STATE OF NEW HAMPSHIRE
Governor's Commission on Domestic and Sexual Violence

DOMESTIC VIOLENCE PROTOCOL
For Health Professionals

Identification and Treatment of Adult Victims

Prepared by the
Healthcare Committee
of the
New Hampshire Coalition Against Domestic and Sexual Violence

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INTRODUCTION

Domestic violence is a pattern of abusive and coercive behaviors, including physical, sexual, and psychological assaults, as well as economic coercion, which adults and adolescents may use against their intimate partners. Domestic violence can also include emotional intimidation, verbal abuse, stalking, destruction of pets and property, and social isolation. Persons of all ages, including those who are elderly and those who are incapacitated adults, can be subjected to abuse and/or neglect. You may see references in the medical literature to Intimate Partner Violence (IPV) instead of domestic violence, but in this document we will use the phrase "domestic violence".

The U. S. Surgeon General's office has cited domestic violence as one of the major health problems facing American families today. According to a study from the Centers for Disease Control & Prevention, published in the February 8, 2008 issue of Morbidity and Mortality Weekly Report, domestic and sexual violence are pervasive and costly, and can create health problems that last a lifetime. The study found 1,200 deaths and two million injuries to women from domestic violence each year, and nearly 600,000 injuries to men. The 2007 Violence Against Women in New Hampshire Survey, a collaborative project of the University of New Hampshire, the New Hampshire Division of Public Health Services, and the New Hampshire Coalition Against Domestic and Sexual Violence (NHCADSV), found rates of violence that were comparable to, or higher than, those in a national survey. This research showed that domestic violence has been experienced by at least 33.4% of New Hampshire women, a figure that is consistent with the findings of the National Violence Against Women Survey. Consistent and comprehensive screening by healthcare providers is one of many ways to address domestic violence.

Because domestic violence is so frequently an underlying reason for women to seek healthcare, abuse should be suspected for every woman who enters any healthcare setting. It is important to note, studies have shown that only one in twenty-five battered women is identified correctly by healthcare providers.

Many women are too embarrassed or afraid to admit the cause of their injuries. Others are ready to talk, but are confronted with disbelief or blame. Some present "only" emotional scars of abuse. Still others are only waiting to be asked. As many as 75% of battered women say they would have told a nurse or physician about the domestic violence if they had been asked the question.

More than half of domestic violence cases present as non-traumatic emergencies. The majority of victims are women, and the problem affects every class, race, religion and age group. Almost half of the time, if the woman (mother) is being physically abused, the children are too. Boys who witness domestic violence are more likely, as adults, to batter their female partners than boys raised in nonviolent homes.

Throughout history, domestic violence has been accepted as a "private matter". In fact, violence in the home is as illegal as violence on the street. There is legislation in New Hampshire that provides the police and courts with procedures and sanctions to stop domestic violence.

Without appropriate intervention, battering usually continues and escalates in frequency and severity. By the time a woman's injuries are visible and she is identified as a battered woman, violence may be a long established pattern. Early detection and intervention can help to prevent future severe battering incidents and break the intergenerational cycle of violence. According to the Family Violence Prevention Fund website, endabuse.org, interventions in a healthcare setting with prompt referral to a local domestic violence advocacy program can result in a significant number of patients reporting a change in their lifestyle to one that is free of violence.

Although domestic violence is a crime that affects males as well as females, for the purpose of this protocol all victims will be referred to as "she". In over 90% of the cases, the woman is the victim and the man is the perpetrator. We will use the word "partner" to refer to the other person in the relationship.

Domestic violence can occur in all relationships, including dating, gay, and lesbian relationships. Actually, it happens in same-sex relationships at about the same frequency as in heterosexual relationships, and also involves issues of power and control. Perpetrators use many of the same threats to intimidate their same-sex partners, but may also threaten their victims with "outing," or public disclosure of homosexuality which the victim may previously have chosen to keep private. The healthcare provider should use the same non-judgmental, confidential approach with people in same-sex relationships who are or have been victims of domestic violence as when working with victims involved in heterosexual relationships.

Each year in New Hampshire, nearly 11,000 victims of domestic and sexual violence contact crisis centers for assistance, including over 8,000 victims of domestic violence and more than 2000 victims of sexual assault. The NH Governor's Commission on Domestic and Sexual Violence has taken a leading role in developing protocols on responding to domestic and sexual violence for a wide range of professions. A key component of the successful use of medical protocols for domestic violence victims is the close collaboration between healthcare providers and local domestic violence agencies that provide crisis intervention, shelter for victims fleeing domestic violence, and legal advocacy and information to all victims of domestic violence, whether in heterosexual or same-sex relationships. To access domestic violence services, the 24-hour telephone number is 1-866-644-3574. Refer to the back of the protocol for a complete list of New Hampshire Crisis Centers.

PROTOCOL

POLICY STATEMENT

This protocol is designed to provide healthcare providers with information about domestic violence – how to recognize victims and how to assist them. The U.S. Surgeon General's office has cited domestic violence as one of the major health problems facing American families today. Battering is the single major cause of injury to women – more frequent than auto accidents, muggings and rapes combined. Because battering is a frequent reason women seek attention at hospital emergency departments and other clinical settings, every patient should be screened for abuse. This protocol is applicable for emergency departments, private medical offices and outpatient clinics, family planning clinics, dentists' offices, and other healthcare providers such as chiropractors or physical therapists.

