

AN ASSESSMENT OF MINNESOTA'S HEALTH CARE AND PUBLIC HEALTH RESPONSE TO VIOLENCE AGAINST WOMEN

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EXECUTIVE SUMMARY

INTRODUCTION

In the fall of 2001, the National Centers for Disease Control and Prevention (CDC) funded the Minnesota Department of Health (MDH) to conduct an assessment and develop a state plan to address violence against women, specifically in the areas of health care and public health.

As the first stage of this planning process, an assessment of state activities and information on this topic was conducted. The assessment includes:

- › A summary of national and local policies and recommendations relating to violence against women,
- › A review of literature and resources related to “best practices” on the topic,
- › Results from key informant interviews (56) conducted to assess present policies and practices in Minnesota, as well as to gather the interviewees’ recommendations for change.

A multidisciplinary advisory committee has provided guidance on the design and implementation of the assessment.

For the complete assessment, go to <http://www.health.state.mn.us/divs/fh/chp/injury.htm>

ASSESSMENT CONTENT

1. SUMMARY OF POLICIES AND RECOMMENDATIONS

Project staff reviewed the policies and recommendations of more than fifteen professional organizations related to violence against women.¹

In general, the recommendations:

- › Call for routine screening for intimate partner, sexual and/or family violence by health care providers, though methods vary.
- › Advocate for provider awareness of community support services.
- › Encourage the referral of identified victims to appropriate resources.

The recommendations, however:

- › Do not include specific recommendations for provider education and training.
- › Do not identify a role for health care/public health in identifying and referring perpetrators of violence
- › Do not provide procedures that guarantee compliance with policies.
- › Do not address the development of screening and response protocols for sexual violence in the same way as intimate partner violence.

Other agencies have underlined their recognition of violence as a health problem, through research, development of materials, and provision of grants and other supportive activities. These include the

U.S. Surgeon General's office (C. Everett Koop, 1985), and the Family Violence Prevention Fund. The Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services have committed public resources to support the development of research and best practices; while the Joint Commission on Accreditation of Healthcare Organizations has developed a policy that establishes standards related to intimate partner violence for accredited institutions.

In addition, several Minnesota agencies and organizations have established policies and guidelines regarding the health care/public health response to violence against women. An example is the Practice Enhancement Project (PEP) of the Minnesota Department of Health, which provides public health nursing guidelines for the prevention of violence against women and children. Also, several Minnesota health plans follow policies of the Institute for Clinical Systems Improvement (ICS12); among them are Blue Cross and Blue Shield, HealthPartners, Medica, Preferred One, and UCare Minnesota.

2. LITERATURE REVIEW OF BEST PRACTICES

A review of literature and resources related to “best practices” on the topic was conducted. In the literature, several ideas emerge repeatedly:

Education and training:

- › It is important to educate staff on the value of a screening protocol, to help them understand how their work may make a difference in someone's life (Siegel, 1999).
- › A one-time education session on a new screening protocol is not nearly enough to ensure continued compliance (Wiist, 1999).
- › More emphasis on domestic violence needs to be part of curricula in programs of education for health professionals (Tilden, 1989).
- › Health care staff at common entry points should receive frequent in-service education programs on domestic violence detection and management (Tilden, 1989).

Agency commitment:

- › Successful screening protocols deal with known barriers to assessment and intervention in health care settings (Wiist, 1999).
- › Clinical interventions are more likely to be effective if they are joined with (a) pragmatic policies regarding screening; (b) a broad, multidisciplinary commitment to a resilient community-based infrastructure that can protect battered women and their children from harm; and (c) a long-term strategy for ensuring economic and emotional empowerment for survivors (Warshaw, 1999).
- › Institutionalizing a responsive, nonjudgmental climate to encourage disclosure requires ongoing effort (Dienemann, 1999).

Coordinated community effort:

- › Success occurs in programs that provide clinicians an opportunity to consult a trained advocate when patients are identified as injured by intimate partner violence (Feighny, 1999).
- › Communities need coordinating bodies with members from medical services, mental health services, criminal justice services, and community services, as well as survivors of domestic violence (Tilden, 1989).
- › Staff access to appropriate support and referral services, within and outside of the health care organization, are essential. Health care professionals have a key role in encouraging women to

acknowledge abuse and then facilitating contact with appropriate referral services; they should not undertake roles, such as counseling, for which they are not equipped (Loughlin, 2000).

Attention to the special needs of minority populations:

› The ethnicity of the communities served by the hospital needs to be taken into account in screening protocol design and implementation, as well as in staff training (Loughlin, 2000).

3. KEY INFORMANT INTERVIEWS

Telephone or in-person interviews were conducted with 56 professionals, all current or recent employees of Minnesota public health agencies, health care organizations, or victim service agencies in Minnesota. They were recommended by the MDH Violence Advisory Committee and by MDH staff, based on their contact with victims or potential victims of violence against women, or their contact with those who provide services to victims.

The interview portion of the assessment has some limitations:

- › Those interviewed were recommended by others and might therefore be more knowledgeable about and committed to addressing violence issues than a broader sampling might be,
- › More urban than rural programs, hospitals and clinics were represented,
- › Clients or victims of abuse were not interviewed, and
- › Interviews were not designed to provide a comprehensive assessment of preventative activities in MN, but rather to act as indicators or highlights.

Those interviewed for the assessment represented:

- › The medical community (physicians, nurses, social workers and related hospital-based program managers),
- › Advocates (sexual assault and domestic violence),
- › Health plan administrators,
- › Members of the Health Care Coalition on Violence, and
- › Public health professionals (state and local).

In January of 1996, the Governor’s Task Force on Violence as a Public Health Problem presented a report outlining The Role of Minnesota’ Health Care Organizations and Professionals in Prevention and Treatment. The report identified nine action areas (Agency Commitment, Primary Prevention, Practice Guidelines, Education and Training, Agency Collaboration, Data Collection, Workplace Violence, Funding, and Future Areas of Focus) to focus work related to violence in Minnesota.

The report, while discussing violence more broadly, provided a useful framework for this assessment. Information was sought concerning work done in the nine action areas in the years since the report was published.

FINDINGS FROM THE INTERVIEWS

1. The commitment of health organizations to violence prevention has increased overall, but is now declining in some agencies.

Most respondents reported that their agency's overall commitment of resources to prevent / respond to violence against women has increased since the 1990s. Violence against women has been a "hot topic" within Minnesota health systems, exemplified by the work of the Health Care Coalition on Violence, and including many other national, state and local efforts as well. Some local examples include:

- > Collaboration between public health nurses and community-based violence prevention efforts (e.g. working with shelters for battered women to provide health care and education);
- > Coordination of a multi-disciplinary Health Care Coalition on Violence, bringing leaders in health care and public health organizations together to identify ways to improve the health care and public health response to victims of violence in Minnesota;
- > Adoption, by numerous Minnesota hospitals and clinics, practices to identify, respond to and prevent sexual and intimate partner violence (ICSI, for example).

The interest, commitment, and direction from national groups has clearly led many agencies in recent years to develop practice guidelines regarding violence against women, and most commonly intimate partner violence.

However, a significant number of respondents reported a much more recent decrease in the time, attention, and resources directed to violence against women, as it has been replaced by "hotter" topics.

2. Policy and practice guidelines are being implemented, but methods and compliance vary.

Although respondents reported that their agencies have guidelines regarding cases of sexual assault and intimate partner violence, compliance with those guidelines varied widely, according to respondents' reports. Every clinic or hospital that is engaged in practices to prevent or respond to violence against women reported a different approach.

"Pregnant women are screened at their first prenatal visit. Women presenting for well-women visits / birth control exams are all screened."(Medical provider)

"With the prenatal data base, those questions are asked, I would say 10percent of the time."(Medical provider)

"The guideline is to screen every female patient at every visit. There are no set questions, and each staff member has his/her own approach."(Medical provider)

"Screening occurs with all adult women at every preventative visit."(Medical provider)

Few reported any mechanism to track implementation of their protocol and who was responsible, and fewer still were able to report screening and referral rates.

While the Joint Commission for Accreditation of Healthcare Organizations (JCAHO)³ mandated the implementation of "standards", or objective criteria for identifying and assessing possible victims of abuse and neglect, there is little in place that ensures that those standards be enforced. Unless prompted by

research activities, few health care or public health agencies are tracking screening and referral rates. For some, while those data are available, they are not accessed. For others, the data are simply not collected.

3. Effectiveness depends on multi-disciplinary collaboration.

When asked, virtually every respondent felt their agency had the resources to respond to victims of violence against women.

“Certainly all of these resources are available if they are needed.” (Medical provider)

“Resources are always changing, at least a bit – but I am confident that we are able to provide whatever our clients are needing.” (Public Health practitioner)

However, the health care organizations that had contractual partnerships with advocacy agencies to provide information and support to victims, reported higher screening and assessment rates than did those that did not have partnerships. They also reported they could better understand and meet the needs of victims.

When a contractual relationship existed, referrals by health care providers to community advocacy services were more frequent. Medical practitioners in this type of relationship often reported they no longer fear the “yes” response from a victim, as they were confident that the patient’s individual needs would be met by a trained advocate.

However, a number of agencies that had this type of cooperative relationship, no longer have resources or administrative support to continue it. Without such a relationship, health care organizations continue to request advocacy services, but to a lesser extent.

“Since the advocate positions were cut, the number of referrals that we receive from health care has drastically decreased and that is also true for the hospital’s own social workers. Apparently, the screening rates have decreased as well.” (Domestic Violence Advocate)

4. On-going training is needed, both on the use of screening protocols and on the dynamics of abuse and violence.

Many respondents reported the need for additional training about intimate partner or sexual violence, both to increase/sustain awareness and to create/refine skills. The majority of health care agencies interviewed however, have provided only “one-shot” training about violence against women and very little on-going training exists.

“New employees receive training at their beginning of their tenure, but there is no on-going training.” (Medical Provider)

“Employees receive initial training; the problem is that it’s not mandatory.” (Medical Provider)

While “one-time” training may be adequate when providers use the skills regularly, others get rusty, and would benefit from on-going training.

5. To sustain improvements, “champions” for violence prevention and intervention are needed, along with sufficient resources, coordination, and on-going administrative support.

Energy is often high at the beginning of a new initiative, but sustainability and expansion of efforts is a challenge. Many respondents emphasized that efforts to address violence against women need ongoing champions, resources, and coordination as well as sustained institutional support. Without the existence of a “champion” or “flag waver” to keep the issue in everyone’s minds, the work is often overlooked, or replaced with other priorities.

Resources may include: staff time to train and implement the intervention, as well as appropriate space to facilitate safe disclosure of victimization. Institutional supports can include department policy provisions, management support, and staff ownership of the intervention. Having institutional support that translates to staff time and appropriate resources makes sustainability more feasible/likely.

6. Recommend an increase of availability and access to culturally appropriate services for non-English speakers.

It was clear from the interviews that immigrants and non-English speakers lack adequate services. Some respondents expressed concern about the ability of smaller communities to meet the needs of Minnesota’s growing immigrant populations.

“Until fairly recently our community has been fairly white. We are seeing more and more Somali families come to live here and our services/resources have not caught up.” (Medical)

There was concern about the appropriateness and effectiveness of interpreter services.

“Our legal department has advised us that when an interpreter is present, screening questions are not to be asked.” (Medical)

“Very few interpreters have training in domestic violence and sexual assault, and this makes a difference in the services that are provided. I don’t doubt that a trained medical translator can do a competent job, but there is the added aspect of violence that makes a difference.” (Medical)

CONCLUSION

Public health and health care are uniquely poised to prevent and respond to violence against women. Numerous policies and professional recommendations exist describing the value of addressing violence against women in the public health and health care fields. Health care and public health have increasingly claimed violence as a health issue and many health organizations have undertaken serious efforts to address it.

In Minnesota, implementation and improvements are threatened by lack of resources and lack of sustained organizational commitment. Practitioners have access to victims and potential victims; they need only continued education, and institutional support. One-time, half-day trainings implemented by

agencies with temporary goals are not sufficient. To be successful, these approaches need to be on-going and sustainable.

Based on this assessment, participants in a planning conference are developing a strategic plan for future policies and activities. The plan will provide valuable information for the state and local communities, to help create opportunities to improve the health care response to, and prevention of, violence against women. This plan can be used to guide prevention programming and implementation, policy and advocacy, treatment and research, surveillance, efforts to acquire additional funding support, and future collaboration among the professionals who respond to violence against women in Minnesota.

Minnesota is a national leader in prevention and intervention in violence against women. But there is a great deal of room for improvement. Those service providers who are doing the work understand what those improvements should be. This assessment reflects their strong voices and their ideas to make a difference in the lives of victim-survivors all over the state.

The purpose of this study was to begin to understand how the current practices of Minnesota's health care and public health practitioners related to violence against women compare to national and state policies or recommendations, and to research "best practices." With such a small, non-representative sample, the study gives only a picture of the current reality. Future research might include:

- > A more formal survey to confirm the results of the in-depth interviews,
- > A study of public health and health care responses in rural Minnesota,
- > An examination of the special needs of victims of violence against women in the immigrant, special needs, elderly and vulnerable populations,
- > "Best Practices" research in sexual violence, particularly relating to health care and public health, where many victims and potential victims go for help.

INTRODUCTION

WHY IS VIOLENCE A HEALTH CARE ISSUE?

In a series of September 2000 focus groups with women across the state, MDH found that Minnesota women view violence as a major health issue. Focus group participants commented that the impact of violence on women's lives is "phenomenal" and that it "crosses all other categories – mental health, life stress, aging, health care access, parenting, teen pregnancy, unintended pregnancy, etc."

Health care and public health settings have been identified as ideal locations for preventing and responding to violence against women. Many organizations have called for an improved health care response to intimate partner violence victims. These organizations include health care facilities, advocacy groups such as the Family Violence Prevention Fund, and professional medical and health organizations such as the American Medical Association, the American Nurses Association, the American College of Nurse-Midwives, the Emergency Nurses Association, and the American College of Emergency Physicians. Institution-wide response, staff training, and development of policies and procedure protocols are acknowledged to be essential to this improvement (Dodge, et al, 2002).

The consequences of violence are both physical and psychological. They may be severe and long term. Short-term physical consequences include broken bones, bruises, and cuts. Medical problems include miscarriage, preterm labor, fetal injury, sexually transmissible infections, hearing or vision loss, chronic headaches, and chronic pain. Psychological and behavioral effects can include depression, anxiety, suicide attempts, substance abuse, post-traumatic stress disorder, and revictimization. The medical consequences of abuse are likely to be underreported, as most women do not disclose their abuse history to their health care providers nor are providers comfortable asking (Misra, 2001).

Advocates for victims of violence against women have stated that routine screening is the single most important step that health care professionals can take to begin addressing the problem. There is increasing recognition of the need for health professionals to take an active role in identifying and intervening in cases of violence against women (Loughlin, 2000).

WHY MINNESOTA?

Minnesota has a long history of serving victims of violence against women, starting with grass roots activism in the early 1970s. The Minnesota Legislature began providing state funding for battered women's shelters in 1977. Today there are 25 shelters, 33 hotel-motel networks, and 15 safe homes within the state, including a number of language- and culture-specific shelters, which provide security, lodging, meals, and other services for women and their children. Programs currently exist across the state to serve victims of sexual and domestic violence and to conduct community education, reflecting Minnesota's concern for the rights and welfare of victims of abuse, and the need for ongoing public awareness about these issues.

Beyond this are many efforts across diverse sectors (health care, law enforcement, victim services, public health, community-based collaboratives, criminal justice, etc.) to address and prevent violence against women. Following are some examples related to health care and public health:

- Beginning in late 2000, an Interagency Task Force for the Prevention of Domestic Violence and Sexual Assault was convened by the Minnesota Legislature specifically to develop a strategic plan to prevent and reduce domestic violence and sexual assault, to coordinate resources, to recommend changes in policies and laws, and to identify the need for related services. This Task Force is charged with taking a comprehensive view of these forms of violence, which disproportionately affect women. The Task Force includes representation from numerous state agencies including the Minnesota Department of Health (MDH), and advocacy groups.
- In 1995 Governor Arne Carlson convened the Governor's Task Force on Violence as a Public Health Problem, to develop recommendations largely focusing on the health care industry. The Minnesota Health Care Coalition on Violence (HCCV), which resulted from the work of this Task Force, was a consortium of health system representatives committed to improving the health care response to violence. Through HCCV committees a variety of efforts took place, including (1) work to implement voluntary E-coding statewide, supporting the development of a statewide injury surveillance system, (2) advocacy for legislative funding for universally offered home visiting for parents expecting and giving birth to newborns throughout the state, and (3) initiatives to increase awareness and capacity to address violence prevention among health care providers. Although HCCV recently disbanded due to a lack of financial resources, many of its members remain committed to its goals. Some of its subcommittee chairs were interviewed for this assessment.
- Minnesota, since the development of the "Duluth Model," has long been a leader in creating coordinated community response teams (CCRs) to ensure that systems are sensitive to victims of domestic, and more recently sexual violence. Over the years, numerous CCRs and Sexual Assault Multidisciplinary Action Response Teams (SMART) have been established to ensure health systems are working in concert with other systems to preserve the health, dignity and rights of victims.
- Minnesota has provided leadership in developing and implementing best practices in providing health care to victims of domestic and sexual violence. Numerous health plans have focused great attention on training staff and conducting public education. In the Fall of 1996, the Minnesota Department of Health Section of Public Health Nursing developed and disseminated the Public Health Nursing and Practice Guidelines for the Prevention of Violence Against Women and Children, available by contacting Sue Strohschein, Public Health Nurse Consultant, at 651/296-9581. The Practice Enhancement Project provides direction to public health nurses in addressing family violence. The Sexual Assault Resource Service (SARS) program, developed in Hennepin County, has served as a national model for nurses who receive specialized training to address sexual assault cases.
- Like other states, Minnesota receives CDC funds for rape prevention and education, through the federal Violence Against Women Act. Administered by the MDH Sexual Violence Prevention Program, these funds support the engagement of state stakeholders and the community at large in the prevention of sexual violence. Major activities related to these funds include: 1) production of a televised town meeting on sexual violence, 2) production of A Place to Start: A Resource Kit for

Preventing Sexual Violence, (see Appendix C) 3) grants to local and statewide prevention activities, 4) establishment of a statewide multidisciplinary Sexual Violence Prevention Network, 5) funding and technical support to the Minnesota Coalition Against Sexual Assault for prevention efforts, including its statewide media campaign, and 6) participation in the development of STOP IT NOW! Minnesota, an innovative child sexual abuse prevention campaign.

➤ In the fall of 2000, the MDH received a grant from the Centers for Disease Control and Prevention to develop a statewide system for intimate partner violence (IPV) injury surveillance. This grant builds on a statewide system that captures traumatic injury data from hospitals and emergency departments. Hospital discharge data identify potential cases of both intimate partner violence and sexual violence, medical records are abstracted, a community-based survey will provide further insight, linkages with criminal justice data are sought, and plans are underway to broadly share data and findings.

While significant work is occurring across agencies and organizations, attention to violence against women within the health care and public health sectors appears to be inconsistent and far from ideal. The resources to assess, develop, and advance greater coordination have not previously been available. Similarly, the experience of the HCCV suggests plans are needed to build on existing work and to address key issues of sustainability.

LITERATURE REVIEW

Violence against women is a significant public health problem in the United States. It crosses all ethnic, racial, and socioeconomic groups. It can affect females of all ages, from infants to elders. Although violent victimization rates for both men and women have declined in recent years, rates remain high. According to 1998 National Crime Victimization Survey (NCVS) data, women experienced approximately 3.5 million assaults, robberies, aggravated assaults, and simple assaults -- compared with 4.6 million experienced by men. What must be noted, however, is that routine data sources are likely to underestimate violence, particularly violence against women by intimate partners. It's only in the last ten years that recognition of violence against women has increased among health care providers (Misura, 2001).

