken
- Record of non-bodily evidence of abuse, such as torn clothing or damaged jewelry
- Name of translator used, if applicable

You may want to consider establishing a way of flagging charts that contain domestic violence cases so that the information in the charts will be better protected, especially from the abuser. For example, an unlabeled, colored sticker could be used to alert staff, while the abuser would not know what the sticker represents. If using an electronic medical record program, discuss with your IT staff how to make a restricted access document so that the information remains confidential.

II. Screening Guidelines

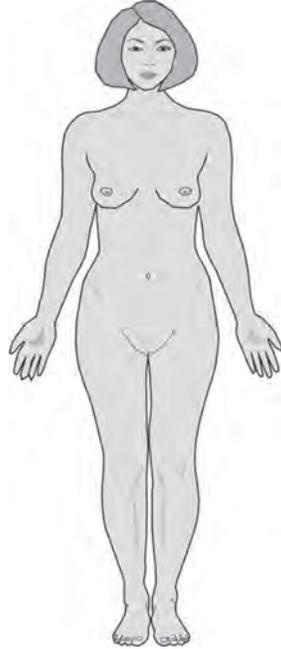
An example of a domestic violence documentation form is given below.

- DV Screen
 DV + (positive)
 DV? (suspected)

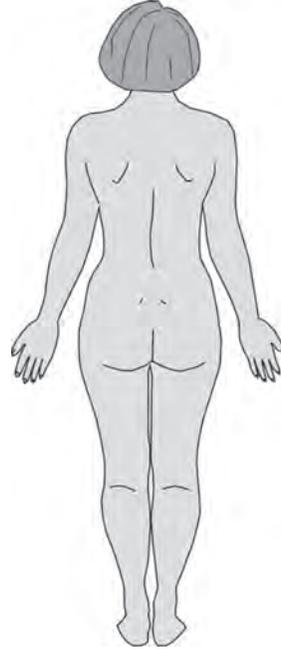
Date _____ Patient ID# _____

Provider Name: _____
 Patient Pregnant? Yes No

Front



Back



Assess Patient Safety

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is patient afraid of partner? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is patient afraid to go home? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has physical violence increased in severity? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has the abuser threatened to kill? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is patient suicidal? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is there a gun in the home? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is there evidence of alcohol or substance abuse? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Was safety plan discussed? |

Photographs

- Yes No Consent to be photographed?
 Yes No Photographs taken?
 Attach photos and consent form.

Referrals

- Hotline number given
 Victim advocate referral made
 Shelter number given
 In-house referral made
 Describe: _____
 Other referral made
 Describe: _____

Reporting

- Law enforcement report made: Time _____
 Agency Name _____
 Phone # _____ Spoke w/ _____
 Child Protective Services report made
 Adult Protective Services report made

III. Reporting Requirements for Health Care Providers

Reporting to Authorities

Providers are under legal obligation to report abuse (Utah Statute 26-23a-2). In Utah, providers cannot incur civil or criminal liability for reporting cases of suspected abuse. Health care providers cannot be discharged, suspended, disciplined, or harassed for making a report.

However, penalties can be pursued against providers who fail to report suspected or confirmed cases of abuse. Such consequences can include being charged with a misdemeanor, time in jail, and both personal and corporate fines.

When possible, a provider may want to offer a patient the option to immediately report to law enforcement. This will empower a victim to take control of his or her own situation and provide law enforcement with more detailed information regarding the crime. Although a provider may want to record information for documentation purposes, a provider who has personal knowledge that a report has been made in compliance with Utah law is under no further obligation to make a report regarding that injury.

When reporting incidents of abuse, providers should report to the municipal or county law enforcement agency where the injury occurred. If abuse occurs in more than one jurisdiction, notify the authorities closest and report the injuries that took place in that jurisdiction. It is required that you report by telephone or by another form of spoken communication. Again, it is important to document that the case was reported. If there are children in the home and they may have witnessed the abuse, DCFS must be notified.