The Joint Commission has recognized the importance of screening patients for abuse. In its standards PC.2.150 and PC.3.10 (2005) it reads, "The hospital addresses how it will, to the best of its ability, protect patients from real or perceived abuse, neglect, or exploitation from anyone. Victims of abuse or neglect may come to a hospital through a variety of ways. The patient may be unable or reluctant to speak of the abuse and she may not see herself as "abused". The abuse may not be obvious to the casual observer. Staff needs to know if a patient has been abused, as well as the extent and circumstances of the abuse, to give the patient appropriate care."

PURPOSE

The purpose of this protocol is to assure that women and men who present in healthcare settings are screened for domestic violence and provided with comprehensive medical and psychosocial interventions as indicated.

It is our goal that all healthcare providers will be oriented to the domestic violence protocol and be familiar with the problem and indicators of such violence.

It is important for healthcare providers to establish a relationship and referral procedure with their local domestic violence agency.

PROCEDURES FOR ASSESSMENT AND INTERVENTION OF DOMESTIC VIOLENCE

ASSESSING and TREATING DOMESTIC VIOLENCE VICTIMS:

I. SCREEN ALL PATIENTS FOR DOMESTIC VIOLENCE IN A PRIVATE AREA

All adult patients should be screened for domestic violence in a quiet, private area where confidentiality is assured. The patient should only be screened when alone. It is possible that the individual presenting as the patient's support person is actually the perpetrator of the violence.

II. CONTACT THE LOCAL DOMESTIC VIOLENCE SERVICE AGENCY

1. If domestic violence is suspected or identified, contact the local domestic violence agency according to any established referral procedure. You may disclose the patient's sex and age group (teen vs. adult). Do not provide any information identifying the patient during this initial phone contact. Document that the domestic violence agency was contacted. Once the advocate has arrived, the patient should be presented with the choice of whether or not to speak with the advocate.

2. Domestic violence agency advocates can provide referrals, crisis intervention, safety planning, shelter, and legal advocacy to all victims of domestic violence, whether male or female, in heterosexual or same sex relationships. The services that will be provided by the domestic violence agency and the introduction to the patient should be outlined in the referral process that is established with the local domestic violence agency.

3. The importance of having a support person from the domestic violence agency available to domestic violence victims cannot be overemphasized. In a hospital setting the social service department can also be helpful in making sure domestic violence victims access appropriate services.

III. ASSESSMENT BY HEALTHCARE PROVIDER FOR VICTIMS OF DOMESTIC VIOLENCE:

1. Take History
   a. Assess the patient alone. Ask anyone accompanying the patient to stay in the waiting room or in another location out of earshot. Given the potential danger of these cases, call Security and/or police if a partner seems disruptive or threatening.

   b. Obtain a complete history of symptoms or injuries.

   c. Information should be supplemented with objective information from the patient's past medical records if possible.

   d. See Appendix B for Indicators of Domestic Violence and Interviewing Strategies.

2. Physical Exam

   a. Have the patient undress and wear a hospital gown so that any hidden injuries are exposed.

   b. Perform a physical assessment with particular attention to signs of abuse, battering or neglect. Order lab work and x-rays as indicated.

   c. Assess mental status and emotional state (include substance or alcohol abuse, suicidal or homicidal ideation) of the patient.

3. Assess Victim Safety

   If the patient is identified as a victim of domestic violence, follow the established referral procedure with the local domestic violence agency to assess the patient's safety and help reduce the danger after discharge from the healthcare setting. While one must respect the victim's evaluation of her/his situation, your documentation should clearly reflect your assessment of the patient's safety. Questions to help you assess the safety of the patient are in Appendix C.

   If the victim's responses to this assessment indicate that the pattern of violence is escalating, or if she is fearful of returning home, then a referral to the local crisis center is particularly important. It may be necessary, to protect the victim's safety, to allow a patient to remain on site until a domestic violence advocate arrives.

4. Treatment

   a. Use caution in prescribing sedatives, muscle relaxants, narcotic pain medications, or sleeping pills if patient is going back to a potentially unsafe home.

   b. Always ask the patient about suicidal/homicidal ideation.

5. Referrals

   a. Confirm that the local domestic violence agency has been contacted without disclosure of confidential patient identifying information and make an introduction of the domestic violence agency advocate if applicable.

   b. Consider a mental health and/or substance abuse referral if appropriate.

   c. If the patient declines to speak to a domestic violence advocate and also declines the referral to a behavioral health provider, give the patient information about the local domestic violence agency, a list of community resources for future reference, and a sample safety plan. (Appendix A).

IV. DOCUMENTATION

Providers should document the patient's statements and should avoid pejorative or judgmental documentation.

1. Document Relevant History
   a. Chief complaint or history of present illness.
   b. Record details of the abuse and its relationship to the presenting problem.
   c. Complete history of symptoms or injuries.
   d. Record objective supplemental information from the patient's past medical records.
   e. For current domestic violence victims, document a summary of past and current abuse including:
      i. Patient's statement about what happened, not what lead up to the abuse (e.g. "boyfriend hit me in the face" not "patient arguing over money").
      ii. Social history, including relationship to abuser and abuser's name if possible.
      iii. Include date, time and location of incidents.
      iv. Patient's appearance and demeanor.
      v. Any objects or weapons used in an assault.
      vi. Patient's account of any threats made or other psychological abuse.