Both sexual assault and intimate partner violence are public health epidemics, and they are entirely preventable. Their rates are staggering; large percentages of women fall victim to one or the other and often to both. Viewed as a public health problem only in recent years, definitions and data are still not able to capture the full extent of the problem. Additionally, these forms of violence are largely underreported because of many factors, including a lack of trust in the systems that are intended to provide assistance to victims of crime. (Data and other considerations specific to Intimate Partner Violence and Sexual Violence are found at the end of this section).

Violence can occur anywhere. In a Minnesota study, 1,693 rural women in western Minnesota were asked about the incidence of emotional abuse over their lifetime. The question was: "Have you been emotionally or verbally abused? This includes yelling, swearing, put-downs, threats, jealousy, stalking and other words or actions intended to control another person." The participants were asked to answer the question in 3 phases of their life: before age 18 (26.8 percent said yes); between 18 and up until the last year (34 percent said yes) and within the last year (21.2 percent said yes) (Kershner, 1998).

SEXUAL VIOLENCE

In 1999 across the U.S., 89,107 cases of attempted or completed forcible rapes against women were reported to law enforcement agencies, according to the Uniform Crime Reporting (UCR) program of the Federal Bureau of Investigation. It is estimated that more than two-thirds of rapes and sexual assaults are not reported to law enforcement agencies and, therefore, are not included in this data. The proportion of women who report drops even further when the rape was committed by someone they know, as are an estimated 80 percent of all assaults. With this in mind, the estimate for sexual assaults and rapes experienced by women ages 12 and older is 307,110, or about 2.7 per 1,000 people, about 10 times the rate for men. Defining rape as forced anal, vaginal, or oral sex, the 1995-1996 NVAW (National Violence Against Women) survey yielded higher estimates of sexual violence than did the NCVS. The NVAW results indicate that one in six women (18 percent) aged 18 years and older had experienced an attempted or completed sexual assault at sometime in their lives (Misura, 2001).

Numerous studies indicate that women are more likely to be the victim of a rape or sexual assault committed by an intimate partner or acquaintance (64 percent) than by a stranger (32 percent). The intimate offender is more likely to be a boyfriend or ex-boyfriend than a spouse, a finding that may reflect some reluctance to report violence by a spouse or to consider the act criminal (Misura, 2001).

The majority of rapes and sexual assaults are committed against children and adolescents. The highest incidence of rape occurs among older adolescents. Age at first rape also shows the preponderance of young women as victims of this crime. A survey of high-school students determined that one in five had already experienced forced sex; however, only half had told someone about the event. Several studies have concluded that women who were sexually assaulted as children and adolescents are at greater risk of being sexually assaulted as adults. The 1995-1996 NVAW survey found that 18 percent of women raped before age 18 were also raped after age 18, twice the rate of those who had not been raped before age 18 (Misura, 2001).

The Minnesota Center for Crime Victim Services publishes a quarterly report summary of data from its Sexual Assault Programs (primarily advocacy programs). In FY00 (July 1, 1999 - June 30, 2000), 8,450 new cases of sexual assault were served. 6,802 of those were primary victims. 7,677 were women and the majority, 4,806 were between the ages of 13 and 44.

The Minnesota Student Survey asks questions of students in the 6th, 9th and 12th grades concerning experiences with sexual violence. According to 2001 data, three percent of 12th grade males and five percent of 12th grade females had experienced date rape. Nine percent of 9th and 12th grade females surveyed indicated that they had been the victims of sexual abuse perpetrated by someone outside the family and four percent by perpetrators within their families.

Table 1: Experience of Sexual Violence in the 6th, 9th and 12th Grades in Minnesota Public Schools

Type of Sexual Violence	Grade					
	6 th		9 th		12 th	
	Male	Female	Male	Female	Male	Female
	%	%	%	%	%	%
Date Rape	n/a	n/a	3 %	3 %	3 %	5 %
Sexual Abuse by someone outside the family.	3%	6%	3 %	9 %	3 %	9 %
Sexual Abuse by family member.	2 %	3 %	2 %	4 %	2 %	4 %

2001 Minnesota Student Survey Statewide Data – Public Schools (Percentages based on students reporting sexual violence in 2001.)

These percentages, though alarming enough, increase dramatically when the youth surveyed are at particularly high-risk, residing in juvenile correction facilities or attending Alternative Learning Centers. Thirty-eight percent of females residing in a correctional facility reported having been sexually assaulted by a non-family member, while fifteen percent were assaulted by a family member. The females attending Alternative Learning Centers also had more experience with sexual assault than the youth attending public high schools in Minnesota, with twenty-eight percent having been the victim of sexual assault by non-family members and twelve percent having been assaulted by a family member.

Though not entirely scientific as the second table does not indicate ages, it is clear that both males and females in Alternative Learning Centers or Juvenile Corrections Facilities experience all three types of sexual violence at higher rates than do those in the general population.

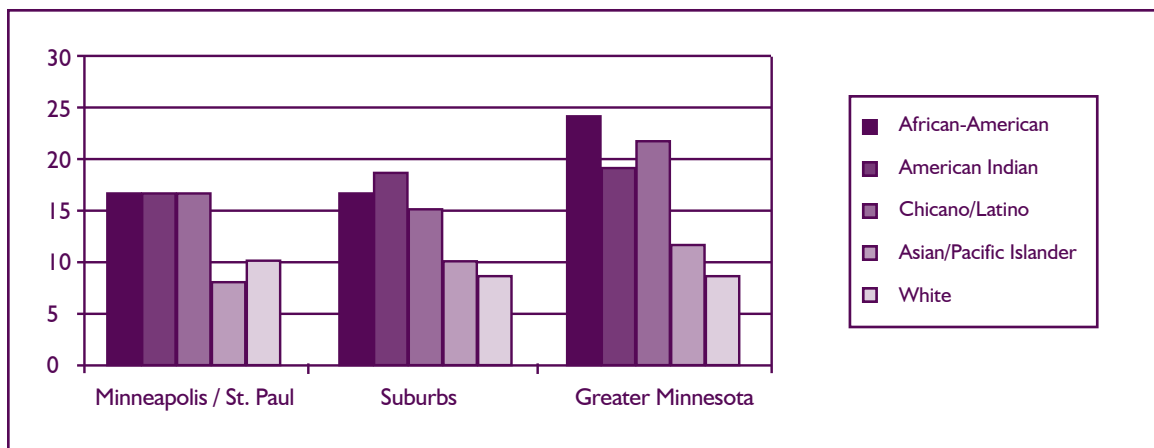
Table 2: Experience of Sexual Violence in High-Risk Minnesotan Youth

Type of Sexual Violence	Juvenile Corrections Facilities		Alternative Learning Centers	
	Males	Females	Males	Females
Date Rape	5 %	20 %	4 %	18 %
Sexual Abuse by someone outside the family	10 %	38 %	6 %	28 %
Sexual Abuse by family member	5 %	15 %	3 %	12 %

1998 Minnesota Student Survey – Statewide Data. (Percentages based on students reporting sexual violence in 1998.)

When broken down by race and geographic location, it looks as though minority youth living in greater Minnesota, are experiencing higher rates of sexual violence than minority youth in the Cities. It appears as though white youth in Minneapolis/St. Paul report more sexual violence in than those in the Suburbs and in Greater Minnesota do. These numbers are percentages, raw numbers may paint a different picture, but there is a message to be read here, and it is that youth are not only experiencing sexual violence in urban Minnesota. The problem is wide spread.

Chart 1: Experience of Sexual Violence in Minnesotan Youth, By Race and Location



Percent of 9th Graders who experienced some kind of unwanted sexual touching, by Geographical Area – Minnesota Student Survey – 1998.

According to A Place to Start, a 1999 publication of the Minnesota Department of Health, everyday, 6.7 rapes are reported to law enforcement, five people are arrested for prostitution and nearly eleven other sex offenses are reported to law enforcement. There are also numerous losses, aside from the monetary that are associated with the experience of sexual violence.

- > Up to 40 percent of rape victims require subsequent mental health treatment.

- 10 percent of rape victims suffer from severely disabling psychological injury.
- 61 percent of rape victims suffer from some form of nonfatal injury.
- Nearly 31 percent of women who disclose rape also reported developing Post-Traumatic Stress Disorder (PTSD) in their lifetimes. These victims were 6.2 times more likely to develop PTSD than women who had never been victims of crime.
- 80 percent of children who have been sexually abused are reported to have some symptoms of PTSD.
- Compared with non-crime victims, women who revealed being raped are 4.1 times more likely to report having attempted suicide.
- In one study, 11 percent of pregnant and/or parenting teenage women reported becoming pregnant as a direct result of rape and 66 percent reported having had at least one experience with molestation, attempted rape, or rape.

Additional physical injuries occur in as many as 65 percent of attempted and completed cases of rape and sexual assault against women. 31.5 percent of female rape victims sustained injuries. Most of these injuries were minor, including scratches, bruises, and welts (72.6 percent), although a few women reported broken bones and dislocations (14.1 percent), head and spinal cord injuries (6.6 percent), lacerations (6.2 percent), and internal injuries (5.8 percent). The longer term physical and psychological consequences of sexual assault may be extensive. They may include chronic headaches, insomnia, fatigue, recurrent nausea, eating disorders, menstrual pain, sexual dysfunction, suicide attempts and substance abuse (Misra, 2001).

DOMESTIC OR INTIMATE PARTNER VIOLENCE

Domestic or intimate partner violence is the threatened or actual use of physical force against and intimate partner that either results in or has the potential to result in death, injury or harm. Intimate partner violence includes physical and sexual violence, both of which are often accompanied by psychological or emotional abuse. It may also include psychological abuse or emotional abuse that occurs without physical or sexual violence when such violence has previously been threatened or committed during the relationship (Centers for Disease Control and Prevention, 1999).

Intimate partners are current spouses (legal or common law), current non-marital partners, dating partners, boyfriends and girlfriends, same-sex partners, divorced, former, or separated spouses (legal or common law), and former non-marital partners, former girlfriends and boyfriends, and former same-sex partners. Intimate partners may be cohabitating, but need not be (Centers for Disease Control and Prevention, 1999). The relationship need not involve sexual activities.

Intimate partner violence is associated with a wide range of physical and mental health problems, including injuries, depression, substance abuse, and child maltreatment. The consequences of intimate partner violence extend beyond the immediate family into subsequent generations and the extended family and into the health care systems, the workplace, schools, faith communities, and service systems, and throughout the community as a whole.

Domestic violence is a common, costly, and complex health problem. An estimated seven to fifteen percent of U.S. women are currently in abusive situations, and 22 percent will be assaulted by an intimate partner during their lifetime. At least \$1.8 billion is spent annually for direct medical care to victims. The

value of the healthcare setting for domestic violence treatment is that it provides an opportunity for early identification, tailored intervention, and primary prevention. These opportunities are unavailable in other environments, such as the criminal justice system (McCaw, 2001). According to the National Violence Against Women Survey, 52 million women have been the victims of an assault in their lifetimes (Tjaden, 1998).

Domestic or intimate partner violence numbers are reported in a variety of ways,

- > 4 to 6 million intimate relationships each year are violent (Rodriguez, 1999).
- > More than 1 million women seek medical assistance each year for injuries caused by domestic violence (Feighny, 1999).
- > 22 percent to 35 percent of visits to the emergency room are related to symptoms resulting from ongoing abuse (Pakieser, 1998).
- > For domestic violence, the lifetime incidence rate has been reported to be between 1 in 2 and 1 in 5 (Sixsmith, 1996).
- > Domestic violence is the single most common cause of injury to women – more common than automobile accidents, muggings, and rapes combined (JAMA, 1990).
- > Between 2 and 4 million women each year sustain injuries from domestic violence; 1 million of these seek help in an emergency room (Wadman, 1999).
- > Every 7.4 seconds, in the US, a woman is beaten by her husband. (McLeer, 1989).
- > In Minnesota, in 2000, 29 women were killed by current or past intimate partners, almost 50 percent more than the 19 women who were killed in 1999 (U.S. Census Bureau).
- > US aggregate is 55 percent of women experience violence over a lifetime (Making the Grade, Minnesota Ratings).

Domestic abuse victims account for more than a quarter of all violent crime victims. Three-quarters of victims are female. Most have experienced two or more incidents. Domestic abuse, rape, and sexual offense crimes are most likely to go unreported (84-90 percent). Minnesota Crime Victim Survey (Minnesota Planning 1999.)

A large body of research has documented the incidence of abuse and its effect on women's health. The Center for Disease Control reports that 30 to 40 percent of women who are murdered in the United States are victims of intimate partner violence (IPV). In large prospective emergency department (ED) studies, 37 percent to 54 percent of women seen in the ED have been abused by an intimate partner at some point in their lives. (Abbott et al, 1998, Dearwater et al, 1998). It is estimated that each year over 2 million women experience intimate partner violence severe enough to cause physical injury (Travis et al, 1996). At least 13-30 percent of all women in the US will experience one or more incidents of intimate partner violence in their lifetime (Wilt & Olson, 1996).

Intimate partner violence, assault by a spouse, ex-spouse, intimate friend or ex-friend, is the most common cause of injury for women. It is the source of significant morbidity and mortality due to acute and chronic effects of physical and psychological injury (Ambuel, 1996). Historically, intimate partner violence was considered the domain of the criminal justice and social services systems. Until recently, physicians were unaware of the incidence of intimate partner violence because they did not ask about it (Zink, 1997). The impact of repetitive violence on an individual's health brings intimate partner violence into the medical setting (Sugg, 1992).

Although any woman can be at risk for violence, certain situations in life pose greater risk. These can include having a past history of abuse, or having a low income. Pregnancy also is a known risk for violence. A recent study revealed that a pregnant or recently pregnant woman is more likely to be a victim of homicide than to die of any other cause. In this study, homicide was identified to be the leading cause of death in 20 percent of all pregnancy-associated deaths (Horon, 2001).

Studies vary in their reporting of the incidence of violence during pregnancy, most fall between 4 percent and 8 percent. “If we apply these percentages to the 3.9 million women in the United States who delivered live-born infants in 1998, we can estimate that between 152,000 and 324,000 women experienced violence during their pregnancies that year. These numbers suggest that violence may be more common for pregnant women than pre-eclampsia or gestational diabetes, conditions for which screening during pregnancy is routine” (Gazmararian, 2000).

IMPLICATIONS FOR PUBLIC HEALTH AND HEALTH CARE SYSTEMS

Many organizations have developed guidelines and standards of care for the identification and acute management of victims of domestic violence and sexual assault (see Results, Policies and Recommendations). Action, however, has been limited.

Victim advocates have stated that routine screening is the single most important step that health care professionals can take to begin addressing the problem. There is increasing recognition of the need for health professionals to take an active role in identifying and intervening in cases of violence against women (Loughlin, 2000).

Compared with women with no history of abuse, abused women have higher levels of health care use. In fact 31 percent to 54 percent of female patients seeking emergency services, 21 percent to 66 percent of those seeking general medical care, and up to 20 percent of those seeking prenatal care report experiencing domestic violence (Rodriguez, 1999).

Research has indicated that when abused women present to health care settings, health care professionals often do not identify the abuse. Further, when abuse is identified, interventions are often restricted to medical and surgical treatment, without providing care for the underlying cause of injury (Loughlin, 2000). Several studies have shown that even with the knowledge of the underlying cause of the trauma, many physicians fail to respond to the battering (Sugg, 1992).

It was estimated, in 1996, that intimate partner violence caused 21,000 hospitalizations annually, accounting for 99,800 days of hospitalization, 28,700 emergency department visits, and 39,900 physician visits (Gerber, 1996).

Many victims of abuse seek help for common medical problems, such as asthma, diabetes, and hypertension -- conditions that may not be considered “red flags” for abuse. Unless clinicians ask routinely, many cases of violence will be missed (Warshaw, 1999). It is only logical that early identification of abuse as the underlying problem leads to more effective care and may be lifesaving (Johnson, 1997). The connections may be missed between abuse and other problems related to it, such as injuries, sexually-transmitted diseases, and chronic pain.

Women abused by their partners are most likely to enter the health care system through prenatal services or through emergency departments where they seek treatment for injuries (Tilden, 1989). If staff in these locations make it possible for victims to disclose their experiences, victims are more likely to obtain appropriate service both at the facilities and at other community resources.

Emergency departments are often seen as a prime site at which to identify cases and to provide counseling (Pakieser, 1998). Women more often present with acute symptoms of domestic violence in emergency departments than in prenatal visits, or with their children in pediatric clinics. Studies indicate that 21 to 54 percent of women seen in emergency departments or primary care clinics have reported physical or emotional abuse by a partner in adulthood and at least one in three have experienced some form of abuse in their lives (Warshaw, 1999).

Health care professionals can play an essential role in identification, counseling, and referral. More than 85 percent of Americans feel that, if asked, they could talk to a physician if they were a victim or a perpetrator of family violence. However, battered women identify medical providers as their least effective professional source of help, despite frequent health care utilization (Alpert, 1998).

In a study of the experiences of victims of domestic abuse at the hands of emergency department staff, one of the women in the study stated the following: “No one asked me anything about being battered. It would have been nice if the nurse had not bought my flimsy story, had asked a few questions, talked to me about options, but this never happened. For them not to probe left me feeling that hospital personnel were cold and uncaring about battered women” (Ellis, 1999). Another woman reported: “No one informed me that there were people and places that could help me. It might have helped me to become victorious more quickly if I had known” (Ellis, 1999).

IMPORTANCE OF SCREENING FOR VIOLENCE

The arguments for universal screening for violence are many. The goal of screening for violence is to identify hidden morbidity in the general population and to conduct preventative education. Women often do not raise the subject of violence on their own, and medical and psychiatric results of abuse are significant and sometimes life threatening. Studies have shown that for most patients who have a history of abuse, clinic visits are related directly or indirectly to abuse (Johnson, 1997).

One study in California found that although screening for intimate partner abuse was common among injured patients, it was less common for routine medical encounters. In circumstances that involved physical injuries, an estimated 79 percent of California primary care physicians often or always ask patients direct questions about intimate partner abuse. But an estimated 10 percent of physicians routinely screen for intimate partner abuse during new patient visits, and 9 percent screen during periodic checkups. Of physicians who provide prenatal care, an estimated 11 percent routinely screen for intimate partner abuse during the first prenatal visit (Rodriguez, 1999).

Screening can help victims understand that violence is a crime and that help is available. Both the health care and public health systems offer many opportunities and points of access for screening: prenatal visits, pediatric clinics, OB/GYN offices, emergency departments, and others. The most common entry

points for women are the emergency department, as they seek aid for their immediate injuries, as well as prenatal clinics and pediatric offices.

Health care settings have been identified as ideal locations for preventing and responding to violence against women. Advocacy groups including the Family Violence Prevention Fund, health care facilities, and professional medical and health organizations including the American Medical Association, the American Nurses Association, the American College of Nurse-Midwives, the Emergency Nurses Association, and the American College of Emergency Physicians have called for an improved health care response to partner violence victims. Institution-wide response, staff training, and development of policies and procedure protocols are acknowledged to be essential to this improvement (Dodge, et al, 2002).

Currently, most protocols include screening only for adult women; to be truly universal, adolescents and men should be included as well (Larkin, 1999). It is important to remember, that not all “victims” appear with blackened eyes and swollen lips. Women often present to the emergency department with a myriad of complaints, ranging from headaches, inability to sleep, depression, anxiety, and suicidal thoughts to abdominal/pelvic pain and chest pain.

