DALLAS MOR I G EWS
DALLAS, TX
SATURDAY 536,153
NOV 29 1997

DV

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Ex-naysayers now applaud police unit

'87 case changed attitude toward family violence

By Stephen Power
Staff Writer of The Dallas Morning News

Dallas police used to battle Jonathan Vickery in court. Now they send him clients.

The president of Legal Services of North Texas — who once accused police of neglecting battered women — says his office gets about half its domestic violence cases in Dallas through police referrals.

"We used to hear firsthand about the department's unresponsiveness," said Mr. Vickery, whose agency represents people who otherwise could not afford legal help. "I don't want to use the word 'rampant,' but it was too common an occurrence. . . . We haven't heard that kind of complaint in years."

A decade after a federal lawsuit transformed city policies toward domestic violence, Dallas police are marking the 10th anniversary of their family-violence unit. And some of their closest allies are former adversaries such as Mr. Vickery.

Each month, attorneys from Mr. Vickery's office visit a local women's shelter with a Dallas police detective. The officers show women how to file criminal charges, obtain protective orders, seek child support or divorce an abuser. Police also hand out dozens of "blue cards" each day to victims that advise the women of their rights and where to go for shelter, food or legal help.

Although such assistance has become routine, former police critics say it's easy to forget how far the department has come.

In 1987, it took a court-approved settlement to force the city to form a family-violence unit. Four women had accused police of ignoring their pleas for help when they had been beaten by men with whom they lived. One victim even was arrested for disorderly conduct because she fought back against her abuser.

"It wasn't that we didn't care, we just didn't know any better," said Sgt. Ches Williams of the family-violence

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Former critics applaud police family-violence unit, changes made since '87 settlement

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unit. "It became really easy for officers to take a hands-off attitude."

The number of family-violence murders in Dallas has fallen from 25 in 1988 to 15 in 1996, according to Police Department records. Last year, a $197,000 federal grant allowed the unit to launch a two-man family-violence fugitive team. The team, which hunts people wanted for abusing someone during a family fight, has made 318 arrests since September 1996 involving 611 offenses. The department also has increased domestic violence training for its patrol officers, who handle most calls.

Although police often arrest women for family-violence charges, most offenders are men, some with a history of abusing or stalking women.

In December 1995, a 28-year-old paralegal was shot to death on a west Oak Cliff highway by an ex-boyfriend who had assaulted and stalked her for months. Don Juan Wallace was convicted of murder and sentenced to 75 years in prison.

The following June, a 30-year-old man beat and stabbed to death a former girlfriend at her Red Bird-area apartment, then drove to another former girlfriend's home in Irving and killed her in front of her 4-year-old daughter. Both women had filed stalking reports with police, but each time the suspect fled before officers arrived.

"We've had failures, and we take them very seriously," Sgt. Williams said. "But for every one of those, there are hundreds of cases that don't make the front page because the system has opened the door for people to get out of an abusive relationship."

> "It wasn't that we didn't care, we just didn't know any better. It became really easy for officers to take a hands-off attitude."
>
> *— Sgt. Ches Williams, police family-violence unit*

Local shelter officials say women are more likely to seek help if their first experience with police is positive.

"When they do call, they find the system is really there to help them," said Jan Langbein, executive director of Genesis Women's Shelter. "I know a woman who ripped up one of those blue cards and threw it in the officer's face because the abuser was sitting right there. But she held onto the part of the card that had the number for the shelter, and she kept it in the lining of her shoe.

"Six months later, she was in that shelter. She was alive because a police officer did what he was supposed to do."

After the settlement with the city, Mr. Vickery said, police initially arrested victims as well as assailants if they had reason to believe both parties had committed a crime. The department has since modified its policies to focus on the "primary aggressor."

"If neither side has incurred an injury, it's very difficult for police to know who's telling the truth," Mr. Vickery said. "But it's not nearly the problem it was in the aftermath of the consent decree."

Police and prosecutors say the county has helped keep offenders off the streets by creating a domestic violence court, which processed 2,400 cases in its first year. A decade ago, the county averaged about 500 domestic violence cases a year, officials said.

Mr. Vickery said city officials ultimately embraced reform because they "realized the seriousness of the problem." It didn't hurt his cause that the settlement called for only $4,000 in damages for the plaintiffs.

"Initially, I was surprised by how receptive they were, but I shouldn't have been," he said. "The important thing was to have a settlement they would believe in and that would succeed. And that's what's happened."

Throughout America, millions of children are exposed to violence in what should be the safest part of their environment -- their homes, their schools, and their neighborhoods. Research has shown that children who are exposed to violence and maltreatment are more likely to suffer from depression, anxiety, post traumatic stress, increased anger, lower academic achievement, and increased likelihood of alcohol and drug abuse. In addition, children who experience violence, either as victims or witnesses, are at increased risk of becoming violent themselves. The majority of children who are exposed to violence are never treated.

In an attempt to address these issues, the New Haven Department of Police Services and the Child Study Center at the Yale University School of Medicine developed the Child Development - Community Policing program, which brings together police officers and mental health professionals to provide each other with training, consultation, and support, and to provide direct, interdisciplinary intervention to children who are victims, witnesses or even perpetrators of violent crime. The Yale-New Haven project became a successful national model that was funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), and was subsequently replicated under an OJJDP grant to four cities: Buffalo, New York; Charlotte, North Carolina; Nashville, Tennessee; and Portland, Oregon.

The positive results of these projects suggest that funding and expansion of such a collaborative approach to addressing the needs of children exposed to violence is worthy of DOJ's continued support.

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Provision	Administration Bill	Conyers - H.R. 357	Biden - S. 51	Hatch - S. 245	
Expanded Definition of DV		yes	yes		
STOP Grants	yes; reauth for 5 years (S301)(188.75, such sums)	yes -- reauth for 5 years	yes - reauth only for 3 years (184, 185, 186M)	yes -reauth only for 3 years	
Role of the Courts: courts as eligible STOP Grantees	yes (S302)		yes (S102)		
National Domestic Violence Hotline	yes (S307)	yes -reauth for 5 years	yes -reauth only for 3 years	yes -reauth only for 3 years	
Battered Women's Shelters		yes -reauth for 5 years	yes-reauth only for 3 years	yes-reauth only for 3 years	
Grants for Community Initiatives		yes -reauth for 5 years	yes -reauth only for 3 years	yes -reauth only for 3 years	
Education & Training for Judges		yes	yes -reauth only for 3 years		
Grants to Encourage Arrests	yes (S303); reauth for 5 years (25M, such sums)	yes	yes -reauth only for 3 years(64, 65, 66M)	yes - reauth only for 3 years	
Rural DV & Child Abuse	yes (S304); reauth for 5 years (25M, such sums)	yes	yes (S108) -reauth only for 3 years (34, 35, 36M)	yes -reauth only for 3 years	

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Provision	Administration Bill	Conyers - H.R. 357	Biden - S. 51	Hatch - S. 245	
National Stalker & DV Reduction		yes	yes -reauth only for 3 years	yes -reauth only for 3 years	
Federal Victims' Counselors		yes	yes -reauth only for 3 years	yes -reauth only for 3 years	
Runaway & Homeless Youth		yes	yes -reauth only for 3 years	yes- reauth only for 3 years	
Victims of Child Abuse Programs		yes	yes -reauth only for 3 years	yes -reauth only for 3 years	
Safe Havens for Children		yes	yes -reauth only for 3 years		
Date Rape Drug Rescheduling		yes	yes -more limited version		
should try to add: Access to Safety and Advocacy for Victims of Sexual Assault (Legal services): makes grants available to enhance safety and justice for victims of sexual violence through access to the justice system and improved legal advocacy and representation (Title III, Subtitle G)	yes (S305) Civil Legal Assistance: AG makes grants to address civil legal assistance needs	yes (similar to Civil Legal Assistance Grant in Admin bill & Biden bill)	yes-same as Admin bill) S201		

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Provision	Administration Bill	Conyers - H.R. 357	Biden - S. 51	Hatch - S. 245	
VAW Prevention in Schools: grants to school systems to develop, modify, and implement policies and programs in elementary, middle, and secondary schools which address domestic violence, sexual assault, and stalking (Title II, Subtitle B)	yes (S306): similar program under the Higher Education Act -- grants to reduce violent crimes against women on campus	yes	yes -more limited version/lower funding; only thru 2002		
should try to add: Family Safety: amends the criminal component of the Parental Kidnapping Prevention Act (PKPA) to provide defenses in domestic violence and child sexual assualt cases; amends the civil full faith and credit provisions of PKPA to include domestic violence, child sexual assault and stalking as factors in determining what state has jurisdciton of a custody case (Title II, Subtitle C)		yes	yes - more limited version		

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Provision	Administration Bill	Conyers - H.R. 357	Biden - S. 51	Hatch - S. 245	
Battered Immigrant Women: allows for adjustment of status for VAWA self-petitioners; prevents changes in abuser's status from undermining victim's petitions; provides for numerous waivers and exceptions to inadmissibility for VAWA eligible applicants; improves access to VAWA for battered immigrant women whose spouse is a member of the armed force; allows for discretionary waivers for good moral character determininations; removes public charge for VAWA applicants; gives VAWA applicants access to work authorization; allows VAWA applicants access to food stamps, housing and legal services; trains judges, immigration officials, armed forces supervisors and police on VAWA immigration provisions	yes (310)	yes	yes -more limited version	yes -very limited version	
Underserved Populations Definition		yes			
Title VII. Violence Against Women and the Workplace					
Clearinghouse -DV/SA/Workplace		yes	yes -only through 2002		
Victims' Employment Rights Act		yes			
Workplace Tax Credit		yes			

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Provision	Administration Bill	Conyers - H.R. 357	Biden - S. 51	Hatch - S. 245	
Should try to add: Battered Women's Employment Protection: ensures eligibility for unemployment compensation to women separated from their jobs due to circumstances directly resulting from domestic violence; requires employers who already provide leave to employees to allow employees to use that leave for the purpose of dealing with domestic violence and its aftermath; allows women to use their family and medical leave or existing leave under State law or a private benefits program to deal with domestic abuse, including going to the doctor for domestic violence injuries, seeking legal remedies, including court appearances, seeking orders of protection or meeting with a lawyer; provides for training of personnel involved in assessing unemployment claims based on domestic violence		yes	yes; more limited version		
Education and Training Grants on VAW		yes	yes; lower funding; only through 2002		
Should try to add: Rape Prevention Education		yes	yes; more limited version; lower funding; only through 2002		
Standards/Training for SA Exams		yes	yes		
Should try to add: Hate Crimes Prevention		yes	yes		

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Provision	Administration Bill	Conyers - H.R. 357	Biden - S. 51	Hatch - S. 245	
Should try to add: DV Victims' Housing: amends the McKinney Homeless Assistance Act to make funding available for transistional housing services for domestic violence victims, including rental assistance for battered women seeking to establish permanent housing (Section IV, Subtitle A)		yes			
Should try to add: Full Faith and Credit **(tribal parts)**: clarifies VAWA's full faith and credit provisions to ensure meaningful enforcement by States and Tribes; provides grants to States and Tribes to improve enforcement and record keeping; reduces Byrne grants to law enforcement for failure to comply with the 1994 VAWA's full faith and credit provisions with significant safeguards to allow law enforcement to come into compliance before a penalty is assessed (Section IV, Subtitle B)		yes	yes; more limited version; no funding	yes; more limited version; no funding	
DV Insurance Protection		yes	yes; enforcement only if states fail to		

Provision	Administration Bill	Conyers - H.R. 357	Biden - S. 51	Hatch - S. 245	
Should try to add: Access to Safety and Advocacy for Victims of Domestic Violence; issues grants to provide legal assistance, lay advocacy and referral services to victims of domestic violence who have inadequate access to sufficient financial resources for appropriate legal assistance; includes set-aside for tribes (Section IV, Subtitle F)	SEE S305 above?	yes	yes; very limited version; only through 2002		
Amendments to Insterstate Stalking	yes (S308)	yes	yes (S110)	yes	
Protections for Victims of Trafficking	yes (S309)				
Disclosure under Child Support Program		yes			
Older Women's Protection		yes	yes		
Protection for Disabled Women		yes	yes; more limited version; lower funding;only through 2002	yes; more limited version; lower funding	
Title V. Violence Against Women in the Military System					
Civilian Jurisdiction for Sexual Assault and Domestic Violence		yes	yes; more limited version		
Transistional Compensation		yes	yes; more limited version		

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Provision	Administration Bill	Conyers - H.R. 357	Biden - S. 51	Hatch - S. 245	
Training for Health Professionals		yes	yes		
Research on VAW		yes	yes; morelimited; lower funding		
Child Custody Resolution		yes			
Child Welfare Worker Training		yes			
Child Abuse Accountability		yes			
Sexual Assault in Prisons: directs the Attorney General to establish guidelines regarding the prevention of custodial sexual misconduct in prisons; prhibits individuals who have been convicted of or found civilly liable for sexual misconduct from becoming correctional staff; criminalizes sexual conduct between correctional staff and prisoners (Title III, Subtitle D)	we have a provision (modified Conyers)	yes			
Summit on Sports and Violence					
"No Guns for Drunks:" adds Intoxication to the list of grounds for prohibiting sale of firearms (Title IV, Subtitle E)		yes			
Workers' Compensation		yes			

DRAFT 3-06-99

Provision	Administration Bill	Conyers - H.R. 357	Biden - S. 51	Hatch - S. 245

MEMORANDUM

TO: TOM FREEDMAN, MARY L. SMITH

FROM: DREW HANSEN

RE: COORDINATED COMMUNITY RESPONSES TO DOMESTIC VIOLENCE

DATE: AUGUST 19, 1997

SUMMARY

In October 1996, the Urban Institute released a report called "Coordinated Community Responses to Domestic Violence in Six Communities: Beyond the Justice System." The thesis of the report is that many agencies involved with domestic violence have turned to "coordinated" responses, involving the criminal justice system, shelters, health care providers (the AMA estimates that 20-33% of women in emergency room visits were victims of domestic violence), child protective services, the clergy, substance abuse treatment centers, the business community, and offender rehabilitation programs. This is a brief summary of some of the highlights of the report.

COMMUNITY CASE STUDIES

- **Baltimore.** A Domestic Violence Coordinated Committee was established in 1985 with representatives from the criminal justice system and shelters. Two area hospitals and a local program serving pregnant mothers and their children have developed screening and intervention protocol for domestic violence victims.

- **Kansas City.** Several agency-supported projects focus on coordinated responses to domestic violence, including Project Assist (legal services), special domestic violence units in the police department and prosecutor's offices, consolidated dockets in local courts, and a Domestic Violence Network (the area's six shelters). A local hospital has an emergency room referral and advocacy program for victims of domestic violence, and a program called the "Phoenix Project" provides services for battered women and their children.

- **Carlton County, MN.** Two groups, Rural Women's Advocates and Mending the Sacred Hoop, provide coordinated services to this largely rural area. The informal social networks and lack of bureaucracy in the area facilitate their responses.

- **North St. Louis County, MN: The Iron Range.** A group called Range Women's Advocates provides service, advocacy, education, and a one-stop center for complaints about the system. A local Family Violence Council involves all of the relevant agencies, including schools, social services, and the health care

Domestic Violence

MEMORANDUM

TO: TOM FREEDMAN, MARY L. SMITH

FROM: DREW HANSEN

RE: CRIME VICTIMS' EMPLOYMENT NON-DISCRIMINATION ACT

DATE: AUGUST 21, 1997

CURRENT LAW

Several states have provisions that forbid employers from taking adverse action against employees who have been victims of crime and must participate in the criminal justice process during working hours. States having such a law include: Arkansas, Colorado, Connecticut, Delaware, Indiana, Iowa, Massachusetts, Michigan, Minnesota, Missouri, Montana, and Vermont. The exact language of the statute and the penalties prescribed vary from state to state (copies of the Connecticut, Iowa, and Indiana statutes are attached.) In addition, the proposed 1992 Uniform Victims of Crime Act has a provision similar to most existing state statutes on the issue (attached).

No state or federal law explicitly protects crime victims from other adverse action which may result from their experiences and status as crime victims.

PROPOSED LEGISLATION

The proposed bill (attached) creates protections from employment discrimination for victims of crime. The general rule is that "An employer shall not take or threaten to take any adverse action against any employee who is or has been a victim of crime based upon that employee's status, experience, or condition as a victim of crime."

- "Adverse action" includes actions such as demotion or suspension, dismissal, or refusal to hire, as well as a more general "failure to make a reasonable accommodation of the victim's health and safety needs arising from the offense." This "reasonable accommodation" is defined as potentially including job restructuring, allowing the affected employee to take part-time or modified work, and installing locks or other protections at the work place.

- The bill specifically excludes adverse job action for participation in criminal justice or civil proceedings.

- The provisions of the bill are to be enforced by liability for damages equal to the amount of wages, etc. lost, as well as punitive damages and equitable relief. The DOJ can bring a civil action to recover the damages.

- The protections of the bill go into effect even if the crime involved does not result in criminal prosecution.

- Defenses to liability are provided in case the employer's compliance would result in threats to other employees, impairment of essential job functions, or undue hardship to the employer's business.

CRIME VICTIMS' EMPLOYMENT NON-DISCRIMINATION ACT

Sec. 1: Short Title

This bill may be cited as the "Crime Victims' Employment Non-discrimination Act."

Sec. 2: Findings and Purposes

(a). **Findings.** Congress finds that--

(1) Violent crime has a substantial impact on interstate commerce. This impact is well-documented and includes the following:

(A) According to the National Institute of Justice, crime costs an estimated $450 billion annually in medical expenses, lost earnings, social service costs, pain, suffering, and reduced quality of life for victims, all of which harm our nation's productivity and drain our nation's resources. Violent crime accounts for $426 billion of this amount.

(C) Rape exacts the highest costs-per-victim of any criminal offense, at an estimated total of $127 billion per year. In 1992, an estimated 607,000 rapes and sexual assaults occurred in the United States. Other violent offenses take unacceptably high tolls on the economy as well, including assault ($93 billion), murder ($71 billion), drunk driving (excluding fatalities) ($61 billion), and child abuse ($56 billion);

(D) Violence is the leading cause of injury to women in the United States, and in the workplace, homicide is the leading cause of death to women; [* will get more figures documenting crime and costs against other groups and its impact on the workplace]

(E) Violent crime results in wage losses equivalent to 1 percent of all American earnings;

(F) Violent crime causes 3 percent of the nation's medical spending and 14

percent of injury-related medical spending;

(F) Employers pay nearly $5 billion annually to cover the cost of crimes against employees and their families;

(2) In addition to the impact of crime on the economy as a whole, victims and their families suffer from crime and its effects on a daily basis:

(A) Domestic crime against adults accounts for approximately 15 percent of total crime costs in the United States each year;

(B) Between 1987-1990, people and households in the United States faced more than 49 million crime attempts annually, including more than 16 million violent crimes;

(3) American workers who have been victims of crime too often suffer adverse consequences in the workplace as a result of their experiences as crime victims. Crime victims are particularly vulnerable to changes in employment, pay, and benefits as a result of their victimization, and are therefore in need of legal protection:

(A) Nearly 50% of rape victims lose their employment or are forced to quit their jobs following the crime;

(B) One-quarter of battered women surveyed have lost a job due in part to the effects of domestic violence, and over half were harassed by their abusers at work;

[add other studies and cases: from victims' groups]

(4) Only twelve States have enacted statutes forbidding employers from taking adverse action against employees who have been victims of crime and must participate in the criminal justice process during working hours. No state explicitly protects crime victims from other adverse action which may result from their experiences and status as crime victims; and

(5) Existing Federal law does not explicitly protect crime victims from retaliation, discharge, or other penalties in the workplace which may result from their experiences and status as crime victims.

(b) Purposes. Pursuant to the affirmative power of Congress to enact this Act under section 5 of the Fourteenth Amendment to the Constitution, as well as under clause 3, section 8 of Article I of the Constitution, the purposes of this Act are–

(1) to promote the national interest in ensuring that crime victims can recover from the effects of crime and participate in the criminal justice process without fear of adverse economic consequences from their employers;

(2) to minimize the negative impact on interstate commerce from dislocations of employees and decreases in productivity that may arise when employees are victimized by crime;

(3) to promote the purposes of the Fourteenth Amendment by protecting the rights of victims of crime and by furthering the right of crime victims to employment free from equal protection and due process violations;

(4) to accomplish the purposes set forth in subsections (1), (2), and (3) of this section in a manner that accommodates the legitimate interests of employers and protects the safety of all of those in the workplace.

Sec. 3: Discrimination

(a) General rule: An employer shall not take or threaten to take any adverse job action against any employee who is or has been a victim of crime based upon that

employee's status, experience, or condition as a victim of crime.

(b) Definitions: For the purposes of this Act:

(1) an "employer" includes any person acting directly or indirectly in the interest of an employer in relation to an employee, and includes a public agency, but does not include any labor organization (other than when acting as an employer) or anyone acting in the capacity of officer or agent of such labor organization.

(2) "Employ" includes to suffer or permit to work for wages, benefits, or other compensation.

(3) an "employee" means any person employed by an employer. This term includes full- or part-time persons employed for a fixed time period, temporary or leased basis, independent contractors, and persons participating in work assignments as a condition of receipt of state or federal welfare benefits.

(4) "victim of crime" includes any employee whom an employer knows or has reason to know has been the target of an act or series of acts that would constitute a crime under applicable State or Federal penal law, or that would form the basis for obtaining an Order of Protection under applicable State or local law. This term also includes those employees against whom threats to commit such criminal offenses have been made, provided the employer knows or has reason to know that such threats have occurred. Evidence that such incidents were reported to the employer, by the alleged victim or by any other employee, shall create a presumption that the employer knows that the employee has been a "victim of crime" under this subsection.

(5) "adverse job action" means any action adversely affecting the employment status,

wages, or benefits payable to the victim, including:

(A) demotion or suspension;

(B) dismissal from employment;

(C) refusal to hire;

(D) involuntary transfers;

(E) failure to make a reasonable accommodation of the victim's health and safety needs arising from the offense; and

(F) loss of pay or benefits. This provision shall not interfere with lawful employment policies providing for unpaid leave, except where state or federal law or the employer's existing leave policies provide for paid leave or continued benefits, that can lawfully be exercised to attend court proceedings or other activities related to the criminal offense.

(6) "based upon" the employee's status, condition, or experience as a crime victim means any action affecting the terms or conditions of employment, as defined in part (b)(4) of this section, which would not have been made in the absence of the employee's status, condition, or experience as a crime victim, and which does not qualify for the exemptions allowed by Section 6 of this Act.

(7) "reasonable accommodation" may include–

(A) job restructuring, part-time or modified work schedules, or reassignment to a vacant position or to another department or facility with equivalent wages and benefits, if necessary to protect the health or safety of the crime victim,

(B) making adjustments to existing facilities, for example, installing locks or

alarms, which are necessary to protect the safety of the crime victim and others in the workplace.

(8) "undue hardship" means an action requiring significant difficulty or expense, or any action that would be unduly costly, extensive, substantial, or disruptive, or that would fundamentally alter the nature of operation of the business, when considered in light of the following factors--

(A) the nature and cost of the accommodation needed under this chapter;

(B) the overall financial resources of the employer; the number of persons employed at the facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility; and

(C) the relationship between the seriousness of the crime and injuries suffered by the employee, or threatened to be made against the employee, and the proposed accommodation. In cases where the employee is a victim of domestic violence, the employer shall take into account the fact that incidents of domestic violence frequently escalate in seriousness, and that threats against the employee may result in violence.

(c) Construction.

(1) No disqualification for failure to prosecute: An employee who otherwise meets the definition of "crime victim" under part (b)(3) of this section shall not be disqualified from this Act's protections if the crime alleged does not result in criminal prosecution or conviction of the perpetrator, provided the employer's actions otherwise fall within the prohibitions of this Act.

(2) No limitation to victims of workplace crimes: A crime victim shall be eligible

for the protections of this Act regardless of the location of the crime or threats to commit crime which have been perpetrated against the employee.

(3) No adverse job action for participation in criminal justice or civil proceedings: It shall be unlawful under this section to take an adverse job action against an employee who has been a victim of crime because that employee was absent from work to testify in a criminal or civil proceeding or to assist in the preparation of a criminal or civil proceeding arising from the offense, and that testimony or preparation could not be made outside the employee's regular working hours. An employee who seeks protection from adverse job actions under this subsection must provide the employer with a minimum of twenty-four (24) hours notice prior to any such absences, and should make all good-faith efforts to provide as much notice as possible.

Sec. 4: Enforcement

(a) Civil action by employees

(1) Liability: Any employer who violates the provisions of this Act shall be liable to any eligible employee affected for--

(A) damages equal to the amount of any wages, salary, employment benefits, or other compensation denied or lost to such employee by reason of the violation, and any interest on that amount calculated at the prevailing rate; and

(B) any punitive damages, up to three times the amount of actual damages sustained, as the finder of fact shall deem appropriate; and

(C) equitable relief as the court may deem appropriate, including employment,

reinstatement, transfer, promotion, and adoption of policies to prevent future violations.

(b) **Action by Department of Justice:** The Department of Justice may bring a civil action in any court of competent jurisdiction to recover the damages described in subsection (a)(1) of this section.

(c) **Exclusivity of Remedies:** These remedies shall be the exclusive remedies applicable to a claim under this title, unless after such claim arises the claimant voluntarily enters into an agreement to resolve the claim through arbitration or another procedure.

Section 5: Attorney's fees. Section 722 of the Revised Statutes (42 U.S.C.§ 1988) is amended in the last sentence--[add language to effect technical amendment]

Sec.6: Defenses

(a) **Extraordinary threats to workplace safety:** It may be a defense to liability under this Act if an adverse job action was necessary to protect the safety of an employee or other persons at the place of employment; provided, to qualify for this exception, an employer must prove:

(1) That the employer took all reasonable steps to protect the safety of the crime victim and others at the workplace which, if successful, would not have required the adverse job action; and

(2) No less detrimental action was reasonably possible without endangering the safety of the employee or others at the workplace.

(b) **Essential job functions impaired:** It may be a defense to liability under this Act

if, despite reasonable accommodation by the employer, the employee's experience as a crime victim has left the employee unable to perform the essential functions of the employee's job. For purposes of this chapter, consideration shall be given to the employer's judgment as to what functions of a job are essential.

(c) **Undue hardship:** It may be a defense to liability under this Act if the employer can demonstrate that reasonably accommodating the health and safety of the crime victim would impose an undue hardship on the operation of the business of the employer. To qualify for this exemption, an employer shall make good faith efforts to implement the employee's proposals for such reasonable accommodations.

(d) **Restoration to position.** An employee who is lawfully discharged, transferred, or suspended under subsection (a) of this section shall be entitled to restoration to the employee's former position provided the conditions necessitating the change in employment no longer persist, and provided that restoration does not constitute an undue burden. The employee shall be entitled--

(1) to be restored by the employer to the position of employment held by the employee when the discharge, transfer, or suspension commenced; or

(2) to be restored to an equivalent position with equivalent employment benefits, pay, and other terms and conditions of employment.

(c) **Burden of Proof:** Once an employee establishes that an employer took an adverse job action against the employee after it knew or had reason to know that the employee had been a victim of crime, it shall be the employer's burden to prove:

(1) that the adverse job action was not based upon the employee's status,

condition, or experience as a victim of crime; or

(2) that the employer's actions fall within the defenses allowed by Section 6 of this Act.

1ST DOCUMENT of Level 1 printed in FULL format.

GENERAL STATUTES OF CONNECTICUT

THIS DOCUMENT IS CURRENT THROUGH THE 1997 EDITION (1995-1996 SESSIONS)

TITLE 54. CRIMINAL PROCEDURE
CHAPTER 961. TRIAL AND PROCEEDINGS AFTER CONVICTION
PART I. DISCOVERY, TRIAL AND WITNESSES

Conn. Gen. Stat. § 54-85b (1997)

Sec. 54-85b. Employer not to discharge employee appearing as witness. Penalty. Action for damages and reinstatement.

(a) An employer shall not deprive an employee of his employment, penalize or threaten or otherwise coerce him with respect thereto, because the employee obeys a legal subpoena to appear before any court of this state as a witness in any criminal proceeding. Any employer who violates this section shall be guilty of criminal contempt and shall be fined not more than five hundred dollars or imprisoned not more than thirty days or both.

(b) If an employer discharges, penalizes or threatens or otherwise coerces an employee in violation of subsection (a) of this section, the employee, within ninety days of such action, may bring a civil action for damages and for an order requiring his reinstatement or otherwise rescinding such action. If the employee prevails, he shall be allowed a reasonable attorney's fee to be fixed by the court.

HISTORY: (P.A. 81-186.)

TITLE NOTES

_____ *Statutory rules of court practice and procedure do not violate constitutional separation of powers (dissent). *161 C. 501*. Cited. 30 CA 381, 392.

CHAPTER NOTES

_____ *In a criminal matter, unless the state makes out a prima facie case of guilt, no unfavorable inference may be drawn from the failure of the accused to testify. *147 C. 502*. The fact that one or more persons jointly charged with the commission of a crime pleaded guilty is not admissible, on the trial of another person so charged, to establish that the crime was committed. A plea of guilty is, in effect, a confession of guilt which, having been made by one of those charged with the crime, can be no more than hearsay as to another who is so charged. The state must prove the whole case against any accused. Sequestration of witnesses is in discretion of trial court. Request must be seasonably made, must be specific and supported by sound reasons, and it must appear probable that, if witnesses were to hear one another's testimony, they would attempt falsely to give corroborating testimony. If these conditions are met, a denial of the motion could constitute an abuse of discretion. It is within the discretion of the court to grant or deny a defendant the right to

inspect statements of the state's witnesses in the possession of the state's attorney. *150 C. 195.* The corpus delicti, that is, that the crime charged has been committed by someone, cannot be established by the extrajudicial confession of the defendant unsupported by corroborative evidence. 22 CS 385; 23 CS 420. §In a criminal case the accused cannot compel the prosecution to produce documents which he himself has made. Furthermore, facts sought to be disclosed must be shown to be exclusively within the knowledge of the state. 23 CS 41. Proof of guilt must exclude not every possible, but every reasonable, supposition of the innocence of the accused. 23 CS 299. In criminal case the state may rest its case upon evidence sufficient to make out prima facie case. A prima facie case is made out when the evidence indicates to a reasonable person such a strong probability of guilt that a denial or explanation by the defendant is reasonably called for. When the state has made out a prima facie case of guilt, an adverse inference may be drawn from the failure of defendant to testify in his own behalf. 23 CS 412. Information disclosed to a prosecuting attorney to enable him to perform the duties of his office is privileged on grounds of public policy, and the adverse party has no right to demand its production. 23 CS 459. If accused has reason to believe witness under examination had made prior statement which was contradictory to his testimony, accused may request statement to be produced for examination by court. Further use of such statement rests in discretion of court. 24 CS 377.

1ST DOCUMENT of Level 1 printed in FULL format.

CODE OF IOWA 1996

*** THIS DOCUMENT IS CURRENT THROUGH THE 1997 EDITION (1996 LEGISLATION) ***

TITLE XVI. CRIMINAL LAW AND PROCEDURE
SUBTITLE 3. CRIMINAL CORRECTIONS
CHAPTER 910A. VICTIM AND WITNESS PROTECTION

Iowa Code § 910A.12 (1996)

910A.12 Employment practices.

An employer shall not discharge an employee from or take or fail to take action regarding an employee's promotion or proposed promotion or take action to reduce an employee's wages or benefits, for actual time worked, due to the service of an employee as a witness in a criminal proceeding. An employer who violates this section commits a simple misdemeanor, and an employee shall be entitled to recover damages. Damages recoverable under this section include but are not limited to, actual damages, court costs, and reasonable attorney fees. The employee may also petition the court for imposition of a cease and desist order against the person's employer and for reinstatement to the person's previous position of employment.

HISTORY: 86 Acts, ch 1178, § 13

NOTES:
Chapter Notes:

Purpose of 1986 amendments; 86 Acts, ch 1178, § 1

Chapter Cross Reference:

Referred to in § 236.14, 562A.27A, 562B.25A

1ST DOCUMENT of Level 1 printed in FULL format.

*** THIS SECTION IS CURRENT THROUGH THE 1997 SUPPLEMENT
*** (1997 SPECIAL SESSION) ***

TITLE 35. CRIMINAL LAW AND PROCEDURE
ARTICLE 44. OFFENSES AGAINST PUBLIC ADMINISTRATION
CHAPTER 3. INTERFERENCE WITH GOVERNMENTAL OPERATIONS

Burns Ind. Code Ann. § 35-44-3-11.1 (1997)

§ 35-44-3-11.1. Interference with witness service

A person who knowingly or intentionally:

(1) Dismisses an employee;

(2) Deprives an employee of employment benefits; or

(3) Threatens such a dismissal or deprivation;

because the employee has received or responded to a subpoena in a criminal proceeding commits interference with witness service, a Class B misdemeanor.

HISTORY: P.L.131-1985, § 18.

purposes could include the need for the prosecution to retain the property for trial, retrial, or during an appellate process that could result in a retrial.

Library References

American Digest System

Punishment and prevention of crime; civil liabilities to persons injured; reparation, see Criminal Law ⇐1220.