Documentation of the report should include:

- Which law enforcement agency was contacted
- What phone number was called
- When the contact was made
- Name of the law enforcement officer spoken with
- Case number assigned by the law enforcement agency

What to include in the report:

- Name and address of the injured person
- Injured person's whereabouts, if known
- Character and extent of the person's injuries
- Name, address, and phone number of the person making the report
- Information on any children who may have witnessed the incident

After the Report

After a report of abuse is made to law enforcement, the health care provider is required to inform the patient of the report, according to the Privacy Rule (HIPAA). However, if the health care provider, in the exercise of professional judgment, believes informing the individual would place the patient in greater danger, he/she is absolved of this requirement.

Health care providers should never dictate a specific course of action to the patient. In abusive relationships, the victim always has been told what to do. By offering information to patients, the provider will be giving them the tools to make choices for themselves.

The patient may, understandably, become distressed when the health care provider informs the patient of a domestic violence report. The patient may beg the provider to forgo notifying the authorities. The victim may be afraid that his/her children will be removed or that he/she will be in more danger once the police are involved. Being supportive, but honest and straightforward, is the best response. Explain to the patient the legal requirements of health care providers. Use this opportunity to educate the patient about domestic violence. Some important messages to convey to the patient are listed below

- Domestic violence is cyclical and may intensify, causing more harm to the victim.
- Abuse is not the victim's fault and the victim is not responsible for the violence inflicted upon her/him.
- There are health risks associated with violence not only for the patient but also for the children. Domestic violence is a crime for which there are solutions.

III. Reporting Requirements for Health Care Providers

It is important for the health care provider to be supportive of the patient after a report to authorities is made. The patient may be nervous, apprehensive or afraid. Some suggestions for supporting the victim after the report is made after the report is made are listed below.

- Contacting a crisis worker or social worker within your organization if one is available.
- Contacting a victim advocate on behalf of the victim.
- Providing the victim with resources and referral numbers.
- Offering to contact clergy of the victim's faith. Many hospitals have clergy on-site who may be able to offer comfort and resources to the victim.
- Discussing with the victim her level of safety and, if feasible, developing a safety plan. Brochures on safety planning are available from the Utah Domestic Violence Coalition at (801) 521-5544 or www.udvc.org. If there are children in the home, encourage the mother to contact his/her physician for appropriate referrals and care. Many victim advocate programs have packets that contain helpful information for victims of domestic violence. However, some patients may not be willing to speak with a victim advocate. Health care agencies should have resource information available if the victim chooses not to talk with a DV advocate or shelter. Give this information to the patient only if it is safe to do so. These packets should include:
 - A business card with the victim advocate's phone number and an after-hours crisis phone number that will automatically page the on-call advocate.
 - A safety plan. Safety plan brochures may be obtained from the Utah Domestic Violence Coalition at (801) 521-5544 or www.udvc.org.
 - Phone numbers and addresses of domestic violence shelters in the area.
 - Information on protective orders and how to obtain one.
 - Resource lists that provide information on emergency shelters, food, crisis nurseries, health clinics, alcohol and drug detoxification centers, legal help, support groups, counseling options, rape recovery centers, and employment services.
 - A crime victim reparation application.
 - A risk and lethality assessment form.
 - A victim impact statement.
 - A guide to the criminal justice system (court process).

Local victim advocate programs will be helpful in obtaining this information. A list of victim advocate programs is provided in Appendix A.

Health care providers are classified as mandatory reporters of abuse by the state of Utah. Mandatory reporting laws require reporting instances of:

- Child abuse (call Child Protective Services) (855) 323-3237
- Elderly/disabled person abuse (call Adult Protective Services at (800) 371-7897)
- Any assault* (call local law enforcement or 911)

***An assault occurs when one person inflicts an injury on another person — this includes abuse. It is against the law even if an acquaintance or a loved one inflicted the injury.**

If any patient presents with an assaultive injury, the health care provider is required by law to report the injury to law enforcement. It is important to note that inflicting any injury on another person with the intent of causing harm is a crime and considered a violation of the criminal statute of the state of Utah.