2. Document Results of Physical Exam
   a. Findings related to domestic violence, neurological, gynecological, mental status exam if indicated.
   b. Record any injuries (present or past), and describe type, size and location.
   c. Use body map and/or photographs to supplement written description. (See Appendix D)
   d. If using photographs, obtain consent before photographing the patient.

3. Document results of any lab tests, x-rays or other diagnostic procedures and their relationship to current or past abuse

4. Document Results of Assessment and Referrals
   a. Your assessment of the patient's safety including the potential for serious harm, suicide and health impact of domestic violence.
   b. Document that the domestic violence agency was contacted, if applicable.
   c. Document referrals made and options discussed.

5. If the patient does not disclose domestic violence victimization, document that screening was conducted and the patient did not disclose. If you suspect abuse, document your reasons for concern.

DIFFICULT SITUATIONS

I. DOMESTIC VIOLENCE DURING PREGNANCY

Over 342,000 pregnant women a year experience battering during pregnancy. Studies of battered women report that 40 to 60 percent of these women were first abused during a pregnancy. Pregnant women have a higher risk of experiencing violence during pregnancy than they do of experiencing problems such as high blood pressure, gestational diabetes or premature rupture of membranes. This abuse includes blows to the abdomen, injuries to the breast and genitals, and sexual assault. Battered women

may report miscarriages, stillbirths, and pre-term deliveries. A Harvard School of Public Health (HSPH) study, published in the July 2006 issue of the *American Journal of Obstetrics and Gynecology*, on the outcomes of abuse during pregnancy showed an increased risk of low birth weight. Given that birth weight is one of the most important determinants of infant well being and subsequent child development, the consequences of battering are significant for the pregnant woman and her developing fetus.

Although few abused pregnant women discuss the abuse with anyone or report it to the police, they are more likely to seek healthcare for injuries. Some partners, however, as part of their pattern of coercive control, may restrict the victim's access to healthcare.

The Surgeon General recommends close surveillance of pregnant women for signs of battering.

- Women battered in pregnancy frequently have multiple injury sites.

- The abdomen is a common site of prenatal injury and ecchymotic areas may be indicative of kicking or beating. Vaginal bleeding may be associated with abdominal or vaginal injury. Evaluation with ultrasound, laboratory studies, fetal monitoring, or other modalities may be required.

- During labor and delivery, an abuser may try to control a woman's decision to have an epidural, pain medication, or other interventions. He may demand that doctors restore his partner's vagina to its pre-birth state and may make disparaging comments about her sexuality or about the sex of the baby following the birth.

- The postpartum woman who has been a victim of emotional or physical abuse must be closely observed for depression, feeding problems with the infant and protracted physical and emotional recovery from birth.

- An abuser may also increase abuse, use a woman's relationship with her baby as a weapon, and deny her access to the baby.

- Battered women may be sexually assaulted during the pregnancy and postpartum period.

- Special attention should be paid to the risk of child abuse for the new infant if a woman has been battered during pregnancy.

II. DOMESTIC VIOLENCE AMONG THE ELDERLY

Domestic violence in relationships of the elderly occurs among older men and women of all racial, ethnic, religious, and socioeconomic groups as well as elders of varying functional abilities and levels of dependency. Similar to domestic violence that occurs in relationships in other age groups, domestic violence in relationships of the elderly includes an escalating pattern of violence or intimidation by an intimate partner, which is used to gain power and control over the other partner. It represents a conscious and deliberate attempt to inflict physical, psychological, or financial harm.

Caregiver abuse is the second highest cause of elder abuse, next to self-neglect. Nearly twenty-four percent of investigated reports on abuse of the elderly are a result of caregiver abuse. The majority of the perpetrators are adult children or other family members.

Indicators of domestic violence in elderly relationships are similar to those associated with domestic violence in relationships in other age groups. These indicators include the likelihood that the frequency and severity of injuries will increase over time, intense confusion and disassociation, and violent incidents that are often preceded by periods of intensifying tension and followed by periods of apparent contrition on the part of perpetrators.

The appropriate response to elderly domestic violence victims is similar to the response to other adult victims. Assure the victim that the abuse is not his or her fault, remind the patient that no one deserves to be abused, and explain the options that are available. Under no circumstances should a healthcare provider tell an elderly victim of domestic violence what to do. It is of utmost importance to allow the victim to make his or her own decisions in their own time.

III. INCAPACITATED ADULTS (Age 18 years and greater)

The New Hampshire Revised Statutes Annotated (RSA 161-F:42) states that any healthcare professional who has reason to believe that an "incapacitated adult" has been subjected to physical abuse, neglect, or exploitation or is living in hazardous conditions shall report this to the New Hampshire Division of Elderly and Adult Services. "Incapacitated" means that the physical, mental, or emotional ability of a person is such that she/he is unable to manage personal, home, or financial affairs in her/his own best interests, or she/he is unable to act or unable to delegate responsibility to a responsible caretaker or caregiver.

If a patient does have a cognitive impairment, it is reasonable to screen for abuse since diminished cognitive functioning does not necessarily negate the person's ability to describe mistreatment. If the victim has dementia or delirium and is unable to answer questions about abuse and neglect, the healthcare provider should seek help from an appropriate respondent.

