

Intimate Partner Violence Screening

Aotearoa New Zealand

Healthcare Worker On-Line Learning Programme

All women and children have the right to a violence-free home

Ko te tapu
o te whare tangata
me te ahua atua
o nga tamariki

Let us hold to the sacredness of our bearers of life,
let us make it safe for the future leaders, and let
us assist them to aspire to their individual greatness^a

Kia Ora,

Welcome to the Intimate Partner Violence (IPV) Screening - Aotearoa New Zealand learning programme. We believe that:

- ❖ The partner violence survivor has a right to be treated with respect and in a non-rushed manner.
- ❖ The survivor has a right to be treated in a physical and social environment conducive to compassionate and culturally safe care.
- ❖ Ministry of Health Family Violence Intervention Guidelines(1) should be adapted and used within your setting for the identification, assessment and referral of persons experiencing intimate partner violence.
- ❖ Healthcare programmes addressing intimate partner violence are developed in consultation with community representatives.
- ❖ Professional training, curriculum development, and continuing education for all health professionals on intimate partner violence should be mandatory.
- ❖ The healthcare provider is an advocate for the survivor of intimate partner violence, empowering rather than rescuing.

We acknowledge that many healthcare workers have experienced partner violence in their own lives. We understand the challenges in addressing intimate partner violence in your practice.

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Chapter 1: Introduction and Background

What is this learning programme for?

- ❖ The goal of this programme is to efficiently educate healthcare workers to screen and intervene in the case of intimate partner violence in order to

^a This whakatauki came out of the Maori Advisory Group convened by the Ministry of Health in preparing the *Family Violence Intervention Guidelines* (personal communications, Tau Huirama and Denise Wilson).

interrupt the cycle of violence that involves abuse, injuries, illness and - all to often - death.

- ❖ By routinely screening you make what is typically hidden, visible. This promotes healthy non-violent communities.
- ❖ This training programme presents an introduction to intimate partner violence. Therefore, it focuses only on the basic competency of healthcare workers to identify cases of intimate partner violence, provide appropriate intervention, and document the care they provide (2, 3). Competencies include the following:
 - Identify, assess, and document abuse.
 - Intervene to promote safety and reduce vulnerability.
 - Recognise that historical, political and cultural factors influence family violence in Aotearoa New Zealand.
 - Recognise ethical and legal issues involved in intimate partner violence screening.
 - Engage in activities to prevent intimate partner violence.

This programme should be thought of as a supplement to a broader programme that addresses family violence in your setting. That system-wide programme should address intimate partner violence, child abuse and elder abuse and reflect collaboration among healthcare specialties and community (such as Women's Refuge) and government (such as Child, Youth and Family, law enforcement and criminal justice) agencies.

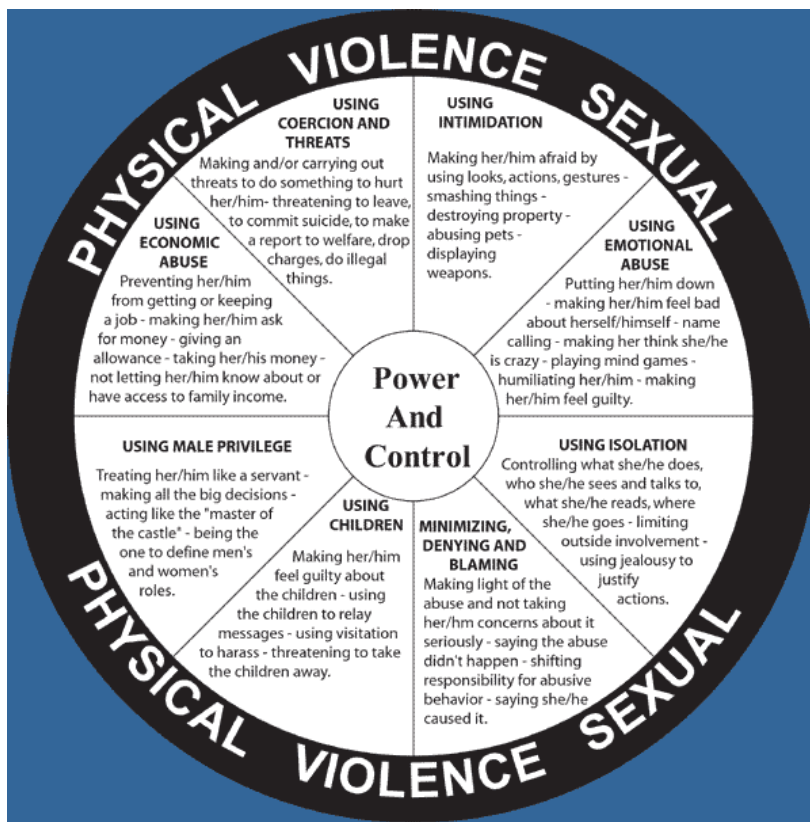
What is intimate partner violence?

- ❖ Intimate partner violence (IPV) is a pattern of violent and coercive behaviours whereby one person seeks to control the thoughts, beliefs or conduct of an intimate partner or to punish the intimate partner for resisting their control(4).

In Aotearoa New Zealand's recent National Survey of Crime Victims (5), 26% of women reported violence by a male partner at some time in their adulthood; 18% of men reported violence by a female partner. Serious partner violence, however, is more common against women. For example, surveying 21 year old participants of the Dunedin cohort study, 11% of women versus 3% of men reported having been "seriously beaten or attacked" by a family member within the prior 12 months (6).

