

COMMUNITY PUBLIC HEALTH SERVICES
DOMESTIC VIOLENCE PROTOCOL

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DOMESTIC VIOLENCE PROTOCOL

Definition

Domestic violence is a pattern of coercive behaviors that involves physical abuse or the threat of physical abuse. It also may include repeated psychological abuse, sexual assault, progressive social isolation, deprivation, intimidation, or economic coercion. Domestic violence is perpetrated by adults or adolescents against their intimate partners in current or former dating, married or cohabiting relationships of heterosexuals, gay men and boys, lesbians, bisexuals and transgendered people.

The US Dept of Justice estimates that 95% of reported assaults on spouses or ex-spouses are committed by men and boys against women and girls. (Douglas, 1991) There are no prevalence figures for domestic violence in gay and lesbian relationships but experts indicate that domestic violence is a significant problem in same sex relationship as well.

This protocol does not address other forms of family violence such as child abuse or abuse of elders by their caretakers which are serious problems and need attention.

Purpose

The purpose of this protocol is to set a standard to improve both the quality of the care given by individual health care providers and the overall CPHS response to domestic violence. This protocol outlines the elements of an effective response.

Guiding Principles

1. Treat patients with dignity, understanding, respect, and compassion.
2. Treat patients of different ages, cultures, and sexual orientation with sensitivity, while remembering that violence is unacceptable in any relationship.
3. Recognize that the process of leaving a violent relationship is often a long and gradual one.

4. Attempt to engage patients in long-term continuity care within the health care system, in order to support patients through the process of attaining greater safety and control.
5. Respect the integrity and authority of patients' life choices.
6. Discuss confidentiality issues with all patients.

Policy

This protocol applies to all staff, students, and volunteers working within Community Public Health Services. The roles and responsibilities of staff in each clinical site should be outlined in Appendix A.

Process

This protocol will be reviewed at a minimum of every 18 months by a CPHS employee/team trained in domestic violence and by the medical director of Community Public Health Services. Staff training will be included as part of the review process.

Training

To respond effectively and appropriately to domestic violence, providers and all other staff in the health care setting should receive orientation to the current protocol and regularly updated training in domestic violence.

Supplies

1. DOMESTIC VIOLENCE PACKET: Blue Folders kept in agreed upon location in each clinic. Contents of folder will be restocked by medical records department.

List locations: _____

2. CAMERA & FILM: Locked in _____.
3. DOMESTIC VIOLENCE RESOURCE MANUALS: Educational Materials and protocol in _____.

I. SCREENING

Standards:

- * In all primary care clinics, family planning clinics, prenatal clinics, mental health clinics, social work intakes, PHN intakes:

Screen all women and adolescent girls. Also, screen men and boys presenting with symptoms or signs of domestic violence (see Appendix B).

- * In pediatric clinics:

Screen mother or other female legal guardian when it is possible to remove children and others from the room to speak with mother/female guardian privately. Screen male parent/guardian when he shows symptoms or signs of domestic violence. Again, screening should be done without child in the room.

- * In drop-in or urgent care clinics:

Screen women, adolescents, and men and boys who present with symptoms or signs of domestic violence (see Appendix B).

* In dental clinics:

Screen all patients with signs of facial, dental, or other trauma.

Procedures:

- A. Screen for domestic violence in a safe environment.
 - Use your own words in a non-threatening, non-judgmental manner.
 - Ask the patient about domestic violence in a private place.
 - Separate any accompanying person or child from the patient while screening for domestic violence.
 - If it is not possible to screen for domestic violence safely do not screen patient. Arrange for return visit.
- B. Use questions that are direct, specific, and easy to understand (see Appendix C).
 - "Has your partner ever physically hurt or threatened you?"
 - If the patient has a physical injury: "Many people come in with injuries like yours and often they are from someone hurting them. Is this what happened to you?"
- C. When unable to converse fluently in the patient's primary language:
 - Use a professional interpreter or another health care provider fluent in the patient's language.
 - The patient's family, friends or children should not be used as interpreters when asking about domestic violence.
- D. Screen verbally, in addition to any written questionnaire forms used.
- E. Document that screening for domestic violence was done.
 - Document that domestic violence is or has been present, has never occurred, or is suspected even though the patient denies it.
 - Document the date and the results of the screening in the life record of the patient's chart as well as in the progress notes.
- F. Routinely discuss with patients confidentiality limits regarding mandatory reporting and the requirement to report child abuse. (see Section V, "Mandatory Reporting").

If patient is positively screened for suspected or known domestic violence proceed with the following guidelines:

II. ASSESSMENT

A. Essential Assessment

1. Obtain history of present complaint.
2. Physical examination: Request that patient disrobe for a more thorough exam. Provider should examine for evidence of further injuries or scars.