Encyclopedias

Victim and witness protection statutes, see C.J.S. Criminal Law § 1783 et seq.

WESTLAW Electronic Research

Criminal law cases: 110k[add key number].
See, also, WESTLAW Electronic Research Guide following the Explanation.

§ 207. Limitations on Employer.

An employer may not discharge or discipline a victim or a representative of the victim for:

(1) participation at the [prosecutor's] request in preparation for a criminal justice proceeding; or

(2) attendance at a criminal justice proceeding if the attendance is reasonably necessary to protect the interests of the victim.

Comment

This is similar to a number of current provisions. *See, e.g.*, Conn.Gen.Stat.Ann. § 54–85b(a) (West 1985) ("An employer shall not deprive an employee of his employment, penalize or threaten or otherwise coerce him with respect thereto, because the employee obeys a legal subpoena to appear before any court of this state as a witness in any criminal proceeding"); Ind.Code Ann. § 35–44–3–11.1 (West 1986) (misdemeanor to dismiss employee, deprive employee of employment benefits, or threaten to do so, because employee has received or responded to subpoena in criminal proceeding); Iowa Code Ann. § 910A.12 (West Supp.1992) ("An employer shall not discharge an employee from or take or fail to take action regarding an employee's promotion or proposed promotion or take action to reduce an employee's wages or benefits, for actual time worked, due to the service of an employee as a witness in a criminal proceeding").

"Discipline" does not mean merely failing to pay an employee for time not worked. Docking pay for *more* than the time missed is discipline.

ABA Victim/Witness Guideline 5 provides:

> Victims and witnesses who request it should be provided with employer and creditor intercession to seek employer cooperation in minimizing employees' loss of pay and other benefits resulting from their participation in the criminal justice process, and to seek consideration from creditors if the victim is unable, temporarily, to continue payments.

See Ill.Ann.Stat. ch. 38, para. 1404(14) (Smith–Hurd Supp.1992) (victim entitled to "appropriate employer intercession services by the State's Attorney or victim advocate personnel to ensure that employers of victims will cooperate with the criminal justice system in order to minimize an employee's loss of pay and other benefits resulting from court appearances").

Many victim/witness programs provide "on-call" programs whereby the victims and witnesses are called in when needed for trial. This enables the witness to remain at work until actually needed, there-

by eliminating wasted time in the waiting room.

Library References

American Digest System

Punishment and prevention of crime; civil liabilities to persons injured; reparation, see Criminal Law ⇐1220.

Encyclopedias

Victim and witness protection statutes, see C.J.S. Criminal Law § 1783 et seq.

WESTLAW Electronic Research

Criminal law cases: 110k[add key number].
See, also, WESTLAW Electronic Research Guide following the Explanation.

§ 208. Information from [Law Enforcement Agency].

(a) After initial contact between a victim and a [law enforcement agency] responsible for investigating a crime, the [agency] shall promptly give in writing to the victim:

(1) an explanation of the victim's rights under this [Act];

(2) information concerning the availability of:

(i) assistance to victims, including medical, housing, counseling, and emergency services;

(ii) compensation for victims under this [Act] and the name, street address, and telephone number of the [agency] to contact;

(iii) protection of the victim, including protective court orders; and

(iv) access by the victim and a defendant to public records related to the case.

(b) As soon as practicable, the [law enforcement agency] shall give to the victim, as relevant, the following:

(1) information as to the suspect's identity unless inconsistent with law enforcement purposes;

(2) information as to whether the suspect has been taken into custody, has escaped, or has been released, and any conditions imposed on the release;

(3) the file number of the case and the name, street address, and telephone number of a [law enforcement officer] assigned to investigate the case; and

(4) the [prosecutor's] name, office address, and telephone number.

Comment

Victims should be informed of the general rule that public records related to criminal proceedings are open to public inspection, of any relevant exceptions to that general rule, and of any relevant procedures whereby a victim may request the court to limit public access. As members of the public with a particular interest in the case, victims of crime should be allowed access to all records and transcripts of the criminal proceedings.

Subsection (a)(2)(iv) deals with *public* records and does not envision disclosure

Tri-fold Panel 1

(Department of Justice Logo)

STOP THE CYCLE OF VIOLENCE GRAPHIC

What You Can Do

The National Domestic Violence Hotline	1-800-799-SAFE (Voice) 1-800-787-3224 (TDD)
Department of Justice Employee Assistance Program	202-514-8236 or 1-800-626-0385 202-514-5000 (Non-Business Hours)

Tri-fold Panel 2

WHAT IS DOMESTIC VIOLENCE?

Any form of coercive behavior by one person to gain power and control over another. It may include:

- physical aggression
- psychological intimidation
- verbal abuse
- stalking
- economic control
- prohibiting friendships and other normal activities
- harassment
- direct or indirect threats of physical harm

Tri-fold Panel 3

WHAT IS THE JUSTICE DEPARTMENT'S POLICY ON WORKPLACE DOMESTIC VIOLENCE?

Domestic violence can have a major impact on the workplace. The domestic abuse an employee receives at home or on the job can lead to lost productivity, increased absenteeism, higher health care cost and increased stress on the part of the victim and coworkers, and thus, is a source of concern to Department employees and to the Department.

Accordingly, violence, threats, harassment, intimidation, and other disruptive behavior associated with domestic violence will not be tolerated in our workplace; that is, all reports of incidents will be taken seriously and will be dealt with appropriately. Such behavior can include oral or written statements, gestures, or expressions that communicate a direct or indirect threat of physical harm. Individuals who commit such acts may be removed from the premises and may be subject to disciplinary action and/or criminal penalties.

Tri-fold Panel 4

WHAT CAN I DO?

- Talk with a trusted co-worker, friend or manager about workplace domestic violence situations that you observe or encounter.
- Call the local police if you or your co-workers are in immediate danger as a result of a workplace domestic violence situation.
- If you are a perpetrator of workplace domestic violence and you want help, contact the Employee Assistance Program at 202-514-8236 or 1-800-626-0385, or the National Domestic Violence Hotline at 1-800-799-SAFE (Voice) and 1-800-787-3224 (TDD)
- If you are a victim of workplace domestic violence, coordinate approved absences from duty with your supervisor. Provide acceptable supporting documentation, be clear about your intention to return to work, and be sure to maintain contact with your supervisor during your absence.

WHAT WILL THE DEPARTMENT DO?

- Maintain a list of services available to victims and perpetrators of domestic violence.
- Each of the Deapartment's bureaus will establish a Critical Incident Response Team(s) that will respond to emergency situations arising as a result of workplace domestic violence.
- Provide education on domestic violence through existing or new channels such as lunchtime seminars, newsletters, posters, pamphlets, and employee and management training sessions.
- Provide security advice, consultation and reasonable assistance to employees who experience workplace domestic violence.

Tri-fold Panel 5

WORKPLACE DOMESTIC VIOLENCE RESOURCES

U.S. Department of Justice Employee Assistance Program	202-514-8236 or 1-800-626-0385
U.S. Department of Justice Security Services	202-514-3271
National Domestic Violence Hotline	1-800-799-SAFE (Voice) 1-800-787-3224 (TDD)
National Coalition Against Domestic Violence	303-839-1852
National Battered Women's Law Project	212-741-9480
National Resource Center on Domestic Violence	1-800-537-2238
Health Resource Center on Domestic Violence	1-800-313-1310
Center for the Prevention of Sexual and Domestic Violence	206-634-1903
National Network to End Domestic Violence	202-434-7405
D.C. Coalition Against Domestic Violence	202-783-5332

BASS AND HOWES INC

Dom. Violence

FAX COVER SHEET

TO: Audrey

FAX: 202/456-7311

FROM: Joanne

DATE: ______ BH ACCOUNT #: ______

NUMBER OF PAGES (including cover sheet): ______

COMMENTS: First — thanks for everything you did to facilitate our First Lady's speaking to the NOCC meeting. As always, she was ~~superb~~ superb!

Second: here's some info on a potential domestic violence event — let's talk.

J

P.S. Lisa Leary, Esta and I have all discussed!

If there is a problem with this transmission, please call: (202) 530-2900

Please Note New B&H Fax Number: (202) 530-2901

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Alabama Governor's Challenge on Domestic Violence

On April 8, 1998 Governor Fob James of Alabama issued the state's first Challenge on Domestic Violence, at a two-hour kick-off event at the State Capitol in Montgomery. Several hundred people -- including law enforcement personnel, judges, and advocates -- participated in the event. In addition, participants in five major cities across the state were connected via televised sites. Governor James issued a challenge to President Clinton and all other governors to follow Alabama's lead in placing the Family Violence Prevention Fund's "There's No Excuse for Domestic Violence" bumper sticker on all government vehicles. He then issued a proclamation mandating that 10,000 of the bumper stickers be placed on every state vehicle in Alabama.

Governor James placed the first bumper sticker on the Governor's vehicle, and hundreds of balloons with the imprint of the bumper sticker were released. Alabama's Lt. Governor Don Siegelman also gave a speech. The event featured a 16-foot replica of the bumper sticker and on the steps of the Capitol, fifty "victim silhouettes" of women from all over the state, with police crime scene tape linking through their arms. The University of Alabama and the Law Enforcement Academy paid for televising the event across the state, and the Alabama Junior League and the Alabama Coalition Against Domestic Violence paid for the 10,000 bumper stickers that will go on all state vehicles.

The State of Kansas has already taken up the Alabama Governor's Challenge. Kansas Governor Bill Graves will host his state's Challenge on Domestic Violence on June 17, 1998 in Topeka, Kansas. GTE Corporation has committed to funding the entire event. Major cities in Kansas, as well as Alabama, will be connected via televised sites. "Resource kits" guiding states on how to take up the Alabama Governor's Challenge will be sent to all the states in early May. States that plan to join the event in June will also be connected via televised sites. Arizona has already expressed interest. CBS's program "48 Hours" is covering the activities leading up to the Kansas event and will cover the Kansas Challenge in June.

The Alabama Governor's Challenge was conceived of and implemented by Mary Beth Burchardt, a domestic violence survivor and now Domestic Violence Project Coordinator of the Law Enforcement Academy of the University of Alabama. In coordinating the event in Alabama and now Kansas, Mary Beth has been in contact with the White House via Emory Mayfield (202-456-2896) in the Intergovernmental Affairs Office and Barbara McMillan (202-456-7560) in the Scheduling Office. Mary Beth had faxed information about the Challenge to Audrey Haines in the Outreach for Women Office in early March but received no response.

PROCLAMATION

BY THE GOVERNOR

WHEREAS, the State of Alabama recognizes domestic violence as the nation's leading cause of injuries to women between the ages of 15 and 44; and

WHEREAS, an estimated two to five million women are abused annually and often times an estimated three million children witness or are affected by the abuse; and

WHEREAS, 26,000 cases of domestic violence are reported each year in the state of Alabama; and

WHEREAS, the University of Alabama Law Enforcement Academy and the University of Alabama, are committed to fully accredited training for law enforcement officials, professionals and the general public on the dynamics of domestic violence and its effects on society; and

WHEREAS, the University of Alabama Law Enforcement Academy and the University of Alabama are additionally committed to education and awareness efforts on domestic violence through local, statewide and national campaigns which carry the message, "There's No Excuse for Domestic Violence"; and

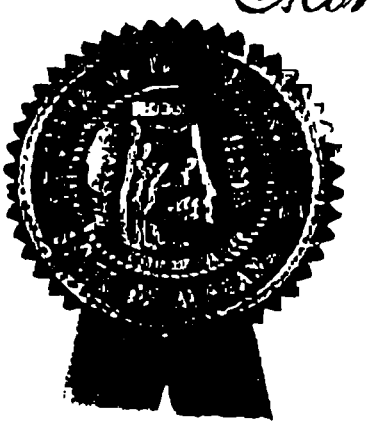
WHEREAS, the Governor's Office supports these efforts and campaigns on domestic violence and encourage state employees and all law enforcement officials to place a bumper sticker on their vehicles bearing the theme slogan and the Alabama Crisis Hotline number; and

WHEREAS, the State of Alabama would like to issue a challenge to other states to take action against such a serious issue, and follow Alabama's lead in bringing about further awareness to the issue of domestic violence;

NOW, THEREFORE, I, Fob James, Jr., Governor of the State of Alabama, do hereby proclaim April 1998 as

Domestic Violence Awareness Month

in Alabama.



GIVEN UNDER MY HAND, and the Great Seal of the Governor's Office at the State Capitol in the City of Montgomery on this 4th day of April, 1998.

FOB JAMES, JR.

Local & Region
THE TUSCALOOSA NEWS
Section B
Friday, April 3, 1998

Event seeks end to abuse of women

■ Head of UA's Law Enforcement Academy has organized Governor's National Challenge.

By MELISSA C. GRAY
Staff Writer

TUSCALOOSA — Mary Beth Burchardt of Montgomery had two good years with her husband. She was married at age 18.

She said her husband, always jealous and insecure, began abusing her about the time their first of two children turned 3 months old.

"I was rocking our little boy," Burchardt said Thursday from her store in Montgomery. "He grabbed me and choked me and pulled me down the hallway."

Although they had planned their family, Burchardt's husband told her early in the pregnancy he couldn't handle the idea of sharing her with someone else.

"I'm not the only one," she said of the women abused nationwide. "And that's the scary thing."

Burchardt has served as project coordinator for the domestic violence program at the University of Alabama's Law Enforcement Academy in Tuscaloosa since January.

To raise awareness of the estimated 4 million American women abused by their husbands or boyfriends last year, Burchardt has been working for the past seven months to organize the upcoming Governor's Nationwide Challenge. To convey her message, she will use a black-and-blue bumper sticker that reads "There's No Excuse for Domestic Violence."

She first saw the bumper sticker sponsored by the Family Violence Prevention Fund, while volunteering at a shelter in Montgomery. The sticker that will be placed on the more than 10,000 government and law enforcement vehicles has been customized to include the telephone number for the state's crisis line.

At a 10 a.m. press conference Wednesday on the steps of the Alabama Capitol, Gov. Fob James will place the first bumper sticker on his own car.

"I'm so proud," Burchardt said, adding that she's tired of the taunting Alabama gets when it ranks low in national statistics. "Now, we're going to be the first."

Lt. Gov. Don Siegelman also will attend the conference, at which James will challenge President Clin-

Please see ABUSE Page 3B

ABUSE

Continued from Page 1B

tps and all other state governors to match Alabama's efforts.

In addition to the more than 1,000 people expected to attend, hundreds more, including police officers and court officials, will be linked around the state for a five-city interactive discourse in domestic violence prevention. The cities are Tuscaloosa, Birmingham, Huntsville, Montgomery and Mobile.

The free, two-hour seminar, provided by the UA Law Enforcement Academy, will begin at 9:30 a.m.

Burchardt became involved with domestic abuse advocacy and education after speaking at a regional law enforcement meeting and receiving phone calls from people wanting her to speak to their groups as well.

Burchardt, whose husband would go several months without striking her, said a lot of people don't understand that abused women initially stay in their relationships because of love and wind up sticking around out of fear.

"In the beginning, I had so much hope for our marriage, and I believed in him," she said. Then, she said she adjusted to the lifestyle. Seven years of abuse went by before it escalated to the point she had to call the police in Montgomery for help in 1987.

"We had just moved to Montgomery from Dallas," said the Kansas native, who has lived in several different towns.

"He moved us 10 times in 11 years," she said. "That's something about people who are controlling. They try to keep you away from your family and friends."

In October 1988, Burchardt filed for divorce. She already had a protection order and a separation.

"He called me constantly," she said. Although she hung up every time he called, she heard him crying the last time.

"Before I hung up with him, he said he was sorry for everything he had done to me," said Burchardt, who married her husband when they were 18.

"Those were the last words I heard him speak."

Although he was carrying around brochures in his car about how to fix a marriage, Burchardt's husband had started dating another woman — and stalking her.

"He was literally chasing this woman in a car," Burchardt said. "His car spun out of control, and another car hit him. It killed him instantly.

"It was ultimately his violent behavior that got him killed."

For more information or to register for the domestic violence seminar, people may call Burchardt at the UA Law Enforcement Academy at 348-5831 or at 1 (334) 279-6771.

Burchardt also may be contacted for the $5 bumper stickers. All proceeds go to the Alabama Coalition Against Domestic Violence's Victims Emergency Fund.

The coalition, along with the Junior Leagues of Alabama, provided funding for the bumper stickers.

Steve Ball, Government editor, 261-1519

DAVID BUNDY/STAFF

Gov. Fob James puts an anti-domestic violence sticker on a patrol car during a news conference at the Capitol on Wednesday morning.

Capitol rally targets domestic violence

By John D. Alcorn
MONTGOMERY ADVERTISER

Gov. Fob James was in front of the Capitol on Wednesday morning to put on the rear bumper of a state trooper car a sticker: "There's NO Excuse for Domestic Violence."

The black and blue sticker also carries the 1-800-650-6522 state domestic violence hotline number.

James said he was encouraging all Alabama employees to obtain the stickers and display them on their vehicles as a means of increasing public awareness of the problem — there were 26,000 reported cases of domestic violence last year.

"If there were that many cases reported, the number that went unreported could be tenfold that number," James said.

James was flanked on the Capitol steps by members of a domestic violence advisory council he appointed last May.

Lt. Gov. Don Siegelman also spoke to those attending the rally. He urged attendees to go across the street to the State House and ask House members to quickly pass a three-bill package of domestic violence measures originated and passed in the Senate.

Those bills would provide a 24-hour "cooling-off period" for those arrested in domestic violence incidents, mandate extended jail time for repeat offenders and give judges more discretion in dealing with offenders who have ignored court protective orders.

Monday, April 13, 1998

Former Battered Wife Leads Campaign Against Abuse

A former battered wife is leading a campaign to stop domestic violence by helping police learn how to more effectively deal with it, leading the nation's governors to take a stand and pushing an awareness effort that includes anti-domestic violence bumper stickers on 10,000 state vehicles.

Mary Beth Burchardt is domestic violence coordinator and instructor with UA's Law Enforcement Academy, which trains the state's police officers. She was a victim of domestic abuse for 18 years at the hands of a husband who was a successful businessman never suspected by friends and acquaintances. After leaving the relationship, Burchardt became committed to domestic abuse intervention and education.

Burchardt was the catalyst in organizing the recent "Governor's Nationwide Challenge," launched with a press conference on the steps of the Alabama Capitol in Montgomery. Alabama's Gov. Fob James and Lt. Gov. Don Siegelman lent their support in efforts against domestic violence. Police officers, court officials, and others linked up around the state for a five-city interactive tele course in domestic violence prevention.

James announced that a bumper sticker reading "There's No Excuse for Domestic Violence" will be placed on all government and law enforcement vehicles, which total over 10,000. Funding for the bumper stickers was provided by the Junior Leagues of Alabama and the Alabama Coalition Against Domestic Violence.

"This campaign was organized to show the nation that this is a state united in its dedication to stop domestic abuse," said Burchardt. "As a result, changes can be made to instill stronger systems of intervention, murder reduction and crime prevention."

As part of awareness activities, UA's Law Enforcement Academy, a division of the College of Continuing Studies, provided a domestic violence training seminar through UA's Intercampus Interactive Telecommunication System at locations in Birmingham, Huntsville, Tuscaloosa, Montgomery and Mobile. IITS allows instructors and students in different locations to interact as if in the same room.

The seminar was offered free to anyone interested in participating, including law enforcement officials, prosecutors, district attorneys, judges, court advocates, shelter directors and volunteers, and others who work with domestic violence cases. The program has been funded by a Domestic Violence Grant from the Law Enforcement Planning Division of the Alabama Department of Economic and Community Affairs, and the training has been approved for credit through the Alabama Police Officers Standards and Training Commission.

A jewelry designer by profession, Burchardt became involved with domestic abuse advocacy and education after she spoke of her experiences at a regional law enforcement meeting.

"After this presentation, phone calls came from all over, asking me to speak for other groups," she said. "People who were there said how touched they were by hearing about this situation from a victim and a survivor."

She has since joined Law Enforcement Academy and leads frequent courses in domestic violence training. Burchardt says her main goal in both roles is to help foster an understanding of the issue and to encourage intervention. "Sadly, most people stay in abusive relationships during the early years because of hope and love; and later they stay because of helplessness and fear," she said.

"Hearing Mary Beth's experiences really gave me a better understanding of how someone in this situation feels," said Kenyata Burton, a Lawrence County deputy sheriff who recently completed Burchardt's class. "When we go on calls as police officers, we need to understand what these women have been through."

The academy has graduated more than 5,500 peace officers since its inception in 1972. For more information on the program, call 348-5831.

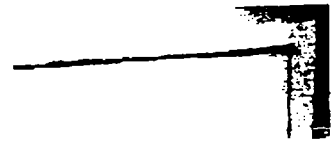
—*M. Rivers, J. Flint*

Mary Beth Burchardt

Rare 3-D Ultrasound Gives High-Tech Help To Expectant Parents

Expectant parents and their doctors — who previously relied on fuzzy ultrasound images to make "educated guesses" — now have precise 3-D technology to see gender and details such as heart valves and the lens of the eye before the baby is born.

Dr. Thomas McHattie, associate professor of obstetrics/gynecology in the



Friday, April 17, 1998

THE CRIMSON White

• The University of Alabama

Weather

Today:
Cooler temps

Domestic violence cases now part of training

By Tricia Wilson
Staff Reporter

Police officers and other professionals involved in Alabama's judicial system are beginning to be educated on domestic violence through statewide interactive televised classrooms.

Until recently, the issue of domestic violence has been one which people refused to discuss openly.

"It was so taboo," said Mary Beth Borchardt, domestic violence coordinator and instructor with the University of Alabama's Law Enforcement Academy. "You just didn't talk about it. It was a family matter."

Less than a year ago, Borchardt ended an 18-year marriage which involved domestic violence.

Borchardt said she tried many things to ease the pain of the violence, including believing in God and the bond of family. She remained in the relationship for so many years because of those beliefs, and out of fear.

"After a while the threats were so real that if I did ever tell anybody, then he would kill me," Borchardt said.

Since leaving her husband, she has become a spokeswoman for the fight against domestic violence.

Borchardt taught a televised class to the Academy's interactive classrooms in November. After she taught the class, the Academy asked her to come back as project coordinator.

"We have a domestic violence training program for law enforcement officers, judges, prosecutors and the entire professional trade that deals with domestic violence," Borchardt said.

The program, which operates out of Borchardt's office in Parham West, is sponsored by a grant from the Law Enforcement Division of the Alabama Department of Economic and Community Affairs which allows the training to be provided to the officers and other professionals at no charge.

"Since the beginning of the grant program we've trained several thousand officers already," Borchardt said.

The Governor's Nationwide Challenge, issued April 8, will include placing a bumper sticker that says "There's No Excuse for Domestic Violence" on all government and law enforcement vehicles. Borchardt said the governor's plan will have a huge effect on the efforts of her program.

"Already the challenge has begun and Alabama is preparing to really be covered with bumper stickers," Borchardt said. "It will trickle down from there."

Borchardt issued a warning to University students who are involved in a violent relationship.

"Set those boundaries," Borchardt said. "If that person is not willing to abide by those boundaries then get out of the relationship. Your life is more important than a violent relationship. They can turn deadly."

Listen Up!

PHILADELPHIA: LET'S STOP DOMESTIC VIOLENCE

THERE'S NO ROOM FOR Domestic Violence IN THIS NEIGHBORHOOD

This is a

Safe Haven!

IF YOU ARE IN A SCARY OR DANGEROUS SITUATION
AND NEED TO GET HELP, YOU MAY USE OUR TELEPHONE
TO CALL A DOMESTIC VIOLENCE PROGRAM OR THE POLICE.

Helping to create a community
free of violence and abuse.

Call 1-800-799-SAFE for help today.

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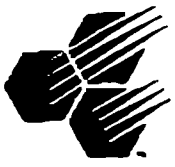

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ATTENTION

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COMMENTS: Tom — As per our discussion

Tom Wheeler

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Number of pages including this cover sheet: 2

Proposed Follow-Up Report on Clinton/Gore Initiative

Last June Vice President Gore challenged the Board of Directors of the Cellular Telecommunications Industry Association to use their technology to help in the fight against crime. Specifically, the Vice President proposed that the industry provide wireless phones to community watch patrols, in response to the President's call for one million additional community watch volunteers.

One month later, July, 1996, the President announced the Communities on Phone Patrol (COPP) program at a White House ceremony. In the intervening year:

8,850	Phones have been approved for distribution to...
7,780	Community watch groups, with ...
115,608	Volunteers, protecting neighborhoods with...
50,000,000	Americans

Polling, immediately after the announcement, showed that 47 percent of Americans were aware of the Administration's establishment of COPP. The effort was criticized by some as election year grandstanding, a photo-op with no follow-through. The facts clearly show that the initiative has been far, far more than a campaign stunt. A public accounting is, therefore, appropriate to make it clear that the Administration's effort had significant and lasting results.

There is another "hook" which can be used in the same timeframe to highlight the Administration's leadership in the success of wireless telecommunications. Around the beginning of August the wireless industry will sign up its 50 millionth subscriber. When the Administration came in there were only 10 million subscribers, the policies of the Administration have not only raised $20 billion in auction revenue for the taxpayers, but also, during the Clinton/Gore Administration...

550,000	New, high quality jobs created in wireless industry,
$21.3 billion	Invested in new plant and equipment (not counting the $20 billion paid for spectrum),
25%	Decline in rates (as a result of new competition)

A White House event built around the first anniversary of COPP and the 50 millionth subscriber would highlight the leadership of the President and Vice President in not only stimulating the development of new, competitive telecommunications technologies, but also fulfilling on the pledge to put that technology to work for the betterment of America.

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FAMILY VIOLENCE PREVENTION FUND

Domestic Violence

Facsimile Transmission Cover Page

DATE: 7/27/98

TO: Tom Freedman

AGENCY: White House

AGENCY'S PHONE #: (202) 456-5587

AGENCY'S FAX #: (202) 456-7431

FROM: Esta Soler

NUMBER OF PAGES TO FOLLOW: 2

MESSAGE:

Tom—

Here's a Thought. Let's talk. All my best—

Esta

383 Rhode Island Street, Suite 304 San Francisco, CA 94103-5133 *web site:* http://www.fvpf.org/ *email:* fund@fvpf.org
Tel: 415 . 252 . 8900 *Fax:* 415 . 252 . 8991 *Publications Orders:* 415 . 252 8089

FAMILY VIOLENCE PREVENTION FUND

To: Tom Freedman

From: Esta Soler

Date: July 27, 1998

Re: White House event on domestic violence

I appreciate this chance to offer suggestions about how the Administration could play a leadership role on a key issue for victims of domestic violence. I see a real opportunity for the Administration to take the lead on increasing the rate at which health care providers screen women for domestic violence, which the Family Violence Prevention Fund and leading experts in the health care field have identified as a key priority.

Because domestic violence is a highly prevalent and preventable health problem, routine screening has become an accepted strategy for domestic violence prevention. Routine screening of all women for domestic violence is supported by the American Medical Association, the American Nurses Association, the March of Dimes and domestic violence advocacy organizations. The U.S. Department of Health and Human Services Departmental Agenda for Action for 1998 identifies "strengthening the health care system's ability to screen, treat, and prevent family and intimate violence" as their top priority. Routine screening gives health care providers the opportunity to intervene with victims of domestic violence early – to ensure that these women receive the appropriate health care and support services they need.

Despite the strong support for screening, studies show that most women are not asked about domestic violence by their health care providers. The Administration could play a key role in translating good policy into standard practice by helping to increase the rate of domestic violence screening in health care plans that contract with the Federal Government. As you well know, when changes begin to occur in Medicaid, Medicare, and Federal Employee Health Benefits Plans, other plans tend to follow.

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Tel: 415 252 8900

We suggest the following program for a White House event on domestic violence:

1. Testimony from a victim of domestic violence who made repeated trips to the hospital emergency department for treatment of injuries from abuse, but who was never asked about abuse by a health care provider. Or, testimony from a victim who made repeated visits to a primary care provider for treatment of a health condition caused by abuse, such as a migraine or hypertension, but was never asked about abuse by her physician.

2. Statements by the Presidents of the American Medical Association and the American College of Obstetricians and Gynecologists.

3. A statement by the President or the Vice President announcing the Administration's plans for increasing rates of domestic violence screening. The new initiative should focus on strategies that will increase screening within Medicare, Medicaid and health care plans for Federal employees. Obviously, we will need to flesh out the details of this plan in advance of the event. We would be pleased to work closely with you on developing this strategy.

I look forward to discussing this with you further. Thank you again for this opportunity.

BASS AND HOWES INC

FAX COVER SHEET

Dorothy Vidnell

TO: Jon Friedman

FAX: 202/456-7431

FROM: Joanne Howes

DATE: _____ BH ACCOUNT #: _____

NUMBER OF PAGES (including cover sheet): _____

COMMENTS: Perhaps this is an opening

If there is a problem with this transmission, please call: (202) 530-2900

250 West 57th Street • Suite 2217 • New York, NY 10107 • 212.245.8735 • fax 212.245.8738 • bh@basshowes.com

1818 N Street, NW • Suite 450 • Washington, DC 20036 • 202.530.2900 • fax 202.530.2901 • bh@basshowes.com

THE WHITE HOUSE
Office of the Vice President

For Immediate Release
Tuesday, June 23, 1998

Contact:
(202) 456-7035

VICE PRESIDENT GORE ANNOUNCES NEW EFFORTS TO MAKE THE HEALTH CARE SYSTEM MORE RESPONSIVE TO FAMILIES

Tipper Gore Announces New Public/Private Network to Support Children of Patients with Serious Mental and Physical Illness

Nashville, TN -- Vice President Gore announced a new directive today to make the Federal Employees Health Benefit Program (FEHBP) more family-friendly, while Tipper Gore launched a new public-private partnership to help families cope with serious mental and physical illness.

"Tipper and I are pleased to be here today to talk about family-centered care -- an approach that relies on the partnership between providers, patients, and families to promote health and healing," the Vice President said on the second day of the Gores' seventh annual conference on policy issues of major concern to families and children. "Family-centered care acknowledges that the fundamental health care provider in America today is the family, and it is designed to unleash the healing power of the family."

The Vice President and Mrs. Gore moderated the "Family Re-Union 7: Families and Health," and each made announcements to help make health care more family-centered.

The Vice President:

Directed the FEHBP to Encourage Family Friendly Health Plans: The FEHBP will hold a series of meetings with families over the next year to identify ways that its health plans can be more responsive to the needs of families, and it will publish these findings in its 1999 annual call letter to insurers as a condition for participation in the program.

Mrs. Gore met with children and their families to discuss their experiences coping with their parents' mental and physical illnesses and the effect of these illnesses on their children.

In her remarks, Mrs Gore:

Launched a public-private network to support children and patients with serious mental and physical illnesses: A network of private and public groups will come together to support children of cancer and other seriously ill patients. In addition, the Substance Abuse and Mental Health Services Administration and the National Cancer Institute will form a partnership to bring together researchers and service providers to help support children.

"We don't give credit, particularly to children, for the empathy, the resilience, and the downright individual strength we see in families facing a medical crisis, whether the crisis affects a sibling, a parent, or a grandparent," Mrs. Gore said.

"And that is why I am pleased that the Federal Government, in partnership with families, scientists, caregivers, private foundations, and health and social services professionals, have joined together to help our children cope with their parents□ illnesses."

The Vice President and Mrs. Gore heard reports from roundtable discussions addressing the following issues: principles of care for families with young children; family-centered elder care at home and in medical settings; successful community-based initiatives; strategies to give families the information they want; bringing families into the design of health care setting and medical training; creating responsive, flexible policy; and measuring success.

The dayIs activities followed on the heels of a discussion the day before with President Clinton, First Lady Hillary Rodham Clinton, Vice President Gore and Tipper Gore. The conference is co-sponsored by the Child and Family Policy Center at Vanderbilt University, and the Children, Youth & Family Consortium of the University of Minnesota.

FAMILY VIOLENCE PREVENTION FUND

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From: Esta Soler

Date: July 27, 1998

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I look forward to discussing this with you further. Thank you again for this opportunity.

Mary L. Smith
03/05/99 10:58:21 AM

Record Type: Record

To: Thomas L. Freedman/OPD/EOP

cc:
Subject: Family Violence Prevention Fund

I just received a fax from Lisa Morena at the Family Violence Prevention Fund. It says it is per a 2/25 conversation with you. Attached are a memo and recommendations on DoD response to domestic violence and the Rx for Abuse Act. What is this? Do I need to consider this for what we are putting in our VAWA bill? Let me know by today. Thanks, Mary

FAMILY VIOLENCE PREVENTION FUND

DATE: 2/25

TO: Mary Smith

PHONE: _____ FAX: 456-7431

FROM: **Lisa Moreno**

PHONE: **(202) 624-9470** FAX: **(202) 371-9142**

COMMENTS: Per 2/25 conversation w/ Tom Freedman

- Memo + recommendations on DOD response to DV
- Rx for Abuse Act
- Welfare bill on children who witness
-

This transmission is _____ pages including this cover sheet.