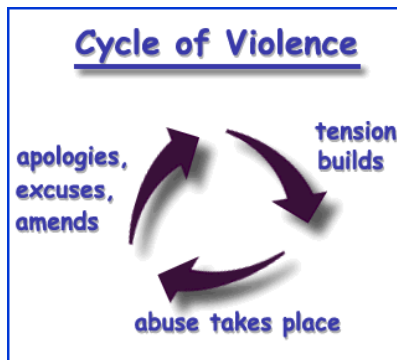
IPV has many names, including spouse abuse, wife bashing, domestic violence, family violence and battering. No matter the term, know that physical assaults are just

one method partners use to control or punish. The power and control wheel you see below lists a variety of tactics that are common in abusive relationships. When you listen to clients talk about what their partner relationship is like, listen closely for whether these tactics are present.



Adapted from Power and Control Wheel, Domestic Abuse Intervention Project, Duluth, MN.

For many, the pattern of abuse in their relationship follows the "cycle of violence" as shown below.



- ❖ Keep in mind that abused persons who come into the healthcare setting may be at various phases of the cycle and will have varying levels of commitment to their relationship (7-10). Respect where they are at in the cycle.
- ❖ Be aware that the cycle is not the same in all IPV cases. The time between cycles may vary; some may not experience a honeymoon phase (apologies, excuses and amends); and some types of violence, such as verbal, may occur throughout the cycle.
- ❖ IPV in our society is generally hidden from view. It is not surprising then, that there are many misconceptions about IPV. Some common myths are listed below.
 - She or he asked for it; she or he deserves to be beaten.
 - These two myths reflect our desire to blame the victim. They act to insulate us from the problem, provide a rationalisation for IPV, and allow us to believe we are not at risk. Victim blaming defers us from being accountable for the perpetuation of abuse by intimate partners. Healthcare workers who remain silent and choose not to screen for IPV abdicate their responsibility to reduce IPV in our society and isolated victims are allowed to continue to accept society's belief that they are at fault (7). By screening and intervening, healthcare workers make a stand that it is a human right not to be abused.
 - She or he is free to leave at any time.
 - The myth that an abused person is free to leave at any time is based on an assumption that leaving will end the violence. For many, leaving is a very dangerous time and incurs threats, stalking and harassing behaviours from her or his partner. And, in some cases, murder (11, 12). Leaving takes money, a support network, and time for planning to ensure a safe separation.

Why should I care?

Before getting to the statistics we want to provide a snapshot of some of our experiences as healthcare workers with persons who have been abused. We have purposefully omitted reference to ethnicity to avoid cultural stereotyping.

- ❖ A woman presented to the ED c/o wheezing. Her lungs cleared following one nebuliser treatment and she was discharged home with instructions. Within a month, she returned three times with the same complaint. "Are you afraid of someone?" and "Is anyone hurting you?" I asked. "Yes," she responded, "I've been coming to the ED to get away from my boyfriend."
- ❖ The police brought a woman to the ED after her husband, when getting out of bed and realising the heater was on, put a gun to her head and threatened to kill her because "she doesn't listen." A child in the home called 111. The woman said, "I thought I was being thoughtful. He didn't want me to turn the heater on before June, but it was cold this morning. I wanted the house to be warm when he got out of bed."

- ❖ An older man presented with cellulitis to his lower leg. He reported that a bookcase had fallen on his leg. The nurse observed a change in his behaviour when his wife was present and later asked about their relationship. He disclosed that when his wife was mad at him she would sometimes hit him in the legs with a stick.
- ❖ A male client with depression said, "My partner always accuses me of being too friendly toward others. He thinks I am involved with the guy downstairs, but I am not. I am tired of his craziness, but he keeps threatening me."
- ❖ "There is no one in this country I know," a refugee woman shared. "I am not allowed to go out of the house or make phone calls. Sometimes he makes me sit in the bedroom for days. My family, when I told them what was going on said, 'don't come back to us'. They believe it is wrong to leave your husband."
- ❖ When a woman got sick, her husband said, "I am not going to get whatever it is you have" and told her to go outside and stay in their van. For 3 days prior to her clinic visit (and subsequent hospitalisation) she remained in the van parked in their driveway. Her husband was the same individual who gave the clinic staff a huge tin of biscuits saying, "You are great! Thanks for taking care of my wife."
- ❖ The sister of a patient seen earlier in the week tracked down the treating doctor and asked how she could have discharged her sister with injuries from "a fall off a ladder" when her sister had clearly been beaten by her husband. She wanted to know how we could have just sent her sister back into the same situation without offering any help.
- ❖ I was screening a woman in her 80s, she took my hand, looked me in the eye, and said with regret, "Dear, I wish someone had asked me these questions years ago."

Why should I screen for intimate partner violence?