3. Address the following four issues before the patient leaves your site:

- Immediate risk: “If you return home, will you be in immediate physical danger?”
- Children: “Is perpetrator (or patient) hurting or threatening patient’s children?”
- State of mind toward situation and readiness for change: “What type of assistance would you like?” “Are there any changes you would like to make?” “What steps would help you towards those goals?” “What actions are you ready to take?”
- Suicide: “Have you had suicidal thoughts in response to your situation?”

B. Further Assessment

Further assessment may be done immediately or over multiple visits. It may be done (and, it is even preferable for it to be done) by different members of a multidisciplinary team at a particular site and/or in conjunction with community domestic violence experts and counselors.

1. Assessing patient’s general view toward situation (state of mind): How has the abuse affected you? What do you do to cope with the abuse? What would you like to see happen for yourself (and for your children)?
2. Safety strategies patient has used: Currently, how do you protect yourself and your children? What safety strategies have you tried? Have you sought outside assistance for domestic violence? From whom or where? Have you ever tried to leave in the past? What happened when you tried to leave?
3. History of past injuries: Have you ever been treated for injuries related to the violence? Have you ever been hospitalized? Have the police ever been called during a domestic violence incident? What happened as a result?
4. Degree of abuser’s control over patient: Does your partner ever try to control you by threatening to hurt you or your family? Does your partner ever try to restrict your freedom or keep you from doing things that are important to you? Do you have your own money or financial support? Do you feel controlled or isolated by your partner?
5. Effects on health: What type of medical and psychological effects have resulted from the abuse (e.g., chronic pain symptoms, worsening medical conditions, psychological distress, anxiety, sleep disorders, miscarriages or substance abuse)?
6. Effects of domestic violence on children: Have your children shown any signs of physical injuries or sexual abuse that could be related to your partner’s abuse? Have your children had any eating or sleeping disorders, somatic complaints, bad

dreams, aggressive behavior, school problems, depressions, suicidal thoughts or attempts? What will enhance your children's safety while protecting yourself?

7. Further assessment of suicide/ homicide: Have you ever attempted suicide in the past? Are you having thoughts of suicide now? Have you thought about how you would do it? Have you ever thought of killing or harming your partner? Have you thought about how you would do it?

III. INTERVENTION

A. Convey the following messages:

- There is no excuse for domestic violence.
- No one deserves to be abused.
- Violence is not your fault. Your partner is responsible and can stop the violence.
- You are not alone. There are people you can talk to for support, shelter and legal advice.
- It must be very difficult for you to change your situation.

B. Provide information on domestic violence:

- Domestic violence is common.
- Most violence continues over time and often increases in frequency and severity.
- Violence in the home can have long-term, damaging effects on children, particularly if they are physically hurt and/or witnesses to the abuse.
- Domestic violence is a crime in the United States even if you are here without legal documentation.
- There are social and legal services available to you including counseling, shelters, police assistance and restraining orders.
- This information should be provided verbally and in written form if patient will accept it.

C. Assist the patient in making a safety plan:

1. Ask the following questions:

- Is your partner in the clinic now?
- What do you want to do?
- Can you stay with friends/family ? Do you want to stay at a shelter?
- Do you want an emergency protection order? Do you want a restraining order?
- Do you want legal assistance such as assistance with custody or visitation issues?
- Do you want immigration assistance? (Note: Presently in San Francisco there are resources for battered women to apply for legal status without having to rely on coercive husband).
- Do you want someone to further discuss your safety plans with you?

2. Contacting the police:

- Do you want police intervention? If the patient wants official police intervention, assist her/him in filing an official report with the local police department.
- Health Practitioners should assist the patient in making the report.
 - If perpetrator is posing immediate danger to patient, clinicians or the safety of others, **call 911**.
 - If perpetrator is not posing immediate danger and patient wants police assistance, **call police dispatch at 553-0123**.
 - Health care personnel should remain with the patient during the police interview, if the patient so desires.
 - Ensure patient is in safe place while awaiting police.
 - Document in the medical record that an official police report was made (include date, time, and officer name and badge number).
 - Urge the patient to call the **Family Violence Project at 552-7550** to obtain an advocate to help her or him navigate the criminal justice system.
 - ***A separate report of injuries must be submitted by the health care provider to law enforcement, as required by California law (see Section V pg. 9)***

3. Safety in Clinic:

- Clinics should discuss and adapt safety strategies. Clinics with institutional police may have different policies than those without police.

4. If the patient is returning home or to previous living arrangement:

- Determine a safe way to contact patient in future (by phone, mail, friend, etc.) Use “DV Contact Form”, (Appendix J).
- Suggest patient gather important papers, (e.g., birth certificates and other documents of identification), some money and clothing for her/himself and children (if any). Tell patient to keep these items in an accessible, hidden place or at a friend's home in case she/he has to leave home in a hurry. (See Appendix D for details on safety planning).

5. Assist the patient with obtaining help to carry out her/his safety plan (See Appendix K for patient resources).

D. Referrals:

All known or suspected victims of current domestic violence should be referred to a CPHS social worker and/or public health nurse if the patient will accept a referral. All PHN referrals should be accompanied by DV Contact Form in (Appendix J).