383 Rhode Island Street, Suite 304 San Francisco, CA 94103-5133 *web site:* www.fvpf.org *email:* fund@fvpf.org
Tel: 415 . 252 . 8900 *Fax:* 415 . 252 . 8991 *Publications Orders:* 415 . 252 . 8089

DOD RESPONSE TO DOMESTIC VIOLENCE

BACKGROUND

Funding: DOD spends approximately $105 million on Family Advocacy Services. This provides services to approximately 2 million service members and dependents in the US and abroad.

Domestic violence in the military is defined as spousal abuse. This is mainly due to the fact that DOD services are only available to military personnel and their dependents. Therefore DOD cannot provide treatment or services to civilian victims cohabiting or dating military personnel.
Their definition of abuse includes emotional as well as physical abuse, which civilian definitions do not.

- **Spouse Abuse**—"assault, battery, threat to injure or kill, other act of force or violence, or emotional maltreatment inflicted by one spouse or the other."

- **Domestic violence in VAWA '94**—"a crime of violence committed by a current or former spouse of the victim, an individual with whom the victim shares a child in common, and individual who cohabits with or has cohabited with the victim as a spouse, or any other similarly situated to a spouse, or any other person who is protected under the domestic or family violence laws of the eligible State, Indian tribe, municipality, or local government entity.

Data collection: DOD keeps a central registry of all reports of domestic violence and their outcomes. The registry includes reports of emotional as well as physical abuse.

Reporting of spousal abuse is mandatory in the military. This means that a report can be made from any source, i.e., a victim, a neighbor, military police, health professional, colleague. The report is filed with the Family Advocacy Program.

THE DOD DOMESTIC VIOLENCE RESPONSE SYSTEM

The responses to domestic violence vary significantly from service to service in terms of the details of how the programs are implemented. However, each service's programs follow the same directive.

The Family Advocacy Program (FAP) is the central player in the military response to domestic violence. The military system addresses domestic violence more as a relationship issue, than as a crime. The system's interest is in the service member and that individual's ability to perform their job. Domestic violence, the recommended treatment and/or sanctions can all disrupt the service member's job performance and availability for deployment. Therefore the FAP is tasked with treating or "fixing" the service member and getting them back to their job.

FAP was first established by DOD directive in 1981. FAP was created to provide a coordinated DOD-wide program for the prevention, identification, evaluation, treatment, follow-up, and reporting of child abuse, neglect, and spouse abuse involving military personnel and their families. The Current directive:

1) Establishes programs and activities that contribute to healthy lives;
2) Promotes early identification and intervention in cases of alleged child and spouse abuse;
3) Defines the program as rehabilitative, not punitive;
4) Requires the Military Services to develop a standardized system for gathering and reporting cases; and
5) Establishes a committee to identify joint service issues and help the FAP manager in coordination of special projects.

FAP is responsible for assessing the needs of the couple, assessing the risk of additional violence, treatment and rehabilitation of the victim and offender, data collection, and case management.

FAP interviews the couple for information on the incident, family history, dynamics, and individual history with abuse and history of abuse in the relationship. Participation in this process is voluntary for the victim, but it is the only opportunity the victim has to tell his/her side. Eventually, every participant's (police, investigation, FAP, etc.) ends up at a case review committee.

Investigations: All suspected cases of abuse are to be reported to the military police, the FAP, and the (individual's) command. Whoever receives the report is responsible for forwarding it on. All reports must be investigated. The investigations can be done by the Service's criminal investigations (CID, NCIS, and AFOSI), military police, or FAP, or the command.

- The command's interest in the case is historically in the military member, not the victim. Therefore a conflict of interest can exist.

The Case Review Committee: The Case review committee is a multi-disciplinary committee that looks at all the evidence presented and decides whether abuse occurred. The make up of the committee varies service to service. They also recommend a treatment for the couple. The command is notified of the treatment recommended. *The committee does not recommend a sanction for offenders.*

What does Treatment Mean? Treatment can include: batterer's programs, stress management, anger management, interpersonal communications, support groups, and classes on power and control issues for less violent or "level one" cases. "Level two" cases, or cases deemed to require counseling and psychotherapy treatment can include: counseling, individual therapy, psychological services, group psychotherapy, drug and alcohol counseling, family therapy, co-joint couples therapy, play therapy for children, or clinically based group therapy.

- Both the Army and the Navy rely regularly on couples' counseling for batterer's treatment. Couples counseling would not be considered an appropriate domestic violence intervention in most civilian setting, and is shown to put the victim's safety at risk.

The Command Role: Once the review committee has made a determination whether the incident occurred (substantiated, unsubstantiated, etc.), the Command is notified of the outcome and recommended treatment. Often, the service member's attitude toward attending or completing treatment is highly influenced by the Command's support or lack of support for FAP recommendation. Any sanction given the military offender is up to the discretion of the Commander.

- Tools at a commanders disposal include: loss of pay, demotion, punitive measures like extra work assignments or desk duty, NJP, court-martial, administrative separation, and incarceration.
- Commanders have little guidance as to what is appropriate sanction for each level of crime/assault.
- Commanders receive little to no training on how to assess victim safety issues, or understand the dynamics of domestic violence.

Protective Orders—Miltary Protective Orders (MPOs) can be requested of the Command by the victim, FAP staff, or Provost Marshall's Office (PMO). This request generally occurs after a report of abuse. Only the command, or his representative (OD, etc.) can issue the Order. Decisions regarding the duration of the MPOs issued and the remedies afforded the victim by the MPO are directed by the issuing commander. These orders vary in effectiveness, as they do in the civilian community. Some offenders will obey the direct order of their Commander, others will not. Enforcement of the MPO is difficult if they are not given in writing, with a copy given to the victim and to PMO. A violation of an order can be prosecuted under the UCMJ (disobeying a direct order). MPOs are not enforceable by civilian police because they do not follow due process. The commander simply orders that the person stay away, desist, etc.

WHAT DOD DOES WELL

DOD excels at the prevention, identification, and early intervention in low-level cases of domestic violence. The combined effect of mandatory reporting, attention paid to emotional abuse, the closed military services, command and law enforcement systems, and treatment intervention models work together to effectively intervene in large numbers of cases the civilian systems would never touch. These cases tend to involve low levels of violence (pushing, shoving, and throwing things) that would not reach the standard of probable cause in a civilian court.

THE PROBLEM

While DOD identifies and intervenes with low level offenders well, the system does not give proper weight and attention to serious abuse cases. Because the military system and institutional interest focus on the service member, the system fails to pay appropriate attention to or even recognize many victim safety issues. Additional factors in the system's failure to give proper weight to serious abuse case may be that the large numbers and numbing details of low level cases can overwhelm Commands and the members of the case review committee. Combine this with the belief that even minor cases can ruin a career and it is understandable how severe cases may be minimized, unrecognized, or lost in the process.

In addition, the system often fails to appropriately assess the context in which the violence occurs. This happens regularly in reports of mutual abuse, and identified reports of low level abuse that actually may be a part of a larger pattern of serious and ongoing abuse.

Finally, the FAP is tasked with dealing with domestic violence and with "fixing" batterers. While FAP is designed to support commands, it is largely civilian run. Commanders, law enforcement, and legal services are all key to addressing domestic violence in a systematic way. Unfortunately, FAP does not generally have the clout to leverage the resources and focus of any organization other than its own.

1. Lack of a framework to guide consistent interventions-- The 1996 final report on Spouse abuse done by Caliber Associates recommended to DOD that "developing an overarching strategy to curtail spouse abuse would be further facilitated by adopting one (or more) causal theories of spouse abuse and implementing response tactics that are consistent with the adopted theories of causation."

2. Offender Accountability:

- There are uncharacteristically high numbers of mutual abuse reported in the services, compared with civilian reports. In general the services either make no effort to identify the primary or predominate aggressor, or issues of self-defense, in the incident of abuse, or do not understand how to make such a determination.

- Lack of Command commitment to treatment services. Field exercises or deployment routinely take precedent over going to batterer's group.

- Lack of consistent disciplinary action or sanction for even serious abuse.

- Command messages that abuse is justified for adultery, drinking, writing bad checks etc., or that the victim provoked the abuse by "talking back, nagging, overspending"

3. Victim Safety: There are numerous impediments to ensuring victims' safety.

- **Protective Orders**—There is currently no way to verify the existence of MPOs. Since most MPOs are verbal orders, most bases do not attempt to keep track of MPOs issued. This makes it extremely difficult to enforce, and impossible to track violations of, these orders.

- In addition, MPOs can not be enforced off base. If a victim lives off base, and her abuser is military, she is better off having a civilian protective order because civilian police cannot enforce a military protective order. Civilian protective orders, on the other hand, are not enforceable on exclusive jurisdiction bases, leaving the victim to slog her/his way through two systems.

3. Fear of reporting —Family member victims that face overwhelming barriers to reporting. Because the military is a closed system, any report could negatively affect a spouse's career, and as a result threaten a family's economic security. A family living on base would have to leave base housing if the military sponsor was incarcerated, or if they separate. Many installations have policies

which result in loss of base housing when a spouse is substantiated of abuse, or if there are too many calls to PMO from a residence. The family may be thousands of miles from their home of record.

- Clear guidance should be established around what level cases should be career busters. Should a career be negatively affected by a single low level case?

4. **No confidentiality for victims and victims' advocates**— Due to the fears mentioned above, many spouses choose not to report because follow through is mandatory. Unlike the civilian system a spouse does not have the option to simply seek advice, safety planning or information about available services without triggering an investigation.

    - There is a need for confidentiality between victims and victims' advocates. Also under the FAP system a social worker is working with the couple and has responsibilities to the Command. There is a need for guidelines to deal with the ethical dilemmas that this creates?

5. **Commanders do not understand issues of victim safety**—Commanders, whose role is to act in the best interest of the unit and therefore, the service member, generally deal with domestic violence cases as they would any other personnel problem. They have little or no training on the dynamics of domestic violence, and do not understand how their action, or lack of action will impact victim safety. ie (insisting on doing an investigative interview with the couple after an incident, refusal to implement requested MPO, excusing violence because of victim's character or behavior issues)

6. Data Collection—the central registry which tracks all domestic violence reports has some serious shortcomings. The manner in which the data is collected fails to tell the whole picture of domestic violence in the military.

- The registry does not include information on the level of violence used in the case. This makes the information somewhat useless over time. An individual could have numerous cases in the system, but OSD would never be able to tell if these are felony level cases or pushing/slapping.

- The registry does not include information on sanctions that the offenders were given for the abuse. There is a mechanism to record this information on the 2486, but Commands do not always or even regularly report to FAP if or what action was taken. All research data on effectiveness of intervention indicates that the most effective deterrent to repeated spouse abuse is a combination of sanction and treatment. The registry is missing half of the story.

- Severity of abuse is classified differently in each branch of the service. There should be one DOD wide matrix.

Recommendations

1) **DOD NEEDS COLLABORATIVE WORK WITH ADVOCATES IN THE FIELD TO IDENTIFY AND DEVELOP A THEORETICAL FRAMEWORK TO GUIDE CONSISTENT INTERVENTIONS ACROSS THE SERVICES.**

DOD should establish a process by which communication/collaboration between the OSD, DOJ, HHS, the services, and civilian domestic violence advocates and service providers can work together to improve issues of **victim safety and offender accountability** within the DOD response to domestic violence. The first step is a collaborative development of a theoretical framework that is tailored to the military system and mission and reflects current practice in the field in the civilian community.

- All current practices and policies should be assessed for impact on victim safety. This process should involve DV advocates (civilian and military) as well as DOD personnel.
- Standardize expectations of accountability for offender, and the military system
- Spouse abuse intervention should be coordinated on base and with civilian responders and MOU's developed.
- A DOD response to domestic violence should be coordinated with all stake- holders, i.e. commanders, law enforcement, etc...

2) **THE MILITARY SHOULD ENFORCE CIVILIAN PROTECTIVE ORDERS**: Improve the ability of military police to enforce and appropriately respond to enforcement of civilian protective orders on military installations.

- Include requirement that MPs turn individuals who violate civilian POs over to civilian authorities in MOU governing interaction between military and civilian authorities on concurrent jurisdiction bases.

- Legislation to require that bases with exclusive jurisdiction give full faith and credit, or simply enforce civilian POs.

3) **ENHANCE THE EFFECTIVENESS AND ENFORCEABILTY OF MILITARY PROTECTIVE ORDERS**:

- Mandate that all MPOs be written orders and filed with the Provost Marshall's office, create process to document violations of these orders.

- Mandate that Provost Marshall's office keep a regularly updated paper file or computerized database of MPO's.

- Track requests for MPO's that were denied by Command, and require documentation of denial.

4) **IMPLEMENT SYSTEM FOR MONITORING AND TRACKING COMMAND RESPONSES TO DOMESTIC VIOLENCE.**

The goal here is not to track numbers but to ensure that case review committee recommendations are being acted on properly and that proper sanctions are being applied to perpetrators, particularly for cases where there are injuries, threats, and for felony level cases.

- The Marine Corps has paid for a tracking system that is ready to run. While the Corps has paid for it, it has chosen not to implement it. It could be used DOD wide.

5) **INTEGRATE COMMAND COMMITMENT TO ISSUES OF SPOUSE ABUSE INTO LEADERSHIP CULTURE.**
   - PROVIDE DOMESTIC VIOLENCE TRAINING AND INTERVENTION STRATEGIES AT COMMAND AND NCO SCHOOLS.
   - Link Command action on spouse abuse issues to leadership ability

6) **DOD SHOULD CONTRACT WITH LOCAL CIVILIAN PROGRAMS** for confidential victims' advocacy services.
   - Civilian advocacy programs need training on how to advocate for military victims of spouse abuse. More collaboration between the military and civilian DV groups would go a long way toward building trust and increasing options for victims.

7) **IMPROVE CAPABILITY OF CENRAL REGISTRY TO CAPTURE LEVELS OF ABUSE AND ACTIONS TAKEN.**

Developed by the Family Violence Prevention Fund and the Battered Women's Justice Project

105TH CONGRESS
2D SESSION

S. 2395

To provide grants to strengthen State and local health care systems' response to domestic violence by building the capacity of health care professionals and staff to identify, address, and prevent domestic violence.

IN THE SENATE OF THE UNITED STATES

JULY 31, 1998

Mr. DOMENICI (for himself and Mr. STEVENS) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

---

A BILL

To provide grants to strengthen State and local health care systems' response to domestic violence by building the capacity of health care professionals and staff to identify, address, and prevent domestic violence.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. GRANTS TO ADDRESS DOMESTIC VIOLENCE IN HEALTH CARE SETTINGS.

(a) IN GENERAL.—The Family Violence Prevention and Services Act (42 U.S.C. 10401 et seq.) is amended by adding at the end the following:

"SEC. 319. GRANTS TO ADDRESS DOMESTIC VIOLENCE IN HEALTH CARE SETTINGS.

"(a) GENERAL PURPOSE GRANTS.—The Secretary, acting through the Office of Family Violence and Prevention Services of the Administration for Children and Families, may award grants to eligible State and local entities to strengthen the State and local health care system's response to domestic violence by building the capacity of health care professionals and staff to identify, address, and prevent domestic violence.

"(b) STATE GRANTS.—

"(1) IN GENERAL.—The Secretary may award grants under subsection (a) to entities eligible under paragraph (2) for the conduct of not to exceed 10 Statewide programs for the design and implementation of Statewide strategies to enable health care workers to improve the health care system's response to treatment and prevention of domestic violence as provided for in subsection (d).

"(2) ELIGIBLE ENTITIES.—To be eligible to receive a grant under paragraph (1) an entity shall—

"(A) be a State health department, nonprofit State domestic violence coalition, State professional medical society, State health professional association, or other nonprofit or

State entity with a documented history of effective work in the field of domestic violence;

"(B) demonstrate to the Secretary that such entity is representing a team of organizations and agencies working collaboratively to strengthen the health care system's response to domestic violence; and

"(C) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(3) LIMITATION.—The Secretary may not award a grant to a State health department under paragraph (1) unless the State health department can certify that State laws, policies, and practices do not require the mandatory reporting of domestic violence by health care professionals and staff when the victim is an adult.

"(4) TERM AND AMOUNT.—A grant under this section shall be for a term of 4 years and for an amount not to exceed $2,000,000 for each such year.

"(c) LOCAL DEMONSTRATION GRANTS.—

"(1) IN GENERAL.—The Secretary may award grants under subsection (a) to entities eligible under

paragraph (2) for the conduct of not to exceed 10 demonstration projects for the design and implementation of a strategy to improve the response of local health care professionals and staff to the treatment and prevention of domestic violence.

"(2) ELIGIBLE ENTITIES.—To be eligible to receive a grant under paragraph (1) an entity shall—

"(A) be a local health department, local nonprofit domestic violence organization or service provider, local professional medical society or health professional association, or other nonprofit or local government entity that has a documented history of effective work in the field of domestic violence;

"(B) demonstrate to the Secretary that such entity is representing a team of organizations working collaboratively to strengthen the health care system's response to domestic violence; and

"(C) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(3) TERM AND AMOUNT.—A grant under this section shall be for a term of 3 years and for an amount not to exceed $450,000 for each such year.

"(d) USE OF FUNDS.—Amounts provided under a grant under this section shall be used to design and implement comprehensive Statewide and local strategies to improve the health care setting's response to domestic violence in hospitals, clinics, managed care settings, emergency medical services, and other health care systems. Such a strategy shall include—

"(1) the development, implementation, and dissemination of policies and procedures to guide health care professionals and staff responding to domestic violence;

"(2) the training of, and providing follow-up technical assistance to, health care professionals and staff to screen for domestic violence, and then to appropriately assess, record in medical records, treat, and refer patients who are victims of domestic violence to domestic violence services;

"(3) the implementation of practice guidelines for widespread screening and recording mechanisms to identify and document domestic violence, and the institutionalization of such guidelines and mechanisms in quality improvement measurements such as

patient record reviews, staff interviews, patient surveys, or other methods used to evaluate and enhance staff compliance with protocols;

"(4) the development of an on-site program to address the safety, medical, mental health, and economic needs of patients who are victims of domestic violence achieved either by increasing the capacity of existing health care professionals and staff to address these issues or by contracting with or hiring domestic violence advocates to provide the services;

"(5) the development of innovative and effective comprehensive approaches to domestic violence identification, treatment, and prevention models unique to managed care settings, such as—

"(A) exploring ways to include compensated health care professionals and staff for screening and other services related to domestic violence;

"(B) developing built-in incentives such as billing mechanisms and protocols to encourage health care professionals and staff to implement screening and other domestic violence programs; and

"(C) contracting with community agencies as vendors to provide domestic violence victims

access to advocates and services in health care settings; and

"(6) the collection of data, implementation of patient and staff surveys, or other methods of measuring the effectiveness of their programs and for other activities identified as necessary for evaluation by the evaluating agency.

"(e) EVALUATION.—The Secretary may use not to exceed 5 percent of the amount appropriated for a fiscal year under subsection (e) to evaluate the economic and health benefits of the programs and activities conducted by grantees under this section and the extent to which the institutionalization of protocols, practice guidelines, and recording mechanisms has been achieved.

"(f) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

"(A) $24,500,000 for each of the fiscal years 2000 through 2002; and

"(B) $20,000,000 for fiscal year 2003.

"(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available until expended.".

(b) TECHNICAL AMENDMENT.—Section 305(a) of the Family Violence Prevention and Services Act (42 U.S.C. 10405(a)) is amended—

(A) by striking "an employee" and inserting "one or more employees"; and

(B) by striking "individual" and inserting "individuals".

O

Rx FOR ABUSE ACT
Helping Health Care Providers Prevent Domestic Violence

BACKGROUND

- Incidence of domestic violence ranges from 960,000 incidents of violence against a current or former spouse, boyfriend or girlfriend per year to 3.9 million women who are physically abused by their husbands or live-in partners per year.

- Thirty seven percent of all women who sought care in hospital emergency rooms for violence-related injuries in 1994 were injured by a current or former spouse, boyfriend or girlfriend.

- A study conducted at Rush Medical Center in Chicago found that the average charge for medical services provided to abused women, children, and older people was $1633 per person per year.

- Of 3,455 adult women surveyed by Allegheny University of the Health Sciences in Pittsburg, PA more than a third (36.9%) said they have experienced emotional or physical abuse by an intimate partner during their lifetime; more than one out of seven (14.4%) said that they have experiened physical or sexual abuse; and 2.2% said they came to the hospital as a result of injuries.

- In a major metropolitan emergency department that had a protocol for domestic violence, the emergency department physician failed to obtain a psychosocial history, ask about abuse, or address the woman's safety in 92% of the domestic violence cases.

DOMESTIC VIOLENCE AS A PUBLIC HEALTH ISSUE

Violence against women takes a tremendous toll on our health care system. Battering is a leading cause of injury to women. Women who have been battered or sexually assaulted utilize the health care system at much higher rates than non-abused women, for a variety of health problems, including repeated injuries, stress-related disorders, depression, and other physical and mental illnesses. And battering during pregnancy increases the risk of premature, low birthweight, or stillborn babies.

Historically, interventions to end domestic violence have focused on either providing shelter and services or improving the law enforcement response. Obviously, both of these strategies are vital to ensuring the safety and meeting the needs of victims. Nevertheless, health care providers and staff are often the first, and only, professionals to see a battered woman's injuries. They are in a unique position to identify abuse before it is reported and to intervene in a way that will result in a reduction in the morbidity and mortality caused by violence in the home. However, to do so, they must acknowledge domestic violence as a health care issue

A QUESTION OF PREVENTION AND ADEQUATE CARE

Unlike shelter providers, health care providers are seldom equipped to identify domestic violence or to intervene in a supportive and effective way. Physicians frequently treat only battered women's injuries without addressing the cause of those injuries. No physician ever intends to discharge a patient with a preventable life-threatening condition without taking steps to treat the problem. However, most battered women who seek medical attention are sent home to the same unsafe situation that was the original cause of their injuries only because their physicians lack the training and support to appropriately identify, treat,

or refer victims of domestic violence. Health care providers who fail to identify and intervene in such cases miss an important opportunity to stop the cycle of violence, and get at the root of their patients' health care problems.

Health care providers and institutions must incorporate a comprehensive response to domestic violence into their definition of adequate care by:

- Routinely inquiring about abuse and violence in their patients' lives.
- Educating health care providers and staff about how to inquire and intervene.
- Establishing an integrated and institutionalized response to domestic violence.
- Developing referral and resource materials.
- Evaluating, on an on-going basis, the effectiveness of the their programs.
- Becoming a part of a coordinated response within the larger community through collaborative partnerships.

The Rx for Abuse Act

The Rx for Abuse Act, or S. 2395, introduced by Sen. Pete Domenici (R-NM) and Sen. Ted Stevens (R-AK) in the Senate, and H.R. 4477, introduced by Rep. Nita Lowey (D-NY), funds demonstration grants that will enable state and local teams to design and implement such responses. The bill authorizes ten grants up to $2 million for statewide teams to develop four-year demonstration programs and ten grants up to $450,000 for local teams to direct three-year local level demonstrations. Eligible state applicants are state health departments, domestic violence coalitions, other domestic violence organizations, or the state medical or health association or society. Local health departments, nonprofit domestic violence organizations or service providers, medical or heath associations or societies, or other nonprofit or governmental entities that have a history of work on domestic violence are eligible local level applicants. All grantees must be representing a collaborative team of organizations.

The Family Violence Prevention Fund
383 Rhode Island St., Suite 304
San Francisco, CA 94103-5133
For more information, please contact:
Lisa Moreno
(202) 624-9470

N O W Legal Defense and Education Fund

"Defining and Defending Women's Rights for 28 Years"

119 Constitution Ave, NE Washington, D.C. 20002 (202) 544-4470 fax: (202) 546-8605 e-mail nowldefdc@aol.com

FAX

Date: 3-3 Fax#: 456-7431

To: Mary Smith

From: Pat Reuss # of pages, incl. cover: 3

Comments:

☆ = where WH should support Conyers!

I've asked NCADV to fax you a clean version of this, & also a summary of this year's BWESA (Weldstone/Murray) due to be introduced next week.

WE WILL NOT BE RAPED
WE WILL NOT BE BEATEN
WE WILL NOT BE KILLED

WOMEN & GIRLS DEMAND...

WE WILL BE STRONG
WE WILL BE EMPOWERED
WE WILL BE HEARD

Please note that we have a new mailing address, but are still in our same office. Thanks

"Thank you for supporting our work through your generous year-end donation"
 # 1914 on CFC/United Way

National Coalition Against Domestic Violence

119 Constitution Avenue NE Washington, DC 20002 ● Phone 202-544-7358 ● Fax 202-544-7893

COMPARISON OF HOUSE & SENATE VERSIONS OF VAWA '99

H.R. 357 (VAWA '99)-- Conyers (D-MI), Morella (R-MD) & Roybal-Allard (D-CA)
S. 51 -- Biden (D-DE) & Specter (R-PA)
S. 245 -- Hatch (R-UT)

☺ - Included ▬ - Not included

Provision	H.R. 357 (VAWA 99)	S. 51 (Biden/Specter)	S. 245 (Hatch)
Expanded Definition of DV	☺	☺	▬
STOP Grants	☺ 5yrs	☺ alternate version; only through 2002	☺ alternate version; only through 2002
Nat'l Domestic Violence Hotline	☺	☺ includes legal services database; only through 2002	☺ only through 2002
Grants for Community Initiatives	☺	☺ lower funding; only through 2002	☺ lower funding; only through 2002
Education & Training for Judges	☺	☺ lower funding; only through 2002	▬
Grants to Encourage Arrests	☺	☺ lower funding; only through 2002	☺ lower funding; only through 2002
Rural DV & Child Abuse	☺	☺ only through 2002	☺ higher funding; only through 2002
National Stalker & DV Reduction	☺	☺ only through 2002	☺ only through 2002
Federal Victims' Counselors	☺	☺ only through 2002	▬
Runaway & Homeless Youth	☺	☺ lower funding; only through 2002	☺ lower funding; only through 2002
Victims of Child Abuse Programs	☺	☺ lower funding; only through 2002	☺ lower funding; only through 2002
Safe Havens for Children	☺	☺ lower funding ,only through 2002	▬
Date Rape Drug Rescheduling	☺	☺ more limited version	▬
Access to Safety and Advocacy for victims of Sexual Assault	☺ legal services	▬	▬
VAW Prevention in Schools	☺	☺ more limited version/ lower funding, only through 2002	▬
Family Safety	☺	☺ more limited version	▬
Battered Immigrant Women	☺	☺ more limited version	☺ very limited version
Underserved Populations Defn	☺	▬	▬

Clearinghouse - DV/SA/Workplace	☺	☺ twice as much funding; only through 2002	▬
Victims' Employment Rights Act	☺	▬	▬
Workplace Tax Credit	☺	▬	▬
Battered ♀'s Employment Protect	☺	☺ more limited version	▬
Educ & Training Grants on VAW	☺	☺ lower funding; only through 2002	▬
Rape Prevention Education	☺	☺ more limited version; lower funding; only through 2002	▬
Standards/Training for SA Exams	☺	☺	▬
Hate Crimes Prevention	☺	☺	▬
DV Victims' Housing — we should all do some serious analysis of this issue — could be a big one!	☺		
Full Faith and Credit — tribal parts	☺	☺ more limited version; no funding	☺ more limited; no funding
DV Insurance Protection	☺	☺ enforcement only if states fail to	▬
Access to Safety and Advocacy for Victims of Domestic Violence	☺	☺ very limited version; only through 2002	▬
Amendments to Interstate Stalking	☺	☺	☺
Disclosure under Child Support Program	☺	▬	▬
Older Women's Protection	☺	☺	▬
Protection for Disabled Women	☺	☺ more limited version; lower funding; only through 2002	☺ more limited version; lower funding
Civilian Jurisdiction for SA & DV	☺	☺ more limited version	▬
Transitional Compensation	☺	☺ more limited version	▬
Training for Health Professions	☺	☺	▬
Research on VAW	☺	☺ more limited; lower funding	▬
Child Custody Resolution	☺	▬	▬
Child Welfare Worker Training	☺	▬	▬
Child Abuse Accountability	☺	▬	▬
Sexual Assault in Prisons	☺	▬	▬
Summit on Sports & Violence	☺	▬	▬
"No Guns for Drunks"	☺	▬	▬
Workers' Compensation	☺	▬	▬

Screening Policy
for the Identification of Domestic Violence Victims

June 9, 1999

The following policy was developed by the Family Violence Prevention Fund in joint with expert health practitioners in the field of domestic violence screening, intervention and prevention and advocates in the domestic violence community. The final draft will be completed by the beginning of July 1999. Please contact us for a copy of that draft.

Family Violence Prevention Fund
383 Rhode Island Street, Ste. 304
San Francisco, CA 94103-5133
415/252-8900
http://www.fvpf.org
Health Resource Center on Domestic Violence
Toll free: 888/ RX-ABUSE

Family Violence Prevention Fund
Screening for Domestic Violence

Screening for domestic violence provides a critical opportunity for disclosure of domestic violence and provides a woman and her health care provider the chance to develop a plan to protect her safety and improve her health. Recent experience with AIDS, smoking cessation and improved outcomes in breast cancer and cardiovascular disease support the efficacy of early identification and intervention. The prevalence and the health, social and economic costs of domestic violence require equivalent attention and equally effective action by the health care system.

For five years, the Family Violence Prevention Fund (FUND), a national domestic violence advocacy organization has promoted routine screening for domestic violence by health care providers. Concurring with this policy are the American Medical Association, the American Nurses Association and a number of other national health care organizations that recommend that health care practitioners screen for domestic violence.[1,2,3]

As screening practice has become more widespread, and as data have been collected that support the efficacy of screening for domestic violence, the need for a set of clear guidelines for screening practice has become apparent. Providers are seeking this information in order to improve patient care, managed care plans and medical organizations in order to promote better practice across their organizations, and researchers and analysts in order to be able to better assess the state of domestic violence practice.

In this document, the FUND presents its recommendations for how screening should occur within the health care system. To develop this policy, the FUND conducted an extensive literature review and held a conference with expert health practitioners in the field of domestic violence screening, intervention and prevention and advocates in the domestic violence community.

The FUND recommends that all health care institutions and practitioners follow these guidelines that include both a general policy statement and health setting specific recommendations. The FUND is currently working with national health and medical associations and state organizations to jointly encourage the widespread implementation of these guidelines.

RATIONALE

Domestic violence is a health care problem of epidemic proportions. It is estimated that between 20% and 30% of all women in the United States are abused by an intimate partner at some point in their adult lives.[4,5,6] In addition to the immediate trauma caused by abuse, domestic violence contributes to a number of chronic health problems including chronic pain in any organ system[1], depression[1,3], alcohol abuse[1,3,78] and substance abuse.[1,3,7,8] In addition, the management of other chronic illnesses such as asthma, seizure, diabetes and hypertension may be problematic in women who are being abused.

DRAFT4

The health care system is positioned to play a pivotal role in domestic violence prevention. Virtually every American woman interacts with the health care system at some point in her life — whether it is for routine health maintenance, pregnancy, childbirth, illness, injury or by bringing her child for health care services. For the 1.5 million women who are physically abused by their partners every year, the health care system can be a primary resource.[9] In fact, according to a report released in November 1998 by the National Institute of Justice and the Centers for Disease Control and Prevention, women make 693,933 visits to the health care system per year as a result of injuries due to physical assault.[4] The majority of these visits were for treatment of injuries that were inflicted by the women's intimate partners. This study did not even measure the illnesses that are related to domestic violence or the effect domestic violence has on the management of other illnesses.

Although domestic violence directly or indirectly brings millions of women to the health care system every year — health care providers often treat these women without inquiring about abuse, therefore never recognizing or addressing the underlying cause of their health problems.[6,10,11,12,13,14] Even when domestic violence results in injuries that were obviously inflicted by another person, health care providers often record the injuries and treat the presenting problem without inquiring about the cause of the injuries.

Historically, the health care system has played an important role in identifying and preventing widespread public health problems. We believe the models developed to prevent other chronic health problems may effectively be applied to domestic violence. Routine screening, with its focus on early identification and its capacity to reach patients whether or not symptoms are immediately apparent[15] is a primary starting point for this improved approach to medical practice for domestic violence. Health care professionals currently screen routinely for a number of common conditions, where the prevalence is less than or similar to that of domestic violence.[16]

Routine and multiple screenings by skilled health care providers, when conducted face-to-face, markedly increases the identification of domestic violence.[19,23,26] Routine screening, as opposed to indicator-based screening, will increase opportunities for identification and intervention with patients presenting with symptoms not generally associated with domestic violence. When victims of domestic violence or those at risk for domestic violence are identified early, providers are able to intervene to help patients understand their options, live more safely within the relationship or safely leave the relationship. Expert opinion suggests that such interventions may lead to reduced morbidity and mortality.[17]

Screening provides women a valuable opportunity to tell their providers about their experiences with abuse. Battered women report that one of the most important part of their interactions with their physicians was being listened to about the abuse.[18]

Published literature also provides guidance for how effective screening should take place, demonstrating the importance of conducting inquiries in private settings and using straightforward, nonjudgmental questions, preferably asked verbally by a health care practitioner.[19,20,21]

DRAFT 4

RECOMMENDED PRACTICE

Anecdotal evidence, expert opinion and a growing body of data support the efficacy of routine screening in identifying women who are victims of domestic violence or at risk for domestic violence.[22,23]

The FUND recommends:

- Routine screening for domestic violence victimization for all female patients over the age of fourteen in primary care, obstetrics/gynecology, emergency department, in-patient, pediatrics and mental health, prenatal and emergency department settings. Routine screening means that inquiry about domestic abuse occurs with all women over the age of fourteen, whether or not symptoms or signs are present and whether or not the provider suspects abuse has occurred.