- ❖ Approximately one-third of abused women seek healthcare regularly; they may seek care because of physical injuries, illness, or perhaps for protection (13, 14) The healthcare system is a common place abused persons will go for help (15). Unfortunately, little is known about abuse among men who seek healthcare (16-19).
- ❖ People do not generally disclose the abuse in their lives without being asked. In studies asking women seeking healthcare in emergency departments about abuse, 15% to 30% report being in unsafe relationships (13, 20-22). For many, it is the first time they disclose the abuse. One study documented a 13% IPV prevalence rate among men in emergency departments (19).
- ❖ Research indicates that women exposed to IPV are at risk for multiple and complex health problems including physical injuries, depression, substance abuse, and gynaecologic problems (23-25). Children are also affected. Children living in homes with partner violence are more likely to be victims of child abuse and neglect. In addition, witnessing IPV increases children's risk of emotional and behavioural problems and may lead to the pattern of violence being continued from one generation to the next (26-29).
- ❖ Early recognition is crucial for the health and safety of the IPV victim. Unrecognised symptoms may further one's sense of entrapment, belief that no one can help, loss of self-esteem, and danger.
- ❖ In a community sample, one out of four women who screened positive for IPV went on to be physically abused one or more times in the four months after being screened (30).
- ❖ Approximately half of all women who are murdered die at the hands of a current or ex-partner, and approximately three out of four were previously assaulted by

the partner who went on to kill them; approximately 6% of men who are murdered die at the hands of a current or ex-partner (12, 31).

- ❖ In a study of women who were killed by a partner, 44% had had one or more ED visits in the 2 years prior to their murder (32).
- ❖ We, as healthcare workers, can make a difference.

How are Māori and the Treaty of Waitangi relevant?

The government has a commitment to addressing the health needs of Māori under the umbrella of the Treaty of Waitangi. Both Māori Health and Family Violence are identified as government health priorities. Healthcare workers in Aotearoa have a responsibility and an obligation to understand Māori issues and provide culturally appropriate care in the instance of family violence.

What do we know about Māori and partner violence?

- ❖ For many Māori, whānau violence has become endemic. Māori women are more likely than Pakeha women to experience violence by an intimate partner (5), representing a significant health inequality. This inequality affects women, children, whānau and hapū across the generations.

What is the context of partner violence for Māori?

- ❖ Although there is a high prevalence of violence in Māori whānau, it is not because Māori are inherently more violent than Pakeha. Colonisation and urbanisation have resulted in a loss of whakapapa (genealogy) for many Māori, and together with socio-economic deprivation, they have contributed to a re-shaping of cultural and spiritual foundations. Issues such as family violence that had been a matter for the whānau and hapū became private matters and important bonds and connections that ensured support and nurturance were lost.
- ❖ Māori have links to each other through whakapapa, with connections back to the atua (gods) and the beginning of all life forms. The whenua (the land and the placenta) is the spiritual link and one origin of Māori women's mana (prestige, power, authority) and status. Therefore, women are te whare tangata ("the house of humankind"). Any violation of te whare tangata such as the abuse of the genital area or rape, is a violation of the body (te tinana) and may result in mental and spiritual distress for Māori women.
- ❖ Healthcare workers should not assume that whānau should be involved in supporting women and children living with violence, especially in situations where the whānau may be knowingly or unknowingly reinforcing abusive and violent behaviours. There is a tendency to romanticise the whānau concept (as with other aspects of Māori culture), thus believing that the whānau is a panacea for all problems afflicting Māori. Romanticising the whānau ignores the socio-economic reality of the majority of Māori and places unrealistic expectations upon a whānau.

How does the Māori context affect the health sector response to family violence?

- ❖ The healthcare system is not immune from the institutional racism that is part of the socio-economic-political context for Māori in Aotearoa New Zealand. Health workers have a role in uncovering racist practices and intervening.
- ❖ The Ministry of Health Family Violence Guidelines (1) provide five activities for positively contributing to Māori health (p. 14):
 - Take account of Māori health needs and perspectives
 - Develop culturally appropriate practices and procedures
 - Engage with whānau, hapū and iwi
 - Develop partnerships with Māori providers of health & social services
 - Recruit and support Māori personnel and health workers.

- ❖ The screening processes described in this on-line training programme promote honouring and respecting all of those we serve. However, there are several considerations for screening and intervening in the case of partner violence for Māori. Some examples follow:
 - Access Māori staff if possible
 - Provide a Māori friendly environment
 - Use a Māori framework, such as Te Whare Tapa Whā to guide actions
 - Use a quality framework such as He Taura Tieke
 - Engage with local Māori groups and hapū and iwi
 - Recognise and refer to community resource people and organisations that are safe for Māori

In our daily practice, the first impression Māori women have of us is important in developing their trust. Before meeting with Māori patients or clients it may be useful to recite a whakatauki such as the following to centre ourselves to things Māori, acknowledging the importance of approaching Māori women and children in a genuine and respectful manner.

E tau hokoi i runga i oku whariki
 E tau noho i toku whare
 E hau kina ai toku tatau toku matapihi

Your steps on my mat, your respect for my home,
 Opens my doors and windows (33)

The implications of the Treaty inform our practice for Māori as well as all populations of difference.

Chapter 2: Screening

What do I need to do to prepare to screen?

Individually

- Learn about IPV (this programme is a good starting point!).
- Reflect on survivor's stories. Consider your personal herstory or history and that of your family and friends.
- Realise that your role is not to "fix" or "rescue" victims of IPV, but rather to empower survivors (34, 35).
- Answer the self-assessment questions on the next page to help uncover your personal beliefs and values.

Be aware of ethical issues

- Any screening and intervention programme must hold two principles supreme: Safety & Confidentiality.
- Screening and intervening in the case of IPV is not to be taken lightly. It should be planned and administered in a respectful way. You need to be aware that screening without respect or without privacy can lead to harm.