- Refer the patient to available community resources (see Appendix K).
- Offer a written list of resources at each visit (from blue domestic violence folder).
- If patient thinks it would be dangerous to take a list of resources offer the phone number of Woman, Inc. for women patients and CUAV for gay patients on small piece of unlabeled paper.
- When the patient is willing, assist her/him in calling a domestic violence hotline during the health care visit.
- Tell the patient she/he can always call or come back for support or more information.

E. Sexual Assault Intervention:

- In the case of sexual assault urge the patient to accept a referral to the **Rape Crisis Center at 206-3222** for advocacy, counseling and evidentiary collection. Currently, San Francisco Law Enforcement recommends that evidentiary collection can be useful for up to 120 hours after assault.
- If the patient does not wish to go to the Rape Crisis Center but you would like advice on examination, documentation and treatment call the Rape Crisis Center for advice.

IV. DOCUMENTATION

Health care providers should complete a legible medical record for each known or suspected victim of domestic violence. This record should include the following:

- A description of domestic violence history, including present complaints or injuries, past experiences of physical/sexual abuse and frequency of abuse. Include date, time and location of domestic violence incidents.
- Whenever appropriate use the patient's own words in quotation marks.
- A description of patient's injuries, including type, location, size, color and age. Document injuries on a body map (See Appendix E for sample Body Map).
- Alleged perpetrator's name, address, and relationship to patient (and children, if any), if patient is willing to provide this information.
- A description of other health problems, physical or mental, which may be related to the abuse.
- Whenever possible, following patient's consent, take photographs of patient's injuries (see Appendix F for photograph consent form). Take Polaroid photographs of all injuries, including:
 - One full body shot (to link injuries with identified victim).
 - One mid-range to show torso injuries.
 - Close-ups of all wounds and bruises.
- Preserve any physical evidence (e.g., damaged clothing, jewelry, weapons, etc.) which can be used for prosecution. (see Appendix F for Receipt of Evidence form).
- Document details of intervention made and all actions taken.
- In the case of rape/sexual assault contact Rape Crisis Center at 206-3222 for advice on transferring patient for appropriate forensic exam.

- This documentation process may take place over more than one visit as further history is revealed. Different members of the multidisciplinary team may document different aspects of the abuse.

DOCUMENT POSITIVE OR SUSPECTED DOMESTIC VIOLENCE THAT IS OCCURRING PRESENTLY OR HAS OCCURRED IN THE PAST ON THE “PROBLEM LIST” IN THE PATIENT’S CHART. (E.G., “DOMESTIC VIOLENCE SUSPECTED - PRESENT” OR “DOMESTIC VIOLENCE POSITIVE - IN PAST RELATIONSHIP”)

V. **MANDATORY REPORT OF INJURY IN SAN FRANCISCO**
(SEE APPENDICES G, H, I)

Health Practitioners are required by California State Law (Penal Code Section 11160 et. seq.) to report certain cases of domestic violence to law enforcement. *This is different from a patient's voluntary formal police report to police and/or request for police assistance.*

1. Report to the local law enforcement agency when providing medical services to a patient who has a physical condition that you know or reasonably suspect is a result of a firearm or assaultive or abusive conduct.
2. Discuss reporting requirements and solicit cooperation from the patient. Patient consent, however, is not required.
3. Reporting health care provider should telephone a report of domestic violence as soon as possible to the San Francisco Police Department by calling 553-9220 to leave a voice mail message. The police will record your message. Document in the medical record that the call was made.
4. Reporting health care provider should complete *REPORT OF INJURIES BY A FIREARM OR ASSAULTIVE OR ABUSIVE CONDUCT* form. (See Appendices G, H & I for form, reporting procedure and other relevant information.) Mail this form within 2 working days to:

San Francisco Police Department Domestic Violence Unit 850 Bryant Street San Francisco, CA 94103

File a copy of report in “correspondence” section of the chart.

5. **If you or the patient want police intervention or follow-up, you must call 911 for emergencies or 553-0123 to make an official police report. Your mandatory report is not an official police report.**
6. **Abuse of a minor and elder/dependent adult abuse require different reporting procedures:**
 - ◆ *For patients under the age of 18, report in accordance with Child Abuse & Neglect Reporting (Article 2.5 of Penal code, commencing with Section 11164), even if alleged perpetrator is also a minor.*
 - ◆ *For patients age 65 and older and for dependent adults, report in accordance with Elder Abuse and Dependent Adult Civil Protection Act (Chapter 11 of Part 3, Division 9 of Welfare and Institutions Code, commencing with Section 15600).*

Child and elder mandatory reports may result in further investigation by Child Protective Services or Adult Protective Services.