- That all practitioners and health organizations within these settings implement programs to ensure routine screening of all female patients.

- That screening be carried out in private settings and through the use of straightforward, nonjudgmental questions, preferably asked verbally by the practitioner.[19,20,21]

- Confidential documentation of screening outcomes.

- That screening be carried out in a culturally competent manner and in ways that increase the safety of abused patients and respect patients' integrity and authority over their lives (the principles of patients' rights).

The FUND is convinced that the prevalence of domestic violence, and the data demonstrating the efficacy of screening in increasing identification of domestic violence, strongly support these recommendations for routine screening in the identified populations and settings.

Practitioners and health care organizations should develop policies that ensure ongoing training for providers on how to implement these screening guidelines as well as policies for assessment, intervention, comprehensive and confidential documentation and referral management if abuse is identified.

FUTURE CONSIDERATIONS

The FUND also believes that a broader recommendation for universal screening of all patients (men and women) in all settings may eventually be demonstrated to be appropriate. However, practice in these broader areas is still in its infancy, and there is little definitive research on which to draw

conclusions. To appropriately address the question of whether a recommendation for universal screening is warranted, the FUND recommends:

- A research focus on the collection and analysis of data on the efficacy of a universal screening policy for domestic violence victimization.

- Interested providers consider adopting a universal screening policy for domestic violence victimization with their patients, particularly if this practice can be tied to research and data collection to demonstrate efficacy.

Expert opinion and initial studies suggest that the prevalence of domestic violence among gay men may be comparable to that of domestic violence among women. Before recommending screening practices for this population, it is critical to ensure that the guidelines address the unique issues related to the delivery of quality health care for gay men. The FUND is working with experts in the field of health care in gay communities to develop appropriate guidelines.

In the pediatric setting, screening for domestic violence is clearly appropriate, but raises important and complex questions including when and how mothers of pediatric patients should be screened. Screening mothers in pediatric settings will reach women who may be victims of domestic violence and who come in contact with health care providers only through their children's care. Screening mothers in this setting will also indicate to providers whether the pediatric patient may be at risk for direct abuse or as a child witness to domestic violence. The FUND is working with experts in pediatrics, family practice and adolescent medicine to develop a set of recommendations for screening in these settings.

On the following pages, practitioners will find a general screening policy and setting specific recommendations. Each addresses who should be screened, which providers should carry out the screening, the recommended frequency of screening and the environment in which screening should take place.

The formal recommendations that follow provide guidance for practitioners and organizations on who should be screened as well as when, where, how and by whom screening should be carried out.

DRAFT4

General Screening Policy

This is a general policy on screening women for domestic violence within the health care system. A more detailed set of recommendations for screening for domestic violence in specific health care settings follow.

Who should be screened routinely for domestic violence?

- All females aged fourteen years and older

Who should screen for domestic violence?

At a minimum, screening should be conducted by a health care provider who:

- Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- Has been trained how to ask about abuse and to intervene with identified victims of abuse
- Is authorized to record in the main body of a patient's medical record

Ideally, screening should be conducted by a health care provider who either:

- Has established a relationship or some trust with the patient, OR
- Has a clearly defined role in an urgent care or emergency setting

How should screening occur?

At a minimum, screening for domestic violence should:

- Be part of a face-to-face health care encounter
- Be direct and nonjudgmental
- Take place in private; no friends or relatives of the patients should be present during the screening and preferably no children over two should be present
- Be confidential, patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality, including the limits of confidentiality of medical records
- Use professional interpreters when needed, rather than a patient's friend or family member

Ideally, screening for domestic violence should also:

- Be included as part of a written health questionnaire
- Be conducted in the patient's primary language with use of professional interpreters when appropriate

When should screening occur?

- As part of routine health history (or "review of systems")
- As part of the standard health assessment
- During an initial visit for a new chief complaint
- During every new patient encounter
- At every new intimate relationship
- During every periodic comprehensive health visit

Where should screening occur?

Trained health care providers should provide domestic violence screening as part of routine patient care in the following settings:

- Primary care
- Urgent care
- Ob/Gyn and Family Planning
- Mental health
- Inpatient

How should a screening policy be implemented?

All health care providers who screen for domestic violence should receive appropriate training on how to ask about abuse, how to respond when it is identified, and on issues of cultural competency and principles of increasing safety and respecting autonomy of battered patients.

Screening can be facilitated by the use of forms or other assessment tools such as the three-question Abuse Assessment Screen.[22] Chart prompts are another effective tool to remind providers to screen and have been shown to increase screening rates.[24]

DRAFT 4

Screening for Domestic Violence in Primary Care

Increasingly, within the managed care system women are being seen in a primary care or obstetrician/gynecologist setting, which serve as their entry point into the health care system. The primary care visit offers a woman the chance to have a private conversation with her health care provider, where screening can be done in a less hectic setting than in the emergency department. The primary care setting also offers an opportunity to screen both women who present for routine health maintenance and those who are presenting for specific health complaints.

Who should be screened for domestic violence?

- All females aged fourteen years and older

Who should screen for domestic violence?

At a minimum, screening should be conducted by a health care provider who:

- Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- Has been trained how to ask about abuse and to intervene with identified victims of abuse
- Has the opportunity to speak to the patient in a private setting
- Is authorized to record in the main body of a patient's medical record

Ideally, screening should be conducted by a health care provider who:

- Establishes a relationship or some trust with the patient

How should screening occur?

At a minimum, screening for domestic violence should:

- Be part of a face-to-face health care encounter
- Be direct and nonjudgmental
- Take place in private; no friends or relatives of the patients should be present during the screening and preferably no children over two should be present
- Be confidential, patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality, including the limits of confidentiality of medical records
- Use professional interpreters when needed, rather than a patient's friend or family member

DRAFT 4

Ideally, screening for domestic violence should also:

- Be included as part of a written health questionnaire
- Be conducted in the patient's primary language

When should screening occur?

- As part of routine health history (or "review of systems")
- As part of health assessment
- During an initial visit for a new chief complaint
- During every new patient encounter
- At every new intimate relationship
- During every periodic comprehensive health visit

What should patients be screened for?

- At the first visit, female patients should be screened for any domestic violence that occurred anytime in their lives
- Annually, women should be screened for abuse over the past year

DRAFT 4

Screening for Domestic Violence in the Emergency Department/ Urgent Care Settings

The extremely high prevalence of domestic violence and severity of injuries due to domestic violence justify universal screening in emergency departments. According to a report issued in November 1998 by the National Institute of Justice and the Centers for Disease Control and Prevention, women make 547,000 visits to the emergency department for treatment of injuries resulting from physical assault.[4] Most of these assaults were committed by the women's intimate partners. The emergency department is a setting where women who are at high risk for immediate physical danger are likely to present. Of 4,448 women presenting in 10 emergency departments in two cities, 37% reported that they had been abused by a partner at some time, 10% reported they were currently in a battering relationship, and 4% said their current visit to the emergency department was for abuse by an intimate partner.[9] Of 3,455 women who completed surveys in 11 community emergency departments, 2.2% were there for acute trauma resulting from domestic violence, 14.4% had experienced domestic violence in the past year and 36.9% had been victims of domestic violence at some point in their lives.[6]

Who should be screened for domestic violence?

- All females aged fourteen years and older

Who should screen for domestic violence?

At a minimum, screening should be conducted by a health care provider who:

- Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- Has been trained how to ask about abuse and to intervene with identified victims of abuse
- Has the opportunity to speak to the patient in a private setting
- Is authorized to record in the main body of a patient's medical record

Ideally, screening should be conducted by a health care provider who either:

- Establishes a relationship or some trust with the patient, OR
- Has a clearly defined role

DRAFT 4

How should screening occur?

At a minimum, screening for domestic violence should:

- Be part of a face-to-face health care encounter
- Be direct and nonjudgmental
- Take place in private; no friends or relatives of the patients should be present during the screening and preferably no children over two should be present
- Be confidential, patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality, including the limits of confidentiality of medical records
- Use professional interpreters when needed, rather than a patient's friend or family member

Ideally, screening for domestic violence should also:

- Be included as part of a written health questionnaire
- Be conducted in the patient's primary language

When should screening occur?

- At every emergency department visit

What should patients be screened for?

- Abuse over the past year

DRAFT 4

Screening for Domestic Violence in Obstetrics/Gynecology and Family Planning Settings

The American College of Obstetricians and Gynecologists recommends that every woman and girl presenting to an Ob/Gyn provider be screened for domestic violence. Because the prevalence of domestic violence in the Ob/Gyn setting is high and because many women use their Ob/Gyn provider as their primary provider of health care and do not access other providers in the health care system, screening in this setting is critical.[22,25,26] Like primary care, Ob/Gyn and family planning settings offer a woman the chance to have a private conversation with her health care provider, where screening can be done in a less hectic setting than in the emergency department, for example.

It is estimated that between 7% and 17% of pregnant women in this country are battered by their partners.[27,28,29] Of 225 pregnant and 142 nonpregnant women presenting to an urban New England urgent care obstetrics and gynecology unit, 184 (46%) reported a history of physical or sexual abuse, and 38 (10%) reported recent abuse.[10] Recent clinical studies have proven the effectiveness of a two minute screening for early detection of abuse to pregnant women. Additional longitudinal studies have tested a 10-minute intervention that was proven highly effective in increasing the safety of pregnant abused women.[30]

Who should be screened for domestic violence?

- All females aged fourteen years and older

Who should screen for domestic violence?

At a minimum, screening should be conducted by a health care provider who:

- Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- Has been trained how to ask about abuse and to intervene with identified victims of abuse
- Has the opportunity to speak to the patient in a private setting
- Is authorized to record in the main body of a patient's medical record

Ideally, screening should be conducted by a health care provider who:

- Establishes a relationship or some trust with the patient

DRAFT 4

How should screening occur?

At a minimum, screening for domestic violence should:

- Be part of a face-to-face health care encounter
- Be direct and nonjudgmental
- Take place in private; no friends or relatives of the patients should be present during the screening and preferably no children over two should be present
- Be confidential, patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality, including the limits of confidentiality of medical records
- Use professional interpreters when needed, rather than a patient's friend or family

Ideally, screening for domestic violence should also:

- Be included as part of a written health questionnaire
- Be conducted in the patient's primary language

When should screening occur?

- At every prenatal and postpartum visit
- At every new intimate relationship
- At all routine gynecological visits
- At family planning visits
- At STD clinics/visits
- At abortion clinics/visits

What should patients be screened for?

- Screening should be for current and past domestic violence that occurred anytime in a woman's life

DRAFT 4

Screening for Domestic Violence in a Mental Health Setting

In mental health services, including substance abuse settings, universal domestic violence screening of women and girls should be routine. The American Psychological Association recommends that "routine screening for a history of victimization be included in standard medical and psychological examinations."[3] Abuse has significant, lasting mental health effects that, if undetected, would hinder care. Domestic violence is a significant risk factor for depression, PTSD, anxiety and substance abuse in women.[3] In one study of women presenting to an emergency room, 29% of the women who had been in abusive relationships had attempted suicide, whereas, only 4% of the women who had never had an abusive relationship had attempted suicide.[31]

Who should be screened for domestic violence?

- All female patients aged 14 years or older should be screened for domestic violence

Who should screen for domestic violence?

At a minimum, screening should be conducted by a health care provider who:

- Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- Has been trained how to ask about abuse and to intervene with identified victims of abuse
- Has the opportunity to speak to the patient in a private setting
- Is authorized to record in the main body of a patient's medical record

Ideally, screening should be conducted by a health care provider who:

- Establishes a relationship or some trust with the patient

How should screening occur?

At a minimum, screening for domestic violence should:

- Be part of a face-to-face health care encounter
- Be direct and nonjudgmental
- Take place in private; no friends or relatives of the patient should be present during the screening and preferably no children over two should be present
- Be confidential, patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality, including the limits of confidentiality of medical records

DRAFT 4

- Use professional interpreters when needed, rather than a patient's friend or family

Ideally, screening for domestic violence should also:

- Be included as part of a written health questionnaire
- Be conducted in the patient's primary language

When should screening occur?

- As part of every initial assessment
- At each new intimate relationship
- Annually, if receiving ongoing or periodic treatment

What should patients be screened for?

- At the first visit, patients should be screened for any domestic violence that occurred anytime in the woman's life
- Annually, women should be screened for abuse over the past year

Screening for Domestic Violence in an Inpatient Setting

The inpatient setting provides an opportunity to screen for domestic violence in a setting in which a woman is safely outside the home for a duration of time. One prevalence study of an inpatient female population found a 26% lifetime prevalence of domestic violence.[32]

Who should be screened for domestic violence?

- All females aged fourteen years and older

Who should screen for domestic violence?

At a minimum, screening should be conducted by a health care provider who:

- Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- Has been trained how to ask about abuse and to intervene with identified victims of abuse
- Has the opportunity to speak to the patient in a private setting
- Is authorized to record in the main body of a patient's medical record

Ideally, screening should be conducted by a health care provider who:

- Has established a relationship or some trust with the patient

How should screening occur?

At a minimum, screening for domestic violence should:

- Be part of a face-to-face health care encounter
- Be direct and nonjudgmental
- Take place in private; no friends or relatives of the patient should be present during the screening and preferably no children over two should be present
- Be confidential, patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality, including the limits of confidentiality of medical records
- Use professional interpreters when needed, rather than a patient's friend or family member

DRAFT 4

Ideally, screening for domestic violence should also:

- Be included as part of a written health questionnaire
- Be conducted in the patient's primary language

When should screening occur?

- As part of admission to the hospital
- As part of discharge from the hospital

What should patients be screened for?

- Abuse over the past year

DRAFT 4

Sample Screening Questions

Framing Questions:

Because violence is so common in many people's lives, I've begun to ask all my patients about it routinely.

I'm concerned that your symptoms may have been caused by someone hurting you.

I don't know if this is a problem for you. But many of the women I see as patients are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely.

Lots of the lesbians and gay men we see here are hurt by their partners. Does your partner every try to hurt you?

Direct Verbal Questions:

Are you in a relationship with a person who physically hurts or threatens you?

Did someone cause these injuries? Was it your partner/husband?

Has your partner or ex-partner ever hit you or physically hurt you? Has he ever threatened to hurt you or someone close to you?

Do you feel controlled or isolated by your partner?

Do you ever feel afraid of your partner? Do you fell you are in danger? Is it safe for you to go home?

Has your partner ever forced you to have sex when you didn't want to? Has your partner ever refused to practice safe sex?

For History Intake Forms/NewPatient Questionnaires:

Option1

Have you ever been hurt or threatened by your boyfriend/husband/partner?

or

Have you ever been hit, kicked slapped, pushed or shoved by your boyfriend/husband/partner?

or

Have you even been hit kicked, slapped, pushed or shoved by your boyfriend/husband/partner during this pregnancy?

and

Have you ever been raped or forced to engage in sexual activity against your will?

Option 2

Are you currently or have you ever been in a relationship where you are phusically hurt, threatened, or made to feel afraid? YES NO

DRAFT 4

Option 3

Have you ever been forced or pressured to have sex when you did not want to?

Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?

For use as a rubber stamp or printed on Intake Form:

Screening: ☐Yes ☐ No ☐DV+ ☐ DV- ☐ DV?

Screening: ☐DV+ ☐ DV- ☐ DV?

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JAMA®

The Journal of the American Medical Association

August 4, 1999

Screening and Intervention for Intimate Partner Abuse

Practices and Attitudes of Primary Care Physicians

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Context Although practice guidelines encouraging the screening of patients for intimate partner abuse have been available for several years, it is unclear how well and in which circumstances physicians adhere to them.

Objective To describe the practices and perceptions of primary care physicians regarding intimate partner abuse screening and interventions.

Design, Setting, and Participants Cross-sectional survey of a stratified probability sample of 900 physicians practicing family medicine, general internal medicine, and obstetrics/gynecology in California. After meeting exclusion criteria, 582 were eligible for participation in the study.

Main Outcome Measure Reported abuse screening practices in a variety of clinic settings, based on a 24-item questionnaire, with responses compared by physician sex, practice setting, and intimate partner abuse training.

Results Surveys were completed by 400 (69%) of the 582 eligible physicians, including 149 family physicians, 115 internists, and 136 obstetrician/gynecologists. Data were weighted to estimate the practices of primary care physicians in California. An estimated majority (79%; 95% confidence interval [CI], 75%-83%) of these primary care physicians routinely screen injured patients for intimate partner abuse. However, estimated routine screening was less common for new patient visits (10%; 95% CI, 7%-13%), periodic checkups (9%; 95% CI, 6%-12%), and prenatal care (11%; 95% CI, 7%-15%). Neither physician sex nor recent intimate partner abuse training had significant effects on reported new patient screening practices. Obstetrician/gynecologists (17%) and physicians practicing in public clinic settings (37%) were more likely to screen new patients. Internists (6%) and physicians practicing in health maintenance organizations (1%) were least likely to screen new patients. Commonly reported routine interventions included relaying concern for safety (91%), referral to shelters (79%) and counseling (88%), and documentation in the medical chart (89%). Commonly cited barriers to identification and referral included the patients' fear of retaliation (82%) and police involvement (55%), lack of patient disclosure (78%) and follow-up (52%), and cultural differences (56%).

Conclusions These findings suggest that primary care physicians are missing opportunities to screen patients for intimate partner abuse in a variety of clinical situations. Further studies are needed to identify effective intervention strategies and improve adherence to intimate partner abuse practice guidelines.

JAMA. 1999;282:468-474 www.jama.com

PHYSICAL VIOLENCE IS ESTIMATED to occur in 4 to 6 million intimate relationships each year in the United States.[1,2] The term *intimate partner abuse* refers to the physical, sexual, and/or psychological abuse to an individual perpetrated by a current or former intimate partner. While this term is gender-neutral, women are more likely to experience physical injuries and incur psychological consequences of intimate partner abuse.[3]

In addition to injuries, abused women often experience somatic and stress-related illnesses, chronic pain syndromes, depression, posttraumatic stress disorder, and substance abuse disorders.[4,5] Furthermore, compared with women with no history of abuse, abused women have higher levels of health care use.[6] In fact, 31% to 54% of female patients seeking emergency services,[7,8] 21% to 66% of those seeking general medical care,[5,9-11] and up to 20% of those seeking prenatal care report experiencing intimate partner abuse.[12,13]

Despite the high prevalence of intimate partner abuse, less than 15% of female patients report being asked about abuse by health care professionals or disclosing abuse to them.[9,14-16] Yet, in 2 studies, the majority of female patients favored physician inquiry and reported that they would reveal abuse histories if asked directly.[14,16] Prior studies examining physician practices suggest that only a small fraction of physicians and other health

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care professionals commonly inquire about intimate partner abuse.[14,17,18] Unfortunately, these findings are limited by small sample sizes, low response rates, and/or the use of convenience samples. Patient attitudes, lack of institutional support, and other environmental factors may hinder efforts to address intimate partner abuse in clinical settings.[19,20] In addition, physicians' feelings of discomfort and powerlessness may also contribute to this low level of inquiry.[21-23]

Early identification of abuse has been a priority in efforts to improve the health care response to intimate partner abuse.[24] Because of the prevalence and associated health care costs of intimate partner abuse, national public health organizations have endorsed the use of interventions such as protocols in clinical settings for the identification of patients experiencing abuse.[25-27] Several national medical organizations have developed practice guidelines for intimate partner abuse that encourage routine screening and interventions.[28-30] Although many of these guidelines have been available for several years, it is unclear how often and in which clinical circumstances health care professionals actually adhere to them.

Lawmakers have attempted to respond to intimate partner abuse by passing legislation, such as mandatory reporting laws, to help improve the health care response. Our previous work addressed physicians' perspectives on mandatory reporting of intimate partner violence to police in California.[31] We previously reported on conflicting attitudes among California primary care and emergency physicians toward mandatory reporting. An estimated 64% of primary care physicians and 25% of emergency medicine physicians might not report abuse if patients object. While almost all states have laws that require reporting certain injuries, 5 states have reporting laws that specifically address reporting intimate partner violence. California's law, which passed in 1994, requires that health care professionals report cases in which they provide medical care for female or male patients whom they suspect are suffering from an intimate partner violence-related injury to the police with or without the patient's consent.

The objectives of the current study included (1) estimating intimate partner abuse screening and intervention practices of primary care physicians in California, (2) exploring how physician specialty, sex, and training might influence screening and intervention practices, and (3) examining primary care physicians' perceived barriers to identification and intervention.

METHODS

Sample

We selected a stratified probability sample of 900 physicians from the California Medical Association database, which includes licensed California physicians (members and nonmembers) and incorporates information from the Medical Board of California and the American Medical Association. Equal proportions were drawn from each of 3 specialties: family practice, internal medicine, and obstetrics/gynecology. In this report, these specialties are collectively referred to as primary care physicians because they provide primary medical care for the majority of female patients. To increase our ability to assess the influence of physician sex, female physicians were oversampled. Because women represent nearly one quarter of physicians in these 3 specialties, they were sampled at 1.5 times their proportion in each specialty. Physicians were excluded if they were retired, in training, practicing outside the state, or working primarily in nonclinical areas. Physicians without a valid California telephone number or address, as verified by local telephone companies and the Medical Board of California, were also excluded.

Recruitment involved 3 mailings of the questionnaire starting in July 1995. Physicians who had not responded after 3 mailings were contacted by telephone and sent an additional survey if requested. A letter that accompanied the questionnaire provided information about the study purpose, procedure, confidentiality, and contact data for further information. Informed consent was implied when a respondent returned the completed questionnaire. This study was approved by the University of California, San Francisco, Committee on Human Research.

Survey Instrument

A 24-item questionnaire was developed based on published research[21,23,32] and discussions with domestic violence advocates. Pilot testing was performed with 30 physicians, both male and female, from all 3 primary care specialties. Based on the feedback from the pilot study, all references to intimate partner abuse were made gender-neutral to enhance acceptability to respondents. Screening practices were assessed in 4 different clinical situations: evidence of injury, new patient visit, periodic checkup, and first prenatal visit. The frequency of screening was assessed by asking, "How frequently do you ask direct, specific questions about domestic violence to patients?" For each clinical situation, respondents were given choices on a 4-point Likert scale of never, sometimes, often, or always. Respondents' use of 7 selected intervention practices was assessed using the same 4-point scale. Perceived barriers to identification and intervention were assessed by providing a list of potential barriers and asking respondents to identify each as a major barrier, minor barrier, or not a barrier.

The survey also included questions about demographics (age, sex, ethnicity), US vs non-US medical training, practice setting, knowledge of relevant legislation, and personal experience with intimate partner abuse. In addition, respondents were asked whether they had "taken a class or continuing medical education course on domestic violence in the last 3 years." To assess childhood exposure to intimate partner abuse, respondents were asked, "When you were growing up, did one of your parents ever threaten, hit, slap, kick or otherwise physically hurt the other?" To assess personal experience with intimate partner abuse, respondents were asked, "Have you ever feared for your safety or been

hit, slapped, kicked, or otherwise physically hurt by an intimate or previously intimate partner?"

Statistical Analysis

Routine screening and intervention practice was defined as a response of "often" or "always" to the different clinical situations and interventions. These variables were dichotomized (never/sometimes vs often/always) for statistical comparison. Similarly, responses to barriers were dichotomized (not/minor vs major) for statistical comparison. The data were analyzed using SPSS statistical software.[33] Analysis of variance was used for statistical comparison of means. For cross-tabulations of proportions with greater than 2 rows or columns, statistical significance was determined using Pearson χ^2. For 2×2 cross-tabulations, Yates corrected χ^2 was used. Statistical significance was defined as $P<.05$.

To generate population estimates, weighted overall proportions were calculated using the inverse of the sampling fraction for each of the 6 sex/specialty strata. Based on data from the 1995 California Medical Association database, practicing California physicians included 5968 family physicians, 9020 internal medicine physicians, and 3831 obstetrician/gynecologists. With the exception of the sample descriptions, all proportions and bivariate statistical analyses make use of weighted estimates. The 95% confidence intervals (CIs) for weighted proportions were calculated by multiplying the SE of proportion by 1.96.

We used logistic regression analysis to estimate adjusted odds ratios (ORs) and 95% CIs for the factors associated with reported screening practices. Four variables were included as predictors in the multivariate models. Three of these variables (specialty, practice setting, and intimate partner abuse training) were included because each was significantly associated with screening practices in at least 1 of the 4 clinical settings using univariate logistic regression models. Although sex was not predictive of screening practices in any clinical setting, it was retained in the models because it was of particular interest. Other potential predictors were not significant in the bivariate analyses. The final models were reviewed for goodness-of-fit and validated using the Hosmer-Lemeshow statistic. Because multivariate models included both specialty and sex, data were not weighted.

RESULTS

Respondents

Of the 900 physicians sampled, 582 were ultimately determined to be eligible for the study and 400 (69%) completed the survey. Of the 400 respondents, 149 (37%) practiced family medicine, 115 (29%) practiced internal medicine, and 136 (34%) practiced obstetrics/gynecology. Response rates for the different specialties did not vary significantly; however, female physicians had a higher response rate compared with male physicians (78% vs 63%; $P = .001$).

The characteristics of the study group are presented in TABLE 1. The mean age was 46 years. Compared with male, female physicians were younger (mean age, 42.0 vs 48.9 years; $P<.001$). The sample was predominantly white and the majority of physicians practiced in private clinic settings.

An estimated 22% (95% CI, 18%-26%) of California primary care physicians had taken a class or continuing medical education course on intimate partner abuse in the past 3 years. This proportion did not differ significantly by physician specialty, sex, age, or practice setting. Overall, the majority of physicians (80%; 95% CI, 76%-84%) had identified intimate partner abuse at some time in their career. However, reported identification varied significantly by specialty: 90% of family physicians, 80% of obstetrician/gynecologists, and 74% of internal medicine physicians ($P = .001$). Identification of a patient who had experienced intimate partner abuse did not differ significantly by physician sex or having taken recent training course on intimate partner abuse.

An estimated 15% (95% CI, 12%-19%) of California primary care physicians had witnessed intimate partner abuse between their parents at some time during their childhood. This exposure did not significantly differ by physician specialty or sex. Overall, 12% (95% CI, 9%-15%) of physicians reported experiencing physical abuse from an intimate partner or feared for their safety as an adult. This experience did not differ by physician specialty. However, compared with male physicians, twice as many female physicians reported having experienced intimate partner abuse (20% vs 10%, $P = .01$).

Table 1. Characteristics of the Physician Respondents According to Specialty*

Characteristic	Family Medicine (n = 149)	Internal Medicine (n = 115)	Obstetrics/ Gynecology (n = 136)	Total (N = 400)
Age, mean (SD), y†	45.3 (10.1)	44.4 (10.8)	48.2 (10.1)	46.0 (10.4)
Women	40	41	44	42
Ethnicity				
White	72	70	73	72
Asian/Pacific Islander	16	23	17	18
Latino	6	3	2	4
Black	3	4	6	4
Practice setting‡				
Private office	60	52	70	61
Health maintenance organization	16	23	17	18
Public clinic	15	6	5	9
Other§	10	19	8	12
Non-US training	24	12	22	20

*Values are expressed as percentages unless otherwise indicated
†Analysis of variance comparison of means, $P = .008$.
‡Pearson χ^2, $P = .02$.
§Other practice settings include academic, in-patient, military, and unspecified clinics.

Screening Practices

Although screening for intimate partner abuse was common among injured patients, screening was less common for routine medical encounters (TABLE 2). In circumstances that involved physical injuries, an estimated 79% of California primary care physicians often or always ask patients direct questions about intimate partner abuse. An estimated 10% of physicians routinely screen for intimate partner abuse during new patient visits and 9% screen during periodic checkups. Of physicians who provide prenatal care, an estimated 11% routinely screen for intimate partner abuse during the first prenatal visit. Obstetrician/gynecologists reported the highest level of new patient screening (17%), followed by family physicians (10%), and internal medicine physicians (6%). Routine screening in the different clinical situations was not significantly associated with physician age, ethnicity, international medical training, personal experience with intimate partner abuse, or knowledge of the California domestic violence injury mandatory reporting legislation.

We used logistic regression to further clarify the relationship between physician characteristics and reported screening practices in new patient encounters (TABLE 3). After controlling for the effects of physician sex, practice setting, and training, the higher level of screening among obstetrician/gynecologists remained significant compared with internal medicine physicians. Although more female physicians reported routinely screening new patients, these sex differences were not statistically significant. Physicians working in public clinics reported the highest level of new patient screening (37%); routine screening was less frequent for physicians in private offices (9%), health maintenance organizations (1%), and other practice settings (12%) ($P<.001$). These differences remained significant after controlling for physician specialty, sex, and training. More physicians with recent intimate partner abuse training reported routine screening, but the effect was not statistically significant.

Similar analytic approaches were used to determine the associations between physician characteristics and reported screening practices in the other clinical situations. In contrast to new patient screening, routine screening during the first prenatal visit did not differ significantly by specialty or practice setting. However, compared with physicians without recent training in intimate partner abuse, a greater proportion of those with training reported routine screening of prenatal patients (24% vs 8%; $P=.007$). Although reported screening during periodic checkups was not significantly associated with physician specialty, sex, or training, physicians working in public clinics reported the highest level of screening (26%) compared with physicians in health maintenance organizations (5%), private clinics (9%), and other practice settings (10%) ($P=.02$). This difference remained significant after controlling for the effects of physician specialty, sex, and training. Screening practices for injuries did not differ significantly by specialty, sex, practice setting, or recent training in intimate partner abuse.

Interventions

The most commonly reported interventions included discussing physician's concern for safety with the patient (91%; 95% CI, 88%-94%), recording battering in the patient's chart (89%; 95% CI, 86%-93%), making referrals to counseling (88%; 95% CI, 85%-92%), and giving information about shelters and services (79%; 95% CI, 74%-83%). Asking about guns in the home (46%; 95% CI, 40%-51%) and reporting to police (44%;

Table 2. Percentage of Respondents Who Routinely Screen for Intimate Partner Abuse in Different Clinical Situations*

Clinical Situation	Family Medicine (n = 149)	Internal Medicine (n = 115)	Obstetrics/ Gynecology (n = 136)	Weighted Overall (N = 400)
Evidence of injury	80 (74-86)	76 (68-84)	84 (78-90)	79 (75-83)
New patient†	10 (5-15)	6 (2-10)	17 (11-23)	10 (7-13)
Routine checkup	14 (8-20)	7 (2-12)	10 (5-15)	9 (6-12)
First prenatal visit	12 (6-18)‡	NA§	14 (8-20)	11 (7-15)

*Values are expressed as percentage (95% confidence interval). Values for each specialty are weighted for sex and are weighted overall for specialty and sex.
†$P=.01$ for internal medicine and obstetrics/gynecology.
‡Only 64% (96/149) of family physicians who provide prenatal care responded to this item.
§NA indicates data are not available because only 22% (25/115) of internists who provide prenatal care responded to this item.

Table 3. Physician Characteristics Associated With Reported Routine Intimate Partner Abuse Screening of New Patients*

Characteristic	Weighted % (95% CI)	OR (95% CI)	Adjusted OR (95% CI)
Medical specialty			
Internal medicine	6 (1-10)	1.0	1.0
Family medicine	10 (5-15)	1.75 (0.75-4.12)	1.60 (0.58-4.42)
Obstetrics/gynecology	17 (11-24)	3.24 (1.38-7.63)	3.61 (1.36-9.55)
Physician sex			
Male	9 (6-12)	1.0	1.0
Female	12 (5-18)	1.42 (0.66-3.05)	1.15 (0.59-2.25)
Practice setting			
Health maintenance organization	1 (0-4)	1.0	1.0
Private office	9 (5-13)	5.69 (0.93-34.94)	4.42 (1.00-19.60)
Public clinic	37 (19-55)	31.73 (4.61-218.23)	20.30 (4.05-101.8)
Other setting†	12 (2-22)	7.43 (1.00-55.24)	5.29 (0.95-29.34)
Intimate partner abuse training			
No recent training	8 (5.3-12)	1.0	1.0
Recent training	14 (6.8-22)	1.73 (0.82-3.64)	1.58 (0.75-3.33)

*OR indicates odds ratio; CI, confidence interval.
†Other practice settings include academic, in-patient, military, and unspecified clinics.

Table 4. Major Barriers to Physician Identification of Intimate Partner Abuse and Referral of Patients

Major Barriers	Weighted Overall % (95% CI)*
Patient-related barriers	
Fear of retaliation	82 (78-86)
Lack of disclosure	78 (74-82)
Fear of police involvement	55 (50-60)
Lack of follow-up	52 (47-57)
Mutual barriers	
Cultural differences	56 (51-61)
Lack of privacy	48 (43-52)
Language differences	39 (34-43)
Provider-related barriers	
Lack of training	39 (34-44)
Lack of time	37 (32-42)
Lack of resources/referrals	30 (25-35)
Sense of inefficacy	18 (15-22)

*CI indicates confidence interval.