The lack of identification of possible victims of abuse is costly. It is calculated that the estimated 57,500 women who are victims of intimate violence incur well over \$61 million dollars in medical expenses annually. This medical expense figure represents 40 percent of all expenses caused by incidents of intimate violence against women. Unidentified intimate partner violence victims continue to be susceptible to increased health issues that frequently result in emergency department visits and ultimately increased hospital costs (Ellis, 1999). Physical and/or sexual abuse against women by intimate partners is one of the most powerful predictors of physician visits and outpatient costs for women (Duffy, 1999).

SUMMARY

The consequences of intimate partner and sexual violence are both physical and psychological. They include broken bones, bruises, cuts, miscarriage, preterm labor, fetal injury, sexually transmissible infections, hearing or vision loss, chronic headaches, or chronic pain, depression, anxiety, suicide attempts, substance abuse, post-traumatic stress disorder, and revictimization. Victims of violence against women utilize health care at alarming rates, and not only for obviously intentional injuries, but for headaches, back pain, depression, and anxiety.

Research indicates that victims are often willing and even eager to talk about their experiences with their public health or health care provider. Both public health and health care identify themselves as appropriate places for victims to seek help. They are in a unique position to offer resources and support in a safe, respected environment. There is no longer any doubt that violence against women is more than a criminal justice issue. It is the responsibility of public health and health care to prevent and respond to violence against women.

OVERVIEW OF PROJECT

The purpose of this study was to begin to understand how the current practices of Minnesota’s health care and public health practitioners related to violence against women compare to national and state

policies or recommendations and to researched “best practices.” An Advisory Committee has guided the assessment, will participate in developing the strategic plan, and will advise on the plan’s dissemination. The assessment on which the plan will be based is summarized in this document. It includes: (1) A summary of policies and recommendations relating to violence against women, (2) A review of literature and resources related to “best practices” on the topic, (3) Key informant interviews to assess present policies and practices in Minnesota, as well as to learn the interviewees’ recommendations for change.

METHODS

PROJECT BACKGROUND

This research project is the result of a one-time grant from the Centers for Disease Control and Prevention. A one-year, \$50,000 award was received by the Minnesota Department of Health's Injury and Prevention Unit to develop a plan to address the prevention of violence against women in Minnesota. The major part of the plan development process was to assess the current situation in Minnesota's public health and health care communities related to the prevention of violence against women. This Assessment is the product of that effort.

In December of 2001, the Minnesota Department of Health approached Ms. Holmes, the Principal Investigator, about undertaking this project. A Violence Against Women (VAW) Advisory Committee was created out of an existing multidisciplinary Surveillance Advisory Committee, and their task was to advise the process and assist in the dissemination of results. Members of the VAW Advisory Committee included, representatives from domestic violence and sexual assault agencies and coalitions, the Minnesota Center for Crime Victim Services, the Minnesota Coalition of Health Plans, Minnesota Planning's Criminal Justice Statistics Center, the Minnesota Department of Health, Otter Tail County Public Health, The Bureau of Criminal Apprehension, the Sexual Assault Resource Center, and Metropolitan Health Plan. This group reviewed interview participant lists, interview question drafts and provided feedback on drafts of the Literature Review and Policy and Recommendation Review.

Minnesota Department of Health Injury and Violence Prevention Unit staff Evelyn Anderson and Amy Okaya and members of the project's Advisory Committee played significant roles in advising the Principal Investigator and providing assistance and support throughout the life of the project.

Assistance was also received from the Principal Investigator's academic project advisor, Dr. Rhonda Jones-Webb, Associate Professor of Epidemiology. Later, additional input was sought from two other members of the Principal Investigator's academic advisory committee, Dr. Wendy Hellerstedt, Associate Professor of Epidemiology, and Dr. Phyllis Pirie, Professor of Epidemiology. Any suggestions made by the abovementioned individuals were discussed and incorporated as needed.

The University of Minnesota Human Subjects Committee reviewed the project proposal and classified it *exempt* on March 12, 2002.

POLICIES AND RECOMMENDATIONS

The Principal Investigator examined more than fifteen local and national, professional, health care and public health agencies' policies and recommendations relating to violence against women. The original policies or recommendations themselves were reviewed, when available. Eleven policies and recommendations were chosen as most closely describing public health or health care practices to prevent or respond to violence against women. The purpose of the activity was to understand the industry standard of care for victims of violence against women. The Investigator wanted to have some basis by which to measure the level of activities occurring in public and private health care in Minnesota.

LITERATURE REVIEW

The Principal Investigator conducted two Literature Reviews for the purpose of this project. The purpose of the first, contained within the Introduction and Literature Review portion of this document, was to establish violence against women as an issue appropriate for action within the health care and public health arenas. In this literature review, only recent (within the last ten years) articles published by peer-reviewed journals were reviewed, with an eye for mention of the role of public health or health care in preventing or responding to sexual or intimate partner violence. Rates and prevalence of violence against women, both sexual assault and intimate partner violence, were also presented.

In the second, more substantial literature review, the intent was to discover the researched “best practices” for health care or public health related to the prevention or response to sexual violence or intimate partner violence. Again, only articles written within the previous ten years were reviewed. The Principal Investigator sought information on programs or initiatives designed to prevent or respond to violence against women, to determine what features were effective. The Investigator’s intent was to understand what was being done throughout the country, to compare with the current status in Minnesota.

KEY INFORMANT INTERVIEWS

Interviews were conducted to gain detailed information on the prevention and intervention policies and practices of both local public health agencies and health care organizations in the state. Interviews were conducted with representatives from public health agencies, hospitals, clinics, health plans, and advocates who interact with these systems. Each of the major health systems in Minnesota was also contacted, as well as some non-affiliated hospitals and clinics.

In order to capture the full breadth and depth of responses, the Principal Investigator determined early in the study design process to use qualitative methods to collect and analyze interview data. The process of interactively gathering qualitative data had the further benefit of promoting interest among interviewees in contributing to a state plan to be later developed, and in promoting that plan’s implementation.

INTERVIEW PARTICIPANTS

The Violence Against Women Advisory Committee members identified potential interview participants, and provided contact information to the Principal Investigator. Potential interviewees were contacted by the Investigator, informed of the possibility for involvement in the study and provided an initial opportunity to abstain.

Potential interviewees interested in participating scheduled a time to receive a phone call from the Investigator. At the time of that phone call, eligibility of potential interviewees was assessed (see below) and if appropriate, the interviewee was asked to give consent to be interviewed. Confidentiality was guaranteed to interviewees. They consented to be interviewed after being assured that neither personal identifiers, nor affiliated agencies were attached to reported interview responses.

ELIGIBILITY REQUIREMENTS

- › Participants must be current or recent employees of a public health agency or private health care provider in the state of Minnesota.
- › Participants must come into contact with victims or potential victims of violence against women, or work closely with those who do.
- › Gender of participants was not a factor.
- › Age of participants was not a factor.

There was a strong effort to achieve a balance among interviewees in terms of type of position held, type of organization or agency they represented, and geographic location.

INTERVIEW INSTRUMENT AND IMPLEMENTATION

Eligible interviewees set up times to participate in a ten-question interview with the Investigator. Interviewees were offered the option of commencing the interview immediately upon determination of eligibility. Interviews were primarily phone-based and lasted between sixty and ninety minutes. Notes were taken on a laptop computer and later formatted, clarified and turned into transcripts. The Principal Investigator conducted all of the interviews herself, to reduce potential for bias, and to increase reliability.

Issues for exploration included the awareness and recognition of violence against women within health care/public health systems; the availability and nature of programs and services, and associated referral mechanisms; staffing, training and other implementation issues; the capacity of health-based intervention services, including counseling and mental health; evaluation methods; ideas and priorities for future programs and services; and policies and resources that are needed to sustain, expand or improve programs or services. The questions asked related to various forms of violence against women, including intimate partner violence, sexual assault, suicide and elder abuse.

DATA ANALYSIS

Upon completion of phone interviews (n=56), the Principal Investigator created transcripts of each conversation. Individual interviews were then summarized according to professional discipline. The Investigator and other MDH staff reviewed these summaries to compare results across disciplines, extracting repeated themes within each of the nine question categories (Violence Contract, Primary Prevention, Practice Guidelines, Service Coordination and Referral, Education and Training, Workplace Violence, Data Collections and Research, Health Plan Coverage and Payments, Funding, and Recommendations). From this analysis, overall findings were identified. To exemplify the nature and range of responses within and across professional disciplines, illustrative quotes were selected to include in the report of findings.

RESULTS

POLICIES AND RECOMMENDATIONS

Many health care organizations and associations have chimed in with their opinions as to health care's responsibilities and roles regarding violence against women including: American Medical Association, American College of Obstetricians and Gynecologists, American Nurses Association, American College of Nurse Midwives, American Psychological Association, American Academy of Pediatrics, American Association of Colleges of Nursing, American College of Emergency Physicians, Emergency Nurses Association, American College of Surgeons, American Academy of Family Physicians and Physicians for a Violence-free Society. In addition, other distinguished agencies have underlined their recognition of domestic violence as a health care problem on record, through research, devotion of resources to development of materials and provision of grants and other supportive activities. These include the Center for Disease Control, the Surgeon General (C. Everett Koop, 1985) and the Family Violence Prevention Fund. Many have sample written procedures to be followed, others present only the recommendation that a certain degree of intervention be performed with specific at-risk populations.

RECOMMENDATIONS

In general, the recommendations:

- › Call for routine screening for intimate partner, sexual and, or family violence by health care providers, though methods vary;
 - › Encourage provider awareness of community support services;
 - › Encourage referral of identified victims to appropriate resources;
- The recommendations however, do not:
- › Include recommendations related to provider education and training;
 - › Do not encourage policy or practice change in health care settings.

The AMA's Council of Scientific Affairs made seven recommendations in its June 1992 Council Report. Four of the recommendations were developed specifically to guide physicians in their practices. These include:

1. Routinely incorporating screening to identify female patients who are or who have been victims of violence;
2. Giving due validation to the experience of victimization and observed symptomatology as possible sequela;
3. Recording patients' victimization histories; and
4. Referring patients to appropriate medical or health care professionals or community-based resources as soon as possible (Hotch, 1996).

The American College of Obstetricians and Gynecologists recommends that physicians screen ALL patients at EVERY visit for both sexual assault and intimate partner violence. ACOG further recommends that women ages 19-64 be counseled on domestic violence as part of periodic evaluation visits, which should occur yearly or as appropriate. Women ages 13-18 should be counseled on abuse and neglect as part of periodic evaluation visits, which should occur yearly or as appropriate. (ACOG Violence Against Women Screening Tools www.acog.org, July 20, 1999).

The **Family Violence Prevention Fund** recommends screening for domestic violence victimization for all female patients over the age of 14 in primary care, obstetrics/gynecology and family planning, emergency department, in-patient, pediatrics, and mental health settings. Routine screening means that inquiry about domestic violence occurs with all women over the age of 14, whether or not symptoms or signs are present and whether or not the provider suspects abuse has occurred. The FUND recommends that all practitioners and health organizations within these settings implement culturally competent programs to ensure routine screening of all female patients. The organization recommends that screening be carried out in private settings and by using straightforward, nonjudgmental questions in a culturally competent manner, preferably asked verbally by the practitioner in ways that increase safety of abuse patients and respect their autonomy.

The Family Violence Prevention Fund publishes a “Health Report Card” rating states on their statutes related to intimate partner violence. They address five topic areas: Training, Screening, Protocols, Reporting, and Insurance.

- **Training:** States are rated based on the existence of laws addressing domestic violence training that applies to health care professionals and involves regular training on screening, identification and referral for domestic violence.
- **Screening:** States are rated based on their laws that require health care facilities to establish and adopt written policies to screen patients for the purposes of detecting spousal or partner abuse.
- **Protocols:** States are required to have domestic violence protocol mandated by law. Under this heading, states must require identification of domestic violence as a part of medical screening and require documentation in the medical record of injuries or illnesses associated with domestic violence.
- **Reporting:** States are rated based on their domestic violence reporting laws requiring health professionals to report incidents of domestic violence to law enforcement in cases of life-threatening injury, gunshot wound, or both. States must prescribe procedures for working with a domestic violence advocate, etc., to coordinate patient’s safety planning and states must mandate that health care systems allow patients to object to the release of information to law enforcement.
Note: States are penalized for laws requiring health personnel to report to law enforcement any person he or she knows or reasonably suspects is suffering from a “wound or injury that is the result of abusive or assaultive conduct,” without informing the victim or obtaining the victim’s consent.
- **Insurance:** States are ranked based on the existence of enacted laws to protect victims of domestic violence from insurance discrimination.

Minnesota received a “D” from the Family Violence Prevention Fund, based on the number and types of laws enacted to improve the health care response to domestic violence as of June 30, 2001 (see Appendix D).

The **American Medical Association** recommends that women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings be screened for domestic violence. The AMA further suggests that physicians assess and discuss safety issues with patients before they leave the office, working with the patient to develop a safety or exit plan for use in an emergency situation. They encourage individual physicians to become involved in appropriate local programs designed to prevent violence and its effect at the community level. AMA also recommends that physicians have lists of resources available for victims of violence, including information on emergency shelters, medical assistance, mental health services, protective

services, and legal aid (BOT Rep. K, A-93; BOT Rep. 9, I-95; Reaffirmation I-96). The AMA has made two related policy recommendations:

Alcohol, Drugs, and Family Violence (H-515.975)

- (1) Given the association between alcohol and family violence, physicians should be alert to look for the presence of one behavior given the diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse, should screen for alcohol use.
- (2) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
- (3) Physicians should be alert to the association, especially among young female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional or sexual abuse among patients who present with alcohol or drug problems.

Mental Health Consequences of Interpersonal and Family Violence (H-515.976)

Implications for the Practitioner: The AMA encourages physicians to

1. Routinely inquire about the family violence histories of their patients, as this knowledge is essential for effective diagnosis and care;
2. Make appropriate referrals to address intervention and safety needs as a matter of course upon identifying patients currently experiencing abuse or threats from intimates;
3. Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; and
4. Become aware of local resources and referral sources that have expertise in dealing with trauma from victimization.

The **American Nurses Association** recommends that all women receive routine assessment and documentation for physical abuse in any health care institution or community setting.

The **U.S. Preventative Services Task Force** recommends direct questions about abuse (physical violence or forced sexual activity) as a part of the routine history in adult patients. Grounds for the recommendation include the substantial prevalence of undetected abuse among adult female patients, the potential value of this information in the care of the patient, and the low cost and low risk of harm from such screening.

The American College of Surgeons (Bulletin of the American College of Surgeons Vol.85 No. 2, February 2000) reports that abuse victims are at increased risk for developing major depression, attempting suicide, and getting involved with drugs and abusing alcohol. Domestic violence should be identified as a causative agent of certain injuries. Failure to diagnose domestic violence will result in failure to identify a disease process that is likely to recur. It is therefore the responsibility of the treating surgeon not only to care for the immediate injury and to reassure the patient, but also to identify and report potential threats to his or her safety, and to encourage an ongoing safety strategy.

The **National Research Council's Board on Children, Youth and Families** and the **Institute of Medicine** in *Confronting Chronic Neglect: The Education and Training of Health Professionals on Family Violence*, 2002 makes three recommendations to health care.

- › Recommendation 1: Health professional organizations – including but not limited to the Association of American Medical Colleges, the American Medical Association, the American College of Physicians,

the American Association of Colleges of Nursing, the Council on Social Work Education, the American Psychological Association, and the American Dental Association – and health professional educators – including faculty in academic health centers – should develop and provide guidance to their members, constituents, institutions, and other stakeholders. This guidance should address (1) competency areas for health professional curricula on family violence, (2) effective strategies to teach about family violence, (3) approaches to overcoming barriers to training on family violence, and (4) approaches to promoting and sustaining behavior changes by health professionals.

- › Recommendation 2: Health care delivery systems and training settings, particularly academic health centers and federally qualified health clinics and community health centers, should assume greater responsibility for developing, testing and evaluating innovative training models or programs.
- › Recommendation 3: Federal agencies and other funders of education programs should create expectations and provide support and incentives for evaluating curricula on family violence for health professionals. Curricula must be evaluated to determine their impact on the practices of health professionals and their effects on family violence victims. Evaluation must employ rigorous methods to ensure accurate, reliable and useful results.

It is notable that recommendations generally do not address provider education and training, and that none identify a role for health care/public health in identifying and referring perpetrators of violence. It should also be noted that the existence of recommendations does little to ensure policy or practice change in health settings, however it is to be hoped that through their dissemination and promotion they influence the development of policies and practices.

POLICIES

Health Care Policy

The **Joint Commission on Accreditation of Healthcare Organizations (JCAHO)**, the board that accredits all hospitals and clinics across the nation, has also made intimate partner violence a part of its standards for hospitals. The standards require institutions to have objective criteria for identifying and assessing possible victims of abuse and neglect. The criteria should focus on observable evidence and not on allegation alone, and address at least the following: physical assault, rape or other sexual molestation, domestic abuse and abuse or neglect of elders and children. The criteria must be used throughout the organization and staff must be trained in their use.

Public Policy

With the passage in 1995 of the Violence Against Women Act (VAWA), Congress and those who helped developed this legislation have brought greater attention and resources to the problem of violence against women.

The **Centers for Disease Control and Prevention** since the early 1980s has focused on preventing violence using a public health approach. In 1984, the CDC's National Center for Injury Prevention and Control, Division of Violence Prevention was funded to strengthen efforts to prevent family and intimate

partner violence and to develop a national prevention program for violence against women. This work continues today in collaboration with other CDC programs and federal agencies. The CDC is currently funding programs throughout the nation to address the problem of violence against women using the public health approach. The main focus of these funded programs is to define the problem, assess the magnitude of the problem and to identify risk and protective factors that point to potential intervention/prevention strategies. CDC advocates for primary prevention and early interventions, from the perspective that these approaches can be more effective than interventions implemented later, when patterns of violence may be well established and difficult to change (Saltzman, 2000).

The **U.S. Department of Health and Human Services** is working to strengthen the health care system's ability to screen, treat, and prevent family and intimate violence. Currently, the Agency for Healthcare Research and Quality (AHRQ) is accepting research applications to study the outcomes, effectiveness, and cost-effectiveness of programs for early identification and treatment of violence against women. The agency hopes to improve the identification of female patients at risk, evaluate outcomes and effectiveness of health care interventions designed to treat victims, and develop new knowledge in the prevention of domestic violence. AHRQ is also supporting research on the effectiveness of team training to help primary care providers identify and manage domestic violence. In another AHRQ study, researchers are examining the relationship between exposure to domestic violence, health status, and use of health care services in Kaiser Permanente's northwest region. As a part of this effort, HHS is supporting a National Nursing Violence Against Women Strategy Initiative with participants from national nursing organizations to begin collaborations and develop a national nursing strategy.

SUMMARY

The majority of policies and recommendations reviewed by the Investigator dealt specifically with screening for domestic violence on the part of health care providers in the hospital or clinic setting. Very few mentioned public health's role and fewer spoke to prevention efforts. Also, sexual violence was noticeably absent from the reviewed policies and recommendations.

It is important to note the difference between a policy and a recommendation. Recommendations are simply stated "best practices" presented by organizations as the way to behave in certain circumstances. Unfortunately, these carry very little weight in terms of evaluation or compliance. Policies, which assume some level of enforcement, are the responsibility of specified agencies and carry consequences for non-compliance.