Be aware of cultural issues

- To provide culturally competent IPV care is not an endpoint but rather, a commitment and active engagement in a continuing, lifelong process. It requires you to explore your own biases, prejudices and knowledge concerning the IPV victim and her or his community (36, 37). Consider the following:
 - Remain open and respectful toward cultural differences.
 - Avoid making assumptions based on personal appearance (IPV occurs in all cultures, socio-economic groups, genders and sexual orientations).
 - Routinely engage in self-assessment exercises to monitor your attitude and response to clients of diverse cultures.
 - Recognise your professional power and avoid imposing your values on the client.

- Become knowledgeable about the cultural beliefs of your clients.
- Ask about their cultural norm regarding access to healthcare, role in the whānau or family, privacy and dignity.
- Realise that for refugees, partners often threaten to report them to the immigration services and have them deported.
- Use language that is comfortable for the client.
- Allow them to safely give their herstory or history, ask questions, verbalise concerns and participate in planning their safety.
- Develop links with culturally based community groups in your service area.
- Provide culturally specific information and whenever possible, utilise culturally-specific community agencies.

Be aware of legal issues.

- Domestic violence is a crime in Aotearoa New Zealand.
- There are legal options available to intimate partner violence victims. These include protection orders (through the Family Court) and notifying the police.
- There is no mandatory reporting (to the police) of abuse of adults in Aotearoa New Zealand. Most professional groups, however, have codes of ethics and practice which would require workers to notify authorities if action could prevent an imminent life threatening situation.

Institutionally

- Create an environment that encourages and enables disclosure. Visual information such as posters and brochures lets clients know that it is OK to talk about abuse in your healthcare setting.
- Be familiar with the policies and procedures in your healthcare setting. It is your responsibility to be familiar with these.
- Know the strategy in your setting for screening in a safe manner, for clients as well as staff.
- Be aware of the security procedure in your area for removing perpetrators safely.
- Be aware of safety strategies when making home visits.
- Know the referral process for advanced IPV interventions in your setting. This might be an IPV counsellor, social worker, mental health nurse, or community advocate.
- Have a plan for employees who are in abusive relationships. Workplace safety planning and confidential counselling through employee assistance programmes should be available.

Self Assessment Questions

Consider each of the following questions. It may be helpful to work through these with a colleague or friend.

- ❖ What behaviours do I display to respect and honour a client's privacy and confidentiality?
- ❖ When caring for a client do I allow her or him to "tell their story" or do I lead the narrative?
- ❖ Do I encourage clients to participate in their plan of care and respect and honour their decisions?
- ❖ When family members speak for a client, how do I respond?
- ❖ Are there differences in the way I respond to male and female clients; elders and teenagers; straight, lesbian and gay; disabled; persons from another culture?
- ❖ Are there differences in the way I respond to clients who admit to using drugs or alcohol?
- ❖ How might my concept of family differ from a whānau concept of family?
- ❖ Which individuals or groups act as my support system?
- ❖ What is my physical and emotional response when in danger?
- ❖ What are my experiences with police and the courts?
- ❖ Do I believe IPV is a private or public matter?
- ❖ What type of client might I associate with IPV?

- ❖ The incidence of IPV in my client population is _____.
- ❖ How have my personal experiences affected, enhanced or limited my response toward victims of IPV?
- ❖ If I wanted to change something about myself, it would require me to _____?
- ❖ If I were in an abusive relationship, what could a healthcare worker say or do to help?

How do I screen?

- ❖ While it is known that many of our clients are in unsafe relationships, we do not know which clients are being abused. There is only one way to know this - ASK! (38)
- ❖ Generally, it is not what you ask, but how you ask it.
- ❖ Most importantly, screening must be done in private. Be aware that controlling partners may enlist the assistance of children, whānau and friends in monitoring their partners. When you ask for a moment of privacy and the client says its OK to talk in front of visitors, reply that it is your policy (and should be that of your department as well), that all clients be assessed in private. To screen publicly can result in harm.
- ❖ Consider the client care areas in your setting. If curtains separate clients, speak quietly and be discrete, just as you would in collecting any confidential information.
- ❖ Be non-judgemental. Both male and female healthcare workers should participate in IPV screening and intervention. Studies show that disclosure of violence is dependent on the healthcare providers' non-judgemental attitude and shared values (e.g., IPV is not OK) rather than whether or not the healthcare worker looks like the client (same culture, gender, sexual identity, religion, etc).
- ❖ Watch your body language, tone of voice, and choice of words.
- ❖ Avoid labels such as "batterer", "abuse", "victim" or "people like you".
- ❖ Avoid negative questions such as "he doesn't hit you does he?"
- ❖ Screen clients in their primary language. If you do not speak their language use professional interpreters. Use a sign interpreter for the deaf.

Who do I screen?

Normalise screening in your setting by making it a routine. Even after years of screening experience and being familiar with characteristics common among abused women, the only way to know if a particular client is abused is to - ASK!

A screening programme will be "routine" or episodic depending on the setting. For example, in emergency departments, every client should be screened for violence. In the primary care setting, screening is indicated for visits that involve a new client, as part of a health history or during a preventive care consultation. Remember to screen the young and old; injured and not; women and men; heterosexual, gay and lesbian. Screening for violence is also advised in paediatric, mental health, sexual health and pre-hospital settings (39, 40) (41-43).

What do I ask?

There are many ways to screen for IPV. Indeed, how and what you ask will evolve as you gain comfort and experience in asking, listening to client's stories, and providing intervention. To get over your initial discomfort, we suggest beginning with an "ice breaker" followed by very simple, straightforward questions.

Ice breakers:

- ❖ We have found that many of the clients we see have issues regarding violence in the home.

OR

- ❖ Because violence has become a part of many peoples lives, we now ask all clients about their experiences.