7. Note: Reporting is not a substitute for thorough documentation of the abuse in the medical records.

VI. CONTINUITY OF CARE

A. At each visit, for patients with known or suspected domestic violence:

1. Ask about history of violence since last visit.
2. Ask about coping strategies.
 - emotional status?
 - called hotline?
 - told any family or friends?
 - attempts to leave?
3. Ask about any abuse of children since last visit.
4. Give messages of support and your concern.
5. Reiterate options to patient (Emergency Protective Order, Temporary Restraining Order, friend's home, shelter, hotline, support groups).

B. For patients with no suspected domestic violence when screened at your site in the past:

There are no studies that address appropriate rescreening intervals. You might consider rescreening the patient at the following times (whichever occurs first):

- patient starts intimate relationship with new partner.
- patient presents with symptoms or signs of domestic violence.
- periodic intervals (at provider's discretion).



Roles & Responsibilities*

Clerical Staff:

- ★ Does not screen for domestic violence.
- ★ Privately and immediately reports suspicion of domestic violence, a witnessed act of domestic violence or a patient's mention of domestic violence to the head nurse or primary provider if patient is coming to clinic for medical visit and to social worker if patient is coming to a social work visit.
- ★ Alerts institutional police if concerned about immediate patient or clinic safety issues.

Social Worker:

- ★ Screens routinely for domestic violence as outlined in this protocol.
- ★ Refers any patient with injuries to urgent medical appointment for evaluation, documentation, treatment and health care mandatory reporting.
- ★ Urges patients with history of known or suspected domestic violence to accept referral to a primary medical provider.

Public Health Nurse:

- ★ Screens routinely for domestic violence as outlined in this protocol.
- ★ Urges patients with history of known or suspected domestic violence to accept referral to a primary medical provider (if patient doesn't have one).
- ★ Evaluates, documents and reports domestic violence as outlined in the protocol. If working with primary medical provider, only one provider should complete mandatory report.

Mental Health Consultant:

- ★ Screens for domestic violence as outlined in this protocol.
- ★ Refers any patient with injuries to urgent medical appointment for evaluation, documentation, treatment and health care mandatory reporting.

Nurses/MEA's:

- ★ Does not screen routinely for domestic violence.
- ★ If symptoms or signs of domestic violence or affirmative answers to abuse questions on written intake forms AND patient is alone, screens for domestic violence as outlined in

protocol. Then, pulls “blue folder” for NP or MD if positive or suspected domestic violence.

* - This is for Maxine Hall Health Center. Each site should adapt this appendix.

- ★ If symptoms or signs of domestic violence or affirmative answers to abuse questions on written intake form AND patient is not alone, attempts to request that accompanying persons wait in lobby when putting patient in exam room. Then, privately informs NP or MD of suspicion of domestic violence. Pulls blue folder to hand to provider privately.
- ★ Asks patients with positive screening for domestic violence whether perpetrator is in clinic and informs provider of perpetrator's presence as promptly as possible.
- ★ Always documents patient's remarks about domestic violence in her/his own words in quotation marks.
- ★ Works with provider to obtain photographs of injuries and collect evidence
- ★ Works with provider to fill out mandatory reporting form.
- ★ Works with provider to assess safety, create safety plan and make referrals upon discharge.
- ★ Alerts institutional police if concerned about immediate patient or clinic safety.

Triage RN:

- ★ Does not screen routinely for domestic violence.
- ★ Screens all patients with symptoms or signs of domestic violence as outlined in protocol.
- ★ Follows protocol for assessment, documentation, planning and reporting in consultation with provider.
- ★ Refers patient with known or suspected domestic violence to urgent care or primary care as deemed appropriate in consultation with provider.
- ★ Completes mandatory health care report when required by law (or helps to do so if patient will see an NP or MD immediately)
- ★ Alerts institutional police if concerned about immediate patient or clinic safety.

Medical Provider (NP or MD):

- ★ Screens routinely for domestic violence and treats patients as outlined in this protocol.
- ★ Determines whether perpetrator is in clinic if not already informed by RN/MEA.
- ★ Urges all patients with known or suspected domestic violence to accept referral to PHN and/or social worker.

- ★ If provider is not the primary provider for the patient, notifies primary provider of known or suspected domestic violence promptly.
- ★ Alerts institutional police if concerned about immediate patient or clinic safety.

Institutional Police Officer

- ★ Helps ensure safety of patient and staff especially when perpetrator is in clinic.
- ★ Helps providers contact SFPD when patient or provider would like SFPD assistance.
- ★ Is informed by providers of any potentially violent situations or persons in advance whenever possible.

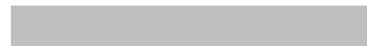
Medical Records Staff:

- ★ Obtains provider permission for xeroxing of records with “sensitive services” designation as per routine existing policy.
- ★ Attempts to obtain provider permission for xeroxing records if domestic violence happens to be noted before copying in chart without “sensitive services” designation.
- ★ Replenishes “blue folders” with appropriate forms.

Custodial Staff:

- ★ Alerts “doctor of the day” or head nurse to any witnessed activity suspicious for domestic violence.
- ★ Alerts institutional police if concerned about patient or clinic safety.