For example, JCAHO's (Joint Commission for the Accreditation of Healthcare Organizations) new policy, requiring hospitals to have intimate partner violence protocols in place is a huge step forward. Hospitals are expected to produce these protocols as a part of their annual accreditation process. The weak part of this policy is that at this point it fails to call for implementation documentation or evaluation measures.

LITERATURE REVIEW OF BEST PRACTICES

DOMESTIC OR INTIMATE PARTNER VIOLENCE

It has been proven time and again that screening increases identification rates. However, even though a one-time training may increase screening numbers initially, it alone does not create sustainable change. One study found that detection rates rose after brief training, but treatment and referral practices did not change (Saunders, 1993). Countless other studies point to a lack of administrative “buy in” as a barrier to successful, continued screening. Other barriers include a lack of private space in which to ask a patient about his/her relationship, as well as competing priorities.

In the literature, several ideas emerge repeatedly, they were summed up nicely by Loughlin in 2000:

- The introduction of a protocol, with appropriate training, can increase staff members’ awareness, knowledge, and understanding of domestic violence; can legitimate raising the issue; and can provide staff members with clear, practical guidelines to address abuse. Together, these factors improve staff members’ response to abused women, which in turn can lead to improvements in the quality and consistency of care.
- Significant barriers to identifying abuse exist and need to be addressed through ongoing training that is tailored to the specific needs of the staff.
- The ethnicity of the communities served by the hospital needs to be taken into account in the protocol design and implementation, as well as the staff training.
- Resources are required, including staff time to train and implement the intervention, and appropriate space to facilitate safe disclosure by women.
- Institutional supports are also important, such as department policy provisions, management support, and staff ownership of the intervention. This means leadership and collegial support, particularly from charge nurses and management, as well as structural changes to foster support and facilitate implementation.
- Staff access to appropriate support and referral services, within and outside of the health care organization, are essential. The key role is for the health care professionals to encourage women to acknowledge abuse and then facilitate contact with appropriate referral services; not to undertake roles, such as counseling, for which they are not equipped.

Violence against women is a complex issue. None of its processes – disclosure, seeking services, or recovery – is straightforward. The conventional approach to health risk assessment, such as in smoking and alcohol use – “The provider asks, the patient discloses, the providers helps”- may not be a good description for an intervention with patients struggling with domestic violence.

One response to these issues is the “systems model,” a comprehensive approach to screening, identification and intervention that uses what has been learned from effective prevention programs for other clinical and safety issues. In 2001, McCaw et.al. demonstrated that a systems model approach can effectively improve

the healthcare response to domestic violence by increasing the amount of screening (as reported by female members of a health plan) and by increasing the number of referrals for further domestic violence evaluation. Their study also measured an increase in women's satisfaction with the health plan's efforts to address violence against women. This systems model approach successfully increased clinician screening and referral by: (1) focusing on familiar steps for clinicians to follow when a patient discloses domestic violence, (2) providing easy and reliable referral to on-site services, (3) forming strong linkages with community agencies, and (4) establishing an environment that prompts physicians to screen and informs patients about services (McCaw, 2001).

What Makes an Effective Screening Protocol?

In an article published in 1999, Rodriguez laid out several factors that influence the success of a screening protocol.

- › Interventions must focus on administrative changes, such as protocols, this may improve adherence.
- › Protocol must address known barriers such as privacy and time.
- › Support and guidance should be offered regularly to providers.
- › A close collaboration with community sources of support for victims is key.
- › Must get “buy in” from staff.
- › Keep staff updated on the “success” of screening.
- › Reinforce protocol with regular training classes.
- › Take into consideration limitations of certain shifts.

Research has shown that screening protocols in a research setting increased identification rates of domestic violence; but in the real-world setting of a busy ED or clinic, screening protocols are often not followed (Feighny, 1999). The health care system is charged with unending amounts of responsibilities. The addition of another screening protocol to this list provides potential for frustration and refusal by staff to comply. To ensure a protocol is followed, several points need to be addressed from the onset.

- › **Successful protocols deal with some of the known barriers to assessment and intervention in health care settings.** The most successful protocol is integrated into routine clinic procedures --including an abuse screen form in all new patient charts and incorporating abuse assessment and referral into the routine first visit intake interview. Time must be made available for both the professional and clinic support staff to obtain education about the protocol (Wiist, 1999).
- › **In-service education sessions about the protocol are essential,** for all clinic staff, including nurses, physicians, nutritionists, counselors, and clerical staff. A session should include information about abuse of women and procedures for conducting abuse assessments and making referrals to an onsite counselor. A nurse trainer to make weekly visits to the intervention clinics to offer support and guidance in maintaining the protocol and to instruct new nurses in how to carry it out is also helpful (Wiist, 1999).
- › **Clinicians should have an opportunity to consult a trained advocate** when patients are identified as injured by intimate partner violence. One program's purpose was to lower barriers for women to access resources available in the community. An unanticipated benefit was that it also made it easier for physicians to ask appropriate questions to identify domestic violence (Feighny, 1999).

- **Staff should be educated on the importance of a screening protocol**, to get their “buy in” and belief that their work may make a difference in someone’s life. Studies show that acceptance of a recommendation is not optimal if clinicians are not convinced of its practicality and necessity (Siegel, 1999).
- **A one-time education session on the new protocol is not nearly enough to ensure continued compliance.** One group found that the decline in implementation of the protocol from the 3-month audit to the 12-month audit suggested a need for continuing education, modification of clinic procedures, or reinforcement. Information about abuse could be included periodically in staff meetings. Data about the number of abused women identified and referred could be included in routine monthly clinic activity reports. Staff turnover could also contribute to a decline in implementation, pointing to the need to include information about the protocol in staff orientation sessions (Wiist, 1999).
- **Clinical interventions are more likely to be effective if they are joined with pragmatic policies regarding screening;** a broad, multidisciplinary commitment to a resilient community-based infrastructure that can protect battered women and their children from harm is helpful; and a long-term strategy for ensuring economic and emotional empowerment for survivors is a great addition (Warshaw, 1999).
- **More emphasis on curricula about domestic violence needs to occur in programs of education for health professionals.** This would lead to an increase in “buy in” on the part of staff. To ensure that this new content will be considered important by students and faculty, it is recommended that licensure exams must also include more test questions about family violence. Thus, content on domestic violence should be mandatory for licensure, license renewal, and certification. In addition to enhancing the content of basic education programs, family violence should be addressed at continuing education programs, annual meetings of professional organizations, and in scientific journals (Tilden, 1989).
- **Health care staff at common entry points should receive frequent in-service education programs** on domestic violence detection and management. Also, personnel who work with the health care system, such as school principals, teachers, clergy, and social service personnel should receive periodic in-service programs on family violence. Coordination between health care professionals, especially in emergency departments and prenatal units, and community-based advocacy services for victims of violence must be improved (Tilden, 1989).
- **Communities need coordinating bodies** with members from medical services, mental health services, criminal justice services, and community services, and women survivors of domestic violence. Women diagnosed with depression or anxiety disorders, when the root of their depression or anxiety is post-trauma response to battery, are further stigmatized by the system to which they have come for help. Standardized protocols should be used routinely in ambulatory care settings to interview and assess all trauma victims, especially in emergency departments (Tilden, 1989).
- **To encourage disclosure, an ongoing effort needs to be made to institutionalize a responsive, nonjudgmental climate.** To maintain momentum, periodic events need to be held to both educate and create enthusiasm for screening and responding. To make these programs effective,

administration must support domestic violence detection and response as a high priority, professionals need to be committed to this value. (Dienemann, 1999).

Ways Screening has Proven Successful

Screening “success stories” were cited by Dienemann in 1999.

- › A hospital-wide task force revised the nursing assessment form, incorporating screening questions and body maps. The emergency department agreed to pilot the new form for the hospital.
- › Educational posters were displayed in the public waiting area, treatment area, and women’s restroom, along with a domestic violence brochure appropriate for low-literacy patients, listing local resources.
- › Activities built professional awareness and increased the staff’s level of comfort with the screening procedures and their response to women who disclose domestic or intimate partner violence.
- › Additional training was planned to reinforce the importance and relevance of domestic violence to emergency-department practice, and to build the skills necessary to be comfortable in responding to women who disclose abuse.
- › Patient education brochures were placed in all staff mailboxes.
- › RNs were surveyed about their comfort in screening and reporting findings.
- › A self-study program was developed to orient new nurses to the domestic violence program.
- › Posters about screening procedures were displayed in the triage and treatment areas.
- › A booklet was developed about protection orders and safety planning.
- › A Domestic Violence Awareness Day was held for all ED employees and students.

SEXUAL ASSAULT

Although few prevention initiatives in this area have been evaluated, the Centers for Disease Control and Prevention has identified the following programs as ones which have promise for rape prevention:

- › A program of **Peer Facilitated Groups Among Men** help men recognize their role in sexual assault prevention. (Berkowitz, 1994)
- › The **STOP IT NOW Program**, currently operating in Vermont, provides a number of preventive services including an anonymous help-line number which provides information to abusers before they act on thoughts of child sexual abuse. (Tabachnick, 1995) (Through a 2002 CDC grant, MDH is helping to establish a similar program in Minnesota.)
- › A **Home-Based Program Utilizing Visiting Nurses** to instruct parents on child development and care with a focus on preventing child abuse and other forms of family violence. This program may act as a primary prevention for the children as they mature since early sexual experience is a risk factor for perpetration. (Olds, 1984)
- › The **Safe Dates Program** is a school-based curriculum that targets gender-role stereotyping and dating violence norms, conflict management skills, help-seeking and cognitive factors associated with help-seeking. Preliminary evaluation suggests the program reduces the perpetration of dating sexual violence. (Foshee, in press)

The National Advisory Council on Violence Against Women and the Department of Justice Violence Against Women Office published *A Toolkit to End Violence Against Women*. The Toolkit includes a chapter (2) entitled *Improving the Health and Mental Health Care Systems' Responses to Violence Against Women*. The Advisory Council and the VAW Office point out several important factors in addressing violence against women in the health care setting.

- › Conduct public health campaigns.
- › Educate all health care providers about violence against women.
- › Create protocol and documentation guidelines for health care facilities and disseminate widely.
- › Protect victim health records.
- › Ensure that mandatory reporting requirements protect the safety and health status of adult victims.
- › Create incentives for providers to respond to violence against women.
- › Create oversight and accreditation requirements for sexual assault and domestic violence care.
- › Establish health care outcome measures.
- › Dedicate increased federal, state and local funds to improving the health and mental health care systems' responses to violence against women.

SUMMARY

There are many ways to effectively address violence against women in the public health or health care setting, and a great body of research defining them. Two “best practices” that are repeated throughout the literature are (1) Ongoing provider or clinician education to gain “buy-in,” provide skills, develop understanding of the importance of the work, erase fears, destroy myths and develop trust, and (2) Sustained institutional support that leads to the provision of resources, in terms of time and dollars, and to the understanding that the institution has declared violence against women a priority topic.

KEY INFORMANT INTERVIEWS

BACKGROUND AND SCOPE OF THE INTERVIEWS

In 1995 the Governor’s Task Force on Violence as a Public Health Problem produced *The Violence Epidemic: The Role of Minnesota’s Health Care Organizations and Professionals in Prevention and Treatment*, a call to action to improve the way health systems address violence. To actively promote implementation of the goals identified in this document, a Health Care Coalition on Violence (HCCV) was organized and led by major Minnesota health systems.

The Task Force identified nine areas for work on violence issues within the health care system: Violence Contract (organizational commitment), Primary Prevention, Practice Guidelines, Education and Training, Agency Collaboration, Data Collection, Workplace Violence, Funding, and Future Areas of Focus.

While not specific to violence against women, these areas and the goals within them have been used in this assessment as a useful framework by which to measure health system improvements. Interview questions were tailored to specific professional groups, and focused on activities and accomplishments that are especially relevant to violence against women (see Appendix B for interview questions).

Telephone or in-person interviews were conducted with 56 professionals, all current or recent employees of public health agencies or health care organizations, or advocates who interact with these systems. Interviewees were identified through the MDH Violence Against Women Advisory Committee and by MDH staff, based on the interviewees' likely knowledge about the issues of concern (see Appendix A for methods and limitations of the interview data).

Interviewees represented six categories:

- › Medical professionals – RNs, MDs, social workers, administrators, and program management (22)
- › Domestic violence and sexual assault advocates (11)
- › State and local public health professionals – (15)
- › Members of the committees of the Health Care Coalition on Violence (6)
- › Health plan administrators (2)

Interviewees working in health care represented all six of the major health care delivery systems in Minnesota (Allina, Children's Hospitals, Fairview/University, Hennepin County Medical Center, HealthEast and HealthPartners), a number of representatives of the major health plans in the state, as well as leaders of the HCCV. Providers worked in clinics and hospitals in units ranging from the Emergency Department to Obstetrics and Gynecology to Social Services. They were from the Twin Cities metropolitan area and its suburbs and from the more rural areas of the state.

Public health and advocacy interviewees came from both the Twin Cities area and rural Minnesota, and included state and local agency staff. Advocates interviewed worked in the areas of sexual assault and/or domestic violence, and had experience assisting clients with health systems and issues.

	Advocacy	HCCV	Health Plans	Medical	Public Health
Urban/ Suburban	4	6	2	19	12
Rural	7	n/a	n/a	3	3

Table 1: Interviewees by Agency Type and Geographic Location

INTERVIEWS AND FINDINGS:

A. VIOLENCE CONTRACT

The Violence Contract question concerned the change (increase or decrease) in their organization's commitment of time, money, or other resources to prevent or respond to violence against women. *(For specific wording of each question, and its variants for the different professional groups, see Appendix A.)*

Most participants noted an overall increase in their agency's commitment of resources.

As in any field, the health care and public health professions have "hot topics" that gain a great deal of time, attention and resources for a period of time and are replaced shortly afterward with a newer, "hotter" topic. Violence against women was a "hot topic" in Minnesota in the mid-1990s, due in large part to the work

of the Health Care Coalition on Violence. *“There has been a definite increase in commitment in the last two years.”* (Medical) The surge of time, attention, and resources eventually led to a great number of agencies developing practice guidelines (mandated by JCAHO) regarding violence against women, most commonly intimate partner violence.

“Awareness has increased as individual staff have invested their own time in learning more about the issue.” (Medical) Respondents said that staff needs to understand the dynamics of intimate partner violence and sexual assault to be able to provide services to victims.

“I’ve noted an increase in staff time devoted to the issue.” (Medical) One of the keys to success described by programs is the existence of a “champion” who has time dedicated to ensuring that this work gets done.

By far, the majority of respondents believed that their agencies had increased the amount of resources allocated to responding to violence against women; however, there was another, concerning finding. That increase may have been short-lived, at least in several agencies.

Other participants noted a decrease in their agency’s commitment.

Violence against women has recently, in many systems, been replaced by “hotter” topics, leading to diminished time, attention and resources dedicated. Competing priorities have been and will continue to be a reality of agencies working on limited budgets.

“Over the last two years, there has been a decrease.” (Medical) Several agencies that previously had staff dedicated to improving efforts regarding violence against women have lost that supportive funding and the work has, in many cases, ended. As previously discussed, one of the factors in a successful program to address violence is the existence of a “champion,” a “flag waver,” someone whose responsibility it is to keep the issue and the work in the forefront of everyone’s minds. Without these people in agencies, the work is often overlooked, or replaced with other priorities.

Another factor in a successful program is formal collaboration with community advocacy agencies. In screening for domestic violence, a barrier for clinicians is the fear of the “yes” response from victims to questions about abuse. When health care or public health agencies have contractual relationships with advocacy agencies, this fear is addressed. Upon receipt of a “yes” response, an advocate is contacted and assumes responsibility for addressing the stated needs of the victim. Agencies interviewed that described the existence of this kind of relationship were far more likely to have confidence in their screening rates and referral success. However, a number of agencies who, in the past, were able to support this type of cooperative relationship, are no longer so lucky.

“There has been a decrease in the commitment of money. In the past we were able to contract with an advocacy agency to provide in-house services. We aren’t able to do that anymore.” (Medical) Agencies that were collaborating, providing the most effective service to victims of violence, are no longer able to provide that level of service as competing priorities receive the dollars. Without a contractual relationship, health care continues to request services from advocacy agencies, services that are happily provided. However, the efficacy of the relationship has been drastically diminished. *“Since the advocate positions were cut, the number of referrals that we receive has drastically decreased and that is also true for the hospital’s own social workers. Apparently, the screening rates have decreased as well.”* (Advocacy)

B. PRIMARY PREVENTION

The Primary Prevention question concerned efforts (external or internal) to prevent or respond to violence against women, and the degree of collaboration with outside agencies. (For specific wording of each question, and its variants for the different professional groups, see Appendix A.)

Respondents reported being involved in a variety of prevention activities, though some are not technically “primary prevention.” Activities include:

- › Candlelight vigil to remember victims of violence.
- › “Touch” (sexual violence awareness) play
- › Parenting Fairs
- › Health Fairs
- › Sexual Assault Awareness Month activities
- › Domestic Violence Awareness Month activities
- › Maintaining stock of brochures in hospital / clinic restrooms
- › Training to service providers (physicians, nurses, EMT staff, etc.)
- › Encouraging use of Anticipatory Guidance questions related to violence in pediatric well-child visits
- › Sexual Violence and Healthy Relationship education to youth
- › Providing accurate, up-to-date information on a web-site (facts about abuse/violence, resources, referrals, etc.)
- › “Take Back the Night”
- › Participating on community Violence Prevention Task Forces
- › Developing culturally specific outreach programs
- › Creating culturally specific education / referral materials
- › Distributing grant dollars to agencies providing violence prevention services
- › Working with students and their parents, creating awareness around sexual violence
- › Ensuring staff receive training regarding violence against women
- › Homevisiting and parent education
- › Stuffing employee paychecks with information and referral sources
- › Training nursing students on homevisiting techniques

Most efforts on the part of health care have not traditionally been preventative.

“There has been some community education, like flyers in the restrooms and health fairs.” (Medical) But most efforts still tend to be more secondary or tertiary. A few agencies are partnering with non-health care organizations to provide education in schools and communities, and those efforts are show great potential for success.

Community clinics often have education programs that work in schools, juvenile detention centers, community centers, etc. providing education on various health-related topics including sexual assault, healthy relationships, and anger management.

An increased number of pediatric clinics have added violence-related questions to their Anticipatory Guidance forms.

As part of the “safety” section of Anticipatory Guidance portion of a well-child visit, *“physicians ask questions and provide age appropriate handouts to parents that contain information on family and community violence.”* (Medical)
The Anticipatory Guidance portion of a well-child visit is reimbursed by health plans – this seems to be one of the few ways work related to violence against women is being funded. (also see Question I: Funding).

Public health is quite active in primary prevention, including home visiting and parent education.

A universally offered (not targeted) homevisiting program is available in Minnesota to all current or expectant parents and families, regardless of risk status. *The purpose of this program is to strengthen families and to promote positive parenting and healthy child development. This program offers parents information on parenting, infant growth and development, health and safety.*(Public Health). By any definition, this program is Primary Prevention.

Other, more targeted homevisiting programs at work in the state are designed to *“prevent child abuse and neglect, promoting positive parenting, and to promote a healthy beginning for every child. The program provides a public health nurse and a family aide to provide home visits to at-risk families.”*(Public Health)

C. PRACTICE GUIDELINES

The Practice Guidelines question concerned practice guidelines regarding sexual assault, intimate partner violence, or elder abuse, such as screening techniques, prevention counseling, safety planning/referral, and whether any changes in those guidelines have been made in the last five years. *(For specific wording of each question, and its variants for the different professional groups, see Appendix A.)*

The majority of health care providers have some sort of screening guideline for providers regarding violence against women.