Simple key questions:

- ❖ Have you been hit, punched, slapped, kicked, pushed, shoved, forced to have sex, or otherwise hurt by anyone?

- ❖ Is there someone who is making you feel unsafe or afraid?

The above questions are general violence questions that can detect not only IPV, but elder abuse and abuse from other relatives and acquaintances. Be aware that approximately 40-60% of abused women also report forced sex.

In some cultures, it may be more appropriate to ask indirect questions such as:

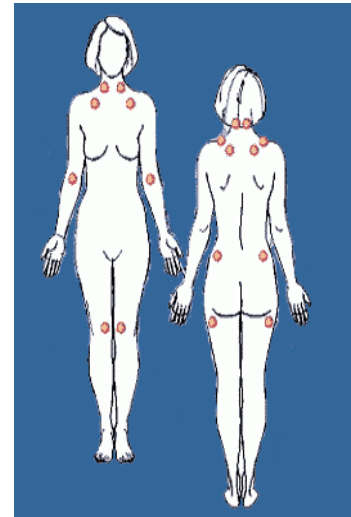
- ❖ Your symptoms may be related to stress. Do you and your partner tend to fight a lot? Have you ever been hurt? (44)

A widely used screening instrument is the Abuse Assessment Scale (34). The screen includes the four questions listed below. A positive (yes) response to any of the questions indicates a "positive" screen.

Abuse Assessment Screen (34)

1. Have you ever been emotionally or physically abused by your partner or someone important to you?
2. Within the last year, have you been hit, slapped, kicked, pushed or shoved, or otherwise physically hurt by your partner or ex-partner?
If YES, by whom _____
Number of times _____
3. Does your partner ever force you into sex?
4. Are you afraid of your partner or ex-partner?

Mark the area of any injury on body map.



Chapter 3: Intervention

What do I do if a client answers "yes?"

If a client answers "yes" there are two important secondary assessments that you must complete.

- ❖ **First**, assess for immediate safety risk. Ask:
 - Is your partner here with you today?
 - If he or she is, implement your safety protocol. This may involve notifying security or police.
- ❖ **Second**, assess for high danger risk. Indicators of high danger include the following:
 - Does the client present with life-threatening injuries?
 - Are children or elders at risk of being harmed?
 - Has the partner threatened to kill or threatened her or him with a weapon?
 - Has she or he recently separated from a partner or considering doing so at this time?
 - Does her or his partner have access to a gun or fascination with swords or knives?

In cases of high danger risk, the designated advanced family violence resource for your setting should be consulted.

If a client answers "no" to the screening questions, take the opportunity to provide a brief educational message such as, "I'm glad that isn't happening to you. It is happening to many of our clients and we want them to know that no one deserves to be hurt and that help is available."

What does an intervention for intimate partner violence include?

Validate experiences and feelings by giving messages such as:

- ❖ This is not your fault.
- ❖ You do not deserve this.
- ❖ There is no excuse for this.
- ❖ You are not alone.
- ❖ You do not have to end your relationship with your partner unless you choose to.
- ❖ I know it is difficult to decide what to do. There are options and I will support your choices.
- ❖ I am here to listen.

Empowering interventions include:

- ❖ Validating the victim's strengths and reinforcing protective factors such as friends or whānau members who may be a source of social support.
- ❖ Recognising the victim's courage in disclosing violence.
- ❖ Acknowledging the extraordinary skills they've adapted to survive.

Help the client plan for safety and the safety of children. It is imperative to inquire about safety before leaving the healthcare setting. The following questions may be useful:

- ❖ Is it safe for you to go home?
- ❖ Do you need immediate refuge?
- ❖ Are your children safe?
- ❖ Is there a friend, neighbour, whānau member to call?
- ❖ Would you like to speak to a crisis counsellor now?
- ❖ Are you aware of the local domestic violence crisis line telephone number?
- ❖ Do you know you can come to the healthcare setting anytime you feel unsafe or afraid?
- ❖ Will it be safe to take a pamphlet with you?

Respect and accept the client's evaluation of the situation, but let the client know that you are concerned for her or his safety. You may say, "This is harmful to you and it can be harmful to your children."

Provide options and support her or his decisions.

- ❖ Allow all victims the right to dictate the course of their action.
- ❖ Let her or him know that he or she is not alone and that there are community resources to help such as:
 - Refuges. Refuges have been around in New Zealand since the 1970s. While they were developed to meet the emergency housing needs of women fleeing violent spouses, in many cases local refuges now provide numerous services such as 24 hour crisis and information hotlines, and women and children's counselling programmes (individual and group). In rural communities individual volunteers sometimes provide safe housing. Local referral numbers are available in the telephone book or on-line.
 - Victim Advocates. Advocates are available in all District Courts. Along with providing crisis intervention and access to safe housing, they can refer clients to financial victim assistance funds. Some communities also have advocates who work closely with court, police and refuge services.
 - Social Workers. Social workers are able to evaluate and make referrals for partner violence as well as co-existing problems such as substance abuse and homelessness. They also address issues for children living in violent homes.
 - Police. Most Police Districts have a family violence liaison staff person who has a responsibility to ensure that police in their area respond effectively to partner violence notifications. They typically work closely with other community agencies.
 - Family Court. The Domestic Violence Act provides protection orders available through the Family Court. This process does NOT involve the police or the criminal court unless a violent partner breaches the

order. Family court counselling coordinators can be a useful source of advice about partner violence services.