REPORTING REQUIREMENTS

According to New Hampshire State law, most domestic violence injuries are not required to be reported to the police. If the patient is 18 years of age or older and has received a gunshot wound or other serious bodily injury, the injuries must be reported to the police. As defined in RSA 625:11 "Serious bodily injury" means any harm to the body which causes or could cause severe, permanent, or protracted loss of or impairment to the health or of the function of any part of the body.

It is important to keep in mind that victims of domestic violence in elder relationships who are not incapacitated are not subject to mandatory reporting laws. Elderly patients, who are not incapacitated and who have injuries caused by domestic violence, must be asked whether they object to having their injuries reported to the police.

Appendix A

DOMESTIC VIOLENCE SAFETY PLAN GUIDELINES

One of the most important things you can do when developing your safety plan is to talk to a victim advocate who can help you fully consider safety issues, understand your legal rights, and identify community resources (e.g., shelters, sources of financial assistance, or food banks). You can locate a victim advocate through a local domestic violence agency, which provides services at no-charge to victims. In New Hampshire, call 1-866-644-3574 to reach the domestic violence program nearest you. The following safety suggestions have been compiled from safety plans distributed by state domestic violence coalitions from around the country. Following these suggestions is not a guarantee of safety, but could help improve your safety situation.

Personal Safety with an Abuser

- Identify your partner's use and level of force so that you can assess danger to you and your children before it occurs.
- Try to avoid an abusive situation by leaving.
- Identify safe areas of the house where there are no weapons and where there are always ways to escape. If arguments occur, try to move to those areas.
- Don't run to where the children are as your partner may hurt them as well.
- If violence is unavoidable, make yourself a small target: dive into a corner and curl up into a ball with your face protected and your arms around either side of your head, fingers entwined.
- If possible, have a phone accessible at all times and know the numbers to call for help. Know where the nearest pay phone is located. Know your local battered women's shelter phone number. Don't be afraid to call the police.
- Let trusted friends and neighbors know of your situation and develop a plan and visual signal for when you need help.
- Teach your children how to get help. Instruct them not to get involved in the violence between you and your partner. Plan a code word to signal that they should get help or leave the house.
- Tell your children that violence is never right, even when someone they love is being violent. Tell them that neither you nor they are at fault or cause the violence, and that when anyone is being violent, it is important to keep safe.
- Practice how to get out safely. Practice with your children.
- Plan for what you will do if your children tell your partner of your plan or if your partner otherwise finds out about your plan.
- Keep weapons like guns and knives locked up and as inaccessible as possible.
- Make a habit of backing the car into the driveway and keeping it fueled. Keep the driver's door unlocked and the other doors locked for a quick escape.

- Try not to wear scarves or long jewelry that could be used to strangle you.
- Create several plausible reasons for leaving the house at different times of the day or night.
- Call a domestic violence hotline periodically to assess your options and get a supportive, understanding ear.

Getting Ready to Leave

- Keep any evidence of physical abuse, such as photographs of bruises and torn clothing.
- Know where you can go to get help; tell someone what is happening to you.
- If you are injured, go to a doctor or an emergency room and report what happened to you. Ask that they document your injuries.
- Plan with your children and identify a safe place for them (for example, a room with a lock or a friend's house where they can go for help). Reassure them that their job is to stay safe, not to protect you.
- Contact your local battered women's shelter and find out about laws and other resources available to you before you have to use them during a crisis.
- Keep a journal of all violent incidents, noting dates, events, and threats made.
- Acquire job skills as you can, such as learning to type or taking courses at a community college.
- Try to set money aside or ask friends or relatives to hold money for you.
- Store some belongings with a friend or relative. Leave clothing, medications, your Social Security card, a credit card (if possible), citizenship documents, children's school/medical records, children's toys, insurance information, copies of birth certificates, money, and other valued personal possessions with them.

The Day You Leave

- Leave when it is least expected, for example, during times of agreement and calm.
- Create a false trail. Call motels, real estate agencies, schools in a town at least six hours away from where you plan to relocate. Ask questions that require a call back to your house in order to leave those phone numbers on record.

General Guidelines for Leaving an Abusive Relationship

- Make a plan for how you will escape and where you will go.
- Plan for a quick escape.
- Put aside emergency cash as you can.
- Hide an extra set of car keys.

- Take with you important phone numbers (of friends, relatives, doctors, schools, etc.) as well as other important items, including:
    - Driver's license
    - Regularly needed medication
    - List of credit cards (account number and date of expiration) held by self or jointly, or the credit cards themselves if you have access to them
    - Pay stubs
    - Checkbooks and information about bank accounts and other assets.

If time is available, also take:

- Citizenship documents (such as your passport, green-card, etc.)
- Titles, deeds, other property information, and tax returns
- Medical records
- Children's school records and immunization records
- Insurance information
- Copy of marriage license, birth certificates, will, and other legal documents
- Verification of Social Security numbers
- Welfare identification
- Valued pictures, jewelry, or personal possessions

After Leaving the Abusive Relationship

If you are getting a restraining order and the offender is leaving:

- Change your locks and phone number.
- Change your work hours and route taken to work.
- Change the route you take to transport children to school.
- Keep a certified copy of your restraining order with you at all times.
- Inform friends, neighbors, and employers that you have a restraining order in effect.
- Give copies of the restraining order to employers, neighbors, and schools along with a picture of the offender.
- If available in your community, register with VINE Protective Order™ to be notified immediately when the order is served, when hearings will be held, and when any amendments to the order are filed. Ask your victim advocate or sheriff's office about this service.