It is the health care provider's responsibility to contact law enforcement if a patient presents with an injury inflicted by another person. A patient may choose not to disclose the actual details regarding the causation of the injury, but this does not absolve the provider from notifying law enforcement. It is important to document that law enforcement has been contacted.

If a patient is being treated for an injury or illness that is not related to abuse, but discloses to the provider that he or she is a victim of domestic violence, the health care provider is not mandated to report this to law enforcement. It is, however, strongly recommended that providers refer the patient to resources to obtain the help they need.

Any health care provider who knowingly fails to report an injury inflicted by another person can be charged with a class B misdemeanor. A link to the Utah Health Code, which includes definitions, requirements, and penalties, is provided at the end of this section.

III. Reporting Requirements for Health Care Providers

After a report is made, health care providers are mandated by HIPAA (Health Insurance Portability and Accountability Act) to inform the patient of the report. However, health care providers are absolved of this requirement if, in their professional judgment, they believe informing the patient would place the patient at risk of serious harm.

Child abuse and neglect is a mandatory reportable crime. In the state of Utah, commission of domestic violence in the presence of a child is considered child abuse (and therefore needs to be reported to law enforcement or the DCFS) as defined in the Utah Statute §76-5-109.1, "...A person is guilty of child abuse if the person commits or attempts to commit criminal homicide...against a cohabitant in the presence of a child; or intentionally causes serious bodily injury to a cohabitant or uses a dangerous weapon...or other means of force likely to produce death or serious bodily injury against a cohabitant in the presence of a child...or commits an act of domestic violence in the presence of a child..."

'In the presence of a child' is defined as: "...in the physical presence of a child; or having knowledge that a child is present and may see or hear an act of domestic violence." Health care providers who are assessing a victim of domestic violence should inquire as to the presence and safety of any children who may be living in the home.

HIPAA Regulations

The Health Insurance Portability and Accountability Act (HIPAA) permits covered entities to disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence. Such disclosures can be made only to government agencies authorized by law to receive such reports, such as:

- Public health authorities
- Social service or protective services agencies
- Law enforcement authorities

HIPAA allows providers to disclose abuse that is required to be reported to comply with state law.

***Utah law allows for reporting of domestic violence to authorities without disclosure to the patient or their representatives prior to the report.**

The following is excerpted from the Health Insurance Portability and Accountability Act 42CFR Section 164.512(c).

Standard: Disclosures about victims of abuse, neglect or domestic violence.

(1) Permitted disclosures. Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) Informing the individual. A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

III. Reporting Requirements for Health Care Providers

JCAHO STANDARD PE.1.9

Possible victims of abuse are identified using criteria developed by the hospital.

Intent of PE.1.9

Victims of abuse or neglect may come to a hospital through a variety of channels. The patient may be unable or reluctant to speak of the abuse, and it may not be obvious to the casual observer. Nevertheless, hospital staff members need to know if a patient has been abused, as well as the extent and circumstances of the abuse, to give the patient appropriate care.

The hospital has objective criteria for identifying and assessing possible victims of abuse and neglect, and the criteria are used throughout the organization. Staff are to be trained in the use of these criteria. The criteria focus on observable evidence and not on allegation alone. They address at least the following situations:

- Physical assault
- Rape or other sexual molestation
- Domestic abuse
- Abuse or neglect of elders and children

When used appropriately by qualified staff members, the criteria prevent any action or question that could create false memories of abuse in the individual being assessed. Staff members are able to make appropriate referrals for victims of abuse and neglect. To help them do so, the hospital maintains a list of private and public community agencies that provide help for abuse victims. In addition, the assessment of victims of alleged or suspected abuse or neglect is conducted consistent with standard PE.8.

JCAHO STANDARD PC.3.10

Patients who may be victims of abuse or neglect are assessed (see standard 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 or 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 hospital. 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.

JCAHO STANDARD PE.8

Patients who are possible victims of alleged or suspected abuse or neglect have special needs relative to the assessment process.