95% CI 38%-49%) were less common. Reported interventions were not consistently associated with physician specialty or sex.

Compared with physicians with no recent training in intimate partner abuse, physicians who had received training in the last 3 years were more likely to report routinely using information about shelters (89% vs 76%; $P = .02$), reporting to police (65% vs 37%; $P < .001$), and asking about guns in the home (58% vs 42%; $P = .02$).

Perceived Barriers

Patient-related factors were most frequently identified as major barriers to identifying and referring patients experiencing intimate partner abuse (TABLE 4). The most commonly cited major barriers included the patient's fear of retaliation by the partner (82%) and the lack of disclosure of battering during history taking (78%). In addition, a majority of physicians agreed that the patient's fear of police involvement, lack of follow-up on referrals, and cultural differences between patients and physicians are major barriers. Less than half of physicians identified lack of training, lack of time, lack of information about local community agencies, or the belief that physicians cannot make a difference in intimate partner abuse as major barriers.

Compared with physicians without recent training in intimate partner abuse, physicians who had received training in the last 3 years were less likely to report the lack of information about local community agencies as a major barrier (17% vs 33%; $P = .005$). Perceived barriers were not consistently associated with physician specialty, sex, or reported screening practices in the different clinical situations.

COMMENT

This study documents significant differences for routine screening for intimate partner abuse, depending on the clinical situation. An estimated majority of primary care physicians (79%) routinely screen patients with injuries. However, for patients seeking care in other clinical situations, screening for intimate partner abuse was less common (9%-11%). The higher level of reported screening of patients with injuries is likely to reflect physician's awareness that intimate partner abuse is an important cause of injury in women. In contrast, the lower level of routine screening of patients in other clinical situations suggests that primary care physicians are missing important opportunities to detect intimate partner abuse and intervene on behalf of those experiencing abuse.

Our findings, which are consistent with previous physician surveys,[14,17] suggest that most physicians do not adhere to current practice guidelines for intimate partner abuse screening. Interventions that focus on administrative changes, such as protocols, may improve adherence. Recently, researchers have begun to examine the sensitivity and specificity of a variety of screening protocols[34-36] and the effect of incorporating screening questions into self-administered history forms.[37] Preliminary results are encouraging. Most of these protocols are concise, easy to use, and effective at identifying intimate partner abuse. However, there are unanswered questions regarding the efficacy of universal screening. While identification of the problem is essential, the utility of screening ultimately depends on the yet unproven benefits of intervention.

In our study, recent education in intimate partner abuse was associated with higher levels of screening of prenatal patients, the routine use of information about shelters and protective services, reporting to police, and inquiring about guns in the home. In contrast, recent training had little effect on reported screening practices in other clinical situations. Previous cross-sectional surveys have found that professional training positively influenced reported intimate partner abuse screening practices[17,32]; however, studies that directly examined the effects of training have produced conflicting results depending on the type of training and length of follow-up.[38-40] Professional training has the potential to increase knowledge, comfort, and skills for effective inquiry and intervention. However, without structural changes, regular in-service education, and institutional policies, physician training is unlikely to be sufficient to change clinical practice.[38,40-42] Controlled studies are needed to determine the effectiveness of interventions for improving physician behavior regarding intimate partner abuse. In light of the evidence that US medical schools require an average of only 2 hours of training in adult domestic violence[43] and less than half of family practice residencies have required education about intimate partner abuse,[44] effective training programs should be identified and expanded. In addition, information about local shelters and community resources should be widely disseminated to health care professionals.

Obstetrician/gynecologists reported the highest level of new patient screening, followed by family physicians and internal medicine physicians. These differences should be viewed with caution given our finding that specialty had only a modest effect on reported screening practices in other clinical situations, including prenatal visits. These variations may be related to differences in patient demographics, types of medical problems encountered, clinical procedures, or advocacy and awareness within the field. In particular,

obstetrician/gynecologists are more likely to provide care for young female patients, who are at the highest risk for intimate partner abuse. A better understanding of these differences will require further investigation.

Physicians working in public clinics reported the highest level of screening in clinic situations involving new patients and routine checkups. Routine screening was markedly less frequent for physicians practicing in health maintenance organizations. These differences may be related to differences in the patient population, clinic procedures, or institutional policies and support. Different clinic settings may also have other health care professionals or staff who provide routine screening procedures. Further research is necessary to explain these compelling results.

Contrary to our expectations, we found no significant associations between physician sex and reported screening practices. Prior research that examined the effects of physician sex on screening for intimate partner abuse has produced conflicting results. Some studies have found that a significantly higher proportion of female physicians reported such screening[17] or had better skills in detecting intimate partner abuse.[39] However, other related research found no effect of physician sex.[40] Although physician sex has been found to significantly affect both patient-physician communication[45] and the delivery of women's preventive care,[46] further work is needed to determine the effects of physician sex on the delivery of care for intimate partner abuse.

Routine interventions reported by a majority of physicians in each specialty included relaying concern for safety to the patient, referral to shelters and counseling, and documentation in the medical chart. These interventions are among the most accepted and recommended.[28-30] Reporting to the police without patient consent is more controversial because of potential risks to patient safety and violations of medical ethics.[47,48] The California law contains recommendations for physicians to refer patients to local intimate partner abuse services and provides protection for these persons from civil or criminal liability.

We estimated that less than half (46%) of California primary care physicians routinely inquire about guns in the home. Given the increased risk of injury and death with firearms, determining the accessibility of guns is an essential part of a safety assessment. Research has demonstrated that the presence of a firearm in the home is a key contributor to the escalation of intimate partner abuse to homicide.[49,50] In 1 study, firearm-associated intimate assaults were 12 times more likely to result in death compared with assaults not involving firearms.[51] Knowledge of the availability of a firearm determines the type and urgency of interventions when physicians discuss gun safety issues.

A greater proportion of respondents identified patient-related barriers to identification and intervention (fear of retaliation, fear of police involvement, lack of disclosure, and lack of follow-up) compared with physician-related barriers (lack of time, lack of training, lack or resources and referrals, and sense of inefficacy). Similar barriers have been identified in previous studies of physicians[21-23] and abused patients.[15,52,53] Knowledge of the specific barriers encountered by different types of physicians helps to shape future training and tools for identification and intervention. Based on the results of our study, future training should provide strategies to deal with patients' fears and reluctance to disclose abuse and address cultural differences. Furthermore, training should be customized to address the unique barriers faced within the different specialties or practice settings.

This study had several limitations. California's mandatory reporting law (adopted January 1994) may have prompted specific policy development within medical organizations that increased awareness of intimate partner abuse among physicians. As a result, physician inquiry in California, particularly in cases of injury, may be more frequent than in states with different reporting requirements.[31] In addition, the potential bias of overreporting socially desirable behavior may have overestimated actual screening practices. Because the definition of intimate partner abuse and other survey language were gender-neutral, we are unable to determine how patient sex affects reported screening practices. Finally, this study did not survey other health care professionals (eg, nurses, physician assistants, social workers, and psychologists) who often play key roles in patient assessment and management, particularly in relation to psychosocial issues.

This study provided insight into the practices and attitudes of a representative sample of California primary care physicians regarding intimate partner abuse. As the discussion regarding the appropriate role of health care professionals in addressing intimate partner abuse evolves, these data will inform our understanding of the patterns, justifications, and barriers to physician inquiry. The rationale for universal screening is based on the high prevalence, the high association with an array of health problems, the low level of suspicion and inquiry on the part of physicians, abused women's general unwillingness to volunteer information, and the high level of patient acceptance of direct physician inquiry. Furthermore, screening incurs minimal costs and risks to patients, while offering significant potential benefits.[54] Because of the newness of intimate partner abuse as a health issue, studies examining the impact of routine health care screening and interventions on health or the prevention of future abuse is unknown. Although recommendations for screening cannot yet be based on evidence of proven efficacy, the magnitude and severity of the problem, coupled with the feasibility of screening and the potential for meaningful intervention, make intimate partner abuse an important issue in primary care practice.

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ness Research Center (Drs Rodriguez and Grumbach), University of California, San Francisco.
Funding/Support: This work was funded by the Trauma Foundation, the San Francisco Centers for Disease Control Injury Center, the California Academy of Family Physicians, University of California San Francisco Center for Health Professions, and Picker-Commonwealth Scholars Program (Commonwealth Fund, New York, NY).
Acknowledgment: We are indebted to the California physicians who generously shared their experiences and opinions that made this study possible. We also wish to acknowledge Eliseo Perez-Stable, MD, for consultation, and Gregory Nah, MA, for assistance with data management.

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Wellness Lecture Series:
Mandatory Reporting of Domestic Violence:
What do Patients and Physicians Think?

Study 1: Perspective of physicians. California Physician Survey
Study 2: Perspective of victims of abuse. Abused Women Focus Group Study
Note: Same study as that featured in Mandatory Reporting of Domestic Violence by Health Care Providers

1995: 26% of murdered women were killed by their spouses or boyfriends.
1985: 12% of women reported being victims of domestic violence.
Abused women account for 20-30% of all women seen in ambulatory care clinics and 20% of pregnant women.
50% of outpatient women in psychiatric care and 29% of women seen for suicide attempts were victims of domestic abuse.

Legislators moving toward pro-arrest laws, education initiatives, etc.

California a good example of a state with strict mandatory reporting laws.
Benefits:

- Crime detection and data collection
- Enhanced victim safety through improved police protection
- Increased responsiveness of the healthcare system
- Relief from the onus of reporting for victims

Risks:

- Retaliation by abusers
  Decreased utilization of healthcare services
- Abused women's loss of control over the decision to involve the legal system
- Patient-physician relationship may be strained

This paper finds that both physicians and abused women have serious reservations about the law.

Physician's Survey vital stats:

- 68% of physicians were aware of the mandatory reporting law.
- 84% had identified a patient who they suspected to be a victim.
- If patient had no objection to reporting, 3% wouldn't report, 27% sometimes reported, 68% always reported.
- If patient asked physician not to report, 10% never reported, 44% sometimes reported, 44% always reported.
- Likelihood of reporting did not correlate with age, sex, ethnicity, training.
- Likelihood of reporting did correlate with ER v. hospital v. private practice physicians.
- The majority of physicians believed that mandatory reporting increased potential risk to patient, discourages patient from seeking help, interferes with patient confidentiality and autonomy.

- One third felt that mandatory reporting keeps physicians from asking about domestic violence.
- The majority of reporting physicians expressed concern about the practice of reporting.

Abused women's vital stats:

78% of participants had children (51 focus group participants)
Opposing because:
- Fear of retaliation
- Mistrust of legal system
- Fear of family separation
- Preference for confidentiality and autonomy

Pro because:
- Possibility of protection from police

Women generally preferred:
- Doctor to document abuse. Then they take action when they're ready.
- Once abuse is documented, they feel empowered to take action.
- But not before they're ready.
- So, they control timing and physician still assists them.

Recommendations:
- Safety of victim must be paramount.
- Legislation should not create barriers to access to medical care.
- Flexibility important so that physicians can create individual strategy for each patient.

On a public policy level:
- Adequate funding for social, legal, and healthcare services
- Healthcare institutions must implement policies, protocols, and education programs.

Family Violence Prevention Fund say:
- Create an environment that enhances the identification of abuse
- Educate healthcare staff about how to intervene with patients who are victims of abuse
- Establish an integrated and institutionalized response to domestic violence
- Develop referral and resource materials
- Evaluate the effectiveness of the program
- Become part of a coordinated response within the larger community.

Potential Legal Liability for Health Professionals for Actions for Inactions in Domestic Violence Cases

If an injured victim of domestic violence is treated by a physician or nurse who does not inquire about abuse or who accepts an unlikely explanation of the injuries, and the patient then returns to the abusive situation and sustains further injuries, the physician or nurse could conceivably be held liable for those subsequent injuries.

Estimated that 4-6MM women are battered by their intimate partners each year in U.S.
Of those, 1MM seek medical treatment for the injuries.
43% of the time women do not seek any form of help.
Often they do not know that shelters exist, or simply refuse to use them.
Health officials not good at identifying women:
    1/5 women treated for injuries are batter.
    1/25 is detected by emergency department staff.
Hence, training is crucial.

3 ways health providers may be open to liability if they act or fail to act:
1. Reporting abuse to the police without permission of an adult victim of abuse.
2. Negligence in identifying victims of domestic violence, documenting their injuries, properly treating victims, providing them with information aobut their options to counter domestic violence (including safety planning), and making referrals to specialists (domestic violence experts).
3. Failure to warn potential victims about the threat of assault from an abuser when the health professional learns that there is a danger of harm to an identifiable victim or victims by a patient who is a perpetrator of domestic abuse.

Often untrained workers treat adult abuse the same as child abuse.
    Unless there's a statute, then they must ask for permission first.

Women who leave their abusers assume a 75% greater risk of being killed by their abusers.

The article has a list of symptoms.

Courts have generally allowed victims to collect damages if information is released without their consent without the presence of a statute requiring the release.

A subpoena requesting medical records of a particular patient is not a court order which protects the health professional from liability. Hence, health care centers must have a protocol to deal with subpoenas.
Hence, they must ask the victim for permission.
But calling may be dangerous. As a result, records of how to safely contact victims should be kept.
If patient doesn't grant permission, person issuing subpoena must be contacted and advised that the information cannot be released.

Physician Liability for Negligence

Physicians must make patients aware of options, refer them to experts.

When negligence suits have been brought against providers, the person has had to prove that the are they received was sub-standard.

Now there is a shift toward reasonable care or reasonably prudent health care provider standards.

AMA guidelines are:

1. inform the patient about the options available to help stop the violence
2. recommend treatment
3. provide appropriate referrals

Health care professionals in Alaska must be informed about and trained on the domestic violence protocols that are being implemented in growing numbers of communities for the identification, referral and treatment of domestic violence victims.

Duty/Breach

AMA says medical organizations need to:

1. Identification – identifying the patient as a victim of domestic violence;
2. Documentation – documenting her injuries and the cause(s) thereof;
3. Treatment – providing validation and appropriate treatment for physical, mental, and emotional injuries;
4. Information – providing information on the domestic violence, risk assessment, legal options, domestic violence services available and safety planning.
5. Referral – The information should provide the patient with appropriate referrals to a specialist in domestic violence.

This document deals, in the extreme, with legal issues associated with mandatory and non-mandatory release of information.

Identification:
Early identification is crucial.
However, as few as 5% of domestic violence victims are identified in emergency rooms

Documentation:
Documenting violence is critical to a battered woman's ability to successfully obtain legal help.
AMA documentation required of doctors in domestic violence cases includes:

- Chief complaints using the complaint's words
- Description of the abusive event
- Medical history
- Relevant social history
- Detailed description of the injuries
- An opinion on whether the injuries were adequately explained
- Results of laboratory and other diagnostic procedures

- Color photographs and imaging studies
- The names of police persons involved

It's important that objective facts, as opposed to subjective comments, be documented.

Treatment:
Often the health professional is the first person to tell the victim that what is happening is not normal.
The health professional should:
- Perform a thorough exam for as-of-yet undetected injuries.
- Assess the victim's emotional status (suicidal tendencies, etc.)
- Evaluate the patient's safety.
- Inform the patient about ALL of the available options.

Any treatment must take into account the situation of domestic violence.

Causation
A health care provider shall be found negligent if s/he fails to provide competent care and that failure causes injury to the patient.

Hence, health care workers are dealing with a two part inquiry:
1. whether the provider acted with reasonable care
2. whether the action or inaction led to injury of the patient.

Clearly, it is most likely that further abuse is directly caused by the abuser. However, if the plaintiff can show that a reasonable health care provider should have recognized the signs of abuse, then she may claim damages.

The *Landeros* court formulated the causation test as one of whether the defendant could reasonably foresee the likelihood of further serious injury to the plaintiff.

Defendants in malpractice suits often have relied on the assertion that the patient was ill and would have succumbed to the illness, regardless of appropriate medical intervention. However, a growing number of courts are rejecting this theory. In the case of a domestic violence victim, the victim likely would have recovered from the emotional and physical damage from the abuse.

No case has yet found a health care provider directly liable for failure to diagnose, inform and refer a patient to appropriate domestic violence services person. However, trends in the law predict that health care professionals will soon be found liable for failure to provide appropriate domestic violence treatment.

Duty to Warn Victims of the Potential for Abuse

Health care providers treating abusers may also be held liable for failure to warn foreseeable victims of the potential for abuse.

The State of Alaska was once held liable for three murders a parolee committed after he was released from prison, among other reasons, because the State failed to warn the small community the victims belonged to about the danger the parolee posed to them.

JAMA Article Summary

Context: Although practice guidelines encouraging the screening of patients for intimate partner abuse have been available for several years, it is unclear how ell and in which circumstances physicians adhere to them.

Objective: To describe the practices and perceptions of primary care physicians regarding intimate partner abuse screening and interventions.

Design, Setting, and Participants: Cross-sectional survey of a stratified probability sample of 900 physicians practicing family medicine, general internal medicine, and OB/GYN in California. After meeting exclusion criteria, 582 were eligible for participation in the study.

Main Outcome Measure: Reported abuse screening practices in a variety of clinic settings, based on a 24-item questionnaire, with responses compared by physician sex, practice setting, and intimate partner abuse training.

Result: 69% response rate. 75-83% routinely screen injured patients for intimate partner abuse. Routine screening was less common for new patient visits (7-13%), periodic check-ups (6-12%), pre-natal care (7-15%). Neither physician sex nor recent intimate partner abuse training had significant effects on reported new patient screening practices. OB/GYN and physicians practicing in public clinic settings were more likely to screen new patients. Internists and physicians in HMOs were least likely to screen new patients. Commonly reported routine interventions included relaying concern for safety (91%), referral to shelters (79%), and counseling (88%). Documentation in the medical chart ran at 89%. Commonly cited barriers to identification and referral included the patients' fear of retaliation (82%), and police involvement (55%), lack of patient disclosure (78%) and follow-up (52%), and cultural differences (56%).

Conclusions: These findings suggest that primary care physicians are missing opportunities to screen patients for intimate partner abuse in a variety of clinical situations. Further studies are needed to identify effective intervention strategies and improve adherence to intimate partner abuse practice guidelines.

Notes on Mandatory Reporting of Domestic Violence by Health Care Providers.

Introduction

Providers should:

- Inquire routinely about domestic violence
- Provide sensitive and non-punitive support
- Address patient safety
- Document the abuse
- Provide information about options and resources

But, should providers bring cases of domestic violence to the attention of state authorities?

Goals of mandatory reporting:

- Enhancing patient safety
- Improving health care providers' response to domestic violence
- Holding batterers accountable
- Improving domestic violence data collection and documentation

However, author states, "Upon close examination...it becomes apparent that mandatory reporting will not...accomplish these goals. Further, the implications of mandatory reporting for patient health and safety as well as ethical concerns raised by such a policy argue against its general application."

Risks and Consequences of Mandatory Reporting:

1. Deterrent to Seeking Care
   Place themselves and their children in danger.
   Undocumented immigrant battered women fear police and deportation.
   So, goal of holding perpetrators accountable not met if the battered won't report.
2. Risk of Retaliation
   Reporting to local law enforcement does not guarantee appropriate response.
   No guarantee that response will meet survivor's safety needs.
   Patient knows best re: his/her situation, so should be integral part of decision.
3. May Not Improve Provider Response
   Doubtful that mandatory reporting enhances provider sensitivity to domestic violence.
   Without proper training and understanding, health care providers may increase danger to patients. **Hence, provider education is a better alternative.**
   Not the proper role of health care system. Should only give all available options.
4. Limited Response to Reports
   If reported and police do not offer adequate protection (ex. husband released almost immediately), will decrease patient trust, diminish patient safety.
5. Data
   Noncompliance and unevenness of reporting throw-off data.
   Better to use specialized studies that preserve confidentiality.
6. Documentation
   Medical records or more complete, accurate, and reliable than reports to third parties.

7. Bias in Reporting

May result in biased and inconsistent reporting to police

In child abuse cases, providers disproportionately report low-income families and persons of color. This will also skew data.

Ethical Issues

1. Patient Autonomy

Competent patients should determine course of action in their best interests.

Perpetuates stereotype of battered women as passive and helpless.

Revictimizes battered patients as again they don't make the decisions.

2. Confidentiality

Confidentiality and trust are vital for candid discussion and successful intervention in domestic violence cases. Interferes with provider-patient relationship, privacy, limit openness and candor of patient, undermine his/her trust.

3. Informed Consent

This is a vital concept in medicine. The patient must consent. An ethics issue.

Attitudes about Mandatory Reporting

1. Patients

Not sure how many women don't report due to the law.

Study in 1993-94 in San Francisco, 51 women with abuse histories in 8 focus groups.

Many voiced "serious concerns" that mandatory reporting is an obstacle.

The law may help a few survivors, but problematic that it places a few at increased risk.

2. Physicians

1995-96, 580 physicians in California responded to survey re: the mandatory reporting law. Over 2/3 believe that mandatory reporting is potentially harmful and interferes with patient-physician relationship.

The majority said that if the women asked them not to report, then they wouldn't.

Overview Of State Statutes'

Summary of Questions / Patterns

1. Who is required to report?

Some states require only physicians while others have a long list and/or "any person."

2. Who Receives the Report?

Most states require reporting to the police. A few require the DA or a specific agency.

3. What happens to the Report?

Usually there is no specification of what must be done with the reports. Sometimes providers who receive reports may need to take certain actions based on other statutory section or directives.

4. Penalties for Failure to Report and/or Immunity from Liability.
   Often a fine is levied. Most states give providers civil and/or criminal immunity from liability that might otherwise be incurred as a result of making a report.

5. Provider-Patient Privilege.
   Some states believe that the provider-patient privileges do not apply to information required to be reported.

6. Purpose of Reporting
   Few states report the purpose for enacting the reporting requirements.

Deadly Weapons
1. 40 states and the District of Columbia mandate report. Gun, Knife, firearm, or other deadly weapon. AK, AZ, AR, CA, CO, CT DE, DC, FL, HI, ID, IL, IN, IA, KS, ME, MD, MA, MI, MN, MS, MO, MT, NV, NH, NJ, NY, NC, ND, OH, OR, PA, RI, SD, TN, TX, UT, VT, VA, WV, WI.

Criminal Law Violation; Violence; Intentional Injuries; Gravity of Injury
1. 18 states and DC mandate reports for injury due to illegal act. AZ, CA, CO, DC, ID, IL, IA, MA, MN, NE, NH, NC, ND, OH, OK, PA, UT, WV, WI.
2. 7 states mandate reports due to acts of violence. FL, HI, MI, NE, NC, OH, TN.
3. 8 states in which injury appears intentionally inflicted. AK, AR, CO, GA, HI, ID, NV, OR. 9 where the gravity of the injury is important to the decision. AK, AZ, HI, IN, IA, KS, NY, NC, OH.

Domestic Violence or Abuse
1. 6 states mandate reporting, specifically for domestic violence and adult abuse, in addition to other provisions. CA, CO, KY, NH, NM, RI.

Voluntary Reporting
1. A few states such as TN have voluntary provisions. Others have reporting for statistical reasons only.

No Statutes Found
1. No requirements found in: Alabama, Louisiana, South Carolina, Washington, Wyoming.

Policy Directions: Recommendations For Health Care Facilities and Institutions

Minimizing Harms to Patient Under Current Laws

1. Recognize that critical intervention is not the report, but rather providing ongoing and supportive care, addressing safety issues, and giving the patient options.
2. Discussing with the patient the obligation to report.
3. Learning how authorities respond to reports and explaining to patient.
4. Need to address the potential risk of retaliation.
5. How to work with patient to meet patient needs when reporting.

6. Maximize role of patient's input.
7. Work with community advocates to improve what happens with reports.

Understanding Interactions with Other Protocols and Laws

1. Screening. If people come in for another problem, but then get screened and subsequently reported, they will not wish to come back for any medical help.
2. Insurance discrimination. Insurance companies have denied survivors health insurance without laws protecting them. Hence, in a state with protection, reporting can eliminate patient's insurance.

Health care providers should engage in public policy debates.

Recommendations for Legislative Action

Revising Your Mandatory Reporting Statute

1. If no current law: Oppose new laws.
2. If deadly weapon law: "Weapon" must be clearly defined. Maybe this is so grave that something must be done. Maybe this is so dangerous that survivor knows best.
3. If criminal/illegal act reporting: Some may not like exempting survivors from such laws. Factors such as ongoing contact, economic dependence, and risk of retaliation must be weighed.

   If state as in number 3, argue for provision's repeal, insert a patient consent provision, maintain mandate to report except if patient objects.

4. Role of report recipient: Amend the provision regarding what report recipient must do to protect survivor.
5. No identity of victim: Report, but without identity. Can be used for data.

Policy Alternatives to Mandatory Reporting

1. Educating health care providers re: domestic violence most important.
2. Domestic violence mandated in schools for health professionals/linked to licensing.
3. Mandate providers to offer referrals, documentation, etc.
4. Make amendments with caution, always thinking about safety of survivor.
5. Always think about quality of care.

Recommendations for Health Associations

Use political pressure to change the rules. Pass resolutions. Distribute information to educate members on the issues.

FAMILY VIOLENCE PREVENTION FUND

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DOMESTIC VIOLENCE GUIDE

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual and psychological attacks, that adults or adolescents use against their intimate partners. Without intervention, violence usually escalates in both frequency and severity, resulting in repeat visits to the healthcare system.

Screen All Patients For Domestic Violence:

- Talk to the patient alone in a safe, private environment.
- Ask simple direct questions such as:
  - ➤ **Because violence is so common in many people's lives, I've begun to ask all my patients about it routinely.**
  - ➤ **Are you in a relationship with a person who physically hurts or threatens you?**
  - ➤ **Did someone cause these injuries? Who?**

The best way to find out about domestic violence is to *ask directly.* However, be aware of:

- History suggesting domestic violence: traumatic injury or sexual assault; suicide attempt, overdose; physical symptoms related to stress; vague complaints; problems or injuries during pregnancy; history inconsistent with injury; delay in seeking care or repeat visits.
- Behavioral clues: evasive, reluctance to speak in front of partner; overly protective or controlling partner.
- Physical clues: any physical injuries, unexplained, multiple or old injuries.

Take a Domestic Violence History:

- past history of domestic violence, sexual assault
- history of abuse to any children

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(NAT)

Inches 1 2 3 4

Send Important Messages (to Patient (avoid victim blaming):

- You are not alone
- You are not to blame
- There is help available
- You do not deserve to be treated this way

Assess Safety:

- Are you afraid to go home?
- Have there been threats of homicide or suicide?
- Are there weapons present?
- Can you stay with family or friends?
- Do you need access to a shelter?
- Do you want police intervention?

Make Referrals:

- Involve social worker if available
- Provide list of shelters, resources, and hotline numbers
- **National Domestic Violence Hotline: 1(800) 799-SAFE**
- Schedule follow-up appointment

Document Findings:

- Use the patient's own words regarding injury and abuse
- Legibly document all injuries; use a body map
- Take instant photographs of injuries

Sponsoring organizations:

American College of Emergency Physicians
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American College of Physicians
American Medical Association
American Nurses Association
Emergency Nurses Association
Nursing Network on Violence Against Women, International
Physicians for a Violence-free Society
Society for Social Work Administrators in Health Care

QUESTIONS?: toll-free (888) Rx-ABUSE

(NAT)

FAMILY VIOLENCE PREVENTION FUND

Date: August 30, 1999

To: Tom Friedman

From: Lisa James, Senior Program Specialist

Re: Health Care Providers Respond to Domestic Violence Day

Thank you for your interest in the Family Violence Prevention Fund's (FUND) national ***Health Care Providers Respond to Domestic Violence Day*** that will be held on **October 14, 1999.** As a follow-up to our conversation I have included materials about mandatory reporting and the newest article about the need for routine screening for domestic violence from the August 1999 issue of the *Journal of the American Medical Association.*

As we discussed, events and activities are being organized in many states across the country, and the FUND is hosting a press conference at a clinic in Washington, DC that currently screens for domestic violence. Leaders from major health associations across the country including the American College of Emergency Physicians and the American College of Obstetricians and Gynecologists have already expressed interest in speaking at the press conference to support screening for domestic violence and the policies it promotes.

We would be honored if President Clinton would join these health care experts and lead the country's efforts in changing the standard of care for patients who are victimized by abuse. ***Health Care Providers Respond to Domestic Violence Day*** is an excellent opportunity to further educate and encourage health care providers to routinely screen for domestic violence and address this major public health epidemic.

I hope these materials are helpful to you. Please note that a revised edition of the "Screening Policy" is currently being printed and will be sent to you upon completion. We look forward to the possibility of working with you on this exciting event!

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Tel: 415 . 252 . 8900 *Fax:* 415 . 252 . 8991 *Publications Orders:* 415 . 252 . 8089

Health Resource Center on Domestic Violence

1-888-Rx-ABUSE (toll-free call)

Mandatory Reporting of Domestic Violence by Health Care Providers

FAMILY VIOLENCE PREVENTION FUND

Prepared by the
Health Resource Center on Domestic Violence
A Project of the Family Violence Prevention Fund
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Updated 9/98

MANDATORY REPORTING OF DOMESTIC VIOLENCE BY HEALTH CARE PROVIDERS: A POLICY PAPER[1]

PREPARED BY ARIELLA HYMAN, J.D.
FOR THE FAMILY VIOLENCE PREVENTION FUND
November 3, 1997

INTRODUCTION

With the increasing awareness about domestic violence as a health care issue, attention has turned to how health care providers can best intervene. Providers need to inquire routinely about domestic violence, provide sensitive and nonpunitive support, address patient safety, document the abuse, and provide information about options and resources. What is not clear, however, is whether providers should be required to bring cases of domestic violence to the attention of state authorities.

The goals potentially served by mandatory reporting include enhancing patient safety, improving health care providers' response to domestic violence, holding batterers accountable, and improving domestic violence data collection and documentation. Upon close examination, however, it becomes apparent that mandatory reporting will not necessarily accomplish these goals. Further, the implications of mandatory reporting for patient health and safety as well as ethical concerns raised by such a policy argue against its general application.

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[1]This paper borrows generously from the following article by the same author: Hyman A, Schillinger D, Lo B. "Laws mandating reporting of domestic violence: Do they promote patient well-being?" *JAMA*. 1995; 273:17811787.

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APPENDIX N

This paper discusses the risks posed to domestic violence survivors by laws mandating health care providers to report instances of domestic violence to the police or other governmental body. It gives an overview of state reporting laws throughout the country. It then sets forth policy recommendations in this area.

RISKS AND CONSEQUENCES OF MANDATORY REPORTING

Deterrent to Seeking Care

Donna, a client at a domestic violence agency in Gilroy was injured by her partner. She went to the hospital but was afraid to go inside because she was aware of the mandatory reporting law. She spent the night in her car in the hospital parking lot and did not receive necessary medical treatment for the injuries she sustained.[2]

Survivors of domestic violence often need medical care and information (assurances that they are not at fault for the battering); alternatives to returning home; an assessment of the dangers posed by their situation; and referrals for counseling, shelter, and legal services. Many survivors of domestic violence believe that calling the police is not a safe or preferred response to their situation. If they fear that reporting will place them and their children in greater danger, survivors may not seek needed medical care or may not tell their providers about the abuse. Undocumented immigrant battered women are made particularly vulnerable by mandatory reporting and may refrain from seeking care, fearing a call to the police will result in their deportation. The increased anxiety when seeking care and decreased candor with the provider may serve only to jeopardize further the health and safety of survivors and prevent them from obtaining necessary care and information. Furthermore, the goal of holding perpetrators accountable will not be met if survivors refrain from seeking care or being candid with their providers because of the law.

Risk of Retaliation

I'm sorry, but if my doctor were to call the police and they went to my husband, my husband would have beat the shit out of me. . . . I don't know, but I don't think a doctor should go over your head, go to the police, it's dangerous. . . . *Battered woman in focus group study*[3]

She [the physician] wanted to call the police and I said, "No, no he is the police." Battered woman in focus group study[3]

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[2]Story appeared in *Mandatory Reporting Stories*, compiled by Ariella Hyman and Pam Wool at San Francisco Neighborhood Legal Assistance Foundation, in collaboration with the California Alliance Against Domestic Violence.

[3]Mooney D, Rodriguez M. "California healthcare workers and mandatory reporting of intimate violence." *Hastings Women's Law Journal*. Winter 1996;7:85111. See also Rodriguez M, Quiroga S, Bauer H. "Breaking the silence." Arch Fam Med. 1996; 5:153158.

Mandatory reporting can place survivors of domestic violence at risk of retaliation by the batterers. Violence typically escalates when survivors seek outside help or attempt to separate from the abusers. Moreover, a report to local law enforcement does not guarantee an appropriate response that meets the survivor's safety needs. As the patient knows most intimately, the kind of danger s/he is confronting, s/he should be an integral part of the decision-making process regarding steps to enhance her/his safety.