- Call law enforcement to enforce the order.
- Carry a charged cell phone preprogrammed to 911.

If you leave:

- Consider renting a post office box for your mail.
- Be aware that addresses are listed on restraining orders and police reports.
- Be careful to whom you give your new address and phone number.
- Change your work hours if possible.
- Alert school authorities about the situation.
- Consider changing your children's schools.
- Reschedule any appointments that the offender is aware of when you leave.
- Use different stores and frequent different social spots.
- Alert neighbors and request that they call the police if they feel you may be in danger.
- Talk to trusted people about the violence.
- Replace wooden doors with steel or metal doors.
- Install security systems if possible.
- Install a lighting system that turns on when a person is coming close to the house (motion sensitive lights).
- Tell people you work with about the situation and have your calls screened by one receptionist if possible.
- Tell people who take care of your children which individuals are allowed to pick up your children. Explain the situation to them and provide them with a copy of the restraining order.
- Call the telephone company to request caller ID. Ask that your phone be blocked so that if you call, neither your partner nor anyone else will be able to get your new, unlisted phone number.
- Receive ongoing support from domestic violence and mental health service providers.

DOMESTIC VIOLENCE, SEXUAL ASSAULT AND STALKING SUPPORT SERVICES IN NH

NH Statewide Sexual Assault Hotline: 1-800-277-5570
NH Statewide Domestic Violence Hotline: 1-866-644-3574

NH Coalition Against Domestic and Sexual Violence
PO Box 353, Concord, NH 03302-0353 - Office Phone: 603-224-8893
General Web Site: www.nhcadsv.org and Teen Web Site: www.reachoutnh.com

The NH Coalition is comprised of 14 member programs throughout the state that provide services to survivors of sexual assault, domestic violence, stalking and sexual harassment. You do not need to be in crisis to call. Services are free, confidential, and available to everyone regardless of gender, age, health status (including HIV-positive), physical, mental or emotional ability, sexual orientation, gender identity/expression, socio-economic status, race, national origin, immigration status or religious or political affiliation. The services include:

- Support and information, available in person and through a 24-hour hotline
- Accompaniment, support, and advocacy at local hospitals, courts, and police departments
- Assistance with protective/restraining orders and referrals to legal services
- Peer Support Groups
- Access to emergency shelter
- Information and referrals to community programs
- Community and professional outreach and education

RESPONSE to Sexual & Domestic Violence
54 Willow Street
Berlin, NH 03570
1-866-644-3574 (DV crisis line)
1-800-277-5570 (SA crisis line)
603-752-5679 (Berlin office)
603-237-8746 (Colebrook office)
603-788-2562 (Lancaster office)

Turning Points Network
11 School Street
Claremont, NH 03743
1-800-639-3130 (toll free crisis line)
603-543-0155 (crisis line)
603-542-8338 (Claremont office)
603-863-4053 (Newport office)
www.free-to-soar.org

Rape & Domestic Violence Crisis Center (RDVCC)
PO Box 1344
Concord, NH 03302-1344
1-866-644-3574 (DV crisis line)
1-800-277-5570 (SA crisis line)
603-225-7376 (main office)
Walk-in Office:
15 Pleasant Street, Concord
www.rdvcc.org

Starting Point: Services for Victims of Domestic & Sexual Violence
1-800-336-3795 (crisis line)
603-356-7993 (Conway office)
603-539-5506 (Ossipee office)
www.startingpointnh.org

Sexual Harassment & Rape Prevention Program (SHARPP)
UNH/Verrette House
6 Garrison Avenue
Durham, NH 03824
1-888-271-SAFE (7233) (crisis line)
603-862-3494 (office)
www.unh.edu/sharpp

Monadnock Center for Violence Prevention
12 Court Street
Keene, NH 03431-3402
888-511-6287 (toll free crisis line)
603-352-3782 (crisis line)
603-352-3782 (Keene office)
603-209-4015 (Peterborough)
603-209-4015 and 603-532-6288 (Jaffrey Office)
www.mcvprevention.org

New Beginnings Women's Crisis Center
PO Box 622
Laconia, NH 03247
1-866-644-3574 (DV crisis line)
1-800-277-5570 (SA crisis line)
603-528-6511 (office)
www.newbeginningsnh.org

WISE
38 Bank Street
Lebanon, NH 03766
1-866-348-WISE (crisis line)
603-448-5525 (local crisis line)
603-448-5922 (office)
www.wiseoftheuppervalley.org

The Support Center at Burch House
PO Box 965
Littleton, NH 03561
1-800-774-0544 (crisis line)
603-444-0624 (Littleton office)
www.tccap.org/support_center.htm

YWCA Crisis Service
72 Concord Street
Manchester, NH 03101
603-668-2299 (crisis line)
603-625-5785 (Manchester office)
603-432-2687 (Derry office)
www.ywcanh.org

Bridges: Domestic & Sexual Violence Support
PO Box 217
Nashua, NH 03061-0217
603-883-3044 (crisis line)
603-889-0858 (Nashua office)
603-672-9833 (Milford office)
www.bridgesnh.org