- Stopping Violence Programmes. Most larger communities have an organisation which provides intervention programmes for men, women and children. They are also a good source of advice and support.
- Child Youth and Family. When children are involved, Child Youth and Family may evaluate child protection issues.
- Community Organisations. In many cases, information and advocacy are available from community groups (see LINKS in Chapter 6).

Recognise the primary concern is always the victim's safety and that safety options will be accepted when it makes sense for the victim to do so.

The advocacy wheel below includes the main aspects of IPV intervention.



The Empowerment Wheel,
Developed by the Domestic Abuse
Intervention Project, Duluth MN.

RADAR (45) is another way to recall intervention steps:

- R = Remember to ask about abuse,
- A = Ask directly, kindly, as well as non-judgmentally,
- D = Document your findings,
- A = Assess for client safety, and
- R = Review options and make referrals.

What about the children?

- ❖ There is a 30-60% co-occurrence of partner abuse and child abuse. There is a serious risk that children are also victims of violence and abuse when their caregiver is a victim of partner violence, and vice versa (27, 46).
- ❖ There is also a growing body of literature documenting the deleterious effects on children who witness partner violence (26, 28, 47, 48).
- ❖ When partner violence is identified you should ask whether there are children living in the home.
 - Has _____ (the abuser) ever harmed the children?
 - Are you concerned for the safety of your children?
- ❖ If there is any concern for the safety of children the advanced IPV resource person should be notified and institutional procedures followed.

Chapter 4: Documentation

What do I document?

Thorough, well-documented medical records can provide concrete evidence of violence and abuse for use in court proceedings. Records should be kept in a precise, legible, professional manner and include written descriptions along with diagrams, sketches or body maps with photographs of injuries.

Written descriptions should include:

- ❖ Chief Complaint and description of the incident. Whenever possible use the client's own words and identify in quotation marks. "My husband slapped me with his hand" is preferable to "Client was hit with a hand" or "Client was abused." Include statements about non-physical abuse such as, "He won't let me keep my doctors' appointments" and "He told me if I leave he'll kill me."
- ❖ Name and date of birth of the abuser. This clearly identifies the perpetrator and can be useful to police and in court.
- ❖ Detailed description of the injuries including the type, number, size, and location. Use diagrams and body maps.
- ❖ Whether findings are consistent or inconsistent with the stated mechanism of injury. For example, rather than writing, "I don't think the client fell" write "findings are inconsistent with a fall down four steps." However, stay within your forensic knowledge in evaluating injuries.
- ❖ Police involvement. Investigating police officer's name, badge number, telephone number and any actions taken (including the police report number).
- ❖ Discharge instructions. Document referrals including the name and telephone number of individuals or agencies to whom you are referring the client, or if the client declined a referral. Complete discharge instructions for the client taking into account safety. If the partner will see the discharge instructions do not directly state the cause of the injuries and work out the safest way to provide referral information. She or he may choose to memorise the local domestic violence crisisline number. If the client is going to a refuge, do not specify the refuge name or location in the medical record.

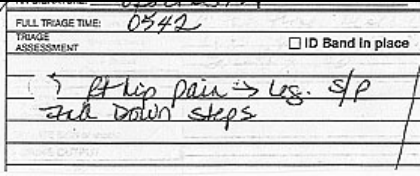
Photographs

- ❖ Photographs of injuries can be useful in court proceedings.
- ❖ Ideally, a person certified in photographic evidence collection is available to take photographs. This may be a crisis intervention team member, a forensic nurse, a hospital photographer, or local police photographer.
- ❖ It may not be possible to take photos in an ideal way, nevertheless, any evidence is better than none.
- ❖ Consent forms are necessary prior to taking photos. They state that the photographs will be released only with the client's permission.
- ❖ Photographs should always include a picture of the client's face for identification purposes.
- ❖ Photographs should be labelled with the client's name, location of injury, date and time, and name of photographer. Clients should also initial the photographs.

Chapter 5: Case Study

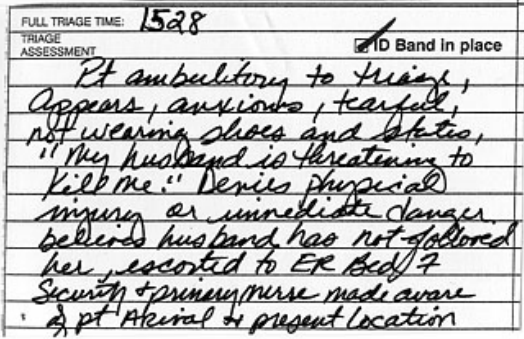
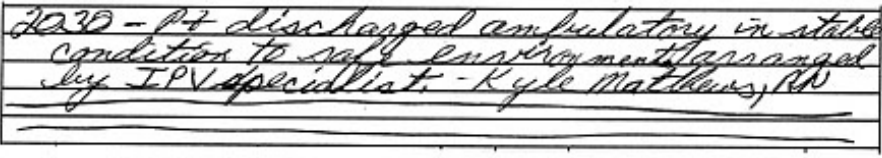
Emergency Department Visit #1

Presentation	Discussion
At 0530 Ms. Carol Jones presented to the ED reporting right hip pain after falling down several steps. She appeared in no acute distress and denied any significant medical history. The triage nurse completed the initial assessment and Ms. Jones was escorted to the treatment area.	While some systems may institute IPV screening at triage, in other systems it would be inappropriate. If privacy and time are available in your system at triage, IPV screening may be the responsibility of the triage nurse. If you have a "quick look" triage system, or privacy is not routine, IPV screening