Intent of PE.8

As part of the initial screening and assessment process, information and evidentiary material(s) may be collected that could be used in future actions as part of the legal process. The hospital has specific and unique responsibilities for safeguarding such material(s).

Policies and procedures define the hospital's responsibility for collecting, retaining, and safeguarding information and evidentiary material(s). The following are documented in the patient's medical record:

- Consents from the patient, parent, or legal guardian, or compliance with other applicable law
- Collecting and safeguarding evidentiary material released by the patient
- Legally required notification and release of information to authorities
- Referrals made to private or public community agencies for victims of abuse.

Hospital policy defines these activities and specifies who is responsible for implementing them.

Adult Abuse Statute

UTAH HEALTH CODE CHAPTER 26-23a INJURY REPORTING BY HEALTH CARE PROVIDERS

26-23a-1. Definitions.

le.utah.gov/xcode/Title26/Chapter23A/26-23a-S1.html?v=C26-23a-S1_1800010118000101

26-23a-2. Injury reporting requirements by health care provider -- Contents of report.

le.utah.gov/xcode/Title26/Chapter23a/26-23a-S2.html

26-23a-3. Penalties.

le.utah.gov/xcode/Title26/Chapter23A/26-23a-S3.html?v=C26-23a-S3_1800010118000101

76-5-111. Abuse, neglect, or exploitation of a vulnerable adult -- Penalties.

le.utah.gov/xcode/Title76/Chapter5/76-5-S111.html

TITLE 77 UTAH CODE OF CRIMINAL PROCEDURE CHAPTER 36 COHABITANT ABUSE PROCEDURES ACT

77-36-1. Definitions.

le.utah.gov/xcode/Title77/Chapter36/77-36-S1.html?v=C77-36-S1_2019051420190514

77-36-2.1. Duties of law enforcement officers -- Notice to victims.

le.utah.gov/xcode/Title77/Chapter36/77-36-S2.1.html?v=C77-36-S2.1_2018050820180508

TITLE 76 UTAH CODE OF CRIMINAL PROCEDURE CHAPTER 5 OFFENSES AGAINST THE PERSON

76-5-102. Assault.

le.utah.gov/xcode/Title76/Chapter5/76-5-S102.html?v=C76-5-S102_2015051220150512

UTAH CODE -- TITLE 62A -- CHAPTER 04A -- CHILD AND FAMILY SERVICES

62A-4a-101. Definitions.

le.utah.gov/xcode/Title62A/Chapter4A/62A-4a-S402.html?v=C62A-4a-S402_1800010118000101

IV. Resources

After identifying and documenting abuse, health care providers should provide a referral to a local domestic violence shelter or victim advocate program. It is not necessary for health care providers to know every resource available to DV victims. However, it is recommended that you refer your patients to at least one resource for further assistance. Victim advocate programs and domestic violence shelters have a wealth of helpful information for those living with domestic violence. It is important to provide victims with a means to access help. Some resources are listed below:

- A 24-hour DV line is available by calling **(800) 897-LINK**. The link line is staffed by caring professionals who are knowledgeable about local shelters and advocate programs.
- A website containing information and referral numbers is available at www.informationandreferral.org.
- A statewide 24-hour rape and sexual assault crisis hotline is available at **(888) 421-1100**.
- This section contains contact information for community resources available for each geographic area of the state of Utah.
- Shelters are accessible 24 hours a day for information, victim advocacy, or housing for victims of abuse.
- The Salt Lake Area Family Justice Center can be reached by calling **(801) 236-3370**.

Victim Advocate Services

Health care providers are strongly encouraged to contact a victim advocate as soon as a report is made. Victim advocates are trained to support victims and help them through the process of making a report. They also assist domestic violence victims and their families with finding social service resources in the community such as temporary shelter, medical assistance, childcare, transportation, and employment/education counseling. Often, victim advocates will respond to the hospital immediately. The goal of a victim advocate is to give the victim options, emotional support, and education on domestic violence, in addition to providing resources to help them take the steps necessary to become independent, functioning individuals. Advocate programs address the immediate needs of victims of crime by responding to victim's needs during hospital visits, helping victims through the judicial system, and providing emotional support. Their knowledge of court processes, the preparation of safety plans, and updated information on arraignments, pre-trials, and hearings are also key services. Victim advocate programs help victims fill out forms for Crime Victim Reparations, protective orders, and other documents that may be related to the case.