WIC Staff: Not yet delineated



Symptoms and Signs of Domestic Violence

Screening for domestic violence on the basis of symptoms and signs will greatly underestimate the prevalence of domestic violence. Universal screening, therefore, should be done as outlined in the protocol.

I. History suggesting domestic violence:

- ★ Traumatic injury or sexual assault;
- ★ Suicide attempt or ideation;
- ★ Overdose;
- ★ Physical symptoms related to stress;
- ★ Vague complaints or non-specific complaints;
- ★ History inconsistent with injury;
- ★ Delay in seeking medical care;
- ★ Repeated visits
- ★ History of spontaneous abortion

II. Physical clues:

- ★ Any physical injuries;
- ★ Unexplained, multiple or old injuries

III. Behavioral clues:

- ★ Reluctance to speak in front of partner;
- ★ Evasive;
- ★ Overly protective or controlling partner

IV. Verbal clues:

- ★ Directly or indirectly brings up the subject of abuse

Approaches for Interviewing the Patient

Sample Questions:

- ★ “Has your partner ever hit you or hurt you in any way?”
- ★ “Do you ever feel frightened of your partner?”
- ★ “Has your partner ever forced you to have sex when you didn’t want to?”

Framing Questions:

If you feel uncomfortable raising the topic of domestic violence or if you think the patient seems uncomfortable you may choose to use a “framing statement” with your questioning. For example:

- ★ “I ask all women about violence in their relationships. Has your partner ever hit you or hurt you in any way?”
- ★ “I know I have been seeing you in clinic for a few years now. I have started to ask all my patients more about their relationships.” “What happens when you and your partner disagree?”

Open ended questions should always be followed by direct questions.

- ★ “Has your partner ever hit you or tried to hurt you?”

Sexual Abuse:

If the patient admits to physical abuse always ask about sexual abuse. Do not use the word “*rape*”. (Many patients define rape as forced sex by a stranger)

- ★ “Has your partner ever forced you to have sex when you didn’t want to?”

Suspected Domestic Violence:

If you are screening a patient and she/he denies domestic violence but you suspect domestic violence use this opportunity to offer messages of support. Anticipate the patient’s fears. For example:

- ★ “I am asking you about this because I am concerned for your safety.”
- ★ “Many people who are being hurt by their partners are afraid or ashamed to talk about it. I want you to know that I would like to talk about this if this ever happens to you.”
- ★ “No one deserves to be hurt or threatened by her/his partner.”
- ★ “There is help here and in other places for people who are being hurt by their partners.”
- ★ “Sometimes people are afraid to talk about this because they think their family and friends will find out . Let me explain the privacy of your care.”
- ★ “Patients do not have to have police intervention unless they want it”.
- ★ “We can help you even if you don’t have legal documentation.”
- ★ “If this ever happens to you please let us help you. We would never ask you to do anything you are not ready to do.”

Encourage patient to take resource list “in case you ever need it.” Highlight hotline numbers for the patient.



Safety Planning

When a patient has been identified as a victim or suspected victim of domestic violence it is important to speak with the patient about immediate and future safety. The severity of current abuse or past injury is not always an accurate predictor of future violence. Patients may minimize the danger they face. Assisting the patient in making a safety plan can increase the patient's awareness of options for increasing her/his safety. Also, safety planning will help the provider assess the situation and better support the patient.

A patient may choose different options such as returning to the abuser, evicting the abuser or leaving the abuser. A patients may choose to remain in a relationship with the perpetrator for many different reasons. Provide messages of support and discuss the dangerous, harmful consequences of domestic violence but respect the patient's choice and work with the patient to help increase safety as much as possible. Also, remember that leaving a violent relationship may be a very dangerous time for the victim.

A. If patient decides to leave, stay elsewhere temporarily or bar perpetrator from patient's place of residence:

- ★ Does patient have a supportive friend or family member with whom she/he can stay?
- ★ Does patient have a friend or relative who will stay with her/him whose presence would deter violence?
- ★ Does patient want to call the police, to file an official police report and/or obtain an emergency protective order or temporary restraining order?
- ★ Does patient want to go to a battered women's shelter, homeless shelter or use other housing assistance programs such as hotel vouchers from social services or advocacy programs?
- ★ Does patient want to move secretly to another community or state? Are there means to help arrange transportation to out-of-state shelter?
- ★ If perpetrator is removed or barred from living situation discuss safety measures such as changing locks on doors and windows, installing alarms and smoke detectors, teaching children to make collect calls in case perpetrator kidnaps them, and telling caretakers of children (school/babysitters) who has permission to pick up children.

B. If patient is planning to stay in relationship:

- ★ What kind of strategies have worked in the past to minimize injuries? Does patient think these strategies would continue to work?
- ★ Can patient anticipate escalation of violence and take any precautions?
- ★ Would patient call the police if perpetrator becomes violent? If patient couldn't get to phone could she/he work out a signal with a neighbor to call police and/or teach her/his children to call 911?
- ★ Does patient have a support network of friends or family that live nearby and would provide help if needed?
- ★ Does perpetrator have or use weapons? Can they be removed from perpetrator or can ammunition be separated from weapon?