	<p>should be the responsibility of the primary nurse.</p>
<p>Ms. Jones' primary nurse, as a part of the nursing assessment (per department protocol), initiated the Safety Assessment Screening questions asking, "Are you afraid of anyone?" and "Have you been hit, slapped, kicked, pushed or otherwise injured by anyone?" Ms. Jones paused before speaking and answered, "No."</p>	<p>Remember, the only way to identify a victim of IPV is to ask the question. We applaud the institution for including an IPV screen on their ED record, and the nurse for including routine screening in her nursing assessment and then documenting appropriately. Our only suggestion is to consider using an "ice breaker" prior to asking the screening questions.</p>
<p>PATIENT SAFETY ASSESSMENT SCREEN (completed by RN) (To be completed for all women 14 years and older and men with high risk indicators) <i>Because abuse and violence have unfortunately become a common part of many people's lives, we are asking the following questions:</i></p> <p>1. Are you afraid of or are you being threatened by a current or former partner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>2. Within the last year, have you been hit, slapped, kicked, forced into sexual activity, or otherwise physically hurt by a current or former partner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	
<p>Recognising the patient's hesitancy in answering the screening questions, the nurse gently added, "If anyone has hurt you, it would be safe for you to talk with me. You can come here anytime for help." Ms. Jones remained silent. Later, she was examined by the ED physician and discharged home.</p>	<p>The nurse was alert to nonverbal signals and provided the patient a second opportunity to disclose. She let the patient know that it is OK to talk about abuse in the ED setting and that she has the option of returning to the ED for help. Another option is to offer a pamphlet or phone number saying "this information may be useful to you or someone you know."</p>

Emergency Department Visit #2

Presentation	Discussion
<p>Four months passed when a woman entered the ED crying, "I need help. My husband is threatening to kill me." The patient was Ms. Carol Jones.</p>	<p>While nurses may feel when they get a negative screen that they have done no good, this case demonstrates that screening for IPV always provides the opportunity for educating people that IPV is not OK and that they have options for their safety.</p>
<p>The triage nurse asked, "Did your husband follow you to the ED?" and escorted Ms. Jones to an ED bed. The nurse then alerted security of the situation and gave report to Ms. Jones' primary nurse.</p>	<p>This nurse recognised a dangerous situation. She assessed for immediate safety and included security as per department policy. She realised that the patient must be brought into the secure patient care area immediately and assigned a higher level acuity based on potential for danger.</p>

	
<p>Ms. Jones' primary nurse listened to her and responded, "You do not deserve this." The nurse then informed Ms. Jones about the hospital IPV advocate who was available to provide further information and support. Ms. Jones stated that she would be willing to meet the advocate.</p>	<p>After hearing Ms. Jones disclose the abuse in her relationship the nurse immediately responded by validating her experience. This nurse also knew the resources that were available to help Ms. Jones - and then made the appropriate referral.</p>
<p>The IPV specialist reported to the ED to complete an advanced IPV assessment and provide intervention. Ms. Jones' safety plan included obtaining an order of protection, making a report to the police, and going to a refuge upon her discharge from the ED.</p>	<p>Advanced intervention included providing Ms. Jones information about IPV dynamics, resources, legal options and safety. The goal was to empower Ms. Jones and to allow her to choose what action should be taken at this time. In some healthcare settings the same interventions may be provided by an emergency nurse or doctor, crisis intervention counsellor, social worker, mental health worker, or community advocate.</p>
<p>As part of her medical record and with a signed consent form, the IPV specialist completed photographic documentation of Ms. Jones' injuries and the doctor used a body map to document those same injuries.</p>	<p>Prior to taking photographs, a signed Consent Form for Photographic Documentation was obtained. This is crucial; otherwise the photographs cannot be kept in a medical record. The IPV specialist was also aware that even when police take photographs, the ED still needs to obtain photographs for the medical record.</p>
<p>After attention to Ms. Jones' injuries and IPV situation, she was discharged.</p>	<p>Careful not to disclose Ms. Jones' destination upon discharge, the nurse simply wrote that Ms. Jones was "discharged to a safe environment." This was vital in maintaining Ms. Jones safety.</p>
	
<p>Epilogue. Two years later, before a large audience, Ms. Jones publicly shared her experience, "I thought there was no way for me to get away from the abuse, and then one day someone said, 'You can come here anytime you need help'. It changed my life."</p>	<p>Ms. Jones worked very hard. She attended IPV and legal counselling that helped move her toward healing after suffering abuse by her husband. Many abused women choose to share their story in order to help others. In this case, Ms. Jones spoke at an ED-sponsored fund raiser for IPV in the U.S. We were reminded once again of the inner strength exhibited by so many IPV survivors.</p>

We would like to acknowledge Ms. Jones (pseudonym) and Sinai Hospital, a LifeBridge Health Center, in Baltimore Maryland U.S. for supporting our retelling of the story.

Chapter 6: Additional Resources

A Personal Note

- ❖ Including partner violence screening in the care you provide for clients is a matter of best practice. Once begun, you will find that people appreciate your willingness to include the trauma that they experience in your picture of their health and well being. With routine screening the long term health effects of trauma such as depression, alcohol and substance misuse, and chronic pain also become apparent.
- ❖ Be aware that incorporating partner violence screening is likely to bring up many issues for you. Identify a support system for yourself, such as the partner violence trainer or a supervisor. Revisit this programme and seek out other learning experiences. Congratulate yourself as you become comfortable asking the questions, validating client's experiences, and making referrals.
- ❖ Take the time to find out your institution's policies and procedures. Also go to the phone book and look up your local partner violence emergency telephone numbers (Personal Help Services in the front of the phone book).
- ❖ Well done!