May Not Improve Provider Response

It is crucial to increase health care providers' identification and awareness of domestic violence. But is mandatory reporting an effective way to enlist more health care workers in the appropriate care of survivors?

It is doubtful that mandatory reporting enhances provider sensitivity to domestic violence.

Without an understanding of the dynamics of domestic violence and without the proper training on how to respond to the needs of survivors, health care providers may report and respond in ways that can result in increased danger to patients. Provider education about domestic violence is likely a more effective means of enhancing provider sensitivity toward and detection of domestic violence.

Furthermore, it is not the role of the health care system to invoke and foster criminal justice intervention. It would seem that health care providers should present a battered patient with the interventions and referral options available and support the patient in carrying out those s/he thinks are best.

Limited Response to Reports

> *A woman came into an Emergency Department in Los Angeles with facial injuries. A mandatory report was made to the police, resulting in her husband being arrested in the hospital waiting room. After the patient was finished being treated for her injuries, she went home thinking she was safe. However, her husband had already been released and was home waiting for her. She came back to the Emergency Department later that day "worse off" than she had been on the first visit as a result of her husband's retaliation.*[2]

> *Each time I have attempted to do this [make a report], the police officers (or sheriff) have gone out to the house and/or contacted the perpetrator resulting in heightened abuse.* Physician in California survey[4]

What will happen to a report, once made? If there is no effective or safe response system in place, mandatory reporting may create expectations of services and protection that cannot be met, decrease patient trust in the provider and system, and diminish patient safety.

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[4]Transcripts from survey (not yet published) of physicians in California on mandatory reporting conducted by Michael Rodriguez, University of California-San Francisco, and Pacific Center for Violence Prevention, San Francisco; and conversations with Dr. Rodriguez on survey results.

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APPENDIX N

Data Collection

Collecting data to highlight the incidence and prevalence of domestic violence is an important goal. It is unclear, however, whether mandatory reporting by health care providers is an effective way to meet that goal.[5] Noncompliance with reporting requirements may be common, and there is likely a significant unevenness of reporting among individual providers and among health care settings. Accurate and useful statistics could be acquired through specialized studies and in ways that preserve the confidentiality and anonymity of survivors.

Documentation

Documentation of domestic violence is critical. Although mandatory reporting has the potential of achieving useful documentation, it is not a preferred means of accomplishing this goal. Documentation of abuse in the medical record serves the goal of documentation while better preserving privacy and confidentiality. In addition, it is a more reliable source of evidence for legal cases than a reporting form submitted to a state agency. A medical record can provide more thorough, detailed information on the abuse, and can include patient statements and provider observations regarding the abuse, body maps, and a history of the abuse. Additionally, a report to a third party is likely less readily available than a medical record and involves multiple levels of hearsay.

Bias in Reporting

Mandatory reporting of domestic violence may result in biased and inconsistent reporting to police. Studies in the child abuse reporting arena reveal that providers disproportionately report low-income families and persons of color. Racial and class bias in the identification of abuse by providers may also skew data collected through mandatory reporting.

[5]As an example, Connecticut had a statute with a five-year sunset provision, mandating health care providers to report domestic violence cases only for data collection purposes. This provision was allowed to lapse as it did not result in accurate data and was perceived to be serving no useful purpose. (Discussions with Anne Menard, who was the executive director of the CT Coalition Against Domestic Violence during the term in which this provision was in effect.)

ETHICAL ISSUES

In assessing the desirability of mandatory reporting, a number of ethical issues must be examined, including patient autonomy, confidentiality, and informed consent.

Patient Autonomy

Mandatory reporting does not respect the autonomy of survivors of domestic violence. In the medical model of health care delivery, competent and informed patients determine the course of action that is in their best interest. In domestic violence cases, patients are competent adults who should be granted the ability to make critical life decisions; if they believe calling the police will jeopardize their safety, then that opinion should be respected. These types of cases can be distinguished from child abuse cases, where the victim is a minor. Mandatory reporting not only impinges on the patient's self-determination, but in the process perpetuates harmful stereotypes of battered women as passive and helpless. By taking away patient autonomy, mandatory reporting revictimizes battered patients: their relationships with the batterers were ones in which the batterers controlled the decisions in their lives.

Confidentiality

> *What made it difficult for me to confide was the fact that I feared for my life, you know. And I knew that if I was to tell them what actually happened, that they would call the police and I would have to file a report and they couldn't guarantee me that they would be there 24 hours to protect me from this maniac. So, therefore, I wasn't taking that chance on my life. . . . What would make it easier for me would be. . . . to be my choice. . . . [I]f this happened to me but I don't want the police involved, can you please treat me and keep my confidentiality? There's supposed to be a law that they keep confidentiality between the patient and the physician.* Battered woman in focus group study[3]

Confidentiality and trust are vital to promoting candid discussion and successful intervention in domestic violence cases. Mandatory reporting interferes with the confidential nature of the provider-patient relationship, infringes on patient privacy, may limit the openness and candor of the patient, and undermine her/his trust in the provider. Though confidentiality and privacy rights must be balanced with public policy interests, the benefits derived from mandatory reporting are not sufficiently clear to justify infringements upon these rights.

Informed Consent

Informed consent is a principal tenet of medicine by which providers empower patients to make informed decisions. Mandatory reporting would require the provider to report domestic violence injuries even if the patient does not give his/her consent. Reporting without patient consent raises ethical issues and compromises the integrity of the provider's relationship with his/her patient. Some would argue that providers should put all patients on

notice, prior to conducting an examination, that if a determination is made that the patient's injury resulted from domestic violence, the provider is required by law to make a report.

ATTITUDES ABOUT MANDATORY REPORTING

Survivors

It is difficult to measure the impact of mandatory reporting laws on survivors of domestic violence. How does one determine, for example, how many survivors are refraining from seeking care because of the law? There is evidence that at least some battered women find mandatory reporting laws troubling or are harmed by such laws. In 1993–1994, a study was conducted in San Francisco in which fifty-one women with histories of domestic violence, representing four ethnic groups (Caucasian, African American, Asian, and Latina), participated in eight focus groups. The participants were asked to talk about their personal experiences with the health care system and their feelings regarding seeking or avoiding help from medical providers. Many of the participants voiced serious concerns about mandatory reporting to the police and perceived it as an obstacle to care.[3] Additionally, anecdotes collected by the San Francisco Neighborhood Legal Assistance Foundation and the California Alliance Against Domestic Violence demonstrate risks to survivors posed by the California mandatory reporting law.[6] Though there may be survivors who are in favor of mandatory reporting, it is problematic to have a law that places even a few patients at increased risk.

Physicians

> *Abused women have had their autonomy taken away by their abusive partners. Forcing me to report her abuse again takes that autonomy and control away from her. She is a better judge than I of the consequences to her of reporting. Morally, it is wrong for me to take that decision away from her. Ethically, it is wrong of me to violate patient-doctor confidentiality. This is a bad law.* Physician in California survey[4]

In 1995–1996, California physicians were surveyed who practice in the areas of family medicine, general internal medicine, obstetrics/gynecology, and emergency medicine, on their attitudes and behaviors regarding mandatory reporting. Five hundred eight physicians responded to the survey. While recognizing some potential benefits of mandatory reporting, over two-thirds of the respondents believed that reporting of domestic violence potentially

[6]See fn [2]. One entry involved a larger group of survivors and is worth noting here: Carole Burke, a licensed social worker and therapist in Contra Costa County, discussed the mandatory reporting law with a seventeen-member support group for battered women that she facilitates. The feedback from the group was overwhelmingly negative. They were very dismayed at being "treated as if they were infants and not able to make up their own minds whether to report to the police." They commented that the mandatory reporting law puts them in jeopardy because all police officers react differently to domestic violence calls. All seventeen members of the group said their injuries would have to be life-threatening before they would go to a doctor again, because of the mandatory reporting law.

harms patients and interferes with the patient-physician relationship. The majority of physicians surveyed responded that if a patient whom they suspect is suffering from domestic violencerelated injuries asks them not to make a police report, they would not necessarily make a report in all situations.4

OVERVIEW OF STATE STATUTES[7]

As advocates for domestic violence survivors, health care providers, and legislators attempt to forge a position on mandatory reporting of domestic violence, it is helpful to have a sense of the laws that presently exist around the country. This section provides an overview of state statutes that affect reporting in domestic violence cases. It first summarizes patterns that emerge from such an overview. It then reviews four categories:

1) states that require reporting of injuries caused by weapons;

2) states that mandate reports for injuries caused in violation of criminal laws, as a result of violence, or through nonaccidental means;

3) states that specifically address reporting in domestic violence or adult abuse cases; and

4) states for which our current research could find no relevant reporting statutes.

Summary Questions/Patterns

Upon examining reporting statutes throughout the country, a number of questions and patterns emerge:

*Who Is Required to Report? Which health care providers are mandated reporters under the reporting laws varies widely from state to state. Some states require only physicians to report while others provide a long list of health care providers who are covered by the statute. A few states mandate "any person" to report in specified situations.[8]

*Who Receives the Report? Almost all of the state statutes addressing mandatory reporting require that reports be made only to law enforcement, though a few exceptions exist in which reports must be made to a specified state agency, the district attorney, or other designated reportee.

[7]This overview does not discuss reporting laws and policies applicable in health facilities in the military, in the Veterans Administration, on Native American reservations, or in the territories. Also not included are laws requiring reporting of burns, poisoning, and suffocation, acts that may be common in domestic violence cases; and statutes relating only to child, elder or vulnerable adult abuse reporting.

[8]Whether health care providers fall within the scope of such statutes can only be assessed after an examination of the interactions between these provisions and the states' provider-patient privileges.

*What Happens to the Report? Very few reporting statutes specify what is to be done with reports made by health care providers. However, providers who receive reports may be obligated to take certain actions based on other statutory sections or directives.

*Penalties for Failure to Report and/or Immunity from Liability. Almost all states impose penalties for failure to comply with the reporting requirements, and most states provide health care providers with civil and/or criminal immunity from liability that might otherwise be incurred as a result of making a report.

*Provider-Patient Privilege. Various statutes claim or have been interpreted to suggest that the physician-patient and other provider-patient privileges do not apply to the information required to be reported.

*Purpose of Reporting. Finally, only a few of the reporting statutes specify what the state's purpose was in enacting the particular reporting requirement.

Deadly Weapons

At least 40 states and the District of Columbia mandate reporting by health care providers in specified instances where the patient has an injury that appears to have been caused by a gun, knife, firearm, or other deadly weapon. States vary as to which deadly weapons trigger the reporting requirement. In some states, the requirement to report deadly weapon injuries applies only if the injury appears intentionally inflicted, criminal in nature, or is likely to result in death. [AK, AZ, AR, CA, CO, CT, DE, DC, FL, HI, ID, IL, IN, IA, KS, ME, MD, MA, MI, MN, MS, MO, MT, NV, NH, NJ, NY, NC, ND, OH, OR, PA, RI, SD, TN, TX, UT, VT, VA, WV, WI]

Criminal Law Violation; Violence; Intentional Injuries; Gravity of Injury

At least eighteen states and Washington D.C. require reports when there is reason to believe the patient's injury may have resulted from an illegal act. Some of these states indicate that the reporting requirement applies only to illegal acts rising to certain levels. For example, they specify that the illegal act must have caused serious or grave bodily injury, that there must have been use of a weapon in addition to the illegal act, or that the illegal act must appear to be of a certain nature. [AZ, CA, CO, DC, ID, IL, IA, MA, MN, NE, NH, NC, ND, OH, OK, PA, UT, WV, WI]

At least seven states require health care providers to report injuries that they have reason to believe resulted from an act of violence, with some indicating that the injury must be grave or that the act appear illegal before the requirement to report would apply. [FL, HI, MI, NE, NC, OH, TN]

Finally, at least eight states require reports under circumstances in which the injury appears intentionally inflicted [AK, AR, CO, GA, HI, ID, NV, OR], and in nine states, the gravity of the injury is of import to the decision to report. [AK, AZ, HI, IN, IA, KS, NY, NC, OH]

Domestic Violence or Abuse

At least six states have mandatory reporting laws that specifically address domestic violence or adult abuse. These provisions often appear in addition to deadly weapon or illegal act reporting requirements. Five of these states mandate reporting in certain instances of domestic violence, while one exempts victims of abuse from its general mandate to report certain injuries. [CA, CO, KY, NH, NM, RI] The following are examples of these statutes:[9]

CALIFORNIA Health practitioners must report to the police if they provide medical services to a patient whom they know or reasonably suspect is suffering from a physical injury that was caused by a firearm or by "assaultive or abusive conduct" (defined to include twenty-four crimes). It is recommended that referrals to local services be given to domestic violence victims and that providers thoroughly document domestic violence in the medical record.

COLORADO Physicians are required to report to law enforcement if they attend or treat an injury caused by a weapon or an injury they have reason to believe involves a criminal act "including injuries resulting from domestic violence."

KENTUCKY Any person having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report to the Cabinet for Human Resources. The Cabinet must notify police, initiate an investigation of the complaint, and make a written report of findings and recommendations. The Cabinet is allowed access to mental and physical health records of the adult if necessary to complete the investigation. The Cabinet can enter the private premises of the adult to investigate the need for protective services. If the adult does not consent, a search warrant may be issued upon a showing of probable cause of abuse. If a determination is made that protective services are necessary, the Cabinet shall provide such services except where the adult refuses them.

NEW HAMPSHIRE A person treating or assisting another for a gunshot wound or any other injury believed to be caused by a criminal act is required to report, except if the injured person has been a victim of sexual assault or abuse, is over eighteen years of age, and objects to the release of this information to law enforcement. This exception does not apply if the person is also being treated for a gunshot wound or other serious bodily injury.

RHODE ISLAND In addition to a deadly weapon reporting provision, the statute requires medical providers to report domestic violence related injuries only for data collection purposes. The reports are not to contain names or any identifying information. The domestic violence data is to be compiled and reported annually by the domestic violence training and monitoring unit of the court system.[10]

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[9]These are brief, simplified summaries. The reader should see the full text of the statutes for complete information.

[10]The statute requires the unit to compile reports only for five years following October 1, 1988.

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APPENDIX N

Voluntary Reporting

Though this paper reviews only mandates to report, note that a few states have voluntary reporting provisions where abuse is concerned. For example, a recently enacted Tennessee provision encourages health care providers voluntarily to report injuries due to domestic violence on a monthly basis to the Department of Health, Office of Health Statistics. The report is not to reveal the name or identification of the patient, in recognition of the importance of confidentiality, of safeguarding against retaliation, and of encouraging abuse survivors to seek care. Laws in Mississippi and Pennsylvania specify that any person may report abuse.

No Statutes Found

Our current research has not been able to locate reporting requirements for health care workers in the following five states: Alabama, Louisiana, South Carolina, Washington, and Wyoming.

POLICY DIRECTIONS: RECOMMENDATIONS FOR HEALTH CARE FACILITIES AND INSTITUTIONS

Minimizing Harms to Patient Under Current Laws

Health care providers and institutions must strive to minimize the harm to the abused patient under current mandatory reporting laws. Health care facilities should ensure that their domestic violence protocols and trainings address, at a minimum, the following issues regarding reporting:

1. Most important is the recognition that the critical intervention is not the report, but providing ongoing and supportive care, addressing safety issues, and guiding the patient through the available options. Providers need to understand that the legal report is only one small piece of a much larger intervention and should be carried out with the utmost caution.

2. Discussing with the patient the obligation to report. (Whether there is an ethical obligation to inform patients prior to taking a history or conducting an exam about the reporting law is an area that needs further exploration. Health care providers and institutions might consult with medical ethicists on this issue.)
3. Learning how authorities respond to reports and explaining this to patients so they know what to expect.

4. The need to address the potential risk of retaliation and precautionary measures, such as seeking shelter or obtaining restraining orders when the report is made.

5. How to work with the patient and the authorities to meet patient needs when reporting.

6. Maximizing the role of the patient's input regarding future action.

7. Working with community advocates for survivors of domestic violence and authorities to implement a process for responding to reports that enhances patient safety and autonomy, and to address problems that arise in response to reports.

Understanding Interactions with Other Protocols and Laws

Certain institutional protocols and state laws concerning domestic violence may interact with mandatory reporting in ways that have the potential to harm survivors of domestic violence. Health care institutions should be aware of these intersections so that they may consider steps to address problems that arise. Below are examples.

1. **Screening** Suppose a health care facility located in a state that mandates reporting of domestic violence injuries adopts a protocol requiring health care providers to screen for domestic violence. Once a survivor is detected through screening, the reporting law may mandate a report to state authorities even without the patient's support. As the adoption of the screening protocol may inadvertently facilitate enhanced reporting, it may have the unintended effect of scaring survivors away from the health facility. This may particularly be the case when the institution believes it has an ethical duty to inform patients subject to screening of the existence of the reporting law.[11] The health care provider is also placed in an uncomfortable position: s/he may want to screen for domestic violence but may not want to have to breach confidentiality and act against a patient's will.

2. **Insurance discrimination** A number of insurance companies have been denying health insurance coverage to patients who are or have been victims of domestic violence. Advocates for survivors have protested these policies, and a number of states now have laws forbidding such practices. If your state still has insurance laws or policies that discriminate against survivors of abuse, it is important to understand their implications for medical record documentation and reporting. Namely, the documentation that results from reporting a particular patient or noting the abuse in the patient's medical record may provide the insurance company with the basis for denying that patient coverage.

Engaging in Public Policy

Health care providers and institutions might engage in policy debates in their communities regarding mandatory reporting and challenge legislation that jeopardizes the well-being of their patients. Collaborating with and seeking input from advocates for survivors of domestic violence around policy issues is critical.

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[11]See remarks of Penny Ablin, M.D., in "Domestic violence reporting law: a hazard or a help to patients/victims?" *California Physician Magazine*. August 1996; 24—32 (Anecdotal evidence that publicity of hospital's screening protocols and the reporting law has resulted in fewer women disclosing abuse in the emergency room.)

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APPENDIX N

RECOMMENDATIONS FOR LEGISLATIVE ACTION

Revising Your Mandatory Reporting Statute

For the reasons set forth in this paper, mandatory reporting by health care providers of survivors of domestic violence is a policy that should be avoided. Working toward legislative reform in this area is quite challenging, however, as in almost all states there is already some sort of reporting law in place. Depending on the nature of the existing law, different issues will need to be explored. These might include the following:

1. If no current law: If yours is one of the few states with no reporting requirements (other than child, elder, or vulnerable adult abuse reporting), it seems best to oppose the adoption of any new laws that would mandate reporting of adult survivors of domestic violence. Given the safety risks to survivors, the medical ethics considerations, and the fact that mandatory reporting laws are of unproven value, doing otherwise would seem unwise policy. This is especially the case for laws that require reports to include the identity of the patient.

2. If deadly weapon law: Although mandatory reporting in all cases is problematic, are there instances of such a grave nature in which reporting is warranted? For example, weapon injuries may indicate particular danger and therefore one might consider leaving unchanged an existing weapon reporting provision. On the other hand, it may be precisely in the most dangerous cases that a survivor's autonomy needs to be respected to best enhance her/his safety. Furthermore, unless "weapon" is limited, for example, to firearms, it may be interpreted so broadly as to subsume virtually all cases (i.e., some might define a fist as a weapon).

3. If criminal/illegal act reporting: If your state requires reports of injuries resulting from criminal acts, injuries due to domestic violence are clearly subject to the mandate. Some may feel uncomfortable exempting survivors from such a law, thereby treating domestic violence differently from other crimes. On the other hand, survivors do require particular advocacy and protection because of such factors as ongoing contact with the perpetrator, economic dependence on the perpetrator, and a higher risk of retaliatory violence.

   If your state requires reports of injuries due to criminal acts, you might consider several approaches. Each of these approaches can be made to apply either to all competent adults or only to domestic violence survivors:

   - Argue for the provision's repeal (for survivors of domestic violence or for all competent adults).
   - Maintain the mandate but insert a patient consent provision, such as, "injuries (due to domestic violence) shall not be reported unless the patient consents to a report being made."

   - Maintain the mandate to report unless the patient objects, such as, "injuries due to criminal acts shall be reported except if the patient (is a victim of domestic violence and) objects to a report being made. The health care provider must inform the patient of the right to object."

Although repealing a harmful provision may be the cleanest approach, maintaining the mandate may, in some instances, be more politically feasible. Additionally, the latter two approaches may indirectly help achieve another goal: encouraging providers to discuss with their patients the option of calling the police.

As in the deadly weapon context discussed above, the question arises as to whether the mandate should be maintained for certain injuries of a particularly grave nature. Can "grave" be defined in a way that does not subsume all cases, and that health providers will evenly apply? Should not the survivor's voice, especially in grave injury cases, be an integral part of the decision making in her case? For those considering a mandate in serious injury cases, it seems imperative to use a term such as "life-threatening" injury, which is both limited and conducive to more uniform application.

4. Role of report recipient: One might also amend the provision regarding who receives the report and what that party is obligated to do with it. For example, it may be specified that the agency receiving a report may, where safe, offer the patient information about options and assist the patient with pursuing those that are desirable, but that no measures will be imposed on the patient against her/his will. Training for agency employees on domestic violence and on how to contact the patient safely is a necessary part of such legislation.

5. No identity of victim: Another strategy is to require or allow anonymous reporting of survivors of domestic violence, with no provision of information being provided concerning the name or identification of the patient. Such reports might be used for surveillance by public health agencies for the purpose of improving intervention strategies. The information might also be used for data collection, but the experiences of Connecticut and Rhode Island with such statutes should first be reviewed.5

Policy Alternatives to Mandatory Reporting

It is clear that health care providers and institutions must play a role in the area of domestic violence. If reporting is not mandated, should any other legal interventions be considered? Educating health care providers about domestic violence is clearly the most important means of enhancing the health care system's response to domestic violence. Domestic violence education might be mandated in schools for health professionals or linked to licensure or funding eligibility. Other legislative proposals might include mandating health care facilities to implement domestic violence protocols regarding screening, safety assessment, documentation, and referrals. Requiring health care providers to offer patients referrals or certain options, including the option to call the police, might be considered. Whatever the approach, it is crucial that legislation be designed or amended with the utmost caution so as to avoid unintended and harmful consequences for survivors of domestic violence. Policy decisions should be informed by the views and experiences of survivors of domestic violence and their advocates. Legislative proposals should be examined to assess whether they enhance the quality of care offered survivors within the health care setting, respect the patient's autonomy and judgments about safety, and reduce the risk that the patient will refrain from seeking care.

APPENDIX N

Recommendations for Health Associations

Local, state, and national health associations can play a key role in effecting policy change. For example, they can pass resolutions in support of preferred policies relating to domestic violence and in opposition to policies that jeopardize the well-being of patients who are survivors. In this way, they can both enhance awareness among their membership and influence local, state, and federal legislation. A number of health associations have already adopted stances opposing mandatory reporting, including the American Medical Association, the American College of Emergency Physicians, the American Association of Women Emergency Physicians, the American College of Nurse-Midwives, and the California Medical Association.[12] Health associations can also distribute information to educate members on the risks of mandatory reporting and the importance of minimizing harms to the patient when complying with existing laws.

CONCLUSION

Mandatory reporting falls short of accomplishing the purported goals of enhancing patient safety and care, improving health care providers' response to domestic violence, holding perpetrators accountable, and increasing data collection and documentation. It also raises serious ethical concerns. The crisis of domestic violence requires a careful, well-conceived, effective response. Until further study demonstrates otherwise, there is ample reason to believe that mandatory reporting of all injuries due to domestic violence represents a threat to the health and safety of survivors of domestic violence. Health care providers and institutions need to strive to minimize harms to the patient under current laws. Advocates for survivors, health care providers, and others engaged in public policy should work together to consider legislative efforts to minimize risks to survivors posed by mandatory reporting laws. Education must be the focus of any attempt to combat domestic violence and must be the centerpiece of our efforts.

[12] The California Medical Association's resolution supports mandatory reporting except where the patient objects to a report being made.

WELLNESS LECTURE SERIES

Mandatory Reporting of Domestic Violence: What Do Patients and Physicians Think?

October 23, 1997

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Prepared for the 1997 California Wellness Foundation/University of California Wellness Lecture Series under a grant from The California Wellness Foundation

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Acknowledgments. I gratefully acknowledge the support of the Trauma Foundation, San Francisco CDC Injury Center, California Academy of Family Physicians, UCSF Center for the Health Professions, California Department of Health Services Emergency Preparedness and Injury Control Branch, and Picker/Commonwealth Scholars Program. I also wish to thank the many collaborators and mentors who made this

research and paper possible, including Dr. Heidi Bauer, Dr. Elizabeth McLoughlin, Dr. Kevin Grumbach, Donna Mooney, Andrea Craig, Dr. Eliseo Perez-Stable, Gregroy Nah, Wendy Sheldon, Jill Thomas, and Robin Tremblay-McGaw. I also appreciate the support of my wife and children: Carolina, Natasha, and Miguelito. I am particularly thankful for the assistance from all the contributing healthcare practitioners, abused women, and their advocates, without whose participation this project would not have been possible.

Mandatory Reporting of Domestic Violence: What Do Patients and Physicians Think?

Introduction

Domestic violence is a social and health problem of high priority in the healthcare and legal communities. The healthcare professions have urged increased professional responsibility toward patients who are survivors of abuse. In response, many healthcare professional programs and other educational forums are training physicians to recognize and treat survivors of domestic abuse. In addition, a number of protocols, intervention strategies, and policies have been designed and implemented.

Currently, in California, healthcare practitioners are required to report to police those patients suffering from injuries suspected to be the result of domestic violence.[1] Mandatory reporting legislation raises professional and ethical considerations for both healthcare providers and victims of domestic violence. This paper addresses these issues and describes the results of two research studies that investigated the implications of California's mandatory reporting law. The first study examined the perspective of physicians, and the second, the perspective of the victims of domestic violence.

Defining domestic violence. For the purposes of this paper, domestic violence is defined as a pattern of assaultive and coercive behaviors—including physical, sexual, and psychological abuses—that adults or adolescents use against their intimate partners. It is also referred to as domestic abuse, wife abuse, marital assault, spousal abuse, battering, intimate violence, and partner abuse. Domestic violence

is influenced by diverse elements, including historical and sociocultural factors. The social and historical significance of gender inequalities is particularly important in understanding abusive behavior by men against women. Some studies indicate that men and women resort to similar physical behaviors when arguing; yet women are more likely than men to be victimized by an intimate partner and suffer more injuries than men.[2]

Consequences of domestic violence. The consequences of domestic violence are felt by the individual victims, their families and communities, and by society as a whole. Individual victims suffer a range of physical and psychological injuries, and children living with domestic violence in their homes are at increased risk for physical and psychological abuse as well.[3] Moreover, communities and society at large bear the consequences of heightened fear and numerous economic costs attributable to domestic violence. These secondary effects are exhibited as decreased worker productivity, increased homelessness, and increased use of social, criminal justice, and healthcare services.

Domestic violence is a leading cause of morbidity and mortality for women. It is estimated that 2 million to 6 million women are physically abused by intimate partners each year.[4,5] Based on national data from 1995, 26% of murdered women were killed by their spouses or boyfriends.[6] In a 1985 national survey of family violence, 12% of women reported being victims of domestic violence.[4]

Domestic violence in healthcare settings. While prevalence rates vary depending on the definitions used, domestic violence victims constitute an alarmingly high proportion of women seeking care for trauma, medical, and psychological problems. Studies of emergency-department patients have indicated that up to one-third of all injuries to women not involving motor vehicles were due to domestic violence.[7] In one study of patients attending an urban hospital drop-in clinic, 45% of women victims of violence reported that the perpetrator was an intimate partner.[8] Abused women account for 20% to 30% of all women seen in ambulatory care clinics[9] and up to 20% of pregnant women.[10] In psychiatric settings, studies report that 50% of female psychiatric outpatients[11] and 29% of women seen for suicide attempts[12] were victims of domestic violence. Because of the high utilization of medical services by victims of domestic violence, healthcare providers are in a unique position to identify and assist victims of abuse. Yet despite the high prevalence of these victims in healthcare settings, only a small proportion of abused women is identified as such in these settings.[13]

As issues of domestic violence gain greater public visibility, the medical community is working to increase sensitivity to abused patients and to improve detection and assessment by physicians and other healthcare providers. Across the country, hospitals and clinics are instituting routine screening protocols, coordinating referral services, and developing continuing medical education courses on

domestic violence. Similarly, lawmakers have attempted to respond to domestic violence by passing mandatory prosecution and related legislation and by setting pro-arrest policies.

Mandatory reporting laws. Mandatory reporting laws are one type of legislation that has directly impacted physicians, patients, and the police. Most states require healthcare providers to report to police those patients who are victims of certain injuries caused by deadly weapons or certain illegal acts. Five states have mandatory reporting laws that specifically address the reporting of suspected domestic violence.[14] In California, healthcare providers are required to report to the police those patients who they reasonably suspect are suffering from a domestic violence–related injury.[1] The healthcare provider must notify the police and submit written findings within two days. These reports must include, but are not limited to, the name of the victim, the victim's whereabouts, the extent of the victim's injuries, and the identity of the alleged perpetrator.

California's mandatory reporting law has certain possible benefits, but it carries certain risks as well.[14,15] Potential benefits include improved crime detection and data collection, enhanced victim safety through improved police protection, increased responsiveness of the healthcare system, and relief from the onus of reporting for victims. Potential risks include retaliation by abusers, decreased utilization of healthcare services, and the abused women's loss of control over the decision to involve the legal system. Additionally, the patient-physician relationship may be strained when confidentiality is compromised.

This paper describes the results from two studies that addressed the implications of California's mandatory reporting law. The first is the California Physician Survey, which was undertaken to assess physicians' knowledge, attitudes, and behavior related to the mandatory reporting of domestic violence. The second is the Abused Women Focus Group Study, a qualitative study of the experiences of abused women in healthcare settings and their perspectives on physician reporting.[16,17] While California's mandatory reporting law may be based on sound policy motivations, our results indicate that in application, both physicians and abused women have serious reservations about the law. This paper concludes by recommending specific areas for improvement in policy development and healthcare response.

Methods

The California Physician Survey. In an effort to assess California physicians' attitudes toward the state mandatory reporting law, a stratified random sample of 1,200 physicians was selected, with 300 physicians drawn from each of the following specialties: family medicine, general internal medicine, obstetrics/gynecology, and emergency medicine. Women physicians were oversampled in order to ensure an adequate number of female physicians for comparative analysis.

The study design involved three questionnaire mailings (see Appendix), with telephone follow-up. The questionnaire consisted of 24 items that covered the following topics: knowledge of, and tendency to conform to, the mandatory reporting law; attitudes about the impact of and appropriate conditions for reporting; barriers to identifying and referring victims of domestic violence; management of victims in the clinical setting; and demographic data. To assess the physician's tendency to conform to the mandatory reporting legislation, respondents were presented with two scenarios: "A patient asks me not to report, but I suspect that s/he is suffering from domestic violence–related injuries," and "A patient does not express a preference one way or the other for filing a police report, but I suspect s/he is suffering from domestic violence–related injuries." For each scenario, respondents were asked if they would report in all situations, some situations, or none of the situations. Respondents were also asked to agree or disagree with potential benefits and risks of the mandatory reporting law on a four-point scale. Survey data were entered into an SPSS statistical database, and the associations between physician nonconformity to mandatory reporting laws and various demographic, practice, attitude, and experience variables were analyzed

The Abused Women Focus Group Study. In an effort to assess the attitudes of domestic violence victims toward the healthcare system and mandatory reporting laws, a qualitative study was conducted using semi-structured focus groups. The focus-group approach, which is based on small-group discussions on a specific topic, was used to gain an in-depth understanding of battered women's experiences within the healthcare system. Fifty-one women with histories of domestic violence were recruited through domestic violence shelters and community-based organizations to form eight focus groups: two groups of Latina ($N = 14$), two groups of Caucasian ($N = 14$), two groups of Asian ($N = 14$), and two groups of African-American ($N = 9$) women

Each focus group was facilitated by two moderators, at least one of whom was female and of the same ethnicity as the rest of the group. Based on a review of the literature, open-ended questions were formulated and posed. The participants were asked to discuss definitions of domestic violence; sources of help for problems related to domestic violence; and the attitudes, feelings, and behaviors that may predispose battered women to seek or avoid seeking, assistance from healthcare providers.

Results

Physician perspectives. Of the original 1,200 physicians sampled, a total of 715 physicians were eligible for the California Physician Survey, and 508 (71%) completed the questionnaire. Respondents' ages ranged from 29 to 83 years, with a median of 44 years. Women represented 38% of the respondents. Forty-eight percent of physicians surveyed practiced primarily in private settings, 17% in HMO

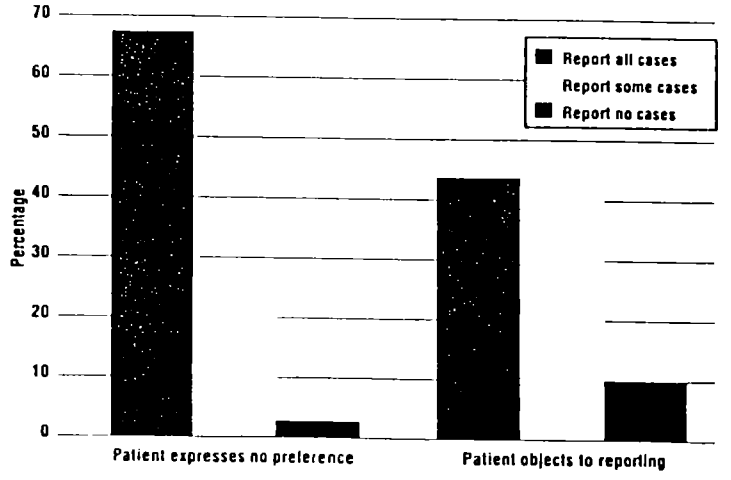
settings, 12% in hospitals, and 23% in other settings that included government, community, and academic facilities.