Every major health care organization has come forward with statements (see Results – Policies and Recommendations) regarding appropriate responses by health care and public health to sexual violence and intimate partner violence. Also, hospitals have been mandated by the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) to develop “objective criteria for identifying and assessing possible victims of abuse and neglect.”

Virtually every respondent was able to identify practice guidelines relating to intimate partner violence. Sexual violence, it is interesting to note, was far less likely to be mentioned by respondents in response to this question. Following are examples of responses:

- > *“Pregnant women are screened at their first prenatal visit. Women presenting for well-women visits / birth control exams are all screened.”*(Medical)
- > *“We’ve been screening for more than 10 years in OB/GYN.”*(Medical)
- > *“With the prenatal data base, those questions are asked, I would say 10percent of the time.”*(Medical)
- > *“The guideline that is in place is that all parents presenting children for “Well Child Visits” receive a handout that is age/development appropriate that includes referrals for those experiencing or concerned about domestic violence.”*(Medical)

- > “Under the topic of ‘Safety’, in the Anticipatory Guidance portion of a well child visit, physicians are asking parents about their safety and the safety of their children in their homes, in their neighborhoods and at work.”(Medical)
- > “We have a two question screen. We ask clear, concise questions ‘Have you ever been hit, kicked, pushed or otherwise hurt by someone close to you?’ and ‘Is someone important to you yelling at you threatening you or otherwise controlling you?’”(Medical)
- > “The guideline is to screen every female patient at every visit. There are no set questions, and each staff member has his/her own approach.”(Medical)
- > “We are on an automated patient history system. Screening questions are asked of every patient at every visit.”(Medical)
- > “New patients are screened as a part of the orientation to clinic.”(Medical)
- > “Screening occurs with all adult women at every preventative visit.”(Medical)

There is concern that though screening guidelines are in place, the medical community may not always be following them.

While JCAHCO mandated the implementation of standards, there is little in place that requires those standards be enforced. As will be discussed later (G. Data Collection and Research) unless prompted by current research activities, few health care agencies are tracking screening and referral rates. For some, that data is available, just not accessed. For others, that data is simply not collected. Health care respondents point to flaws in their programs and areas for improvement. Responses include:

- > “We still have room to grow, more practice and more awareness need to happen.”(Medical)
- > “These processes were more successful in the past when we were provided the support of an administration that funded positions focused on the issue. Screening is still happening, victims are still being identified and services are being provided, just not as efficiently as in the recent past.” (Medical)
- > “I think we are more successful at certain times in certain settings. There are so many competing priorities and not all clinicians are convinced of the validity of this issue’s claiming priority.”(Medical)
- > “I believe 90percent to 100percent of women are being screened at their annual exams. Our goal is every woman at every visit and by that standard, perhaps we are not doing so well, but that is a huge proportion of women who are at least asked every year.” (Medical)
- > “I believe that implementation is fairly successful. Certainly, we could be doing a much better job, but we are doing better today than we were 10 years ago.”(Medical)
- > “We are as successful as we can be with the available resources, in terms of having social work staff available to provide requested services.”(Medical)
- > “I think that screening questions are often targeted; they are asked of patients who look like violence may be an issue.”(Medical)

Local Public Health is involved in a great number of projects regarding violence against women.

One local department claims to “have a fairly active effort related to violence against women directed towards women, families and the community.” (Public Health) That same local department “participated in a series of violence prevention education,” and made that information “available to the rest of human services.” Another local department sent “all

managers to a training on domestic violence,” “brought in speakers to talk with staff about violence against women,” and made “stickers and pamphlets available in all of the restrooms.”

Local public agencies have set up committees to find ways to address violence against women in their communities. Some of the activities underway include:

- › Table tents have been created describing unhealthy relationships.
- › Pamphlets have been designed, describing local services available to victims of violence.
- › Posters have been displayed depicting violence and its consequences.
- › Teams have been created to hold community forums to find community solutions.
- › Sexual Assault Nurse Examiner (SANE) programs have been begun.
- › Education programs aimed at high school students, discussing good decision-making and gender socialization aimed at reducing violence.
- › Family forums have been held to discuss sexual abuse and community referrals.

Local public health agencies are also heavily involved in home visiting and other individual service provision.

At one agency, a significant portion of one employee’s time is devoted to violence against women, “she offers in-house services to the local women’s shelter, works with shelter staff to provide community education, provided consultation on research projects, and to medical and advocacy facilities around the state.” (Public Health)

Funding is always a problem, as priorities compete for funding, violence against women is often placed on the back burner. When federal funds are available, more directed, exciting work is often begun. One federal grant facilitated the creation of a multi-disciplinary team that addressed the needs of violence against women in a way that had never before been done. That work continues and has been modeled by other states.

As a whole, the Minnesota Department of Health is doing far less related to violence against women; however, one unit is doing a great deal of work.

Department representatives claimed “violence against women is not specifically addressed in our program,” or “violence against women is not really a focus of our program, there really aren’t any current efforts to address it,” or “our section is not doing much in terms of violence against women. We used to have a staff member that did quite a bit of work, but when she left, that work ended.” “Violence against women is not a mandatory component of our program, it is an optional piece that we have decided not to include.”

A rather strong comment, made by another department of health employee really puts in focus what could be the source of the problem at the state level, *“the Minnesota Department of Health has never received state dollars to address violence against women.”*

There is, however, one unit active in violence prevention at the state level. Some of the activities created by, supported by, or funded by this unit are:

- › Created a Sexual Violence Prevention Resource kit (see Appendix B Sexual Assault).
- › Created and implemented statewide public awareness campaigns.

- Held a statewide “Town Meeting” aired on Minnesota Public Television (and since on more than 70 public television stations nation-wide) to address the problem of violence and its impact on communities.
- Funded local prevention partnerships and shared results of each with the rest of the state.
- Encouraged partnerships with local public health departments and the advocacy agencies that serve their communities.
- Held conferences and informal gatherings to present and discuss best practices regarding sexual violence.
- Participated in the implementation of *Stop It Now* campaign in Minnesota, which seeks to prevent child sexual abuse by reaching perpetrators and potential perpetrators.

D. SERVICE COORDINATION AND REFERRAL

The Service Coordination and Referral question concerned resources available to women (non-employees) who disclose violence, including: social worker, chaplain, translator, culturally specific services, sign interpreter, SANE nurse, private room, telephone, an advocate, etc.

There is a great deal of confidence in agencies’ ability to provide any services necessary to victims of violence against women, once identified.

Virtually every respondent had the same opinion when questioned about their agency’s ability to provide services to victims of violence against women. Almost universally respondents said that *“certainly all of these resources are available if they are needed.”* (Medical). *“Resources are always changing, at least a bit – but I am confident that we are able to provide whatever our clients are needing.”* (Public Health)

There is some concern about the ability of smaller communities to meet the needs of growing immigrant communities.

“Until fairly recently our community has been fairly white. We are seeing more and more Somali families come to live here and our services / resources have not yet caught up.” (Medical)

There is also some concern about the appropriateness / effectiveness of providing services within the presence of interpreters.

“Our legal department has advised that when an interpreter is present, screening questions are not to be asked.” (Medical)

“Very few interpreters have training in domestic violence and sexual assault and this makes a difference in the services that are provided. I don’t doubt that a trained medical translator can do a competent job, but there is the added aspect of violence that makes a difference.” (Medical)

Relationships have increased in the last five years between advocacy agencies and the health care organizations that serve the same communities, though more recently some of those relationships have lost support.

Typically, advocacy agencies have verbal agreements with the health care agencies in their communities to provide services to identified victims. In recent years, with increased attention on screening for domestic violence, these services have been requested more and more. The most successful of these relationships maintain a working contract between the agencies. A contract usually guarantees the services of an advocate within a certain period of time following request. Medical practitioners in this type of relationship no longer fear the “yes” response from a victim, as they are confident that the patient’s individual needs will be met by a trained advocate. Thus, they tend to screen more and refer more, and more victims get the assistance they need.

As successful as this kind of situation is, similar contractual arrangements throughout the state have ended due to financial constraints or lack of administrative support.

There is growing interest in providing the services of Sexual Assault Nurse Examiners (SANEs) to victims of sexual assault.

“Not all hospitals have access to SANEs, but that is improving as more and more communities start programs.” (Medical)

“(Name of hospital) provides the greatest number of outreach requests at this point. We anticipate that with the introduction of a new SANE program at that hospital, the number of requests (for outreach) that we receive will increase even more.” (Advocacy)

Larger, urban hospitals are able to provide a great deal of these services “in-house,” and smaller clinics, urban or rural, often maintain working relationships with a number of different service providers in their areas.

E. Education and Training

The Education and Training question concerned staff training and updating on (a) issues relating to violence against women, (b) screening, (c) documentation, (d) referral sources. *(For specific wording of each question, and its variants for the different professional groups, see Appendix A.)*

The majority of health care agencies have provided “one-shot” training relating to violence against women. Very little on-going training exists.

Violence against women was more on the “front burner” in many health care organizations and public health agencies a couple of years ago, possibly as a result of the work of the Health Care Coalition on Violence. The enthusiasm seems to have died down in many places and with it the demand for on-going follow-up training for service providers. *“New employees receive training at their beginning of their tenure, but there is no on-going training.” (Medical)* *“Employees receive initial training; the problem is that it’s not mandatory.” (Medical)*

“In the past staff was trained in orientation, to screen.” Violence training played a large role in a major health care organization’s training process for all employees, but in recent months that in-person segment in training has been replaced by a bulletin board outside the entrance to the orientation hall, an optional stop for new employees.

Other agencies continue to place emphasis on the importance of on-going training for employees. Often, the agencies that maintain a commitment to training and awareness, are the same ones that regularly screen and refer victims.

Often training is related to funded research projects; when the project runs its course, training ends too.

“For a while, when we were in the middle of research projects we had a lot of on-going training. There is less training available right now.” (Public Health)

There appears to be a correlation between the amount of training received and the quality of services provided.

“More training is always better, it’s just difficult to get the time.” In the health care world, as in many others, competing priorities and different issues are popular at different times. Those issues most often receive the majority of the time and attention, not to mention funding.

Often agencies provide training only to new employees. While that may be adequate for service providers who use those skills on a regular basis, for those who do not, *“they get rusty.”* *“The motivation to screen comes from the positive screen who wants to talk to an advocate.”* If providers use their skills only rarely, that motivation decreases.

“The increased awareness that comes from training makes providers more comfortable with asking the questions.” (Medical) In the training, providers also become aware of the less obvious “red flags” that might point out a victim not seen before. Often, they are also offered support for their own personal experience with violence. *“Every time we hold a training, we have employees who self-identify.” (Medical)*

F. WORKPLACE VIOLENCE

The Workplace Violence question concerned initiatives and policies to prevent or respond to workplace violence at the agency and any change in the attention paid to workplace violence. Respondents were asked to address training, resources, or referrals regarding workplace violence. *(For specific wording of each question, and its variants for the different professional groups, see Appendix A.)*

The majority of respondents are confident that their agency has policies and practices relating to workplace violence.

It is clear that attention paid to workplace violence has increased a great deal in the last few years. Most agencies have developed policies and procedures related to workplace violence, it was common to hear something similar to *“Yes, we have had a Workplace Violence committee in the past that may continue its work”.* *(Medical)* It is also fairly common that those agencies have incorporated information related to workplace violence into new employee training as well as annual safety training. *“Part of our annual, required training includes information regarding workplace violence.” (Medical)*

Something that was interesting to discover was the impact that the discussion of workplace violence has had on several agencies – prompting them to look at their employees as potential victims needing services as much as their patients / clients. *“We have recently begun to look at our employees’ personal experience with intimate partner violence. We are in the process of surveying all of our managers, asking for their perception about the extent to which their employees are victims of intimate partner violence.”* (Medical)

Most respondents however, are unaware of what those policies and practices are.

Respondents were almost universally certain that their agencies had policies and procedures regarding the appropriate response to workplace violence, however it was rare that a respondent was aware of what those policies and procedures were. *“Yes there are policies. I can’t tell you what they are off hand, but I could get to them if needed.”* (Medical)

For managers, there was a sense of responsibility to know what their agency had in place *“I should be more aware than I am.”* (Public Health) But it was often a small part of an exhaustive list of information for which they were responsible.

It was clear, however, that most respondents knew where to go to get information about their agencies’ policies’ regarding violence against women. *“I’m not sure what they are, I could easily go to Human Resources with questions.”* (Public Health)

Agencies in general have support services and resources that employees are encouraged to contact when confronted with violence in their professional or personal lives.

Employee Assistance Programs are extremely common; the majority of respondents described them as available to employees experiencing physical, emotional, or sexual abuse either in the workplace or at home. *“As employees we have the EAP that we can use 24/7 for counseling or support or for referrals.”* (Public Health)

G. DATA COLLECTION AND RESEARCH

The Data Collection and Research question concerned data collected in cases of sexual assault or intimate partner violence, or elder abuse. Respondents were asked to describe how data are used. *(For specific wording of each question, and its variants for the different professional groups, see Appendix A.)*

About half of the health care agencies interviewed are collecting screening and referral rates.

Responses to the question, “What data are you collecting related to violence against women?” include these:

- > *“We are tracking screening rates with prenatal visits. Referral rates would be difficult to get a handle on, except to say that we refer if there is a positive screen.”* (Medical)
- > *“We document screening with a number system. We also document who did the screening, the date of the screening and if the (advocacy agency) was contacted”* (Medical)
- > *“Our guidelines ask that we report the percentage of patients age 18 and older that are screened. We are not collecting data on follow-up or referrals.”* (Medical)
- > *“For sexual assaults, we collect the number of (forensic) exams, the length of exams, success of follow-up and prosecutorial results.”* (Medical)

- > “We track e-codes so we can get a sense that those patients who presented with injuries consistent with domestic violence are getting assigned the correct codes.” (Medical)
- > “None of those rates are collected at this point, at least not that I am aware of.” (Medical)
- > “We are not collecting screening rates and referral rates related to violence.” (Public Health)

As is true with other forms of data collection, the easier, more routine the process is, the more likely that data will be collected with any regularity. “The health history form includes a domestic violence checkbox for staff to fill out once they have screened a patient.” Setting up a systematic approach to data collection seems to have helped many health care systems stay on top of screening as well.

Some clinics or hospitals find it easier than others to collect data regarding to violence against women. “Screening and referral rates for domestic violence are collected from the clinics easily because there is a system in place. This isn’t true in the hospitals; it’s too time intensive to do (chart reviews) more often than every couple of years.” (Medical)

Data collection is often a part of the evaluation process of a time limited research project.

Often a data collection process is a part of an internal or external research project. The collection of data often ends with the end of the project. “We did collect some (data) in our walk-in clinic as a part of a research study a couple of years ago. Otherwise, no, we collect no screening rates, no referral rates.” (Medical)

H. HEALTH PLAN COVERAGE AND PAYMENTS

The Health Plan Coverage and Payments question concerned reimbursement from third parties for costs in providing services such as screening, prevention counseling, safety planning/referral. (For specific wording of each question, and its variants for the different professional groups, see Appendix A.)

Virtually no health care agency interviewed receives reimbursement from third parties for costs in providing services relating to violence against women. Many of the interviewees, however, saw screening as an essential prevention tool that should be supported financially.

The question concerning the receipt of reimbursement for services provided regarding violence against women (for example, screening, prevention counseling, and safety planning) was received by most health care professionals with a mixture of amusement and frustration. They are not receiving reimbursement, and that fact impacts the degree to which these services are provided.

Responses included:

- > “It’s a part of history taking; it’s not being covered by anything. . . . We need to point to an expenditure of time by a physician, or a referral to behavioral health.”
- > “Reimbursements are very much based on face time with physicians. When doctors aren’t involved, the cases fall into that gray area.”
- > “They don’t pay for much in ambulatory care – they’d rather pay for an ER visit than for prevention.”
- > “. . . if the abuse is related to a mental illness and services are required for treatment, we may be able to bill, but this happens rarely.”
- > “The barrier that most often impedes reimbursement from third parties is the assignment of the appropriate code.”

- > *[There is] “a lack of understanding of these services as preventative.”*
- > *“The more that we can convince everyone that this work is prevention and (that) addressing violence as early as possible leads to a decrease in patient visits and possibly impact the severity of injuries, the better off we’ll all be.”*

Pediatrics offices / clinics and mental health providers, are reimbursed, at least partially.

“As a part of the well-child check and under the topic of safety on the Anticipatory Guidance form, we may be receiving some reimbursement for that counseling portion in a rather round-about way.” However, those well-child visits are reimbursed for a prescribed period of time. The more items a physician discusses with his/her patients, the longer that visit takes – often exceeding the prescribed period of time. The addition of violence questions to this visit impacts the amount of time spent.

Mental health providers are more likely able to assign billable codes to their patient’s charts. *“Treatment for a diagnosis like PTSD (Post Traumatic Stress Disorder) may be an exception.” “If the abuse is related to a mental illness and services are required for treatment, we may be able to bill.”*

I. FUNDING

The Funding question concerned funding limitations for agency in addressing violence against women, and activities that are not done due to lack of funding. *(For specific wording of each question, and its variants for the different professional groups, see Appendix A.)*

Funding is often a barrier in addressing violence against women.

When asked, the majority of respondents indicated that funding limitations restricted an agency’s ability to provide services related to violence against women.

- > *“As we develop programs, we wonder how we’ll fund it, how we can prove that it is a value to patients, to the community.” (Medical)*
- > *“[Funding] was the biggest problem in the continuation of the work of the HCCV.” (HCCV member)*
- > *“[Grant-funded local] projects already have a number of pieces to implement; violence is not high on their list of priorities. If we had something that we added to their grant contract, it might be a way to highlight violence as a priority area.” (Public Health)*
- > *“If we were able to take the time to develop a relationship with our patients, to work towards building trust, we’d be able to accomplish so much more.”*
- > *“There have been concerns that with the increase in screening, we may need another social worker.”*
- > *“We’d be at HCMC every day if we had the dollars/staff to do it.” (Advocate)*

Others believe that the work still gets done.

Agencies where work related to violence against women is supported are finding the financial resources they need to provide the appropriate services. *“That (funding) hasn’t been a barrier for us.”*

Those who truly believe in providing services to victims of violence against women are finding ways to keep the work moving forward. *“It has long been our policy to get worthy projects done. That ‘advocate way of thinking’ has often been a sort-of double-edged sword – we’ll do the impossible with or without funding; as funders know that, they are often left without incentive to fund us.” (Advocate)*

A few respondents pointed to insurance companies and other third parties as potential funding sources.

Considering the fact that victims of violence, particularly intimate partner violence, utilize the health care system at a higher rate than others, it seems clear that to screen and intervene will decrease visits to the emergency department. *“What about insurance companies? Who would benefit more from preventing violence?” (Medical)*

J. INTERVIEWEE CONCLUSIONS AND RECOMMENDATIONS

The Conclusion and Recommendation question offered respondents the opportunity to have input on both what their agency can do to better prevent/address violence against women, and how MDH can provide assistance. *(For specific wording of each question, and its variants for the different professional groups, see Appendix A.)*

Respondents cited the need to educate health care professionals and administrators about the significance of violence as a priority public health issue.

It is only through education and training that public health and the health care system will create a place where victims feel safe to disclose the violence they have experienced. *“Health care is still not an appealing/accessible place for victims to access. We really need to increase access and sensitivity.”(Medical)* The situation in the majority of Minnesota’s hospitals and clinics and public health offices is much better than it was even five years ago, but professionals in these fields have described how much work there remains to be done.