Domestic Violence Shelter Services

The goal of domestic violence shelters is to provide all victims of domestic violence with resources and options to help them break the cycle of violence. These shelters provide short-term emergency shelter and support services for victims and their children at no cost to the victim. Shelters provide clothing, food, and other needed items. Most shelters provide crisis counseling, weekly support groups, individual counseling, and referrals to other agencies in their communities. Shelters also provide crisis counseling and supportive services to non-shelter clients.

Shelters/safe houses are available to victims of domestic violence 24 hours a day, seven days a week. When referring a victim to a shelter, remember that shelter staff prefer to speak to the victims personally prior to their arrival.

V. Appendices

Appendix A. Victim Advocate Programs Statewide

For more information or an updated list call **1-800-897-LINK (5465)**

BEAVER COUNTY

Beaver County Sheriff's Office
2160 South 600 West
Beaver, UT 84713
(435) 438-6494

BOX ELDER COUNTY

YWCA, Box Elder County
P.O. Box 756
Brigham City, UT 84302
(801) 734-2233
1-877-723-5600

CACHE COUNTY

Cache County Victim Services
11 West 100 North, Suite C
Logan, UT 84321
(435) 716-8373

CARBON COUNTY

Carbon County Sheriff's Office
240 West Main
Price, UT 84501
(435) 636-3250
(435) 636-3251

DAGGETT COUNTY

Refer to Uintah County

DAVIS COUNTY

Davis County Attorney's Office
(Prosecuted cases only)
Victim of Crime Assistance
800 West State Street
Farmington, UT 84025
(801) 451-4341

Layton City
Layton City Attorney's Office
437 North Wasatch Drive
Layton, UT 84041
(801) 546-8539

DUCHESNE COUNTY

Duchesne County Attorney's Office
255 South State Street
Roosevelt, UT 84066
(435) 722-0828

EMERY COUNTY

Refer to Carbon County

GARFIELD COUNTY

Refer to Iron County

GRAND COUNTY

Grand County Attorney's Office
125 East Center Street
Moab, UT 84532
(435) 259-1384

IRON COUNTY

Iron County Attorney's Office
95 North Main, Suite 26
Cedar City, UT 84720
(435) 865-6368

JUAB COUNTY

Refer to Sevier County

KANE COUNTY

Kane County Sheriff's Office
76 North Main Street
Kanab, Utah 84741
(435) 644-4989

MILLARD COUNTY

Millard County Attorney's Office
765 South Highway 99, Suite 3
Fillmore, UT 84631
(435) 743-6522

MORGAN COUNTY

Refer to Weber County

PIUTE COUNTY

Refer to Sevier County

RICH COUNTY

Refer to Cache County

SALT LAKE COUNTY

Draper City Police Dept
12441 South 900 East
Draper, Utah 84020
(801) 576-6355

Midvale City
Midvale City Police Dept.
South Main Street
Midvale, UT 84047
(385) 468-9350

Murray City
Murray City Police
5025 South State Street
Murray, UT 84107
(801) 284-4203
(801) 284-4201

Salt Lake City
Victim Resource Center
320 East 200 South
Salt Lake City, UT 84111
(801) 799-3756

Salt Lake County
Salt Lake County Sheriff's Unified
Police
3365 South 900 West
Salt Lake City, UT 84119
(801) 743-5860
(801) 743-5861

Sandy City
Sandy City Police Dept.
10000 South Centennial Parkway
Sandy, UT 84070
(801) 568-7283
(801) 568-6059

South Jordan
South Jordan Police Dept.
11175 South Redwood Rd.
South Jordan, UT 84095
(801) 254-4708, ext. 216