Awareness of and experience with domestic violence issues. The majority of physicians surveyed had prior knowledge of mandatory reporting legislation or had identified a patient suspected to be a victim of domestic violence. Sixty-eight percent stated that they were aware of California's mandatory reporting law prior to reading the survey, and 84% of physicians indicated that at some time in their career they had identified a patient who was a victim of domestic violence. Twenty-nine percent of respondents reported having taken a domestic violence course within the previous three years.

Factors associated with nonconformity with mandatory reporting. Nonconformity with the mandatory reporting law varied significantly according to whether the patient objected to reporting. In responding to the scenario in which the patient expressed no preference about reporting, 3% of physicians said they would report none of the time, 27% said they would report some of the time, and 68% said they would report all of the time (Figure 1). In contrast, in responding to the

FIGURE 1

Physicians' Anticipated Conformity with Mandatory Reporting Law According to Patient Preference



scenario in which the patient asked the physician *not* to report, 10% of physicians said they would report none of the time, 44% said they would report some of the time, and 44% indicated they would report all of the time. Overall, physicians were more likely not to conform in a situation in which the patient specifically asked them not to report to police.

Other factors associated with physicians' anticipated nonconformity included their type of specialty, practice setting, prior knowledge of the law, and exposure to a recent course on domestic violence (Table 1). Primary care providers (family physicians, internists, and obstetrician/gynecologists) were much more likely not to conform than emergency physicians. Providers in private office settings were more likely not to conform than hospital-based providers. In addition, those respondents who were not aware of the law before reading the questionnaire, or who had not taken a course on domestic violence in the previous three years, were less likely to report. Of note, nonconformity with mandatory reporting legislation

TABLE 1

Factors Associated with Physicians' Anticipated Nonconformity with Mandatory Reporting Law When Patient Objects ($N = 508$)

Physician Factor	Nonconformity, %
Medical specialty	
Emergency medicine	25*
Family medicine	57
General internal medicine	67
Obstetrics/gynecology	67
Medical practice setting	
Hospital-based	20*
HMO	43
Private	65
Other/combined	63
Awareness of legislation	
Aware	45*
Unaware	78
Course on domestic violence	
In previous 3 years	43*
Not in previous 3 years	60

*$p < .001$ based on Pearson Chi-square test.

did not differ by sex, age, ethnicity, training (United States versus international medical schools), or prior identification of an abuse victim in a clinical setting. A logistic regression model demonstrated that medical specialty, practice type, and prior awareness of the law are independently predictive of physician nonconformity in cases where a patient objects to reporting.

Physician perceptions regarding mandatory reporting. The majority of physicians surveyed agreed that current mandatory reporting legislation creates a potential detriment to patient care and raises important ethical concerns (Table 2). Specifically, the majority of physicians believed that mandatory reporting discourages victims from seeking medical care and places patients at higher risk of retaliation by their partners. Most physicians also believed that this legislation interferes with the patient-physician relationship by violating the ethics of patient confidentiality and patient autonomy. One-third of physicians believed that mandatory reporting discourages physicians from asking about domestic violence.

TABLE 2

Physicians' Perceptions of the Risks and Benefits of Mandatory Reporting Law ($N = 508$)

Physician Perception	Agreement, %
Potential risk	
Discourages medical care seeking	71
Increases risk of retaliation by partner	67
Discourages physicians from asking	33
Ethical concern	
Violates patient confidentiality	74
Violates patient autonomy	67
Potential benefit	
Provides useful statistics	80
Helps with prosecution of perpetrators	75
Improves physician responsiveness	60

On the other hand, most physicians also felt that mandatory reporting has potential medical and legal benefits. The majority of respondents believed that this legislation improves the collection of useful statistics, helps with the prosecution of perpetrators, and improves physician responsiveness. Eighty-nine percent of physicians felt it did not decrease the need for physicians to ask about domestic violence during future visits.

As might be expected, those physicians who would not necessarily make a police report if a patient objected were more likely to have negative perceptions of mandatory reporting compared to those physicians who said they would report to police in all situations. However, the majority of conforming physicians also expressed serious concerns about the risks associated with the law.

Perspectives of abused women. The 51 focus-group participants were aged 22 to 60 years, with a median age of 34 years. The median length of formal education was 12 years. Seventy-eight percent of the participants had children. All of the Latina and Asian participants were immigrants. Participants discussed physician reporting of domestic violence to police in all eight focus groups. The specific reasons that were identified for opposing mandatory reporting included fear of retaliation by the abuser, mistrust of the legal system, fear of family separation, and preference for confidentiality and autonomy. One specific perceived benefit of mandatory reporting was the possibility of police protection. All of the quotations below are taken from the focus-group discussions.

Fear of retaliation by the abuser. Many of the participants were afraid the violence would escalate if a physician report resulted in police intervention. In some cases, women were reluctant to seek medical care because they believed that police intervention resulting from physician reporting would have dangerous consequences for them. In other cases, women lied to providers about the cause of their injuries or withheld information about the abuse in order to avoid police involvement.

> And I was scared for my life. I never went to the police and I never went to the hospital 'cause I knew that if I went to the hospital, I would have to file a report with the police and I was scared.

Many of the fears of retaliation were based on concerns regarding the limitations of police protection. The abused women felt that their safety could not be ensured by the police and thus avoided disclosing their abuse to physicians as a way of preventing future violence.

> What made it difficult for me to confide [in a physician] was the fact that I feared for my life, you know. And I knew that if I was to tell them what actually happened that they would call the police and I would have to file a report and they couldn't guarantee me that they would be there twenty-four hours to protect me from this maniac. So, therefore, I wasn't taking that chance on my life.

Mistrust of the legal system. Another reason that some women were resistant to police involvement stemmed from previous negative experiences within the legal system. Some of these experiences were related to the process of filing a police report and negotiating the court system.

> What makes it difficult is that . . . when you tell the doctor, the doctor going to call the police and when the police get here, you already been through so much trauma and stuff that . . . it's like you just going through it all over again. It's really hard to do because . . . you have to go through the whole system. . . . And at that time, you're not looking to go through all that stuff.

Other participants were reluctant to involve law enforcement because they believed police officers responded poorly to domestic violence incidents. Reported police responses included judgmental attitudes toward victims, disbelief, or dismissal of complaints.

> [The police] get tired of coming or they take their time about coming if they know what's wrong. . . . I mean, so what if you don't follow through the first couple of times? You're going to get enough and follow through one time or another. And they just [say], "All you're going to do is let him come right [back]."

In addition, some abused women were reluctant to have their partners reported to the police due to a desire to protect their partners from possible harm.

One issue related to mistrust of police was particular to the immigrant focus groups. Many Asian and Latina immigrants said they were reluctant to disclose partner abuse to physicians for fear that the Immigration and Naturalization Service would subsequently become involved with the case.

> Because one is an immigrant, as an illegal in this country one believes that in the moment in which one will ask for help, . . . they will return you to your country and this is something that perhaps we the Latina women are obliged to put up with—this type of violence—for fear that we will be deported.

Fear of family separation. Some participants were opposed to police involvement because they feared that it might result in separation of their families. These participants were concerned that a marital separation would be more harmful to their children than living in a violent home. For many women, dissolution of the family meant loss of the father as the symbolic head of the household, the potential loss of child custody, and/or loss of the family's financial resources. These fears created ambivalence among the abused women with children about how to address the violence.

> [My friend] confessed she's been in a battered situation for eight years. . . . I don't know if she's gone to the hospital or not, but it could ruin it for her. You don't know what will happen to your children. If you're in a battered situation, they'll take your kids, you know.

Preference for confidentiality and autonomy. Participants also expressed a desire for privacy and anonymity. They were concerned that if doctors were required to report to police, patient-physician confidentiality would be compromised and their own ability to participate in the decision-making process would be limited. Several participants remarked that without confidentiality between themselves and their physicians, it would be difficult for them to discuss the very sensitive subject of domestic violence. Many believed that they should retain control over decisions about when to involve the police. They indicated that mandatory reporting requirements impaired the patient-provider relationship and diminished their trust in their physicians and in the medical system.

> I was going to say I don't think it would be a good idea, actually, to ask the police and the doctors [to] cooperate. Because it's hard enough to get the doctor to understand, and if you think that it might be going further, you're going to be even more reluctant to say anything. . . . I think it would make people less apt to tell the doctor what they need to tell him for their own health. They're thinking of all the repercussions.

> What would make it easier for me would be to, um, preferred to be my choice. Well, I need help, can you call the police? Or if, um, this happened to me but I don't want the police involved, can you please treat me and keep my confidentiality? There's supposed to be a law that they keep confidentiality between the patient and the physician.

Alternatives to mandatory reporting. Participants reported that when physicians took action on their patients' behalf by documenting the abuse without making a police report, they felt empowered to prosecute the perpetrators when they were prepared to do so. When discussing possible healthcare interventions, participants preferred approaches that would allow abused women to control the timing of criminal justice involvement, while simultaneously permitting their physicians to assist them.

> But [the hospital staff told] me that it would . . . be up to me to make a full [domestic violence] report. That they would just notify the police that it had happened, but the police would not come out or do anything till I had made the report. So the control was still in my hands even though it was good that they did what they did. I felt that was appropriate.

> I think the doctor can ask you whether or not you have been involved in domestic violence and ask you, "Do you want to go through the procedures of pressing charges?" or whatever. And if you say yes, they'll help you out, and if you say no, they'll just put it on your chart and leave it alone.

Desire for police protection. Some of the abused women supported mandatory reporting because of their desire for police protection. Reported desires included police protection in acute violent episodes and physician assistance in communicating their needs to law enforcement. Some participants reported positive past experiences with medical providers who had helped make linkages with the criminal justice system. These women believed that physicians *should* take the responsibility for reporting to law enforcement.

> [Facilitator:] When you were abused by your husband, . . . where would you . . . normally go for help? [Participant:] Usually my first thought is to call the police [about a battering incident].

> Until he would bring me thrown on the floor . . . in this moment is when one looks at things truly and when one grabs the initiative of calling the police.

> I think that a doctor can help a lot of women who ask for help in terms of getting cured physically, but also that the doctor should pay attention to her emotional ailment. . . . The doctors should see the need, that if one needs the police in this very place, the doctor can take care of it. . . I feel the need that a doctor should take this responsibility of informing the police.

Conclusion

The results of both studies indicate that California's mandatory reporting law may have a number of unintended negative consequences for both domestic violence victims and their physicians. In particular, many of the physicians and abused women in our studies felt that this legislation potentially jeopardizes the safety of patients, deters abused women from seeking medical services, and compromises professional standards of confidentiality and patient autonomy. In addition, the abused women participants expressed several concerns about police involvement and indicated that the constraint on patient-provider communication associated with mandatory reporting is related to their fear of increased violence, fear of family separation, and mistrust of the police. On the other hand, it appears that there are instances when mandatory reporting may be appropriate, such as when there are serious injuries or immediate threats to a patient's safety.

Fear of increased violence. The fear of increased violence associated with mandatory reporting to police was one of the most prominent concerns voiced by both the abused women and physician participants. The safety of victims and their

children should be a priority when healthcare providers intervene with survivors of domestic abuse. Inappropriate interventions are potentially harmful. Since an important role for physicians is to help their patients find safety, even the *possibility* of increased violence should be avoided. If patients feel that disclosure of the violence in their lives to healthcare providers may lead to increased danger, they may seek to avoid this consequence by avoiding the healthcare system altogether.

Avoidance of health care. Indeed, a common theme seen in the focus groups was avoidance of the healthcare system because of abuse victims' concerns that physicians would report to police. Our research indicates that these real or imagined consequences of reporting serve as powerful deterrents to seeking help from medical institutions. Regardless of whether these effects of mandatory reporting are seen in practice, any intervention that potentially deters women from seeking health care is suspect.

Infringement on confidentiality and autonomy. Abused women and physician participants also expressed concerns about the impact of mandatory reporting on confidentiality and patient autonomy. The abused women indicated a desire to maintain confidentiality with their doctors and control over making decisions in their own best interests. Some of these participants chose to avoid talking with physicians about domestic violence in order to maintain their autonomy. The fact that many physicians were less likely to report to police when the patient expressed objections indicates the high value physicians, too, place on confidentiality and patient autonomy. The preservation of confidentiality creates a climate of trust in the patient-provider relationship, and trust is a critical element when working with victims of abuse. The negative impact of mandatory reporting on confidentiality and autonomy may undermine current efforts by the healthcare profession to improve communication about domestic violence.

Desire for police involvement. Mandatory reporting may be appropriate in limited situations. Both physicians and abused women participants acknowledged a role for police and for mandatory reporting. Physicians in our study indicated that the law potentially assists with prosecution. Physicians who worked primarily in acute settings, such as emergency departments, were more likely to express willingness to comply with the law. This may be due to the requirement in a majority of states that serious assault (seen mostly in acute care settings) be reported to police. Abused women in our study expressed their desire to have access to police protection, particularly in some physically violent situations.

Dilemmas for patients and providers. Policy choices that seek to address the needs of abused women in healthcare settings are necessarily complex. Because of the competing interests at stake, physicians and abused patients face significant dilemmas under the current mandatory reporting law. Abused patients may not be sure how well their families are served by involving the police, a step that might

either lead to protection from the abuser or result in further violence or an unwanted separation of family members. If an abused patient does not want to involve the police, she may choose not to communicate at all with her physician about the abuse—a choice that may prevent her from receiving much-needed assistance, such as treatment of injuries, documentation of the abuse, emotional support, and referrals to domestic violence services. The right of an adult patient to exercise control over important decisions and to expect confidentiality within the patient-physician relationship increases the complexity of the problem. Doctors must choose between honoring their medical ethics and obeying a law that often requires them to breach confidentiality and interfere with patient autonomy. The results obtained in both studies, as presented here, seem to indicate that current mandatory reporting requirements in California may place an undue burden on patient-provider communication about domestic violence.

Limitations and further research. In the physicians' study, the results were limited to the sample group of California physicians in four specialties. It is unclear if the self-reported responses of the participants accurately reflect their practice. In the study of abused women, the sample was small and was not randomly selected. Therefore, the results obtained may not be generalizable. Further research should be pursued to determine whether the sentiments of participants presented here are shared by physicians and abused women throughout California and in other states. Research on the direct impact of this legislation on victims of domestic violence is needed to establish which (if any) of the potential risks or benefits have been realized. Such research should be conducted before mandatory reporting legislation is enacted elsewhere.

Recommendations

Legislative considerations. Domestic violence policy should be guided by several considerations. First, the safety of the victim should be of paramount importance. It is imperative to ensure that our interventions "do no harm" to survivors of domestic violence and their children. Second, legislation should not create barriers to access to medical care. Healthcare settings should be safe havens, not places where women have to consider carefully the consequences of talking about their experiences. Because of the variety of reactions that women have to domestic abuse, policies guiding the healthcare response to this problem should be flexible enough to allow physicians to provide for the needs of individual patients. Third, policymakers should consider the impact of legislation on the patients' autonomy and confidentiality. Infringing on confidentiality and autonomy often leads to impaired patient-provider communication and thus precludes abused women patients from receiving the referrals and support they need. In light of the already-existing barriers to the identification and treatment of abused patients,[18,19] it is important to avoid placing further constraints on the patient-provider relationship.

Fourth, healthcare institutions should be allowed to maintain their independence from immigration authorities, and this should be made clear to the public. Finally, healthcare policy should be developed collaboratively in a process that includes healthcare practitioners, abused women, and their advocates.

Institutional responses to domestic violence. Given the myriad needs of abused women, a comprehensive approach to the problem of domestic violence is essential. On a public policy level, it is critical to ensure adequate funding for social, legal, and healthcare services to meet the needs of abused women better. Healthcare institutions have a role to play in developing and implementing policies, protocols, and educational programs for clinicians.[20] Currently in California, all hospitals and licensed clinics are required to establish policies and procedures for the routine screening of patients for domestic violence.[21]

Several models exist for establishing a response within healthcare organizations One approach, promoted by the Family Violence Prevention Fund, includes the following objectives:

- creating an environment that enhances the identification of abuse;
- educating healthcare staff about how to intervene with patients who are victims of abuse;
- establishing an integrated and institutionalized response to domestic violence;
- developing referral and resource materials;
- evaluating the effectiveness of the program; and
- becoming part of a coordinated response within the larger community.[22]

The role of healthcare providers. In addition to providing treatment, the healthcare professional's role is to be an advocate for an abused woman, to educate her about her options, and to make recommendations.[23] Healthcare providers are increasingly able to identify symptoms and assist abused women with the serious, often life-threatening, circumstances in which they find themselves. Therefore, practitioners should routinely screen their patients for domestic violence and thoroughly document all abuse-related visits in the patient's medical records. As part of this process, providers should assess the immediate danger to the patient and her children. Finally, they should be able to convey messages of support, provide information about domestic violence, assist the patient in making a safety plan, and make available a variety of options and referrals, including legal, social, and psychological services.

Afterword

No single approach will eliminate domestic violence. As patients and healthcare providers become more collaborative in developing the policy and programs needed to address domestic violence effectively, the healthcare system will be able to play an increasing role in reducing this problem. By ensuring a safe place for survivors to talk about abuse, we promote their ability to end it. By working together, we can help establish the social, institutional, and individual changes necessary to reduce—and in time, perhaps, prevent—the devastating effects of domestic violence.

Appendix

Domestic Violence and Statewide Mandatory Reporting to Police

A Statewide Survey of Physicians' Preferences

Let policy makers know your views on
the role of physicians in caring for battered patients.

Please take 10 minutes to complete this survey.

Thank you for your help.

In this survey, **"domestic violence"** is defined as: **"the physical, sexual, and/or psychological abuse of an individual by someone with whom s/he has or has had an intimate or romantic relationship."** Domestic violence may occur in any intimate relationship, including gay and lesbian relationships, and either partner may be the victim.

1. There are many barriers to identifying patients who are victims of domestic violence. To what extent are the following situations barriers to identifying patients who are victims of domestic violence? *Please circle the number that best represents your experience.*

	MAJOR BARRIER	MINOR BARRIER	NOT A BARRIER
The patient does not raise the issue of battering during history-taking.	1	2	3
The patient's primary language is not English.	1	2	3
The patient's cultural norms and customs interfere with the discussion of battering.	1	2	3
The patient is accompanied by partner or children (i.e., lacks privacy)	1	2	3
Physicians do not think they can make a difference in domestic violence.	1	2	3
The patient fears retaliation by partner.	1	2	3
The patient fears police involvement.	1	2	3
Physicians don't have enough time to address domestic violence in a practice setting.	1	2	3
Physicians are not trained to identify domestic violence.	1	2	3

2. There are many barriers to the referral of patients who are victims of domestic violence. *Please circle the number that most agrees with your experience*

	MAJOR BARRIER	MINOR BARRIER	NOT A BARRIER
I do not have a list of local community agencies for referral.	1	2	3
The patient does not follow up on referrals.	1	2	3

3. In the following circumstances, how frequently do you ask direct, specific questions about domestic violence to patients?

	NEVER	SOMETIMES	OFTEN	ALWAYS	NOT APPLICABLE
New patient visit	1	2	3	4	5
Periodic check-up	1	2	3	4	5
With injury (e.g., bruises)	1	2	3	4	5
First prenatal visit	1	2	3	4	5

4. Have you ever identified a patient who was involved in a domestic violence situation at the time you saw her/him?

☐ Yes

☐ No If you respond No, answer question #5 by indicating what you believe you would do as an intervention.

5. Physicians respond to victims of domestic violence differently. When you identify a patient who is a victim of domestic violence, how often do you:

	NEVER	SOMETIMES	OFTEN	ALWAYS	NOT APPLICABLE
Tell patient you are concerned for her or his safety	1	2	3	4	5
Suggest that the patient leave the relationship	1	2	3	4	5
Ask about guns in the home	1	2	3	4	5
Record battering in patient's chart	1	2	3	4	5
File report with the police	1	2	3	4	5
Give information about shelters or victim services	1	2	3	4	5
Refer patient to counseling	1	2	3	4	5

MANDATORY REPORTING OF DOMESTIC VIOLENCE

As of January 1994, California physicians are required by law to report to the police any patients to whom they provide medical care who they suspect are suffering from domestic violence–related injuries.

6. Before reading this questionnaire, were you aware of this new law? ☐ Yes ☐ No

7. Physicians have different opinions about the appropriateness of mandatory reporting of patients who are suffering from domestic violence–related injuries to the police. Comment on the following scenarios:

A patient **asks me not to report**, but I suspect that s/he is suffering from domestic violence–related injuries. *(Check the sentence that most agrees with your response.)*

☐ I would report in **all** situations even if a patient asked me not to report.

☐ I would report in **some** situations even if a patient asked me not to report.

☐ I would **not** report in **any** situation in which a patient asked me not to report.

A patient **does not express a preference** one way or the other for filing a police report, but I suspect s/he is suffering from domestic violence–related injuries. *(Check the sentence that most agrees with your response.)*

☐ I would report in **all** situations in which a patient does not express a preference.

☐ I would report in **some** situations in which a patient does not express a preference.

☐ I would **not** report in **any** situations in which a patient does not express a preference

8. Indicate your agreement/disagreement with the following statements about mandatory reporting of domestic violence to the police. *Please circle the number that most agrees with your answer.*

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
It infringes on patient confidentiality.	1	2	3	4
It improves collection of useful statistics on domestic violence.	1	2	3	4
It puts patients at higher risk for retaliation by their partners.	1	2	3	4
It discourages victims of domestic violence from seeking medical care.	1	2	3	4
It improves a physician's response to victims of domestic violence.	1	2	3	4
It infringes on a patient's autonomy to decide what is in her/his best interest.	1	2	3	4
It helps with prosecution of perpetrators of domestic violence.	1	2	3	4
It decreases the need for physicians to ask about violence during future visits.	1	2	3	4
It discourages physicians from asking about domestic violence.	1	2	3	4

9. Some physicians believe there are special situations that require reporting domestic violence to police whether or not there is a law. Indicate how strongly you agree with reporting domestic violence in the following circumstances. *Circle one number for each situation.*

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
The patient is pregnant.	1	2	3	4
The domestic violence leads to hospitalization	1	2	3	4
The patient has obvious physical injuries (e.g., scars, bruises, etc.).	1	2	3	4
The patient has presented multiple times with complaints of physical abuse.	1	2	3	4
There are children in the home.	1	2	3	4
The patient's safety is of concern.	1	2	3	4
There are guns in the home.	1	2	3	4

10 Most people have been exposed to or have experienced violence in their lives. To help us better understand this problem, please mark the answer that best reflects your experiences.

When you were growing up, did one of your parents ever threaten, hit, slap, kick, or otherwise physically hurt the other?

☐ Yes ☐ No

Have you ever feared for your safety or been hit, slapped, kicked, or otherwise physically hurt by an intimate or previously intimate partner?

☐ Yes ☐ No

Finally, we would like to ask a few questions about you to help us interpret the results.
Please answer the following questions.

11. What is your age? ☐☐

12 What is your gender? ☐ Female ☐ Male

13 What is your medical specialty?

☐ Emergency medicine ☐ Family practice ☐ Internal medicine
☐ Obstetrics/gynecology ☐ Other _____

14. How do you identify yourself?

☐ African-American ☐ Asian ☐ Caucasian ☐ Latino/Hispanic ☐ Pacific Islander
☐ Other (please specify) _____

15. In addition to English, in what other languages are you fluent?

☐ Spanish ☐ Chinese ☐ Tagalog ☐ Vietnamese ☐ Korean ☐ Other _____

16 Where do you see the largest number of your patients? (check one)

☐ Health maintenance organization (e.g., Kaiser) ☐ Military ☐ Private office
☐ Community clinic ☐ State or public health department
☐ Academic site (teaching) ☐ Other, please specify: _____

17. What percentage of your patients do you estimate are on medicaid? (check best answer)

☐ 0-5% ☐ 6-10% ☐ 11-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

18 What percentage of your patients are uninsured?

☐ 0-5% ☐ 6-10% ☐ 11-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

19 Please estimate the racial/ethnic breakdown of your patient population

African-American ☐☐☐ % Asian/Pacific Islander ☐☐☐ %
Latino ☐☐☐ % Caucasian ☐☐☐ %

20. Did you obtain your medical school training outside of the United States (i.e., International Medical Graduate)?

☐ Yes ☐ No

21. Are you affiliated with a fellowship, residency, or medical student training program (e.g., teacher, fellow, resident)?

☐ Yes ☐ No

22. Zip code of main practice location: ☐☐☐☐☐

23. Have you taken a class or continuing medical education course on domestic violence in the last three years?

☐ Yes ☐ No

24. Do you want to learn more about the issue of domestic violence?

☐ Yes ☐ No

If there is anything else you would like to tell us (e.g., personal experiences) which might help in our future efforts to understand how physicians feel about domestic violence and mandatory reporting to the police, please use this space for that purpose or call Michael A. Rodriguez, MD.

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Your contribution to this effort is greatly appreciated. If you would like a summary of results, please print your name and address on the back of the return envelope (NOT on this questionnaire). We will see that you get it.

Pacific Center for Violence Prevention
San Francisco General Hospital
San Francisco, CA 94110

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Potential Legal Liability for Health Professionals for Actions for Inactions in Domestic Violence Cases

By Leslye E. Orloff and Minty Siu Chung[1]

If an injured victim of domestic violence is treated by a physician or nurse who does not inquire about abuse or who accepts an unlikely explanation of the injuries, and the patient then returns to the abusive situation and sustains further injuries, the physician or nurse could conceivably be held liable for those subsequent injuries.[2]

Introduction

Studies estimate that four to six million women are battered by their intimate partners each year in the United States. Of those, each year more than one million women seek medical treatment for injuries deliberately inflicted upon them by their husbands or boyfriends.[3] Battering accounts for 22-35% of cases in which women seek care in emergency departments.[4] Violence is the second leading cause of injuries to women generally, and the leading cause of injuries to women 15 through 44 years.[5]

Oftentimes health care providers are the only professionals in a position to see and help battered women. In 43% of spousal abuse cases, the victim turns to no one to discuss the problem.[6] Many battered women do not know that shelters exist or will not use them[7]. Only 10% of abuse victims report any prior

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[1]This paper has been prepared by Leslye Orloff and Minty Siu Chung of Ayuda, Inc. as a legal memorandum for the State of Alaska, Department of Health and Social Services, Division of Public Health, Section of Maternal and Child Health for its Train the Trainers Workshop 1996. Its purpose is to provide an overview of evolving issues in tort liability law that could form a basis for finding liability against health care professionals who see victims and perpetrators of domestic violence. The legal advice in this memo should not be used in any specific case without consulting an attorney who can evaluate how the law would apply to the facts of any specific case. This memo was prepared with the assistance of Rachel Arnold of George Washington University Law School and Dafna Hacker of American University Law School.

[2]Carol Warshaw and Anne Ganley, IMPROVING THE HEALTH CARE RESPONSE IN DOMESTIC VIOLENCE: A RESOURCE MANUAL FOR HEALTH CARE PROVIDERS 78 (Family Violence Prevention Fund 1995).

[3]Evan Stark and Anne Flitcraft, "Medical Therapy as Repression: The Case of the Battered Women," Health and Medicine, Summer/Fall 1982

[4]Caroline Knapp, "A Plague of Murders: Open Season on Women" The Boston Phoenix, August 1992; also "Physicians and Domestic Violence: Ethical Considerations," Trends in Health Care, Law and Ethics Vol. 8, No. 2, Spring 1993, p.13.

[5]American Journal of Epidemiology, 1991, Vol. 134 pp. 59-68.

[6]Mark A. Schulman, A Survey of Spousal Violence Against Women in Kentucky 4, U.S. Department of Justice, Washington, D.C. 1979

[7]Women of color, in particular, use battered women's shelters at a lower rate than women from the majority culture. Angela Browne, Violence Against Women By Male Partners: Prevalence, Outcomes, and Policy Implications, 48 AM. PSYCHOL. 1077 (1993). Instead, when they flee an abuser they seek refuge with friends and family members who offer

effort to seek assistance from a domestic violence program.[8] Only seven percent of assaults between spouses are reported to the police.[9]

In many cases, health care workers are the first people to encounter battered women.[10] One third of battered women see health professionals, often repetitively. Thus, health providers have enormous potential to identify and assist battered women.[11] Yet, health care providers have not been effective in meeting this potential. While one out of five women treated for serious injuries in hospitals are battered, only one out of twenty-five is detected by emergency department staff.[12]

In light of these statistics, all health care providers need to be trained in identification, treatment and referral of domestic violence victims. Training should include informing health care providers that they are open to legal liability if they fail to diagnose domestic violence or if they act inappropriately once domestic violence has been identified. Evolving trends in American tort law may lead to health professional liability if health care providers fail to act or fail to act in an appropriate manner when offering medical care to victims and perpetrators of domestic violence. There are three common circumstances in which health care providers may be open to liability if they act or fail to act in domestic violence cases.

1- Reporting abuse to the police without permission of an adult victim of abuse;

2- Negligence in identifying victims of domestic violence (diagnoses), documenting their injuries, properly treating victims, providing them with information about their options to

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support in a more culturally comfortable setting.

[8]Susan Schechter, Women and Male Violence, Boston, South End Press, 1982, p. 308

[9]Muarry Straus and Christine Smith, "Family Patterns and Primary Prevention of Family Violence," Trends in Health Care, Law and Ethics Vol. 8 No. 2 Spr. 1993, p.19.

[10]Cynthia Lynne Pike, Note: The Use of Medical Protocols in Identifying Battered Women, 38 Wayne L. Rev. 1941, 1943 (1992).

[11]Howard Holtz and Kathleen Furniss, "The Health Care Providers Role in Domestic Violence," Trends in Health Care, Law & Ethics, Vol. 8, No. 2, Spr. 1993, p.47

[12]Anwar & McLeer, *reprinted by* National Woman Abuse Prevention Project, "Some Commonly Asked Questions about Domestic Violence," Domestic Violence Fact Sheet.

counter domestic violence (including safety planning), and making referrals to specialists (domestic violence experts).

3- Failure to warn potential victims about the threat of assault from an abuser when the health professional learns that there is a danger of harm to an identifiable victim or victims by a patient who is a perpetrator of domestic abuse.

Potential Liability for Unauthorized Disclosure

Long experience with child abuse cases may inappropriately color how health care professionals act in cases of adult partner abuse. Too often health care professionals who have not received adequate training in the dynamics of adult partner abuse will report to law enforcement officials incidents of domestic violence that their patients have suffered without obtaining permission from the adult abuse victim. Absent a statute that requires reporting of adult partner abuse (domestic violence), reporting of incidents of abuse without the permission of the patient is a breach of patient confidentiality. Reporting of abuse without permission also sends a message to abuse victims that the health care setting is not a safe place for them and discourages victims from seeking medical treatment in the future.

When it comes to reporting of assaults that occur within the family, child abuse differs significantly from adult partner abuse. Crime statistics and research on battered women show that the lethality of the perpetrator's violence often increases when he suspects that the victim has left or is about to leave the relationship. [13] Women who leave their abusers assume a seventy-five percent greater risk of being killed by their abusers.[14] Many battered women have finely honed survival skills that have allowed them to survive in the relationship.[15] Adult victims of abuse need to be able to choose when and if it is safest to leave the

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[13]M. Wilson and M. Daly, "Spousal Homicide Risk and Estrangement," VIOLENCE AND VICTIMS 8(1), 3-16 (1993).

[14]Catherine F. Klein and Leslye E. Orloff, "Providing Legal Protection for Battered Women: An Analysis of State Statutes and Case Law," 21 HOFSTRA L. REV. 801, 1112 (Sum. 1993) (*citing* "National Estimates and Facts About Domestic Violence," NCADV VOICE, Special Edition: Battered Women in Prison 12 (Win. 1989)).

[15]Id.

-- Injuries caused by a knife or other sharp or pointed instrument, unless clearly accidental; and

-- Life-threatening injuries, unless clearly accidental.

Reporting of injuries other than those required by law may result in financial liability for the health care provider. Furthermore, when there is a statue requiring reporting of specific crimes the health care provider may not selectively comply with the statute by reporting only those injuries related to domestic violence. Selective reporting of domestic violence related injuries and not those injuries resulting from other forms of violence may result in successful suits by domestic violence victims against the health care provider.[17]

Common injuries suffered by battered women include: contusions, abrasions, minor lacerations, fractures, sprains, as well as injuries to the head, neck, chest, breasts and abdomen.[18] Pain, with or without a readily apparent physical source, is a common presenting symptom of abuse. Battered women often suffer from headaches, chest pain, back pain and pelvic or abdominal pain. Stress, anxiety and depression may also be signs of domestic abuse.[19] The vast majority of medical visits that are made by battered women are for routine medical care and health care for somatic symptoms or non-life threatening injuries rather than for overt trauma or the type of injuries listed above.