They said things like:

- *“I think it’s really important to keep everyone aware of new resources and techniques . . . [and to help] nurses become comfortable in asking the questions and responding appropriately.”*
- *“Help with E-codes would be really appreciated. It’s a huge issue – we train and train, but if we can’t document, we can’t get reimbursed.”*
- *“I’d like to see more emphasis in addressing this issue . . . and training physicians in the techniques it takes to create a relationship with patients that encourages disclosure.”*
- *“It would be public health’s role to determine the contributing factors to domestic violence and to begin to find ways to address risk factors.”*
- *“[We need to] improve primary education process for physicians, in medical school and in residency programs. If we don’t infuse the concept right up front, it never gets added later. If they come out of school with an awareness and understanding that violence is a health care issue, they would be much more likely to address violence as an issue with their patients.”*
- *“If the goal of health care organizations is to improve the health of their members/patients, violence must continue to be seen as a priority – its impact on health is so profound.”*

- > “[We need to] work more with organizations that are outside of the Twin Cities – keep pushing, keep putting resources toward the issue.”
- > “Training dollars are definitely needed. If you really want to jumpstart this, get a person to work from within. . . . Public health is certainly a piece of the pie, but to have someone who knows the system and how it works is extremely helpful.”
- > “More should be done to improve the response to communities of color. . . allow them to identify ways to make the whole process more inviting/welcoming. . . . have more people of color on staff.”

Other issues raised were the need for interpreters, the need for understanding and acceptance of nontraditional medicine, concerns about residency status, and payment for services if victim is illegal alien and partner is abuser and is arrested.

One respondent suggested his/her agency “fund these collaborative health care communities like the HCCV – to provide training and resources that create excitement about the issue and bring it back to the forefront in the list of priorities for health care.”(Medical)

OTHER COMMON RESPONSES CONCERNED THE NEED FOR MORE SPECIFICALLY TRAINED STAFF, AND “CHAMPIONS” TO KEEP THE WORK GOING.

“[We need an] onsite social worker, to assist with domestic violence and sexual assault victims and to help with the elderly.”
The alternative to an onsite social worker is a relationship with a local advocacy agency.

“The existence of ‘champions’ is so very important. . . . We need to find ways to keep the projects alive . . . as a part of agencies’ budget.”

They saw the MDH roles as providing training, supporting local initiatives, sharing resources, and advocating with administrators to provide guidelines and expectations.

Responses included such things as:

- > “If MDH took this as a major issue and domestic violence was defined as a major health issue, we’d be in a better position to convince administration to support this work.”(Medical)
- > “MDH could work to establish the provision of services as a reimbursable service for third party payers. MDH also could develop curricula/evaluation methods, a cost model relating to violence against women, and better tracking of V-Codes.” (Medical)
- > [MDH can] “facilitate the process of getting great ideas out into the communities . . . and get great ideas from those very communities.”(Medical)
- > “Data is used to shore up funding. Frequently updated fact sheet with numbers relating to domestic violence, with links to respected sources.”
- > “Research and protocol development around relationship between advocacy programs and health care and public health would be really helpful.”

SUMMARY

The health care practitioners and public health professionals interviewed for this project are doing an amazing amount of work related to preventing and responding to sexual and intimate partner violence. They are often working with limited staff, and more limited budgets. They are working with little to no (in many cases) institutional support – in the form of dollars or time. They are doing projects and implementing initiatives without the existence of the demands of a policy, but because they understand that it is the right work to do.

There are a couple of themes repeated by many of the individual interviewed. There is fear that the work they have done thus far is now receiving less and less support, and may not continue. They are concerned that their staff do not receive adequate training to do this work and that the few “champions” that keep the momentum going are not receiving the support they need. Many have implemented protocols, but are not sure about their compliance as little to no evaluation is being done. But they continue to push for more time and more agency commitment, they believe in the work that they are doing and feel that they have an opportunity to make an impact on the lives of victims of sexual or intimate partner violence.

DISCUSSION AND RECOMMENDATIONS

DISCUSSION

Three major tools were used to compare and understand the practices and policies used in public health and health care in Minnesota to address violence against women. These included a Review of Policies and Recommendations, a Literature Review of Best Practices, and a number of Key Informant Interviews. Four broad themes emerged from our assessment. These include: (1) Guidelines have been implemented, but compliance varies; (2) Multi-disciplinary collaboration is a necessary piece impacting efficacy; (3) On-going training is necessary, training on protocol, as well as on dynamics of abuse and violence; (3) Sustainability is challenging, “champions” are needed, resources and coordination are needed, and on-going administrative support.

GUIDELINES HAVE BEEN IMPLEMENTED, BUT COMPLIANCE VARIES.

According to a 1999 Rodriguez article, “Interventions must focus on administrative changes, such as protocols, this may improve adherence.” Every clinic or hospital that is engaged in practices to prevent or respond to violence against women reports a different approach. Not many reported any sort of mechanism to track who and when they were implementing their protocol, and fewer were able to report results.

- *“Pregnant women are screened at their first prenatal visit. Women presenting for well-women visits / birth control exams are all screened.”(Medical)*
- *“With the prenatal data base, those questions are asked, I would say 10percent of the time.”(Medical)*
- *“The guideline is to screen every female patient at every visit. There are no set questions, and each staff member has his/her own approach.”(Medical)*
- *“New patients are screened as a part of the orientation to clinic.”(Medical)*
- *“Screening occurs with all adult women at every preventative visit.”(Medical)*

While JCAHCO mandated the implementation of standards, there is little in place that requires those standards be enforced. Unless prompted by current research activities, few health care or public health agencies are tracking screening and referral rates. For some, that data is available, but not accessed. For others, the data is simply not collected.

EFFECTIVENESS DEPENDS ON MULTI-AGENCY COLLABORATION.

According to a 1999 Rodriguez article, “A close collaboration with community sources of support for victims is key.” A number of health care or public health agencies interviewed have contractual relationships with advocacy agencies to provide specific information and support to victims. These agencies indicated they were far more likely to have confidence in their screening rates and referral success. However, a number of agencies that, in the past, were able to support this type of cooperative relationship, no longer have resources to do so.

When asked, virtually every respondent felt their agency had the capacity to respond to victims of violence against women. *“Certainly all of these resources are available if they are needed.” (Medical) “Resources are always changing, at least a bit – but I am confident that we are able to provide whatever our clients are needing.” (Public Health)*

The frequency of referral by health care providers to community advocacy services appears to be related to the existence of contractual relationship. Medical practitioners in this type of relationship no longer fear the “yes” response from a victim, as they are confident that the patient’s individual needs will be met by a trained advocate. Thus, they tend to screen more and refer more, and more victims get the assistance they need.

As successful as this kind of situation is, similar contractual arrangements throughout the state have ended due to financial constraints or lack of administrative support. Without such a relationship, health care continues to request advocacy services, but to a lesser extent. *“Since the advocate positions were cut, the number of referrals that we receive has drastically decreased and that is also true for the hospital’s own social workers. Apparently, the screening rates have decreased as well.” (Advocacy)*

ON-GOING TRAINING IS NECESSARY, ON PROTOCOL AND THE DYNAMICS OF VIOLENCE.

“Reinforce protocol with regular training classes, support and guidance should be offered regularly to providers,” (Rodriguez 1999). However, the majority of health care agencies interviewed have provided “one-shot” training relating to violence against women. Very little on-going training exists. Interviewees reported that staff needs to understand the dynamics of intimate partner violence and sexual assault to be able to provide services to victims.

Respondents observed that violence against women was more on the “front burner” in many health care organizations and public health agencies a few years ago, possibly as a result of the work of the Health Care Coalition on Violence. The enthusiasm seems to have died down in many places, and with it the demand for on-going follow-up training for service providers. *“New employees receive training at their beginning of their tenure, but there is no on-going training.” (Medical) “Employees receive initial training; the problem is that it’s not mandatory.” (Medical)* While such training may be adequate when providers use the skills regularly, for others, *“They get rusty.” “The motivation to screen comes from the positive screen who want to talk to an advocate.”*

TO SUSTAIN IMPROVEMENTS, “CHAMPIONS” OF ARE NEEDED, ALONG WITH SUFFICIENT RESOURCES, COORDINATION, AND ADMINISTRATIVE SUPPORT.

By far, the majority of respondents believed that their agencies had increased the amount of resources allocated to responding to violence against women; however, that increase may have been short-lived, at least in several agencies. As in any field, the health care and public health professions have “hot topics” that garner a great deal attention and resources for a period of time. Violence against women has been a “hot topic” within Minnesota health systems during the 1990s, exemplified by the work of the Health Care Coalition on Violence, but including many other national, state and local efforts as well. This interest, commitment and direction from national groups has clearly led many agencies in recent years to develop practice guidelines regarding violence against women, and most commonly intimate partner violence. *“Awareness has increased as individual staff have invested their own time in learning more about the issue.” (Medical)*

However, as violence against women has been replaced by “hotter” topics, the time, attention, and resources dedicated to it have decreased in some agencies. *“Over the last two years, there has been a decrease.” (Medical)* Several agencies have lost staff and supportive funding for violence work. Without the existence of a “champion” or “flag waver” to keep the issue in everyone’s minds, the work is often overlooked, or replaced with other priorities.

Getting programs going is one thing, energy is often high at the beginning of a new plan, it is that sustainability piece that is hard. Resources are required, including staff time to train and implement the intervention, and appropriate space to facilitate safe disclosure by women (Loughlin, 2000). Institutional supports are also important, such as department policy provisions, management support, and staff ownership of the intervention (McCaw, 2001). Having institutional support that translates to staff time and appropriate resources makes sustainability more feasible.

RECOMMENDATIONS

For Health Care and Public Health Practitioners During the interviews, virtually every respondent was able to identify practice guidelines relating to intimate partner violence. Guidelines related to sexual violence were far less likely to be mentioned by respondents.

It was also clear from the interviews that immigrants and non-English speakers lack adequate services. Some respondents expressed concern about the ability of smaller communities to meet the needs of Minnesota’s growing immigrant populations. *“Until fairly recently our community has been fairly white. We are seeing more and more Somali families come to live here and our services/resources have not caught up.” (Medical)*

There was also concern about the appropriateness and effectiveness of interpreter services. *“Our legal department has advised us that when an interpreter is present, screening questions are not to be asked.” (Medical)* *“Very few interpreters have training in domestic violence and sexual assault, and this makes a difference in the services that are provided. I don’t doubt that a trained medical translator can do a competent job, but there is the added aspect of violence that makes a difference.” (Medical)*

For Further Research: The purpose of this study was to begin to understand how the current practices of Minnesota’s health care and public health practitioners related to violence against women compare to national and state policies or recommendations and to researched “best practices.” With such a small, non-representative sample, it is clear that only a picture of the current reality is its result. In future research, it would be interesting to conduct a more formal survey to confirm the results of the in-depth interviews.

More information is needed about public health and health care responses in rural Minnesota. In addition, information related to the special needs of victims of violence against women in the immigrant, special needs, elderly and vulnerable populations would be helpful.

“Best Practices” research is abundant in intimate partner violence, it is sadly lacking in sexual violence. There is much done in the area of prevention, for schools and communities, but very little for health care and public health, the very place many victims and potential victims go for help.

LIMITATIONS

Because of this qualitative method, the assessment has some limitations: (1) those interviewed were recommended by others and might therefore be more knowledgeable about and committed to violence issues than a broader sampling might be, (2) more urban than rural programs were represented, (3) clients or victims of abuse were not interviewed, and (4) the interview questions do not cover the whole range of current activities, but can be seen as indicators or highlights.

CONCLUSION

Public health and health care are uniquely poised to prevent and respond to violence against women. Numerous policies and professional recommendations exist describing the value of addressing violence against women in the public health and health care fields. These are supported by researched and proven “best practices,” as well as the comments and suggestions made by interview respondents. Practitioners have access to victims and potential victims; they need only continued education, and institutional support. One-time, half-day trainings implemented by agencies with temporary goals are not sufficient. To be successful, these approaches need to be on-going and sustainable.

Based on this assessment, interviewees and other participants in a planning conference developed a strategic plan⁴ for future policies and activities. The plan provides valuable information for the state and local communities, to help create opportunities to improve the health care response to, and prevention of, violence against women. This plan can be used to guide prevention programming and implementation, policy and advocacy, treatment and research, surveillance, efforts to acquire additional funding support, and future collaboration among the professionals who respond to violence against women in Minnesota.

Minnesota is a national leader in prevention and intervention in violence against women. But there is a great deal of room for improvement. Those service providers who are doing the work are in a unique position to understand what those improvements should be. This assessment reflects their strong voices and their ideas to make a difference in the lives of victim-survivors all over the state.

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APPENDIX A

Interview Questions

Prevention of Violence Against Women Planning Supplement Interview Tennessee

Background Information and Procedures: Thank you for taking time to talk with us. The Minnesota Department of Health received a grant from the Centers for Disease Control and Prevention to do an assessment of the current efforts regarding violence against women by public health and health care in the state of Minnesota. The assessment is the first step in creating a state plan for addressing this issue. To do this assessment, we are talking with a cross-section of professional who work in health care and public health. You have been selected because of the role you play within your organization and the awareness of violence related issues you bring to your work.

Today, we would like to get your view on the current state of prevention and intervention efforts regarding violence against women at your agency. We are interested in understanding the policies regarding violence against women and as well as the actual practices that result. We are interested in the barriers your agency faces in addressing violence against women and hope to gain a clearer picture of potential ways the Minnesota Department of Health can be of assistance.

Procedures: If you agree to be in this study, we would ask you participate in a short, ten-question interview.

Confidentiality: The records of this study will be kept private. In any report published, we will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only researchers will have access to the records. In a final report, we will summarize the comments made by the people with whom we conduct interviews. If you agree to have your comments included, your name will remain anonymous in this report. We might; however, indicate what responses we received from people within certain professions, or among certain kinds of programs or facilities. While we are compiling the report, if we find that we would like to utilize your name, we will call you to make that request. You still have the option to say “no” at that point, and your comments will remain confidential.

Risks: We will be discussing violence against women and prevention methods as well as intervention methods pertaining to that subject. We are aware that this topic and these questions may be sensitive in nature.

Voluntary Nature of the Study: If you do not want to answer a particular question, just say so. If at any point you no longer want to participate please let us know and we will conclude the interview. What you share with us today will in no way impact your professional relationship with the Minnesota Department of Health. In an effort to generate the most accurate report possible, I will be taking notes as we speak.

Contacts and Questions: The researcher conducting this study is Maureen Holmes. You may ask any questions you have now. If you have questions later, you may contact Maureen at the Department of

Health. Phone: (651) 281-9871. The project coordinator, Evelyn Anderson, can be contacted at (651) 281-9870. As this is a University of Minnesota, School of Public Health graduate project, you may wish to contact Rhonda Jones-Webb at the University of Minnesota, (612) 626- 8866.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), contact Research Subjects' Advocate line, D528 Mayo, 420 Delaware Street Southeast, Minneapolis, Minnesota 55455; telephone (612) 625-1650.

Not all of our questions may be relevant to your work. We have no expectation that you will be able to comment on all of them. If you are unable to answer a question, just let us know and we'll move on. For the purposes of this discussion, we will define violence against women as physical, sexual, emotional, or psychological abuse against women age 16 and older, including older adults.

Do you have any questions before we begin?

DOMESTIC VIOLENCE AND SEXUAL ASSAULT ADVOCATES

Key Informant Interviews – Violence Against Women Project Minnesota Department of Health

INTRODUCTION Please describe the position you currently hold and the agency for whom you work. How long have you held this position?

VIOLENCE CONTRACT Please describe your agency’s relationship with hospitals and clinics in the area? In the past five years have you noted a change in those relationships? Please describe that change.

PRIMARY PREVENTION If not mentioned above, probe for prevention activities for example, health fairs.

PRACTICE GUIDELINES Are you aware of the existence of practice guidelines regarding sexual assault (such as screening techniques, prevention counseling, safety planning/referral), domestic abuse or elder abuse in the hospitals and clinics you serve? Has your agency been involved in assisting in the improvement of these kinds of practice guidelines? (Probe for details on guidelines, for example: *If screening, universal? Who does it? Where?*) In your opinion, how successful has the implementation of these guidelines been? (*If successful, why? If not successful, describe barriers.*)

SERVICE COORDINATION Are you aware of what resources are made available to women who disclose violence to a healthcare provider or public health agency (probe to find out: social worker, chaplain, translator, culturally specific services, sign interpreter, SANE nurse, private room, telephone, an advocate, etc.) Has your agency noted an increase in receipt of referrals from public health and health care organizations? What kind of agencies are referring most regularly?

EDUCATION AND TRAINING Do your agency’s staff provide training on (a) violence against women, (b) screening, (c) documentation, (d) referral sources, to staff at area clinics / hospitals? How has the content and issues addressed in training changed in the last five years?

DATA COLLECTION Are you involved with the health care or public health agencies you serve in documenting cases of violence against women? If so, have there been any changes in those processes or policies?

HEALTH PLAN COVERAGE Are you aware of any reimbursement received by your agency from health care for cases of violence against women? For example, SPIP received reimbursement from United for the services they provide.

FUNDING Do funding limitations restrict your ability to work with public health or health care organization? If so, what has not been done because of a lack of funding?

CONCLUSION What improvements do you feel should be made by public health or health care organizations to better prevent/address violence against women? How can MDH assist health care and public health agencies in making these improvements? Do you have any final comments, thoughts, or advice?

HEALTH CARE COALITION ON VIOLENCE – MEMBERS

Key Informant Interviews – Violence Against Women Project Minnesota Department of Health

Note to interviewer: Frame questions in terms of agency employed by at time of committee work. Also, add general question concerning HCCV committee work / purpose / tangible results appropriate to interviewee and the committee chaired.

Example: Data Collection and Research – What did the data collection and research committee do? Were there tangible results of the work? Describe.

INTRODUCTION Please describe the position you held while you chaired the _____ committee with the Coalition. Please briefly describe that agency’s efforts to address violence against women. Please describe the goal of the _____ committee.

VIOLENCE CONTRACT In the past five years, has there been increase or decrease in the commitment of your organization’s (the one you were employed with at the time of the HCCV) time, money, or other resources to addressing (preventing, responding to) violence against women (sexual assault, domestic violence, elder abuse)? Or has it remained about the same?

PRIMARY PREVENTION Has your agency (the one you were employed with at the time of the HCCV) participated in efforts (external or internal) aimed at preventing or responding to violence against women? For example, public information campaigns, initiatives to provide health coverage to victims. What kinds of efforts have been implemented? What have been the results of these efforts?

PRACTICE GUIDELINES Are you aware of the existence of practice guidelines regarding sexual assault, domestic abuse or elder abuse within your agency (such as screening techniques, prevention counseling, safety planning/referral)? In the past five years, has your agency been involved in the improvement of these kinds of practice guidelines. Describe the types of guidelines. (Probe for details on guidelines, for example: *If screening, universal? Who does it? Where?*) In your opinion, how successful has the implementation of these guidelines been? (*If successful, why? If not successful, describe barriers.*)

SERVICE COORDINATION What resources are made available to women who disclose violence (probe to find out: social worker, chaplain, translator, culturally specific services, sign interpreter, SANE nurse, private room, telephone, an advocate, etc.) How have these referral sources changed in the past five years? To what agencies or services *outside* your program do you make referrals?

EDUCATION AND TRAINING Are staff regularly trained and updated on (a) violence against women, (b) screening, (c) documentation, (d) referral sources? How has this training impacted the work that you do??