Voices Against Violence
PO Box 53
Plymouth, NH 03264
603-536-1659 (crisis line)
603-536-5999 (public office)
603-536-3423 (shelter office)
www.voicesagainstviolence.org

A Safe Place
6 Greenleaf Woods, Suite 101
Portsmouth, NH 03801
1-800-854-3552 (crisis line)
603-436-7924 (Portsmouth crisis line)
603-436-4619 (Portsmouth office)
603-330-0214 (Rochester crisis line)
603-890-6392 (Salem crisis line)
www.asafeplacenh.org

Sexual Assault Support Services
7 Junkins Avenue
Portsmouth, NH 03801
1-888-747-7070 (crisis line)
603-436-4107 (Portsmouth office)
603-332-0775 (Rochester office)
www.sassnh.org

Appendix B

INDICATORS OF DOMESTIC VIOLENCE AND INTERVIEWING STRATEGIES

Because victims of domestic violence can present in clinical settings without indicators of abuse, the best way to identify domestic violence is to ask all patients routine screening questions. However, the following is a list of potential indicators that a clinician might see. It is important to understand that this list is not all inclusive. It is to be used as a guide and should not replace routine screening. Battered women might have one, several, or none of these signs, symptoms, or characteristics.

1. The patient admits to past or present physical or emotional abuse, as a victim or witness.

2. The patient denies physical abuse, but the extent or type of injury is inconsistent with the explanation offered by the patient. For example, the patient presents with unexplained bruises, whip-lash injuries consistent with shaking, areas of erythema consistent with slap injuries, grab marks on arms or neck, lacerations, burns, scars, fractures or multiple injuries in various stages of healing, fractured mandible, or perforated tympanic membranes.

3. The patient presents with injury sites suggestive of battering. Common sites of injury are areas hidden by clothing or hair (e.g., face, head, chest, breasts, abdomen and genitals). Accidental injuries usually involve the extremities whereas domestic violence often involves both trunk and extremity injuries.

4. The woman is pregnant. Violence often begins with the first pregnancy, and with injuries to the breasts or abdomen. (For additional information on battering during pregnancy refer to Difficult Situations, Section I, Domestic Violence During Pregnancy, page 8.)

5. The patient presents evidence of sexual assault or forced sexual actions by her partner. Refer to New Hampshire Sexual Assault Protocol (fifth edition, 2008) for evaluation of sexual assault aspect.

6. The partner (or suspected abuser) accompanies the patient, insists on staying close to the patient and may try to answer all questions directed to her.

7. The patient is afraid of returning home and fears for the safety of her children.

8. A substantial delay exists between the time of the injury and presentation for treatment. The patient may have been prevented from seeking attention earlier, or may have had to wait for the batterer to leave.

9. The patient describes the alleged "accident" in a hesitant, embarrassed or evasive manner, or avoids eye contact.

10. The patient has complaints such as panic attacks, anxiety, headaches, feeling weak and dizzy, choking sensation, or depression.

11. The patient has complaints of chronic pain (e.g., back or pelvic pain) with no substantiating physical evidence. This may signify fear of impending or actual physical abuse.

12. The patient or partner has a history of psychiatric problems or alcohol or drug abuse.

13. The patient has a history of suicide attempts, or suicidal ideation. Battering accounts for one in every four suicide attempts by all women and half of all suicide attempts by black women.

14. Review of medical records reveals repeated use of Emergency Department (ED) or other medical and/or social services. Medical history reveals many "accidents" or remarks by nurse or physician indicating that previous injuries were of suspicious origin.

15. The patient has a history of self-induced abortions or multiple therapeutic abortions.

16. The patient has a pattern of avoiding continuity in healthcare.

People may be at different points in their lives in defining a problem or preparing for change. Some women may not identify themselves as abused, and others may identify abuse but not yet be ready for changing their situation. Still others may be ready to make major changes with minimal assistance. Assessing a woman's position on this spectrum permits more effective assistance by healthcare providers. The role of provider is to help name the problem and assist the woman in exploring her options, such as contacting the local domestic violence agency, not to mandate or prescribe a specific action or thought process.

Women in battering relationships may feel a great deal of conflict about leaving their partners. For example, they may feel that it is important to recognize the abuse and its effect on their lives, yet at the same time they care deeply for their partner/abuser. Also, abusers are often emotionally dependent upon the women they abuse and put pressure on their partners not to leave them.

Different cultures accept different behaviors within relationships as normal. Sensitivity to these norms is important. However, acceptance of these norms is not appropriate, and we must act within the framework of law and our current understandings.

Ask the patient direct, non-threatening questions in an empathetic manner. You may find it difficult to ask these questions. However, asking the question and identifying the woman as battered is the first step toward appropriate treatment. Examples are:

1. Almost a third of women are victims of assaults at the hands of their intimate partners at some point in their lives, so I'm asking all my patients, "Is this happening to you?"

2. Is anyone in your home being hurt, hit, threatened, frightened or neglected?

3. Do you feel safe in your current relationship?

4. Do you ever feel afraid at home? Are you afraid for your kids?

5. Sometimes patients tell me that they have been hurt by someone close to them. Could this be happening to you?

6. I noticed you have a number of bruises. Could you tell me how they happened? Did someone hit you?

7. You seem frightened of your partner. Has your partner ever hurt you?

8. You mention your partner loses his/her temper with the children. Does he lose his temper with you? Does he/she become abusive when he/she loses his/her temper?