LINKS

NEW ZEALAND LINKS

- ❖ Women's Refuge
<http://www.womensrefuge.org.nz/>
Along with wonderful resources (such as the power and control wheel in Māori), this site includes a listing of the 51 refuges across New Zealand that are members of the National Collective of Independent Women's Refuges Inc.
- ❖ Family Violence Intervention Guidelines (Ministry of Health)
<http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/a8de1720534369f6cc256c6d006eb15a?OpenDocument>
- ❖ A Guide to Protection Orders (New Zealand Police)
<http://www.police.govt.nz/safety/home.domesticviolence.php>
- ❖ Te Rito Family Violence Strategy (Ministry of Social Development, MSD)
<http://www.mosp.govt.nz/publications/te-rito/te-rito-toc.html>
From the MSD homepage you can also access the Agenda for Children.
- ❖ Position Statement on Family Violence (New Zealand Nurses Organisation)
http://www.nzno.org.nz/SITE_Default/SITE_About_Us/x-files/2232.pdf
- ❖ Building Tomorrow: Paths to Prevent Child Abuse
<http://www.buildingtomorrow.org.nz>
- ❖ Feeling Angry: Playing Fair (1998)
<http://www.hma.co.nz/Publications/Feeling-angry-playing-fair.asp>
Ken McMaster's book written for men who want to stop the abuse in their relationships is available on-line.
- ❖ Interdisciplinary Trauma Research Unit
<http://www.trauma-research.info>
Go to "Research Activities" then "Family Violence" then "Safety Plan" for a tool to guide safety planning with women in violence situations.
- ❖ Domestic Violence Centre
<http://www.dvc.org.nz>
An Auckland centre that includes information about domestic violence in New Zealand as well as Auckland-based services.
- ❖ Auckland Rape Crisis
<http://www.rapecrisis.org.nz/home/index.asp>

INTERNATIONAL LINKS

- ❖ Australian Domestic and Family Violence Clearinghouse
<http://www.austdvclearinghouse.unsw.edu.au/>
This excellent site serves as central point for the collection and dissemination of Australian domestic and family violence policy, practice and research resources.
- ❖ Fiji Women's Crisis Centre
<http://www.fijiwomen.com/>
See the "Pacific Women Against Violence" newsletter.

❖ Hitting Home (U.K.)

<http://www.bbc.co.uk/health/hh/>

A site produced by the BBC.

❖ Domestic Violence Against Women

<http://www.who.int/gender/violence/en/>

Access the World Health Organization (WHO) initiatives addressing partner violence from this site.

❖ Minnesota Center Against Violence and Abuse (U.S.A.)

<http://www.mincava.umn.edu/>

A clearinghouse providing research, education and violence related resources.

❖ National (U.S.A.) Advisory Council on Violence Against Women: Toolkit To End Violence Against Women

<http://toolkit.ncjrs.org/files/fullchapter2.pdf>

This Chapter within the toolkit addresses "What the Health and Mental Health Care Systems Can Do To Make a Difference".

❖ Nursing Network on Violence Against Women International

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

This organisation seeks to eliminate violence through advancing nursing education, practice, research, and public policy.

❖ American Association of Colleges of Nursing: Violence as a Public Health Problem

<http://www.aacn.nche.edu/Publications/positions/violence.htm>

This site includes a Position Statement on Family Violence (1999). Included in the appendices are competencies for providing care to victims of family violence.

❖ Office on Violence Against Women

<http://www.ojp.usdoj.gov/vawo/>

A site by the U.S. Department of Justice to implement the U.S.A. Violence Against Women Act (VAWA) and to lead the national effort to stop domestic violence, sexual assault, and stalking of women.

❖ Family Violence Prevention Fund

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

Go to the "Health" programme pages.

❖ American Bar Association Commission on Domestic Violence

<http://www.abanet.org/domviol/home.html>

❖ Domestic Abuse Project

<http://www.mndap.org/communit.asp>

This site from Minnesota programme includes some useful community education resources.

SOME SPECIALISED SITES

❖ Medical Evidentiary Photography

http://www.digevent.com/events/client/polaroid/00-09-10_polaroid/downloads/PolaroidDV.PDF

An on-line Polaroid workshop regarding photography and domestic violence.

❖ The White Ribbon Campaign

<http://www.whiteribbon.ca/>

A men's campaign for ending violence from Canada.

❖ When Love Hurts: A Guide on Love, Respect and Abuse in Relationships

<http://www.dvirc.org.au/whenlove/>

A site by the Domestic Violence & Incest Resource Centre in Melbourne Australia for teens.

❖ Love Doesn't Have to Hurt Teens

<http://www.apa.org/pi/pii/teen/homepage.html>

A site developed by the American Psychological Association in collaboration with others about teen violence.

❖ Love Is Not Abuse

<http://www.loveisnotabuse.com/home.asp>

A site about relationship violence for teens by Liz Claiborne Inc. See also <http://www.loveisnotabuse.com/default.asp> for other partner violence guides.

❖ Gay on Gay Violence

<http://www.web.apc.org/~jharnick/violence.html>

❖ The New York City Gay and Lesbian Anti-Violence Project

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

❖ Corporate Alliance to End Partner Violence

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

Provides resources for workplace domestic violence programmes.

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