WORKPLACE VIOLENCE Are you aware of any initiatives to prevent or respond to workplace violence at your agency? Are there any policies regarding workplace violence at your agency? In the past five years has there been a change in the attention paid to workplace violence in your program/agency? Have your employees been offered / received any training regarding workplace violence? Have resources / referrals (posters, pamphlets, help-lines, etc.) been made available to employees who may be experiencing physical, emotional or sexual abuse in the work place or at home?

DATA COLLECTION How and what data are collected in cases of sexual assault or domestic violence? Elder abuse? Are you aware of how these data are used? Have you noted changes in the policies regarding documentation processes related to cases of violence against women? What are these changes?

HEALTH PLAN COVERAGE Does your agency receive any reimbursement from third parties for your costs in providing services. If yes, how are receiving reimbursements, from whom? What barriers are you aware of? What improvements might you suggest?

FUNDING Has funding been presented as a limitation for your agency in addressing violence against women? If so, what has not been done because of a lack of funding? Are specific funds earmarked for preventing and/or responding to violence against women? If so, from what source, and for which programs?

CONCLUSION Have you noted changes in programs other than the one you worked at that can be attributed to the work of the HCCV? In your mind, why did the work of the HCCV end? If health care, in the state of Minnesota is to move forward in better providing services to prevent and respond to violence against women, what is needed?

HEALTH PLAN ADMINISTRATORS

Key Informant Interviews – Violence Against Women Project Minnesota Department of Health

INTRODUCTION Please briefly describe your agency’s efforts to address violence against women.

VIOLENCE CONTRACT In the past five years, have you noted an increase or decrease in your organizations commitment of time, money, or other resources to addressing (preventing, responding to) violence against women (sexual assault, domestic violence, elder abuse)? Or has it remained about the same?

PRIMARY PREVENTION Has your agency participated in efforts (external or internal) aimed at preventing or responding to violence against women? For example, public information campaigns, initiatives to provide health coverage to victims. What kinds of efforts have been implemented? Has your agency collaborated with any other agencies in these efforts? Which agencies? What have been the results of these efforts?

WORKPLACE VIOLENCE Are you aware of any initiatives to prevent or respond to workplace violence at your agency? Are there any policies regarding workplace violence at your agency? In the past five years has there been a change in the attention paid to workplace violence in your program/agency? Have your employees been offered / received any training regarding workplace violence? Have resources / referrals (posters, pamphlets, help-lines, etc.) been made available to employees who may be experiencing physical, emotional or sexual abuse in the work place or at home?

DATA COLLECTION How and what data is collected in cases of sexual assault or domestic violence? Are you aware of how these data are used? Have you noted changes in the policies regarding documentation processes related to cases of violence against women? What are these changes? Does your agency collect data outside of patient visits (ex. Member surveys, etc.)?

HEALTH PLAN COVERAGE Does your agency provide reimbursement as a third party for costs in providing services to victims of violence against women. How are agencies receiving reimbursements. What barriers are you aware of? What improvements might you suggest?

FUNDING Has funding been presented as a limitation for your agency in addressing violence against women? If so, what has not been done because of a lack of funding? Are specific funds earmarked for preventing and/or responding to violence against women?

CONCLUSION What can your agency do to better prevent/address violence against women? How can MDH assist you? Do you have any final comments, thoughts, or advice?

PUBLIC HEALTH - MDH PROGRAMS (WIC, HOME-VISITING)

Key Informant Interviews – Violence Against Women Project Minnesota Department of Health

INTRODUCTION Please briefly describe your agency's efforts to address violence against women.

VIOLENCE CONTRACT In the past five years, have you noted an increase or decrease in your organizations commitment of time, money, or other resources to addressing (preventing, responding to) violence against women (sexual assault, domestic violence, elder abuse)? Or has it remained about the same?

PRIMARY PREVENTION Has your agency participated in efforts (external or internal) aimed at preventing or responding to violence against women? For example, public information campaigns, initiatives to provide health coverage to victims. What kinds of efforts have been implemented? Has your agency collaborated with any other agencies in these efforts? Which agencies? What have been the results of these efforts?

PRACTICE GUIDELINES Are you aware of the existence of practice guidelines regarding sexual assault, domestic abuse or elder abuse within your program, such as screening techniques, prevention counseling, safety planning/referral? Please describe these guidelines. (*Probe for details on guidelines, for example: If screening, universal? Who does it? Where?*) How have these guidelines changed in the past five years? In your opinion, how successful has the implementation of these guidelines been? (*If successful, why? If not successful, describe barriers.*)

SERVICE COORDINATION What resources are made available to women who disclose violence (probe to find out: social worker, chaplain, translator, culturally specific services, sign interpreter, SANE nurse, private room, telephone, an advocate, etc.) How have these resources changed in the past five years? To what agencies or services *outside* your program do you make referrals?

EDUCATION AND TRAINING Are staff regularly trained and updated on (a) violence against women, (b) screening, (c) documentation, (d) referral sources? How has this training impacted the work that you do??

WORKPLACE VIOLENCE Are you aware of any initiatives to prevent or respond to workplace violence at your agency? Are there any policies regarding workplace violence at your agency? In the past five years has there been a change in the attention paid to workplace violence in your program/agency? Have your employees been offered / received any training regarding workplace violence? Have resources / referrals (posters, pamphlets, help-lines, etc.) been made available to employees who may be experiencing physical, emotional or sexual abuse in the work place or at home?

DATA COLLECTION How and what data are collected in cases of sexual assault or domestic violence? Elder abuse? Are you aware of how these data are used? Have you noted changes in the policies regarding documentation processes related to cases of violence against women? What are these changes?

HEALTH PLAN COVERAGE Does your agency receive any reimbursement from third parties for your costs in providing services. If yes, how are receiving reimbursements, from whom? What barriers are you aware of? What improvements might you suggest?

FUNDING Has funding been presented as a limitation for your agency in addressing violence against women? If so, what has not been done because of a lack of funding? Are specific funds earmarked for preventing and/or responding to violence against women? If so, from what source, and for which programs?

CONCLUSION What can your agency do to better prevent/address violence against women? Do you have any final comments, thoughts, or advice?

MEDICAL PRACTITIONERS

Key Informant Interviews – Violence Against Women Project Minnesota Department of Health

INTRODUCTION Please briefly describe your agency's efforts to address violence against women.

VIOLENCE CONTRACT In the past five years, have you noted an increase or decrease in your organizations commitment of time, money, or other resources to prevent or respond to violence against women (sexual assault, domestic violence, elder abuse)? Or has it remained about the same?

PRIMARY PREVENTION Has your agency participated in efforts (external or internal) aimed at preventing or responding to violence against women? For example, public information campaigns, initiatives to provide health coverage to victims. What kinds of efforts have been implemented? Has your agency collaborated with any other agencies in these efforts? Which agencies? What have been the results of these efforts?

PRACTICE GUIDELINES Are you aware of the existence of practice guidelines regarding sexual assault, domestic abuse or elder abuse within your agency, such as screening techniques, prevention counseling, safety planning/referral? Please describe these guidelines. (*Probe for details on guidelines, for example: If screening, universal? Who does it? Where?*) How have these guidelines changed in the past five years? In your opinion, how successful has the implementation of these guidelines been? (*If successful, why? If not successful, describe barriers.*)

SERVICE COORDINATION What resources are made available to women (non-employees) who disclose violence (probe to find out: social worker, chaplain, translator, culturally specific services, sign interpreter, SANE nurse, private room, telephone, an advocate, etc.) How have these resources changed in the past five years? To what agencies or services *outside* your program do you make referrals?

EDUCATION AND TRAINING Are staff regularly trained and updated on (a) issues relating to violence against women, (b) screening, (c) documentation, (d) referral sources? In what ways? How often? How do you believe this training (or lack of) has impacted the work that you do?

WORKPLACE VIOLENCE Are you aware of any initiatives to prevent or respond to workplace violence at your agency? Are there any policies regarding workplace violence at your agency? In the past five years has there been a change in the attention paid to workplace violence in your program/agency? Have your employees been offered / received any training regarding workplace violence? Have resources / referrals (posters, pamphlets, help-lines, etc.) been made available to employees who may be experiencing physical, emotional or sexual abuse in the work place or at home?

DATA COLLECTION How and what data is collected in cases of sexual assault or domestic violence? Elder abuse? Are you aware of how these data are used? Have you noted changes in the policies regarding documentation processes related to cases of violence against women? What are these changes? Does your agency collect data outside of patient visits (ex. Member surveys, etc.)?

HEALTH PLAN COVERAGE Does your agency receive any reimbursement from third parties for your costs in providing services such as screening, prevention counseling, safety planning/referral? If yes, how do you receive reimbursements, and from whom? What barriers are you aware of? What improvements might you suggest?

FUNDING Has funding been presented as a limitation for your agency in addressing violence against women? If so, what has not been done because of a lack of funding? Are specific funds earmarked for preventing and/or responding to violence against women? If so, from what source, and for which programs? Do you have any suggestions to pursue for future funding of violence against women prevention and intervention?

CONCLUSION What can your agency do to better prevent/address violence against women? How can MDH assist you? Do you have any final comments, thoughts, or advice?

PUBLIC HEALTH PRACTITIONERS (MDH AND LOCAL PUBLIC HEALTH)

Key Informant Interviews – Violence Against Women Project Minnesota Department of Health

INTRODUCTION Please briefly describe your agency's efforts to address violence against women.

VIOLENCE CONTRACT In the past five years, have you noted an increase or decrease in your organizations commitment of time, money, or other resources to addressing (preventing, responding to) violence against women (sexual assault, domestic violence, elder abuse)? Or has it remained about the same?

PRIMARY PREVENTION Has your agency participated in efforts (external or internal) aimed at preventing or responding to violence against women? For example, public information campaigns, initiatives to provide health coverage to victims. What kinds of efforts have been implemented? Has your agency collaborated with any other agencies in these efforts? Which agencies? What have been the results of these efforts?

PRACTICE GUIDELINES Are you aware of the existence of practice guidelines regarding sexual assault, domestic abuse or elder abuse within your agency, such as screening techniques, prevention counseling, safety planning/referral? Please describe these guidelines. (*Probe for details on guidelines, for example: If screening, universal? Who does it? Where?*) How have these guidelines changed in the past five years? In your opinion, how successful has the implementation of these guidelines been? (*If successful, why? If not successful, describe barriers.*)

SERVICE COORDINATION What resources are made available to women who disclose violence (probe to find out: social worker, chaplain, translator, culturally specific services, sign interpreter, SANE nurse, private room, telephone, an advocate, etc.) How have these resources changed in the past five years? To what agencies or services *outside* your program do you make referrals?

EDUCATION AND TRAINING Are staff regularly trained and updated on (a) violence against women, (b) screening, (c) documentation, (d) referral sources? How has this training impacted the work that you do??

WORKPLACE VIOLENCE Are you aware of any initiatives to prevent or respond to workplace violence at your agency? Are there any policies regarding workplace violence at your agency? In the past five years has there been a change in the attention paid to workplace violence in your program/agency? Have your employees been offered / received any training regarding workplace violence? Have resources / referrals (posters, pamphlets, help-lines, etc.) been made available to employees who may be experiencing physical, emotional or sexual abuse in the work place or at home?

DATA COLLECTION How and what data are collected in cases of sexual assault or domestic violence? Elder abuse? Are you aware of how these data are used? Have you noted changes in the policies regarding documentation processes related to cases of violence against women? What are these changes?

HEALTH PLAN COVERAGE Does your agency receive any reimbursement from third parties for your costs in providing services. If yes, how are receiving reimbursements, from whom? What barriers are you aware of? What improvements might you suggest?

FUNDING Has funding been presented as a limitation for your agency in addressing violence against women? If so, what has not been done because of a lack of funding? Are specific funds earmarked for preventing and/or responding to violence against women? If so, from what source, and for which programs?

CONCLUSION What can your agency do to better prevent/address violence against women? Do you have any final comments, thoughts, or advice?

APPENDIX B

RESOURCES

PRINT RESOURCES

VIOLENCE AGAINST WOMEN – GENERAL

Advocacy in a Coordinated Community Response: Overview and Highlights of Three Programs

Author: Rose Thelen, Gender Violence Institute, for Battered Women’s Justice Project Description: Gives an overview of individual and systems advocacy and describes them as an integral part of community response, working collectively in enabling battered women to overcome obstacles. Published or Added Date: 6/8/2000 Available from the Violence Against Women Office at <http://www.vaw.umn.edu/mp.asp>.

Assessing Justice System Response To Violence Against Women: A Tool for Communities to Develop Coordinated Responses

Author: STOP-TA Project’s Promising Practices Initiative in Washington DC Description: Profiles 13 communities that have undertaken efforts to reduce and prevent violence against women. The communities have developed a coordinated criminal justice response while maintaining a focus on victim safety and offender accountability. Published or Added Date: 6/8/2000. Available from the Violence Against Women Office at <http://www.vaw.umn.edu/mp.asp>.

Assessing Justice System Response To Violence Against Women: A Tool for Law Enforcement, Prosecution, and Courts

Author: STOP-TA Project’s Promising Practices Initiative in Washington DC. Contains an assessment tool for jurisdictions to use in developing effective responses by law enforcement, prosecution, and the courts. Published or Added Date: 6/8/2000 Available from the Violence Against Women Office at <http://www.vaw.umn.edu/mp.asp>.

Assessing Justice System Response To Violence Against Women

Author: STOP-TA Project’s Promising Practices Initiative, Washington DC. Contains profiles of 17 non-profit victim advocacy organizations around the nation. The profiles highlight innovative outreach and service delivery strategies that address the needs of victims of sexual assault, stalking, and domestic violence. Published or Added Date: 6/8/2000 Available from the Violence Against Women Office at <http://www.vaw.umn.edu/mp.asp>.

Intimate Partner Violence and Sexual Assault: A Guide to Training Materials and Programs for Health Care Providers National Center for Injury Prevention and Control, 1998. <http://www.cdc.gov/ncipc/pub-res/ipvasa.htm>

Measuring Violence – Related Attitudes, Beliefs, and Behaviors Among Youths: A Compendium of Assessment Tools

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, Atlanta Georgia. 1998. www.cdc.gov/ncipc/pub-res/measure.htm This Compendium provides researchers and prevention specialists with a set of more than 100 tools for evaluating programs to prevent youth violence. Measures are intended for use with youth ages 11-20, to assess factors such as attitudes toward

violence, aggressive behavior, conflict resolution strategies, self-esteem, self-efficacy, and exposure to violence.

Promising Practices: Assessing the Justice System Response to Violence Against Women (A Tool for Communities to Develop Coordinated Responses) Author: Kristin Littel, M.A. Mary B. Malefyt, J.D. Alexandra H. Walker Description: Profiles 13 communities that have undertaken efforts to reduce and prevent violence against women. The communities have developed a coordinated criminal justice response while maintaining a focus on victim safety and offender accountability. Published or Added Date: 8/20/98 Available from the Violence Against Women Office at <http://www.vaw.umn.edu/mp.asp>.

Promising Practices: Law Enforcement, Prosecution and the Courts Author: Kristin Littel, M.A. Mary B. Malefyt, Esq. Alexandra Walker Deborah D. Tucker, M.P.A. Sarah M. Buel, J.D. Description: In anticipation of the publication of the Promising Practices Manual, the Violence Against Women Office released this assessment tool for jurisdictions to use in developing effective responses by law enforcement, prosecution, and the courts. Published or Added Date: 4/21/98 Available from the Violence Against Women Office at <http://www.vaw.umn.edu/mp.asp>.

Promising Practices: Victim-Service Providers Author: Mary B. Malefyt, J.D., Alexandra H. Walker, STOP-TA Project's Promising Practices Initiative. The document contains profiles of 17 non-profit victim advocacy organizations around the nation. The profiles highlight innovative outreach and service delivery strategies that address the needs of victims of sexual assault, stalking and domestic violence. Published or Added Date: 5/27/98 Available from the Violence Against Women Office at <http://www.vaw.umn.edu/mp.asp>.

Responding to Domestic Violence: Public Health Nurses Created by the Domestic Abuse Intervention Project and St. Louis County Health Department, in Duluth Minnesota, these materials are a guide to assist public health nurses as they work with women and children who are potential victims of violence against women. The materials include introductory information about the dynamics of domestic abuse and a step-by-step protocol to identify and intervene. For further information, contact the Domestic Abuse Intervention Project at 202 East superior Street, Duluth, MN 55802. 218/722-2781

The Sexual Victimization of College Women Fisher, B., Cullen, F., Turner, M. National Institute of Justice, Bureau of Justice Statistics. Report includes important data about the prevalence and nature of violence against college women.

Sourcebook on Violence Against Women Renzetti, C., Eflson, J., Kennedy Bergen, R. Sage 2000. www.sagepub.com Examines the theoretical and methodological issues in research, types of violence, prevention and direct intervention, and continuing and emerging issues on domestic and international public policy. Chapters include: Measurement Issues for Violence Against Women; Collaborating for Women's Safety, Partnerships between Research and Practice; From Prevalence to Prevention, Closing the Gap Between What We Know About Rape and What We Do; From Crisis Intervention to Complex Social Prevention; Getting the Message Out, Using the Media to Change Social Norms on Abuse.

Toolkit to End Violence Against Women National Advisory Council on Violence Against Women [http://toolkit.ncjrs.org/](http://toolkit.ncjrs.org) Provides concrete guidance to communities, policy leaders, and individuals engaged in activities to end violence against women. The recommendations were reviewed by experts in the fields of

sexual assault, domestic violence, and stalking. Chapters include: Community-Based Services; Children and Youth; Health and Mental Health Care; Educating the Public; Civil Remedies; The Media and Entertainment Industries; Criminal Remedies; Faith-Based Groups and Organizations; Additional Justice System Responses; Sports; Economic Security; Native Women; College and University Campuses; The U.S. Military; The Workplace; The International Community

VAWnet Applied Research Documents www.vawnet.org/VNL/applied

The Applied Research Forum has commissioned researchers and advocate to create brief summaries and interpretations of current research on violence against women. Document topics and authors are selected based on feedback from VAWnet project participants and the Applied Research Advisory Group.

Violence Against Women in the African American Community – Bibliography Institute on Domestic Violence in the African American Community www.dvinstitute.org/VAW.htm. Bibliography includes books, articles, and other documents related to domestic violence in the African American Community.

Violence Against Women, Changing Clinical Practice and Public Policy American Journal of Preventative Medicine. Vol 19, November 2000, Number 4. Special issue on violence against women, topics include: dating violence and rape, violence against women: legal and public policy perspective.

Violence Against Women in the Latino Community – Bibliography National Latino Alliance for the Elimination of Domestic Violence www.dvalianza.org/bibliography.htm
20-page bibliography includes books and articles related to domestic violence among Latinos.

Violence and Teen Pregnancy: A Resource Guide For MCH Practitioners This guide is primarily directed at maternal and child health professionals – providers of health services, both directly and indirectly, to mothers, children, and adolescents. Domestic violence practitioners, youth workers and others with an interest in adolescent health, pregnancy prevention, and violence prevention should also find it useful. Copies of this guide can be purchased for \$10 each, plus \$3 shipping by sending a check payable to Education Development Center, Inc., to: Michelle Stober, Children’s Safety Network Education Development Center, Inc. 55 Chapel Street, Newton, MA 02158-1060. Phone 617/969-7100, ext. 2207.

INTIMATE PARTNER VIOLENCE / DOMESTIC VIOLENCE

Abuse During Pregnancy: A Protocol for Prevention and Intervention, 2nd Edition March of Dimes Nursing Modules (2001) Judith McFarlane, DrPH, RN, Barbara Parker, RN, PhD, FAAN, Barbara Cross, MN, RN, FNP http://www.modimes.org/Programs2/ProfEd/module_1st.htm Presents research documentation and clinical protocols designed to enable health care providers to prevent abuse, interrupt existing abuse, and protect the safety and well-being of pregnant women. Includes vignettes written from the perspective of abused pregnant women as well as from their health care providers.