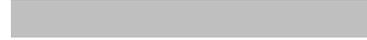
C. Escape Plan

For many people, deciding to leave an abusive relationship is one of the most difficult decisions they will ever make. Arranging an "escape plan" can help a patient feel less need to return to an abusive relationship after leaving.

- ★ Encourage patient to keep the following items in a safe but easily accessible place:
 - As much cash as possible, a checkbook, an ATM card and credit cards.
 - Loose change for pay phones.
 - A small bag of extra clothing for the patient and any children.
 - Medications
 - Extra keys to car, apartment or house.
 - Documents:
 - Bank accounts
 - Insurance policies
 - Marriage license
 - Abuser's date of birth
 - Social Security numbers (perpetrator's, patient's, and any children's)
 - Birth certificates (the patient's and the children's)
 - List of important phone numbers (family and friends)
 - Sentimental valuables
 - "Green card"
 - Passports

- Work authorization and any other immigration documents
- Medical card
- Driver's license and title to car with proof of insurance

Remember to always give messages of support, hotline numbers and to refer patient to an advocate to discuss options further.



Appendix E



Appendix F

(Place patient label here).

Consent to Photograph

(In the event a photograph is taken, be sure to complete this form, including the patient's signature)

The undersigned hereby authorizes _____ and the attending
(Name of Agency)

clinician to photograph or permit other persons in the employ of this facility to photograph

_____ while under the care of this facility, and agrees
(Name of Patient)

that the negatives or prints be stored in patient's medical records, sealed in a separate envelope, in the event they may be needed later for evidence. These photographs will be released to the police or prosecutor only when the undersigned gives permission to release the medical records. The undersigned does not authorize any other use to be made of these photographs.

Date _____

Patient's Signature _____

Street Address _____

City _____

State, Zip _____

Witness _____

Parent or Legal
Guardian _____

(Place patient label here).

Receipt For Evidence

(Upon receipt of any evidence, fill out all necessary information below.)

Date: _____

Received From: _____

Medical Facility: _____

■ Photograph of or items from:

Name: _____

Address: _____

City, State, Zip: _____

■ Items (List) _____

Signed: _____

Police Officer:

Name (Print or Type) _____

Department Badge # _____

Prosecutor's Office:

Name _____

Title _____

Reporting Procedure

When health care provider provides medical services to a patient suffering from a physical injury known or suspected to be a result of domestic violence she or he should do the following:

- ★ Inform the patient of clinician's duty to report.
- ★ Inform patient that if she/he wants police intervention or follow-up, she/he must call 911 for emergencies or 553-0123 for non-emergency situations to make an official police report.
- ★ Make a telephone report to the Domestic Violence Unit of the SFPD by calling 553-9220 to leave a voice mail message as soon as possible.
- ★ Complete a **“Report of Injuries By a Firearm or Assaultive or Abusive Conduct”** form (see included form) and send within two working days to the Domestic Violence Unit:

San Francisco Police Department
Domestic Violence Unit
850 Bryant Street
San Francisco, CA 94103

- ★ When two or more health care providers have knowledge of a known or suspected instance of violence requiring reporting, only one person is required to submit the report.
- ★ All health care providers involved are equally responsible to see that the report is made according to State requirements.
- ★ File a copy of the report in the patient's medical record in the correspondence section.
- ★ Maximize role of patient's input; advocate for the patient's needs with authorities.
- ★ Keep the report confidential; it cannot be accessed by friends, family, or other third parties without the patient's consent.

Appendix H

Appendix I

Common Questions and Answers About Mandatory Reporting Requirements for San Francisco Health Practitioners

This information is intended to be a general reference guide for questions about mandatory reporting. Information presented herein should not be construed as legal advice. Specific questions regarding interpretation of the law should be referred to your local district attorney.

1. If I provide counseling or social work services to a patient who has domestic violence injuries, but do not provide medical treatment, do I have to report?

No. You only report if you are a health practitioner who provides medical services for a physical condition to a patient you know or reasonably suspect is suffering from a wound or physical injury due to assaultive or abusive conduct or a firearm.

2. If I am treating a patient for injuries or conditions unrelated to the battering, but am aware that the patient has other physical injuries due to domestic violence, do I have to report?

The language of the law is vague regarding this issue. The legislator who wrote this law, Assembly Member Jackie Speier, specified that her intent was that provider does not have to be treating the domestic violence injury in order for the reporting requirements to apply: the provider must be providing medical services for a physical condition, and the patient must have a domestic violence physical injury, but the former condition and latter injury do not have to be related. Until courts begin interpreting this statute, however, the answer to this question remains unclear.

3. What must be included in the health practitioner report made to the police?

The report must include the following:

- (A) The name of the injured person, if known.
- (B) The injured person's whereabouts.
- (C) The character and extent of the person's injuries.
- (D) The identity of any person the injured person alleges inflicted the injury.