Courts have generally recognized and upheld the right of the patient to recover damages from a health care provider for unauthorized disclosure concerning the patient on the grounds of invasion of privacy

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[17]Courts across the country have ruled that police departments violate the Equal Protection Clause of the Fourteenth Amendment when they discriminate against domestic violence victims in they manner that they respond to calls for assistance. See Catherine F. Klein & Leslye E. Orloff, Providing Legal Protection for Battered Women: An Analysis of State Statutes and Case Law, 21 Hofstra L. Rev. 801 (1993), at 1015n1350. Hospitals who selectively report cases of domestic violence assault while failing to report other forms of assault to authorities also be open to liability.

[18] American Medical Association, Diagnostic and Treatment Guidelines on Domestic Violence, (1992), at 9.

[19] Warshaw, supra note 2, at 54.

abuser. Victims who fear retribution from their abusers will be discouraged from seeking needed medical assistance and will not disclose abuse to health care professionals if they cannot be assured that their disclosures will be kept confidential and will not be reported to the police without their permission.

An abuser strictly controls his victim's life and undermines her self-esteem to hold her hostage in the abusive relationship. For many women who are isolated by their abuser from all friends, family and social services, the health care provider may the only professional to whom she has access, and the only person who can in a safe setting communicate with her that she need not continue to suffer abuse. A breach of health professional-patient confidentiality reinforces the victim's low self-esteem, her sense of helplessness and powerlessness and cuts off an important avenue of support and potential escape.

Over exuberant reporting can lead to liability for unauthorized disclosure of patient information. Because reporting of child abuse is legally mandated in all fifty states and the District of Columbia, health care providers will generally be immune from liability for good faith disclosure of child abuse to the appropriate authorities. Child abuse reporting is required because children are presumed to be unable to protect themselves.[16] Because the reporting of non-dependent adult abuse is not mandatory in Alaska no immunity from liability exists for those who report adult abuse. Alaska has no mandatory reporting statute for adult partner abuse and does not require that health care professionals report abuse of a non-dependent adult.

Alaska Business and Professions Code Sec. 08.64.368 requires only that the following injuries be reported to the Department of Public Safety, a local law enforcement agency or a village public safety officer:

-- Second or third degree burns to 5% or more of the patient's body;

-- Burns to the patient's upper respiratory tract or laryngeal edema due to inhalation of superheated air;

-- Wounds from the discharge of a firearm;

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[16]See generally, Ariella Hyman and Ronald Chez, "Mandatory Reporting of Domestic Violence By Heath Care Providers: A Misguided Approach" published in Carole Warshaw and Anne L. Ganley, Improving the Health Care Response to Domestic Violence (Family Violence Prevention Fund, 1995).

or breach of confidence.[20] Unauthorized disclosure is often a ground for a malpractice action. In Alaska, breach of confidence may also give rise to a claim for emotional distress.[21]

Domestic violence victims are competent adults who have the right to choose when and whether to report abuse to the police and to assess the dangerousness to themselves and their children of such a report. Health care professionals who breach patient confidence and report injuries, absent a statutory mandate, not only further endanger the lives of their patients, but also risk liability for the unauthorized disclosure.

The only circumstance under which a health care provider has been found not liable for making an unauthorized release of patient medical information or medical records to a third party is when the information was released to the Anchorage District Attorney under a valid court order.[22]

It is important for health care professionals to know that a subpoena requesting medical records of a particular patient is not a court order which protects the health professional from liability. Any person involved in litigation can obtain a blank subpoena from the court, fill it in with a request that the information they are seeking be produced at a specific time and place and serve the subpoena on a person who is not a party to the litigation. Release of medical records subpoenaed by a party in a court action without obtaining prior consent from the patient may give rise to a successful law suit against the health care professional for breach of confidence or invasion of privacy. It is therefore important that health care centers develop protocol about how they will respond to subpoenas.

Protocols should include instructions to contact the client routinely upon receipt of a subpoena and seek permission to release the information. Calls to victims who are still residing with their abusers could potentially place the victim in danger. To reduce this risk of danger, it is advisable that health care professionals routinely include in the record of patients who are domestic violence victims information about how, when, where and, if necessary, through whom domestic violence victims may be safely contacted by

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[20]Judy E. Zelin, Annotation: Physician Liability for Unauthorized Disclosure of Confidential Information about Patient, 48 ALR 4th 668

[21]Chizmar v. Mackie, 896 P.2d 196 (Alas. 1995).

[22]Arnett v. Baskous, 856 P.2d 790 (Alas. 1993)

the health care provider. Once the patient has provided permission, the records may be released in response to the subpoena. If the patient does not grant permission, the health care professional must contact the person who issued the subpoena and inform them that the records cannot be released.

To obtain the records without the permission of the patient, the person seeking the records must ask the court for an order that the records be released. Before granting such an order the court will hear arguments from the parties in the case and will determine whether the records are relevant and necessary to the court proceeding and will either deny the request or issue the court order. Once the health care provider receives an order from a judge ordering release of the patients records the provider must comply with the order and will be protected from liability for breach of patient confidentiality.

Physician Liability for Negligence

When working with victims of domestic violence, health care professionals must be aware of the potential for negligence liability if they fail to identify domestic violence, and thereafter if they fail to inform the patient of risks and options and if they fail to make appropriate referrals to domestic violence experts in the community. Historically, patients who brought negligence claims against their health care provider had to prove that the provider failed to exercise the degree of care ordinarily exercised by a health care professional in a similar community. In Alaska, a health care provider must have the degree of knowledge or skill, and must exercise the degree of care, ordinarily exercised by providers practicing the same specialty in similar communities.[23] A health care professional whose failure in this charge causes a patient to suffer injuries that would otherwise not have occurred will be liable for malpractice.[24]

An increasing number of courts, however, are adopting the reasonable care or reasonably prudent health care provider standard in negligence cases. Proof of medical custom then becomes relevant to, but

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[23] Poulin v. Zartman, 542 P.2d. 251 (Alas. 1975).

[24] Alaska Stat. § 09.55.540.

signs of domestic violence in his or her patients, inform the patient about the options available to help stop the violence, recommend treatment[27] and provide appropriate referrals. Under this approach, if a jury found that compliance with the AMA Guidelines was reasonable under the circumstances, a health care professional could be held liable for failure to do follow those guidelines , even if the practice is not yet customary. A health care providers wishing to avoid malpractice litigation may not succeed in convincing a court to dismiss a malpractice claim when their practice was inconsistent with that set forth in the American Medical Association Guidelines.

[27] Treatment might include discussing steps that the victim might take to improve her safety. Safety planning is needed for battered women who plan to stay with their abusers as much as it is needed for those who are planning to leave. The health care professional should train their staff in basic safety planning and should identify domestic violence victim advocates in the community to whom patients suffering abuse in the home can be referred for more complete safety planning.

not conclusive on, the issue of due care, consistent with the general tort law .[25] As growing numbers of communities are establishing protocols for the identification, treatment and referral of domestic violence victims the likelihood is rapidly increasing that health care providers who do not follow recommendations of major health care associations and institutions on domestic violence will be found liable either for not having the knowledge or exercising the customary degree of care in a community in which more and more health care professionals are adopting domestic violence procedures, or for failing to provide the care that would be provided by a reasonably prudent health care professional under similar circumstances.

Health care professionals in Alaska must be informed about and trained on the domestic violence protocols that are being implemented in growing numbers of communities for the identification, referral and treatment of domestic violence victims. A reasonably careful health care provider, at minimum, would be expected to comply with increasingly common trends in the medical profession. Organizations such as the American Medical Association, the American College of Obstetricians and Gynecologists, the American College of Nurse Midwifery and the Joint Commission on the Accreditation of Health Care Organizations as well as hospitals and clinics, throughout the nation have adopted procedures for diagnosing patients as victims of domestic violence, documenting injuries, informing victims of their options and referring identified patients to domestic violence specialists (i.e. domestic violence service providers and special hospital based social workers who have been explicitly trained on the dynamics of domestic violence.0[26] These trends signal that a health care provider of ordinary skill in any community should be able to recognize

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[25] Kalsbeck v. Westview Clinic, P.A., 375 N.W.2d 861 (Minn. App. Ct. 1985); Brown v. Dahl, 705 P.2d 781 (Wash. App. Ct. 1985) ("reasonably prudent practitioner"; references in charge to jury to "average" and "ordinary" care improper). Culbertson v. Mernity 602 N.E. 2d 98 (Supreme Court of Indiana 1992) (requiring evidence of what a "reasonable" physician would have done under the case's circumstances); Catron v. Bohn 580 So. 2d 814 (Flo. App. Ct. 1991) (the plaintiff must prove a breach of standard of reasonably prudent similar health care provider); Madlin v. Crosby 583 So. 2d 1290 (Supreme Court of Ala. 1991); Hutchinson v. Paterl 637 So. 2d 415 (Supreme Court of Louisiana 1994); Caughell v. Group Health Coop. Of Pugent Soud 124 Wash. 2d 217 (Supreme Court of Wash. 1994); St. Joluis Regional Health Ctr. Inc. v. Windler 847 S.W. 2d 168 (Missouri App. Ct. 1993); Jones v. Malloy 226 Neb. 559 (Supreme Court of Nebraska 1987); Shaw v. Caldor Inc. 1995 Super. Lexis 567 (Supreme Court Conn.) (The prevailing professional standard of care for a given health care provider shall be that level of care, skill and treatment which, in light of all relevant surrounding circumstances is recognized as acceptable and appropriate be reasonable prudent similar health care provider).

[26] Cynthia Lynne Pike, Note: The Use of Medical Protocols in Identifying Battered Women, 38 Wayne L. Rev. 1941 (1992).

DUTY/BREACH

Guidelines promulgated by the American Medical Association recognize a duty by physicians to diagnose and address domestic violence. They recommend that medical organizations need to implement policies and procedures which include:

-- Identification -- identifying the patient as a victim of domestic violence;

-- Documentation-- documenting her injuries and the cause(s) thereof;

-- Treatment-- providing validation and appropriate treatment for physical, mental and emotional injuries;

-- Information-- providing information on the domestic violence, risk assessment, legal options, domestic violence services available and safety planning.

-- Referral-- The information should providing the patient with appropriate referrals to a specialist in domestic violence.[28]

According to the American Medical Association risk management in domestic violence cases requires that health care professionals treating repeated or chronic injuries recognize signs of domestic violence and treat not only the symptoms but address the underlying causes of the abuse by offering the patient information and referrals.[29]

Identification

Failure to recognize signs of domestic violence can result in negligence liability in the same manner as failure to diagnose other health conditions. Across the country courts have found physicians liable for failure to diagnose various conditions, such as failure to diagnose pregnancy,[30] cancer,[31] cerebral aneurysm,[32]

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[28] AMA, supra note 18.

[29] AMA supra note 18, at 9, 11.

[30] Rinard v. Biczak, 441 N.W. 441 (1989), Clapham v. Yanga, 300 N.W. 2d 727 (Mich. App. 1980), Debora S. v. Sapega, 392 NYS 2d. 79 (1977), Chapman v. Schultz, 367 NYS 2d 1018 (1975) Ziemba v. Sternberg, 357 NYS 2d 265 (1974).

[31] Williams v. Bay Hospital, 471 So. 2d, 626 (1985); DeBurlate v. Louvar 393 N.W. 2d 131(Supreme Court of Iowa 1986); Turner v. Massiah 656 So. 2d 636 (Supreme Court of Louisiana 1995); Savelle v. Heilbrunn 552 So. 2d 52 (Louis. App. Ct. 1989); Evers v. Dollinger 95 N.J. 399 (Supreme Court of N.J. 1983); Marciniak v. O'Connor, 430 N.E. 2d 536 (Ill. App. 1981); O'Brien v. Stover, 443 F.2d 1013 (8th Cir. 1971); Herskovits v. Group of Pugent Soud 99 Wash. 2d 609 (Supreme Court of Wash. 1983); Scafidi v. Seiler 119 N.J. 93 (Supreme Court of N.J. 1990).

[32] Brillant v. Royal, 582 So. 2d 512 (Ala. 1991); Larkin v. State 84 A.D. 2d 438 (Supreme Court of N.Y. 1982).

infections,[33] and glaucoma[34]. Similarly, state laws also recognize a failure to diagnose conditions as a ground for liability[35].

Since battering often increases in frequency and severity over time, early identification is crucial for the health and safety of the woman patient. In fact, when the abuse is not identified, treating only the symptoms may increase the patient's sense of entrapment and her feeling that there is no way she can escape from the violence. Still, the diagnosis of abuse is often missed. Indeed, research shows that as few as 5% of domestic violence victims are identified as such in emergency departments.[36] Due to the prevalence of the phenomena and the fact that some women may not initially recognize themselves as "battered", the AMA guidelines require that a physician will routinely ask all women direct, specific questions about abuse.[37]

Courts have already recognized that health care providers may be held liable for failure to diagnose and treat child abuse. In Landeros v. Flood,[38] a child plaintiff successfully sued his doctor for common law malpractice after the doctor failed to diagnose and report child abuse. The California Supreme Court held that the existence of a duty to diagnose and address child abuse was a question of fact for the jury to decide after it hears expert testimony.[39] The Landeros court pointed to the medical profession's own recognition of the battered child syndrome as a factor in allowing a jury to impose liability.

No reported appellate court decision to date has imposed liability for failure to diagnose and treat domestic violence when the victim is an adult. Courts may be reluctant to impose liability before the AMA

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[33]Schuler v. Berger, 275 F. Supp. 120 (Pa. 1967); Allen v. State 520 So. 2d 761 (Louis. App. Ct. 1988); Kashner v. Geisinger Clinic 638 A. 2d 980 (1994).

[34]Romero v. Riggs, 29 Cal. Rptr. 2d 219 (1994); Morrison v. Homas 519 P. 2d 981(Supreme Court of Wash. 1974); Broussard v. Sears 568 So. 2d 225 (Louis. App. Ct. 1990).

[35]Ark. Stat. Ann. § 16-114-201 (1995); Cal. Civ. Code §1714.8 (1995); RSA 507-C:1 (N.H. 1994).

[36] California Hospital Emergency Departments Response to Domestic Violence - Survey Report - August 1993.

[37] The AMA guidelines recommend that the physician should make an opening supportive statement, such as: "Because abuse and violence are so common in women's lives, I've begun to ask about it routinely". The guidelines provide a series of questions to help a physician identify an abusive situation. See AMA, supra note 18, at 8-9.

[38]551 P.2d 389, 393, 131 Cal. Rptr. 69, 73 (1976)

[39]Id.

about the abuse are medical records which carefully document the injuries that resulted from the abuse. Documentation chronicles the violence is particularly important when there have been multiple attempts to leave by the victim. With well-documented evidence of abuse, the patient will have significantly greater success in undertaking legal proceedings to halt the violence.

The AMA requires that records will be kept in a precise, professional manner and include: chief complaints using the complaint's words, description of the abusive event, medical history, relevant social history, detailed description of the injuries, an opinion on whether the injuries were adequately explained, results of laboratory and other diagnostic procedures, color photographs and imaging studies and the names of police persons involved.[40] It is important that objective facts documented as opposed to subjective comments. Recording the complainant's words and eliminating subjective speculative observations or opinions from the medical record will improve the victim's ability to used these records to help her prove the domestic violence she has experienced in court proceedings. When the patients descriptions of the events that have led to her injuries are inconsistent with the injuries, it is best to quote what she reported, state in detail the extent and location of her injuries and make a note in the medical record -- "suspected abuse: screen for domestic violence at next checkup."

Treatment

The AMA guidelines recognize the importance of physician's validation as part of the needed intervention. For many battered women the health professional will be the first person who has an opportunity to tell the her that they believe that she has been abused, that abuse is not normal, that she need not live with abuse, and that the health care professional and others are willing to help her stop the violence. Recognition, acknowledgment, and concern confirm the seriousness of the problem and the need to solve it.[41]

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[40] AMA, supra note 18, at 15.

[41] AMA, supra note 18, at 11.

has fully implemented the AMA Guidelines, but the chances that liability will be imposed will continue to increase dramatically as the AMA Guidelines are adopted in greater numbers of hospitals and health care facilities. Even before the AMA Guidelines become common practice, a plaintiff may succeed in basing a negligence claim on a health care provider's failure to conform to the reasonable provider standard arguing by analogy to the child abuse cases. The burden on and ability of a health care professional to diagnose child abuse would not differ substantially from diagnosing domestic violence.

The policy reasons for imposing a duty to diagnose domestic violence on health professionals are clear. Domestic violence is a significant health problem for women in the United States. Health care providers are for many abuse victims the only professional they see who can offer them a safe confidential place in which they can disclose the violence and learn about what options they may have to reduce domestic violence in their lives. Health care professionals see battered women before they disclose abuse, when they decide to stay with their abusers, when they try to leave their abusers and when they return to their abusers. Justice system professionals only have contact with abuse victims when they are trying to use the legal system to end the abuse. If they fail or get frustrated and decide that it is safer to return to their abusers contact with justice system professionals ceases and only health care professionals may have continued access to these abuse victims.

Documentation

Documenting the violence is critical to a battered woman's ability to successfully obtain legal help, either now, or in the future. The better the documentation the victim has of abuse the more likely a judge will be to award her the house, custody and reasonable child support. In addition good documentation in medical records provides supporting documentation for a future civil protection order action, for an action to enforce an existing civil protection order and can play a crucial role in criminal prosecution of abusers. Enforcement of civil protection orders and criminal domestic violence prosecutions require that the abuse victim prove that the abuse occurred beyond a reasonable doubt. Since too often abuse occurs within the home, behind closed doors, the only evidence that may be available to corroborate the victim's testimony

The injury or complaint of the patient requires appropriate treatment. The health care provider should conduct a thorough physical exam to reveal hidden and not yet visible injuries.[42] In addition to treating the patient's injuries, the health care professional should assess her emotional status for suicidal tendencies, depression, anxiety reaction, or abuse of drugs, alcohol, or other medications.[43]

An integral part of the treatment is an evaluation of the patient's safety. The physician should assess the situation and discuss with the patient various options to minimize future injuries and damages.[44]

Duty to Inform The Patient About Options

A patient who is a victim of abuse cannot made an informed decision not to seek assistance from experts about domestic violence unless she is provided with information about the existence of legal and social services available to help victims of domestic violence. Without information here, as with any medical condition there can be no informed choice. Generally, health care providers are in a position to advise appropriate courses of treatment to a patient. Treatment of a recurring physical victimization by domestic violence should be addressed in the same manner as all other patient maladies. Patients should be educated about the hazards of her condition and circumstances. She should be fully informed about appropriate treatment or appropriate actions she can take to secure her physical, mental and emotional well-being.

Any treatment plan for injuries or other health complaints recommended by a health care provider should take the domestic violence into account. A health care professionals who does not recommend appropriate referrals, counseling, and follow-up action must inform the patient that he or she has other treatment options. In fact, a health care professional has a duty to disclose to the patient any feasible alternative method of treatment.[45] A health care provider's failure to disclose feasible alternatives has

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[42] Warshaw, supra note 2, at 69.

[43] ACOG Technical Bulletin, August 1995, at 4.

[44] AMA, supra note 18, at 12.

[45] John H. Derrick, ANNOTATION: MEDICAL MALPRACTICE: LIABILITY FOR FAILURE OF PHYSICIAN TO INFORM PATIENT OF ALTERNATIVE MODES OF DIAGNOSIS OR TREATMENT, 38 A.L.R. 4th 900.

resulted in a finding that the provider thereby failed to obtain the patient's informed consent to the treatment method employed by the physician, and the physician was thereby liable for malpractice.[46] When health care professionals fail to ask about abuse or discuss options with victims whom they know have been abused either because the victim discloses abuse or because the victim's injuries appear to be the result of abuse, such inaction is tantamount to denying an abuse victim information critical to her health and safety. Inaction by health care professionals under these circumstances may be actionable and result in liability. A patient who is not referred to appropriate domestic violence services is not making an informed choice to not seek services.

The California Supreme Court first articulated in Cobbs v. Grant,[47] and later confirmed in Moore v. Regents of the University of California [48] what would become three well-established principles of physician disclosure.

> First, a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. Second, the patient's consent to treatment, to be effective, must be informed consent. Third, in soliciting the patient's consent, a physician has a fiduciary duty to disclose all information material to the patient's decision.

A health care provider has a duty to disclose all information necessary to help a patient make an informed choice.[49] If a patient is not fully informed that she can get help escaping from the violence, she is not giving informed consent to a treatment plan that deals only with the immediate physical trauma.

Failure to obtain informed consent by a patient may also form the basis of a negligence claim. Alaska law recognizes the liability of a health care who fails to obtain informed consent:

> A health care provider is liable for failure to obtain the informed consent of a patient if the claimant established by a preponderance of the evidence that the provider has failed to inform the patient of

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[46]Id.

[47] 502 P. 2d 1 (Cal. 1972).

[48]Moore v. Regents of University of California, 51 Cal. 3d 120 (1990), *cert. denied,* 111 S. Ct. 1385 (1991).

[49]Mathis v. Morrissey, 11 Cal. App. 4th, 332 (1992).

over the first aspect, and must act to exercise due care. A health care professional must act with reasonable diligence in identifying domestic violence, providing the patient with appropriate information and making the appropriate referrals. A health care provider that acts with reasonable diligence identifying, treating, informing and referring domestic violence victims will not be insulated from liability based on what might be the predictable actions of the victim's abuser. On the other hand, when a health care provider does not identify abuse, inform the patient about options and make appropriate referrals, the health care provider is gambling that the behavior of the abuser will change in the future. If the abuser causes subsequent harm to the victim, the health care provider may be held liable for that additional harm.

An essential element of any negligence claim is that there be some reasonable connection between the act or omission of the health care provider defendant and the damage which the plaintiff has suffered. Although when a domestic violence patient suffers further injury, it is most likely directly caused by the abuser, the health care professional who failed to diagnose and refer the patient is not free from liability. A patient can demonstrate that a reasonable health care provider would have suspected abuse and made appropriate inquires and referral, but the provider in her case failed to do so, and that the health care professional's failure to act was a substantial factor in her ultimately suffering subsequent harms. If the health care provider's failure to appropriately diagnose and treat the patient is a substantial factor in the woman's injury or death, the provider becomes liable for negligence.

The *Landeros* court formulated the causation test as one of whether the defendant could reasonably foresee the likelihood of further serious injury to plaintiff.[55] The independent acts of a third party, such as an abuser, do not relieve a health care professional of liability when the risk of harm is foreseeable under the circumstances. Once a health care provider has or should have identified a battered child (as in *Landeros*), or an adult domestic violence victim, it is then a question of fact whether the provider's failure to diagnose and address the abuse would be a causal factor in the resumption of the abuse.

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[55] Landeros, 551 P.2d at 395.

the common risks and reasonable alternatives to the proposed treatment or procedure, and that but for that failure the claimant would not have consented to the proposed treatment or procedure.[50]

The Supreme Court of Alaska held that the way to measure the a physician's duty to inform is according to the modern trend test of the "reasonable patient" and not the traditional test of the "reasonable physician".[51] This approach requires that a health care provider disclose all information a reasonable woman would need to know in order to make an informed and intelligent decision about the proper treatment she needs.[52]

Upon a diagnosis of domestic violence a health care professional has a duty to advise the patient to consult a specialist. The specialist to be consulted would be a domestic violence shelter, domestic violence advocacy program or a counseling service with domestic violence experts that are recommended by the local domestic violence shelter or state domestic violence coalition.[53] The health care provider's duty to refer the patient arises when the provider knows, or should have known, that he or she does not possess the requisite skill to provide relief for the patient's condition. In those cases, where the patient might also need psychiatric treatment, the health care provider must in addition to referring the patient to domestic violence experts refer her to mental health professionals who can work with her to develop a treatment plan that includes psychiatric evaluation and treatment.[54]

CAUSATION

A health care provider shall be found negligent if he or she fails to provide competent care and that failure causes injury to the patient. Health care professionals may consider the professional negligence a two part inquiry: first, whether the provider acted with reasonable care, and secondly whether the action or inaction led to injury of the patient. In domestic violence cases, health care providers have the most control

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[50] Alaska Stat. Code of Civil Procedure 09.55.556 (1995).

[51] Korman v. Mallin 858 P. 2d 1445 (Alaska 1993), at 1148-49.

[52] Id. at 1149.

[53] Jerald J. Director, Annotation: Malpractice: Physician's Failure to Advise Patient to Consult Specialist or One Qualified in a Method of Treatment Which Physician is Not Qualified to Give, 35 A.L.R. 3d 349 (1995).

[54] AMA, supra note 18, at 11.

Often defendants in malpractice suits have relied on the assertion that the patient would more likely than not have succumbed to illness, and that even appropriate medical intervention would not have raised the likelihood of survival to a probability. However, a growing number of courts are rejecting this theory and find liability under two theories. First, the malpractice itself causes the patient emotional distress for which she will be able to recover.[56]

In the case of a domestic violence victim, a patient who comes to a health care professional for care and does not receive appropriate intervention may subsequently be able to recover for the emotional distress of discovering that her risk and danger was increased by the physician's failure to act appropriately, and for the emotional distress of not receiving help despite her urgent needs. Secondly, under the "lost chance" doctrine, some states apply a mathematical formula for recovery for patients whose suffer increased risk through a health care provider's malpractice.[57] For instance, if a patient's chance of survival would have been 40% absent the malpractice, but was decreased to 13% due to the health care professional's inaction, traditionally patients would not have recovered against the negligent provider because death was more likely to occur than not. However, the "lost chance" doctrine allows the patient's estate to recover 27% of what would have been awarded in a successful wrongful death action.

Although no case has found a health care provider directly liable for failure to diagnose, inform and refer a patient to appropriate domestic violence services, trends in the law predict that health care professionals will soon be found liable for failure to provide appropriate domestic violence treatment. At this time, malpractice issues along these lines will be questions of fact for a jury, requiring extensive litigation to resolve. Wise health care professionals will protect themselves from liability and potential litigation by making appropriate inquiries and providing information and referrals to domestic violence victims.

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[56] Werner v. Blankfort, 42 Cal. Rptr. 2d. 229 (1995); Duarte v. Zachariah 22 Cal. App. 4th 1664 (1994); Smith v. State 677 So. 2d 653 (App. Of Louisiana 1994).

[57] Scafidi v. Seiler 119 N.J. 93 (Supreme Court of N.J. 1990); Thomson v. Sun City Community Hospital 688 P. 2d 605 (Supreme Court of Arizona); DeBurkarte v. Louvar 393 N.W. 2d 131 (Supreme Court of Iowa 1986); McBride v. U.S. 462 F. 2d 72 (9th Cir 1972).

Duty to Warn Victims of the Potential for Abuse

Health care providers treating abusers may also be held liable for failure to warn foreseeable victims of the potential for abuse. Under Alaska law, the general rule of negligence law is that a defendant owes a duty of care "to all persons who are foreseeably endangered by his conduct, with respect to all risks which make the conduct unreasonably dangerous".[58] This doctrine can be applied to physician-patient relations, as has been done in cases across the country. In Tarasoff v. Regent of the University of California,[59] a case that became one of the most celebrated cases in tort law in all the U.S.,[60] the court found hospital therapist liable for not warning a minor child and those responsible for her that a patient is planning to kill her. The Tarasoff court held that:

> Once a therapist[61] does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, [the therapist] bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.[62]

Many jurisdictions either have followed or have indicated they would follow the lead of Tarasoff and impose a duty to warn.[63]

The Supreme Court of Alaska in Division of Corrections v. Neakok [64] adopted Tarasoff as Alaska law in a case in which they held the State of Alaska liable for three murders a parolee committed after he was released from prison, among other reasons, because the State failed to warn the small community the victims belonged to about the danger the parolee posed to them. The Neakok court decided that the prison's

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[58] Division of Corrections v. Neakok, 721 P.2d 1121, 1125-26 (Alas. 1986).

[59] 551 P. 2d 334 (Cal. 1976).

[60] Peter F. Lake, Revisiting Tarasoff, 58 Albany L. Rev. 97 (1994).

[61] The term "therapist" is a broad category. Court have relied on Tarasoff doctrine in different kind of trust relations, such as doctor-patient, state-parolee, university-professor etc. See Id, at 98-90.

[62] Tarasoff, supra note 59, at 345.

[63] Timothy E. Gammon & John Hulston, The Duty of Mental health care Providers to Restrain Their Patients or Warn Third parties, 60 Miss. L. Rev. 749 (1995), at 749-50.

[64] Division of Corrections v. Neakok, 721 P. 2d 1121 (Alas. 1986), at 1126.

professional personal who observed the one who committed the crimes acts have a duty to warn when the acts were foreseeable.[65]

The Alaska court's holding that "consideration of the foreseeability of injury is central to a determination of whether a duty to care exist"[66] can be satisfied in cases where a health care provider cares for an abuser who discloses to the health care provider the abuser's intent to hurt his wife in a way that exposes her to a serious danger of violence.

Even the most narrow interpretation of the foreseeability demand, that there will be "a specifically identifiable, potential victim"[67] can be satisfied in domestic abuse cases since the specifically identifiable victims in almost always apparent. Unlike a mental patient that might threaten to harm people in general, without specific targets, when a health care provider identifies the patient as a perpetrator of domestic violence the potential victim is specific and known -- usually the wife or the abuser's intimate partner, her friends or extended family members. It is clear from the Neakok court's adoption and expansion of Tarasoff to require warning not only to individuals, but in that case to the victim's community, that Alaska law will continue to evolve to hold health care professionals liable for failing to warn an abuse victim that her husband or intimate partner intends to severely harm her. The health professional is authorized to breach client confidentiality with the abuser and required to warn the potential abuse victim. Failure to warn is likely to result in liability for injuries that could be foreseeable caused by the actions of the patient who is the perpetrator of the abuse.

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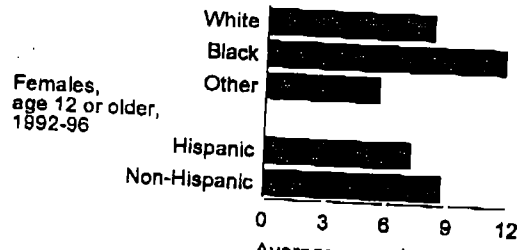
[65]Many cases regarding therapist liability towards third parties required specific threats to a readily identifiable victim. See Eckhardt v. Harold, 534 N.E. 2d 1339 (Ill. App. Ct. 1989); Evans v. Morehead Clinic 749 S.W. 2d 696 (Cent. App. 1988); Sherrill v. Wilson 653 S.W. 2d 661 (Mo. 1983); Bradley v. Hopper 570 F. Supp. 1333 (D. Colo. 1983); Thompson v. County of Alamed 27 Cal. 3d 741 (1980).

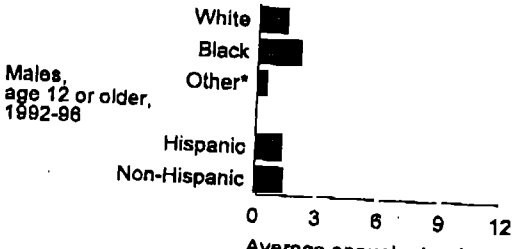
[66] Neakok, supra note 59, at 1127.

[67]Kirk v. Michael Reese Hospital, 117 Ill. 2d 507 (1987).

Characteristics of victims of violence by intimates

Among female victims of nonlethal intimate violence, blacks experienced higher rates than whites. White and black males experienced the same rates of intimate violence.

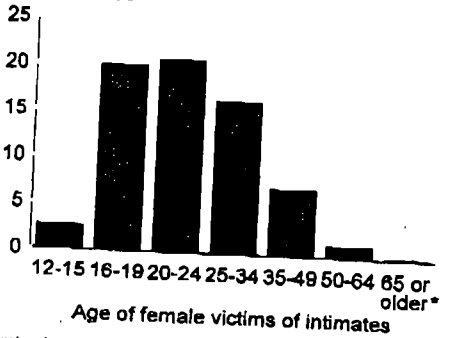




Note: Nonlethal violent victimizations include rape, sexual assault, robbery, and aggravated and simple assault. Intimates include current and former spouses, boyfriends, and girlfriends.
*Fewer than 10 sample cases.

- On average each year between 1992 and 1996 about 12 per 1,000 black women experienced violence by an intimate, compared to about 8 per 1,000 white women.
- For men the rate of victimization by an intimate was about a fifth of the rate for women.

Average annual rate of violent victimization per 1,000 females, 1992-96



Note: Violent victimizations include murder, rape, sexual assault, robbery, and aggravated and simple assaults. Intimates include current and former spouses, boyfriends, and girlfriends.
*Fewer than 10 sample cases.

The highest rates of intimate violence affected women ages 16 to 24.

- Women age 16 to 19 and women age 20 to 24 had nearly identical rates of intimate victimization — about 1 violent victimization for every 50 women.
- Annual rates of intimate violence by age of female victims showed little change from 1992 to 1996.