9. Have there been times during your relationship when you have had physical fights?

10. Do your verbal fights ever include physical contact?

11. Have you been hit, punched, kicked or otherwise hurt by someone within the past year? If so, by whom?

12. You mentioned your partner uses drugs/alcohol. How does your partner act when drinking or on drugs?

13. Does your partner consistently control your actions or put you down?

14. Sometimes when others are overprotective and as jealous as you describe, they react strongly and use physical force. Is this happening in your situation?

15. Your partner seems very concerned and anxious. Was he responsible for your injuries?

16. Is there a partner from a previous relationship who is making you feel unsafe now?

If the patient states that battering has occurred, give her time to verbalize openly before beginning your physical assessment. Allow her to control the timetable of the discussion.

Assure the patient that this information will be addressed after the medical examination and testing is complete. At this point, it is appropriate to provide information to the patient about the local domestic violence advocacy agency. Remain non-judgmental, supportive, and relaxed. Reassure her that no one has the right to hurt others, and that she is not responsible for someone else's abusive behavior.

Appendix C

QUESTIONS TO HELP ASSESS PATIENT SAFETY

1. Where is _____ (name) now? (Try to identify the abuser by either name or relationship.)

2. Does he know that you are here?

3. Has _____ (name) ever used or threatened to use weapons?

4. Are weapons available to _____ (name)?

5. Has _____ (name) been drinking or taking drugs?

6. Has the abuse been increasing in frequency and/or severity?

7. Does _____ (name) verbally threaten you?

8. Has _____ (name) threatened your friends and relatives?

9. Has _____ (name) threatened to commit suicide if you leave?

10. Do you have a restraining order at this time?

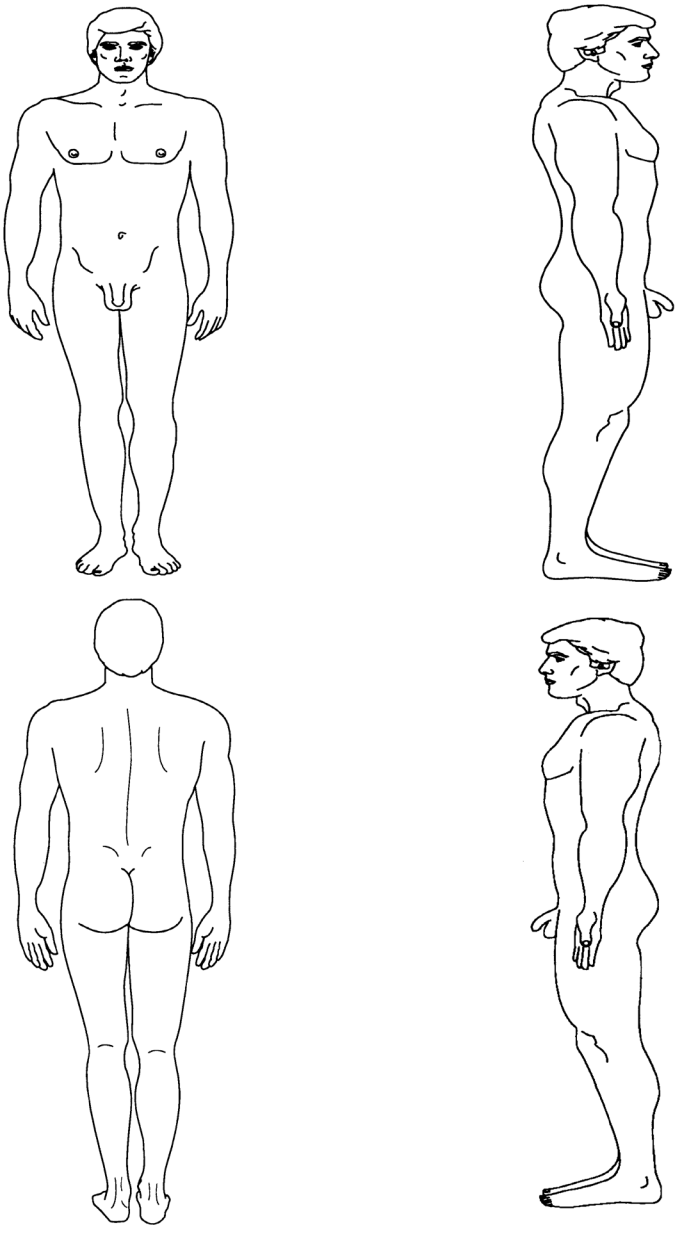
11. Have you had a restraining order against _____ (name) in the past? If so, was it ever violated?

Addressograph

Appendix D

BODY INJURY MAP

Using the appropriate set of anatomical drawings, mark and describe all bruises, scratches, lacerations, bite marks, etc.