4. How do I make my health practitioner report?

Telephone the San Francisco Police Department at 553-9220 as soon as possible and leave a voice mail message. Document in the Medical Records that the call was made. Within 48 hours, mail the confidential mandatory health care reporting form to:

San Francisco Police Department
Domestic Violence Unit
850 Bryant Street

San Francisco, CA 94103

5. What happens in San Francisco to the health practitioner report once it is made?

If you follow the instructions above, your report and compliance with the law will be noted and kept on file at the Domestic Violence Unit at the police department. According to current police department practices, there will be no police follow-up on your confidential report.

There may be exception to the above procedure. In Emergency Room cases, the police may already be involved. Either they were at the scene of the crime or they have been called to the hospital to conduct an investigation, make a report, and possibly make an arrest.

In addition, if you do not use the voice mail number and address specify above in number 4 police response may vary. For example, police intervention may occur regardless of patient wishes if you call a different police number.

6. How do I get the police to intervene or follow up on the case?

If you or the patient want police intervention or follow-up, you must call 911 for emergencies or 553-0123 to make an official police report. An officer will come to your location to make the report. Your medical mandatory report is not an official police report. Depending on the circumstances, the police report may lead to arrest, prosecution, and/or incarceration.

7. If a patient was injured by the batterer in another county, do I report to law enforcement which oversees the jurisdiction where the clinic is located, or to the police in the county in which she was injured?

The law states that a report must be made to “a local law enforcement agency.” Practically speaking, it may be that upon calling the local police, or sheriff, they will tell you that they cannot do anything and that you should call the law enforcement agency in the county in which he or she was injured.

8. Are we required to tell battered patients that we are going to make a report?

There is no legal requirement to inform patients of the report. However, ethically it would seem imperative. In order to best protect themselves, patients should be aware of any actions that may be taken by the police and any documentation that is being created.

9. Should we tell all patients prior to screening for domestic violence that we are required to make a report if domestic violence is suspected?

The law does not specify any particular procedure. On the one hand, informing patients of the reporting law prior to screening may enhance their autonomy; if patients believe they will be in more danger if a report is made, they can decide to refrain from discussing the abuse or even leave the facility. On the other hand, health care providers can provide life-saving care and information to patients they identify as being battered, and such pre-screening warnings may only provide obstacles to that end. Providers must not let their

misgivings about reporting laws prevent them from routinely inquiring about domestic violence and providing appropriate care to patients. Each facility should have a discussion and form its own protocols around this issue.

10. If the battered patient does not want to report, do I still have to make one?

Legally, you are required to report whether or not the patient consents to a report, even though there may be countervailing ethical principles. You should find out why the patient does not want a report made, and advocate on behalf of his or her needs and concerns with the authorities. (see questions 11 and 12 below for more discussion)

11. May reporting result in any negative repercussions for my patient?

Providers should be aware of the potential harmful consequences mandatory reporting presents for battered patients. Reporting may put battered patients at risk for retaliation if police intervene against patients' wishes. It may deter patients from seeking health care or being candid with their clinicians about the causes of their injuries. There may be an ineffective response to reports of abuse. Reporting without patient consent infringes on personal autonomy, and may also revictimize patients by controlling their life decisions. The abrogation of provider-patient confidentiality that may result from reporting is also harmful and may undermine the patients' trust in their providers. In San Francisco, many of these concerns may be alleviated as the police response is largely dictated by the request of the providers/patients (when providers follow the reporting protocol outlined on Section V, Mandatory Reporting in San Francisco).

12. What can I do to minimize some of the potential dangers to my client from reporting?

Most importantly, providers should provide ongoing, supportive care, address patient safety and guide the patient through available options. Institutions must support providers in meeting the needs of battered patients. Collaboration with domestic violence programs in developing policies, practices and trainings is essential to this process. Providers should learn how authorities respond to reports and discuss this with the patient. They should address the risk of retaliation and need for safety precautions in cases where there will be police intervention or follow-up. Providers should work with the patient and authorities to meet patient needs when handling the report and strive to maximize the patient's input into any future plan of action.

13. If the battered patient is a minor, under what law do we report?

Whenever the Child Abuse and Neglect Reporting Act applies, that reporting act supersedes the reporting act discussed here. If a minor is battered by an intimate partner, that falls within the definition of child abuse in the Child Abuse and Neglect Reporting Act, and should therefore be reported pursuant to that law.

14. If a patient's children are also being abused and I report to Child Protective Services, will CPS be sensitive to the needs of my patient?

Child Protective Service workers may not always be trained on adult domestic violence. Punitive state measures such as taking the child from the mother's care for her failure to protect her child may occur. Such measures do not always address the source of the problem-- the batterer-- and may be harmful to the mother and the child. Clinicians should go beyond simply filing reports; they might consult their ethics and risk management committees, and battered women's advocates on how to protect the child and also facilitate the mother's safety and empowerment.