South Salt Lake City
South Salt Lake Police Dept.
2835 South Main
South Salt Lake, UT 84115
(801) 412-3660

West Jordan City
West Jordan Public Safety Dept.
Program
8000 South 1700 West
West Jordan, UT 84088
(801) 566-6511

West Valley City
West Valley City Attorney's Office
3375 South Market Street
West Valley, UT 84119
(801) 963-3223

SAN JUAN COUNTY

San Juan County Sheriff's Office
P.O. Box 788
Monticello, UT 84535
(435) 587-2237
(435) 459-1819

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SANPETE COUNTY

Refer to Sevier County

(801) 852-6280

SEVIER COUNTY

New Horizons Crisis Center
Richfield, UT 84701
1-800-343-6302

South Utah County
439 West Utah Ave
Payson, UT 84651
(801) 465-5224

SUMMIT COUNTY

Summit County Attorney's Office
6300 North Silver Creek Rd.
Park City, UT 84098
(435) 615-3850

Springville/Mapleton
Springville Police Dept.
45 South Main
Springville, UT 84663
(801) 489-9421
(ask for advocate)

TOOELE COUNTY

Pathways
Tooele County Shelter
(435) 843-1677
1-800-833-5515

Utah County Sheriff's Office
3075 North Main
Spanish Fork, UT 84660
(801) 343-4336

UINTAH COUNTY

Vernal Police Dept.
437 East Main Street
Vernal, UT 84078
(435) 789-4250

WASATCH COUNTY

Wasatch County Attorney's Office
Victim Assistance Program
55 South 500 East
Heber, UT 84032
(435) 657-3300

UTAH COUNTY

Alpine/Highland Police Dept
20 North Main
Alpine, UT 84004
(801) 756-9800

WASHINGTON COUNTY

DOVE Center
P.O. Box 2972
St. George, UT 84771
(435) 628-0458

American Fork Police Dept.
98 North Center Street
American Fork, UT 84003
(801) 763-3020

WAYNE COUNTY

Refer to Sevier County
Weber County Attorney's Office
2380 Washington Blvd, Suite 230
Ogden, UT 84401
(801) 399-8377

Lehi City
150 North Center Street
Lehi, UT 84043
(801) 768-7117

ALL COUNTIES IN UTAH

Federal Victim/Witness Program
1-800-949-9451

Orem City
Orem Dept. Of Public Safety
95 East Center
Orem, UT 84057
(801) 229-7128

Department of Corrections
Victim Services Program
(801) 545-5899

Pleasant Grove
Pleasant Grove Police Dept.
87 North 100 East
Pleasant Grove, UT 84062
(801) 785-3506

Utah State Board of Pardons
Victim Assistance Program
(801) 261-6464

Provo City
Provo City Police Dept.
351 West Center Street
Provo, UT 84603
(801) 852-6375