Signature: _____ MD/RN

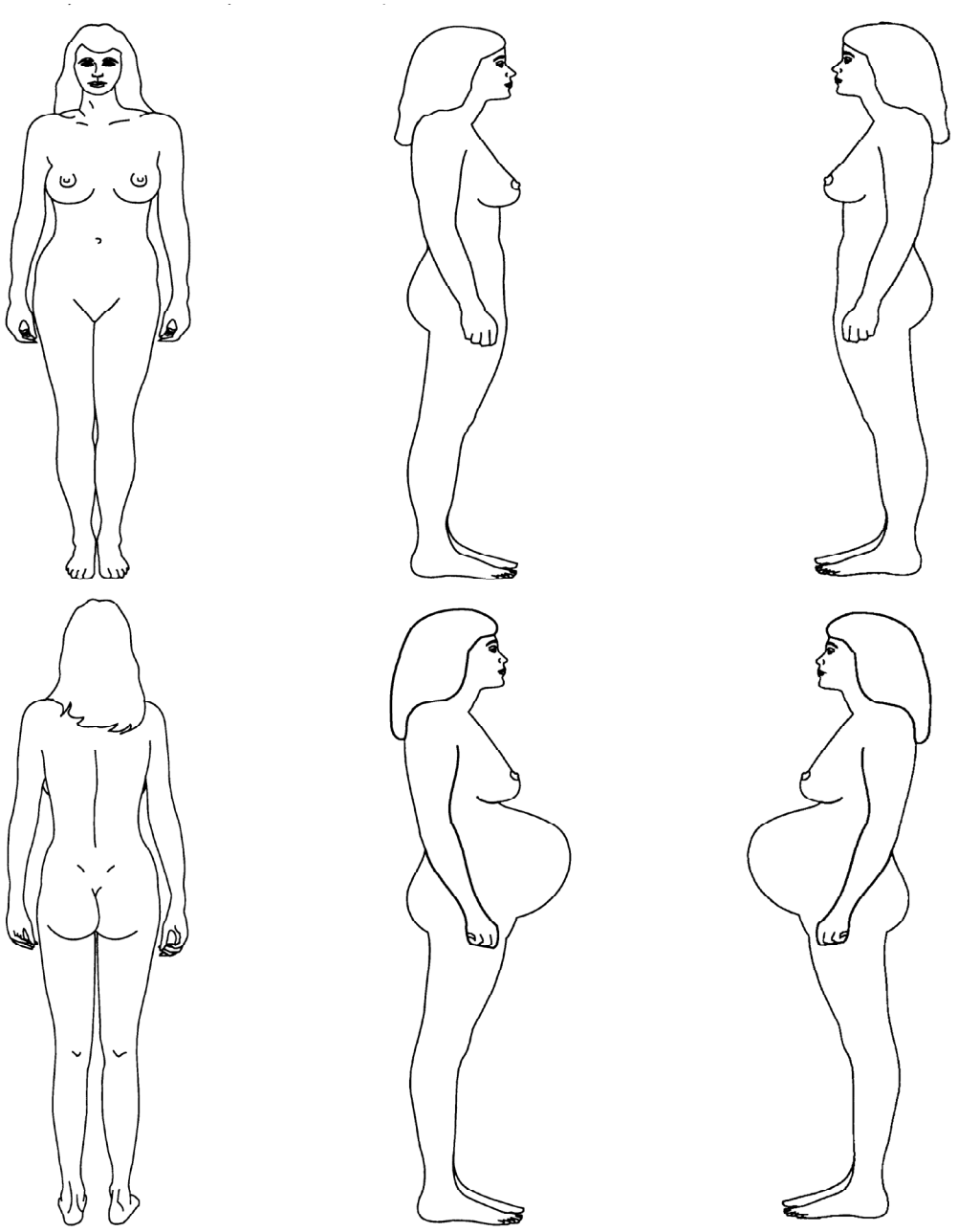
Date: _____

Addressograph

Appendix D (cont.)

BODY INJURY MAP

Using the appropriate set of anatomical drawings, mark and describe all bruises, scratches, lacerations, bite marks, etc.



Signature: _____ MD/RN

Date: _____

Appendix E

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WEBSITES

Family Violence Prevention Fund's websites:
www.endabuse.org
www.fvpf.org

New Hampshire Coalition against Domestic and Sexual Violence:
www.nhcadsv.org

Nursing Network on Violence Against Women, International:
www.nnvawi.org

American College of Obstetricians and Gynecologists:
www.acog.org

Elder Mistreatment
National Center on Elder Abuse (NCEA)
Phone (202) 898-2586
Web Site: http://www.gwjapan.com/NCEA
E-mail: ncea@nasua.org

This agency provides information on all aspects of elder abuse.

Area Agency on Aging
Web Site: http://www.aoa.dhhs.gov/aoa/webres/are-agn.htm

This state or local agency operates an information and referral program to help you locate services for preventing and treating elder mistreatment. You can obtain a listing of state and locate agencies from the Department of Health and Human Services' Administration on Aging Web Site.

State Elder Abuse Hot Lines
Web Site: http://gwjapan.com/NCEA/report/index.html

Many states have 24-hour toll free hot line for reporting suspected elder mistreatment. The NCEA provides a state by state listing at the above web site.

Long-term Care Ombudsman Program
Web Site: http://www.dhhs.gov/aoa/pages/ltcomb.html

The ombudsman investigates and resolves complaints about nursing homes and other institutions. For addresses, phone numbers, and email addresses of each state' programs, use the above listed web site.

Administration on Aging Elder Care Locator
Phone: 1-800-677-1116
Web Site: http://www.aoa.dhhs.gov/elderpate/locator.html

Immigration Spousal Abuse
Web Sites: www.ndvh.org or www.ojp.usdoj.gov/vawa

Contains information about immigration spousal abuse.