This paper reflects Mandatory Reporting procedures for San Francisco County only. If you are outside of San Francisco County, please check your local Mandatory Reporting procedures and police response as they vary from county to county.

Prepared by Ariella Hyman of the San Francisco Legal Assistance Foundation for the San Francisco Family Violence Council's Health Committee.

Appendix J

Referrals

⊕ = Spanish spoken on regular basis ⌘ = Cantonese spoken on regular basis
 ✧ = Gay/lesbian/transgendered resources available

Additional language capacities available on regular basis are noted in parenthesis

POLICE

Emergency.....911

Non-Emergency..... 553-0123

Domestic Violence Unit..... 553-9225

24 HOUR CRISIS LINES

✧⊕ San Francisco Domestic Violence Hotline (Woman, Inc.)..... 415-864-4722
 (Spanish spoken 24 hours)

✧⊕ Community United Against Violence (CUAV)..... 415-333-HELP
 (10am - 6pm, Spanish spoken)

San Francisco Suicide Prevention..... 415-781-0500

⊕ Spanish (8-12pm)..... 415-989-5212

⊕⌘✧ San Francisco Women Against Rape..... 415-647-7273

SHELTERS

⌘✧ Asian Women’s Shelter..... 415-751-0880
 (Various Asian Languages and dialects)

Connecting Point..... 415-863-HOME

✧⊕ La Casa de las Madres..... 415-333-1515

⊕ Raphael House (Christian)..... 415-474-4621

⊕ The Riley Center..... 415-255-0165

Teen Mom Shelter (if needed, can call collect)..... 415-923-0785

COUNSELING

Woman, Inc (for Mission District).....	415-864-4722
⌘ ♻ Asian Women’s Shelter..... (Various Asian Languages and dialects)	415-751-0880
Cameron House (Mandarin, Vietnamese).....	415-781-0401
⌘ ⌘ ♻ Center for Special Problems.....	415-292-1500
La Casa de Las Madres.....	415--333-1515
⌘ ♻ Family Violence Prevention Fund’s Community Outreach & Advocacy Program....	415-552-7550
⌘ Latino Family Alcoholism Counseling Center.....	415-826-6767

COUNSELING FOR BATTERERS’

⌘ ♻ Man Alive (for batterers).....	415-552-1361
♻ Move (Men Overcoming Violence Effectively).(for batterers).....	415-626-MOVE

CHILD ABUSE RESOURCES

⌘ ⌘ Child and Adolescent Sexual Abuse Resource Center.....	415-206-8386
⌘ Child Crisis Service.....	415-695-5195
⌘ San Francisco County Child Protective Services-Child Abuse Reporting Hotline.....	415-558-2650

ELDER ABUSE RESOURCES

Adult Protective Services- Elder/Dependant Adult Reporting Hotline.....	415-557-5230
Consortium for Elder Abuse Prevention	415-885-7850
⌘ ⌘ Senior Information and Referral (Mandarin).....	415-626-1033

LEGAL ASSISTANCE

⌘ Cameron House (Mandarin, Vietnamese).....	415-781-0401
⌘ Cooperative Restraining Order Clinic.....	415-864-4555
⌘ ♻ Family Violence Project.....	415-552-7550
⌘ Immigrant Assistance Line..... (Mandarin).....	415-543-6767 415-543-6769
⌘ Nihonmachi Legal Services..... (Mandarin, Japanese, Vietnamese)	415-567-6255
San Francisco Bar Association Lawyer Referral Service.....	415-764-1616
♻ San Francisco District Attorney.....	415-553-1754

- ☎ ☞ San Francisco Neighborhood Legal Assistance Foundation..... 415-982-1300
(Mandarin, Vietnamese, Tagalog)
- San Francisco Police Department - Domestic Violence Unit..... 415-553-9225
- ☎ Legal Services For Children, Inc..... 415-863-3762

NATIONAL HOTLINE

- ☎ ☞ NATIONAL HOTLINE ON DOMESTIC VIOLENCE 800-799-SAFE
TDD..... 800-787-3224

FACE TO FACE

NATIONAL DOMESTIC VIOLENCE PROJECT..... 1-800-842-4546

Free plastic and reconstructive surgery for women who have been disfigured by domestic abuse.

*CITY & COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
COMMUNITY PUBLIC HEALTH SERVICES*

SIGNATORY PAGE

DOMESTIC VIOLENCE PROTOCOL

APPROVED:

David Ofman, M.D., M.A.
Medical Director, Community-Oriented Primary Care

Date

Jan Murphy, MBA
Primary Care Administrator, CHN

Date

Mary Anne McGuire-Hickey, R.N., M.S
Director of Nursing

Date

Leigh Kimberg, M.D.
Domestic Violence Coordinator for
Community Public Health Services

Date

Kate Monico Klein

Date

Coordinator of Women's Services

Maureen O'Neil, LCSW
Social Work Supervisor

Date