Attorney General's Office
Victim Services Unit
(801) 366-0223

Appendix B. Domestic Violence Shelters Statewide

For more information or an updated list call **1-800-897-LINK (5465)**

Shelter	Phone/Fax	Pet Boarding	Transitional Housing	Outreach Coordinator	Children's Services	Beds	Cribs
BLANDING Gentle Ironhawk Shelter	Office: (435) 678-2445 Crisis: 1-866-206-0379 Fax: (435) 678-3827	None	Assistance for transitional housing available.	Yes	Support groups and Children's Cultural Camps.	26	3
BRIGHAM CITY New Hope Crisis Center	Main/24hr: (435) 723-5600 Crisis: 1-877-732-5600 Fax: (435) 723-0670	Private Kennel provides boarding for up to two weeks. Asks that victims try to provide food.	Transitional rental assistance for up to 1 year very limited.	Yes	Children's support group 2X per month for children of women attending support group.	14	3
CEDAR CITY Canyon Creek Women's Crisis Center	Main: (435) 867-9411 Crisis: (435) 865-7443 Fax: (435) 867-9412	None	Make referrals for transitional housing through the Cedar City Housing Authority and/ or the Iron County Care & Share.	Outreach into rural areas, underserved communities, and Indian Tribes.	Weekly women's support group (in conjunction with the children's group) every Wednesday evening. The women's and children's groups run Wed. from 6:30 - 8:00.	28	2
DAVIS Safe Harbor	Main: (801) 444-3191 Crisis: (801) 444-9161 Fax: (801) 444-9170	Davis County Animal Shelter provides up to 30 days free boarding of cats & dogs.	Opened summer of 2004-currently in full operation.	Yes	Childcare provided for women's support groups. Children's groups once a week. Women's groups provided in English & Spanish.	31	4
LOGAN Community Abuse Prevention Services Agency	Main/24hr: (435) 753-2500 Fax: (435) 753-7054	"Safe Pet Shelter" w/foster pet homes.	Yes	Yes	A children's group is held for children of women attending the support group. Parenting classes available.	32	4
MOAB Seekhaven	Main/24hr: (435) 259-2229 Crisis: 1-888-421-1100 Fax: (435) 259-7856	Works with the Humane Society for pet boarding.	None	Yes	With the Family Support Center to provide childcare during women support groups.	9	1
OGDEN Your Community Connection	Main: (801) 394-9456 Crisis: (801) 392-7273 Fax: (801) 394-9457	Some informal services	Yes	Yes	Childcare available for Shelter and TH clients	26	4

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Shelter	Phone/Fax	Pet Boarding	Transitional Housing	Outreach Coordinator	Children's Services	Beds	Cribs
PARK CITY Peace House	Main/24hr: (435) 647-9161 Fax: (435) 655-8341	Work with Friends of Animals for boarding.	Transitional housing available through other organization.	Yes	Children's services including pet therapy, art and projects, weekly children's group and childcare.	15	2
PRICE Colleen Quigley Women's Center	Main: (435) 636-2375 Crisis: (435) 637-6589 Fax: (435) 637-3904	Relationship with Humane Society, free shelter stay and minimal free private kennel stay.	None	None	Nothing onsite.	14	1
PROVO Center for Women and Children in Crisis	Main: (435) 636-2375 Crisis: (435) 637-6589 Fax: (435) 637-3904	None	8 units available at shelter	Yes	Children's rec. therapy, weekly activities and homework club.	25	2
RICHFIELD New Horizons Crisis Center	Main: (435) 896-9294 Crisis: 1-800-343-6302 Fax: (435) 896-4655	None	Four-plex @ shelter	None	Children's groups, childcare available while women are in group.	45	20
SALT LAKE CITY YWCA Women in Jeopardy	Main/24hr: (801) 537-8600 Crisis: (801) 537-8600; Crisis: 1-855-992-2752 Fax: (801) 355-2826	None	Yes, 48 Units	Yes	Advocacy, case mgt, therapeutic groups, academic support, after-school, summer camp, teen program, child care, parenting support.	100	10-12
ST. GEORGE D.O.V.E. Center	Main: (435) 628-1204 Crisis: (435) 628-0458 Fax: (435) 628-0823	Have resources available.	Work in collaboration with the Erin Kimball Foundation for transitional housing.	Spanish-speaking Advocate.	Children's support group while mothers are in support groups. Parenting classes with children's group at same time.	24	6
TOOELE Pathways	Main: (435) 843-1677 Crisis: 1-800-833-5515 Fax: (435) 843-0151	Works with the City Animal Shelter.	None	Yes	Info sessions and support groups provided off-site.	11	2
VERNAL Women's Crisis Shelter	Main/24hr: (435) 781-2264 Fax: (435) 781-0049	Animal Shelter provides free service for victims in shelter.	None in Duchesne, Uintah or Daggett	None	DWS helps provide funding for daycare of women in shelter.	8	3
WEST JORDAN South Valley Sanctuary	Main/24hr: (801) 255-1095 Fax: (801) 255-7319	Makes referrals to local animal shelters.	None	Yes. Spanish support groups.	Activity program from 1-5pm. Weekly creative art workshop. Support group weekly.	57	12

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