Best Practices: Innovative Domestic Violence Programs in Health Care Settings In Boston, Massachusetts, the child abuse program at Children’s Hospital includes support and advocacy for battered women; in Minnesota hospitals, doctors wear buttons that read, “It’s OK to talk to me about family violence and abuse”; and in Pittsburgh, Pennsylvania, Mercy Hospital has an on-site apartment available for domestic violence victims when shelters are full. These initiatives are among the health care based domestic violence

projects profiled in *Best Practices: Innovative Domestic Violence Programs in Health Care Settings*. *Best Practices* was written for health care and domestic violence professionals looking for replicable models representing new and creative ways to strengthen the health care response to domestic violence. The *Best Practices* guide also includes: A historical overview of the health care response to domestic violence A step by step description of how to set up a clinic or hospital based domestic violence response program Useful contact information, as well as ordering information for training curricula, resource materials, and patient and provider education materials. Available from the Family Violence Prevention Fund, 383 Rhode Island Street, Suite 304, San Francisco, CA 94103-5133. www.fvpf.org ordering@fvpf.org

Coordinated Community Responses to Domestic Violence: Lessons from Duluth and Beyond

Editors: Shepard, M.: University of Minnesota, Duluth, Pence, E.: Domestic Abuse Intervention Project, Duluth. Sage Publishing, 1999. The “Duluth Model” is a widely disseminated approach to community-based intervention in domestic violence. This volume examines how to develop a response to domestic violence using the Model. Key issues addressed include: enhancing networking among service providers; providing sanctions and rehabilitation opportunities; addressing the needs of children; and evaluating the effectiveness of community response. Information and materials available at <http://www.duluth-model.org/npcatl.htm>.

Domestic Violence: A Directory of Protocols for Health Care Providers Children’s Safety Network, 1993. Contains 25 protocols from across the county for health care providers in clinical settings as well as emergency medical services. Protocol address domestic violence, youth violence, as well as elder abuse. Available from the Children’s Safety Network, Education Development Center, 55 Chapel Street, Newton, Massachusetts, 02160.

Domestic Violence and Health Care What Every Professional Needs To Know Schornstein, S.

US Department of Justice, Washington DC Published By: Sage Publications, Inc www.sagepub.com Of all women battered by their intimate partners each year, only a small percentage are correctly diagnosed as victims of abuse. The medical community has a unique opportunity to intervene, but many health care professionals need more training to recognize the abuse, tools to intervene, and information on where to refer victims for additional assistance. Comprehensive yet easy to delve into, *Domestic Violence and Health Care* helps practitioners treat those seeking help after a violent episode. Author Sherri L. Schornstein, a career prosecutor experienced both on the front lines and at the systems level in Washington, DC, dispels common myths about domestic violence and skillfully takes the reader through practical, how-to steps in the examination process. Examples and insights provide vital information regarding the impact that examination and documentation may have upon a subsequent prosecution of the batterer, while sample questions and forms assist the examiner in recording the most accurate information possible. This essential volume also explores safety issues for everyone at a health care facility who deals with such cases. *Domestic Violence and Health Care* alerts health care professionals to the signs of abuse and helps prepare them to deal sensitively and appropriately with the needs of victims. This timely book is recommended for all medical personnel as well as professionals and practitioners in the fields of mental health, substance abuse, victim advocacy, criminal justice, hospital administration, public health, and law enforcement. As a text, *Domestic Violence and Health Care* works as an excellent supplement for courses in medicine, nursing, social work, and for CME/CE credit workshops.

Domestic Violence Awareness: Tips, Tactics & Resources The Domestic Violence Awareness Project & the National Resource Center of Domestic Violence. Harrisburg, Pennsylvania, 2001.

www.vawnwt.org/vnl/library/general This manual provides advocates with adaptable tools and resources to create successful public awareness campaigns or events that reach broad and diverse audiences. It included information to help advocates communicate more effectively through the media and promote a unified theme.

Ending Domestic Violence: Changing Public Perceptions / Halting the Epidemic Liein, E., Cambell, J., Soler, E., Ghez, M. Thousand Oaks, CA. Sage Publishing, 1997

Based on public opinion surveys, the authors examine current public perception of the problem, interventions and the dramatic shifts that have occurred in recent years. To better understand the role of cultural context, three experts, each a person of color herself, were invited to collaborate on a chapter detailing the results from their research in to African American, Latino and Asian American populations.

Establishing LA VIDA: A Community-Based Partnership to Prevent Intimate Partner Violence Against Latina Women Maciak, B. 1999. *Health Education and Behavior* 26; 821-840. Article describes the process of mobilizing diverse organizations, conducting community diagnosis and needs assessment activities, establishing goals and objectives within a social ecological framework, and integrating evaluation during the development phase.

Evaluating Services for Survivors of Domestic Violence and Sexual Assault SAGE Series on Violence Against Women Riger, S., Bennett, L., Wasco, S., Schewe, P., Frohmann, L., Camacho, J., Campbell, R. National Association of Social Workers, National Coalition Against Domestic Violence. www.sagepub.com Chapters include: The Evolution of the Violence Against Women Social Movement and Services for Victims; Collaboration in Evaluation Research; Why Evaluate?; Basic Concepts in Evaluation; Using Evaluation Results; Lessons Learned in Evaluating Domestic Violence and Sexual Assault Services.

Future Interventions with Battered Women and Their Families SAGE Series on Violence against Women Edleson, J., Eisikovits, Z. www.sagepub.com The innovative character of the battered women's movement is evident in countries around the world. Providing an integrated and balanced view of the many facets of this international problem, Future Interventions with Battered Women and Their Families critically examines the progress made and assesses the strategies for the future. This much-needed volume addresses the surge of efforts in the battered women's movement while challenging the reader to reflect, assimilate, and take action. An outstanding group of experts from around the globe studies important features of the movement, including --the way in which different societies define the problem --global organizing efforts to end violence against women --innovative strategies to organize informal social networks --new interventions to assist victims/survivors, perpetrators, and their children --practice research that informs intervention Future Interventions with Battered Women and Their Families provides diverse perspectives and directions for the movement that will influence a wide range of professionals serving battered women and their families, including medical and mental health professionals, battered women's advocates, legal and law enforcement professionals, policymakers, and students in social work, psychology, counseling psychology, and women's studies.

It Could Happen To Anyone: Why Battered Women Stay LaViolette, A., Barnett, O. Published By: Sage Publications, Inc www.sagepub.com Based on sound research and accessibly written, this second edition of the widely read and highly praised It Could Happen to Anyone offers all readers a unique amalgamation of the practical clinical experience of Alyce LaViolette and the extensive research efforts of

Ola Barnett on battered women and their batterers. This second edition includes a wealth of new material and case examples, and retained sections have been carefully rewritten to reflect contemporary thinking. It continues to provide understanding and empathy regarding this complex issue and presents an integrated learning theory explanation of the conditioning that culminates in wife abuse, in the resulting state of the victim, and in the decision to stay with an abuser. This extensively revised and expanded new edition, like the widely acclaimed original book, is a must read for anyone working in or training to work in the field of domestic violence.

Improving the Health Care Response to Domestic Violence, Includes A Resource Manual for Health Care Providers Authors: Carole Warshaw, M.D. and Anne L. Ganley, Ph.D. and, A Trainer's Manual for Health Care Providers Author: Anne Ganley, Ph.D. Contributing authors: Ariella Hyman, J.D., Anita Ruiz Contreras and John Fazio Health care practitioners and domestic violence experts who want to implement a comprehensive response to domestic violence now have two powerful tools available to them. The Family Violence Prevention FVPF's Resource Manual and Trainer's Manual give health care providers in all settings the information, tools and ideas they need to provide battered women with the care they need to get well and stay safe. www.fvpf.org.

Making the Peace: An Approach to Preventing Relationship Violence Among Youth National Resource Center on Domestic Violence, Harrisburg, Pennsylvania, 2000. Comprehensive curriculum, training and organizing program designed to prevent male-to-female family and dating violence among youth ages 14-19. Includes organizers' manual, teachers' guide, 15-session curriculum and handout packages for educators, administrators and family-violence community-based organizations on preventing family/relationship violence in an entire school district. Available by contacting <http://www.kdva.org/MakingthePeace.html>.

Preventing Domestic Violence: Clinical Guidelines on Routine Screening Family Violence Prevention Fund, 1999 <http://endabuse.org/programs/display.php3?DocID=31> Includes a discussion of screening policies, including specific questions to ask, who to ask and where to ask. This is the first national, multi-specialty, comprehensive routine screening document on domestic violence. In addition to specific guidelines for primary care, ob-gyn, family planning, urgent care, mental health, and inpatient settings, Preventing Domestic Violence includes an extensive bibliography, documentation forms, and other useful materials.

Practice Enhancement Project: Public Health Nursing Practice Guidelines for the Prevention of Violence Against Women and Children Project of the Minnesota Department of Health, Public Health Nursing. Available by contacting Sue Strohschein, Public Health Nurse Consultant, 651/296-9581.

Responding to Domestic Violence: Public Health Nurses Created by the Domestic Violence Intervention Project, Duluth, Minnesota. 206 West 4th Street, Duluth, Minnesota 55806. 218/722-2781, xt.120. Handbook contains discussion of dynamics of domestic violence, and a protocol for screening and assessing for public health nurses.

Workplace Domestic Violence Manual Montgomery Work-Life Alliance Rockville, Maryland alliance@mhamc.org An employer manual to help companies develop a safety policy that recognizes the potential for domestic violence in the workplace. Manual includes: sample company policy, role of the company, and a chapter on personalized safety plans.

SEXUAL ASSAULT

Averting the Campus Date Rape Drug Crisis: Seven Solutions for Colleges, Law Enforcement and Medical Professionals Final Report of the Emergency Campus Summit on Date Rape Drugs, Illinois Attorney General Jim Ryan, Springfield, Illinois. 1999. www.ag.state.il.us Guidelines for law enforcement, campus, and medical response to sexual assault reports. Information on how to implement a community task force, campus education tools, and prevention education training modules for students, police training, and legislative recommendations.

Carver County Needs Assessment Report *A report of the Carver County Sexual Assault Interagency Council* August 1998 Carver County Sexual Assault Interagency Council (SAIC) c/o Sexual Violence Center 510 Chestnut Street North, Suite 204 Chaska, MN 55301 612/448-5425. Developed as a beginning step in the process of creating a multi-disciplinary, victim-centered response to victims of sexual assault in Carver County. Contains in-depth examination of resources available to victims of sexual assault in the County.

Carver County Adult Sexual Assault Response Protocol August 1999 Carver County Sexual Assault Interagency Council (SAIC) c/o Sexual Violence Center 510 Chestnut Street North, Suite 204 Chaska, MN 55301 612/448-5425. A multi-disciplinary, victim centered sexual assault protocol. Contains step-by-step protocol for Advocacy, Law Enforcement, Medical and Prosecution as well as specifics on available community resources.

Family Violence Handbook for the Dental Community Health Canada, National Clearinghouse on Family Violence Health Promotion and Programs Branch 613/957-2938. Manual deals with how dental professionals should address the issue of family violence in their professional practice, in educational settings, during discussions at professional conferences and in the community at large.

Fond du Lac Reservation Community Needs Assessment Report: *A report of the Fond du Lac Sexual Assault Protocol Interagency Council* June 2001 Fond du Lac Sexual Assault Protocol Interagency Council (SAPIC) c/o Min No Aya Win Clinic 927 Trettel Lane Cloquet, MN 55720 218/879-1227, ext. 252. Developed as a beginning step in the process of creating a multi-disciplinary, victim-centered response to victims of sexual assault on Fond du Lac Reservation. Contains in-depth examination of resources available to victims of sexual assault on the Reservation.

Isanti County Needs Assessment Report *A report of the Isanti County Sexual Assault Interagency Council* August 1998 Isanti County Sexual Assault Interagency Council (SAIC) c/o Isanti County Government Center 555 18th Avenue SW Cambridge, MN 55008 612/689-2253. Developed as a beginning step in the process of creating a multi-disciplinary, victim-centered response to victims of sexual assault in Isanti County. Contains in-depth examination of resources available to victims of sexual assault in the County.

Isanti County Adult Sexual Assault Response Protocol August 1999 Isanti County Sexual Assault Interagency Council (SAIC) c/o Isanti County Government Center 555 18th Avenue SW Cambridge, MN 55008 612/689-2253. A multi-disciplinary, victim centered sexual assault protocol. Contains step-by-step protocol for Advocacy, Law Enforcement, Medical and Prosecution as well as specifics on available community resources.

Olmsted County Needs Assessment Report *A report of the Olmsted County Sexual Assault Interagency Council* June 2000 Olmsted County Sexual Assault Interagency Council (SAIC) Law Enforcement Center 101 4th Street, Rochester, MN 55904 507/287-2338. Developed as a beginning step in the process of creating a multi-disciplinary, victim-centered response to victims of sexual assault in Olmsted County. Contains in-depth examination of resources available to victims of sexual assault in the County.

Olmsted County Adult Sexual Assault Response Protocol August 2001 Olmsted County Sexual Assault Interagency Council (SAIC) Law Enforcement Center 101 4th Street, Rochester, MN 55904 507/287-2338. A multi-disciplinary, victim centered sexual assault protocol. Contains step-by-step protocol for Advocacy, Law Enforcement, Medical and Prosecution as well as specifics on available community resources.

Paper Dolls and Paper Airplanes: Therapeutic Exercises for Sexually Traumatized Children Geri Crisci, Marilyn Lay and Lianna Lowenstein (1997) ETR Network PO Box 1830 Santa Cruz, CA 95061-1830 408/438-4060. Model addresses both treatment and prevention; components include defining sexual abuse, family and community relationships, identifying and coping with dealings, secrets, post-disclosure experiences, documenting sexual abuse, responsibility, offenders, triggers, sexuality and personal safety.

A Place to Start: A Resource Kit for Prevention Sexual Violence Sexual Violence Prevention Program, Division of Family Health, Minnesota Department of Health, PO Box 64882 St. Paul, MN 55164-0882 651/215-8954. Materials developed and gathered (Information, Strategies and Tools) for use in community education, public awareness events, community notification meetings, support groups, lobbying efforts, and others. Kit is also available at <http://www.health.state.mn.us/svprevent>.

Ramsey County Needs Assessment Report *A report of the Ramsey County Sexual Assault Protocol Team* June 2000 Ramsey County Sexual Assault Protocol Team (SAPT) c/o Sexual Offense Services of Ramsey County 1619 Dayton Avenue, Suite 201 St. Paul, MN 55104 651/643-3017. Developed as a beginning step in the process of creating a multi-disciplinary, victim-centered response to victims of sexual assault in Ramsey County. Contains in-depth examination of resources available to victims of sexual assault in the County.

Ramsey County Adult Sexual Assault Response Protocol June 2001 Ramsey County Sexual Assault Protocol Team (SAPT) c/o Sexual Offense Services of Ramsey County 1619 Dayton Avenue, Suite 201 St. Paul, MN 55104 651/643-3017. A multi-disciplinary, victim centered sexual assault protocol. Contains step-by-step protocol for Advocacy, Corrections, Law Enforcement, Medical and Prosecution as well as specifics on Cultural Competency and available community resources.

The Response to Sexual Assault: Removing Barriers to Services and Justice Michigan Sexual Assault Systems Response Task Force, Okemos, MI. 517/347-7000. 2001. Report includes sections of sexual assault prevention education, survivor services, the medical system, and the criminal justice system.

Responding to Sexual Assault Survivors: A Training Manual for EMS Texas Department of Health, Texas Office of the Attorney General, PO Box 12548 Austin, TX 78711 512/936-1270. Manual designed to educate emergency medical professionals on how to assist sexual assault survivors, during the first stage of healing. Contains information of sexual assault, a guide for talking to survivors, information on documentation and treatment and information in the criminal justice system.

SART / SANE (*Sexual Assault Response Team / Sexual Assault Nurse Examiner*) Orientation Guide

Forensic Nursing Services, PO Box 2515 Santa Cruz, CA 95063-2512 408/465-9826. Guide designed to assist organizations in developing community-based, multi-disciplinary sexual assault response team and sexual assault nurse-examiner programs. Includes recommendations on how to introduce these programs to community leaders, as well as information, which allows the user to tailor the program to meet individual community needs.

Sexual Assault Prevention Resource Manual Stringer, G. Washington Coalition of Sexual Assault, Sexual Assault Prevention Resource Center, Olympia Washington. 2000. www.wcsap.org Informational resource guide for programs and individuals seeking to create a sexual assault prevention program utilizing a community development model. Contains theoretical information and practical tools for use by program planners, as well as articles of interest related to various aspects of prevention and community development.

Sexual Violence Prevention: A Catalog of Educational Materials JSI Research and Training Institute and the Massachusetts Coalition Against Sexual Assault, 2000. www.vawnet.org The purpose of this catalog of educational materials is to provide a resource for programs to efficiently enhance their sexual assault prevention and education efforts in a variety of ways.

A Vision to End Sexual Assault CALCASA Strategies Forum, California Coalition Against Sexual Assault, Sacramento, CA, March 2001. www.calcasa.org Report includes recommendations and strategies to be used by organizations working to prevent sexual assault in California. It is a framework for action to be used by those individuals and agencies with the resources and the initiative to bring about change.

Winona County Needs Assessment Report *A report of the Winona County Sexual Assault Interagency Council* August 1998 Winona County Sexual Assault Interagency Council (SAIC) 171 West Third Street Winona, MN 55987 507/457-6310. Developed as a beginning step in the process of creating a multi-disciplinary, victim-centered response to victims of sexual assault in Winona County. Contains in-depth examination of resources available to victims of sexual assault in the County.

Winona County Adult Sexual Assault Response Protocol August 1999 Winona County Sexual Assault Interagency Council (SAIC) 171 West Third Street Winona, MN 55987 507/457-6310. A multi-disciplinary, victim centered sexual assault protocol. Contains step-by-step protocol for Advocacy, Law Enforcement, Medical and Prosecution as well as specifics on available community resources.

WORLD WIDE WEB SITES

MEDICAL SITES

www.mnadvocates.org

This agency works to improve the lives of women by using int'l human rights standards.

http://www.opdv.state.ny.us/coordination/model_policy/frames.html

This is an extensive screening protocol from Columbia-Presbyterian Medical Center's CPMCnet in New York City. Clinicians should be alert to the various presentations of child abuse, spouse and partner abuse, and elder abuse. (032200)(ca, elderv) model domestic violence policies for NY counties. Contains 3 "health care" sections: victim safety and self-determination; abuser accountability; and system's responsibility.

<http://police.sdsu.edu/CLEW/Trn/DVDRAFT398.html>

This is online and contains 42 pages of information including 911 operator/dispatcher response, patrol officer response/investigation, follow-up investigation, sexual assault investigations, same-sex assault investigations, investigating stalking cases, domestic violence and child witnesses, Federal domestic violence laws and their enforcement, and much more. (092998, 042700)(law)

http://www.feminist.org/gateway/vs_exec2.html

This page offers an extensive list of electronic links regarding violence against women, emotional abuse, research, stalking, shelters, and services. It is a subsection of Feminist Majority Foundation's extensive Web-site. (030900)(survivor, servprov)

<http://www.vaw.umn.edu/Documents/faith.htm>

This is a brochure by The Center for Prevention of Sexual Assault and Domestic Violence, An Interreligious and Educational Ministry, posted on the Violence Against Women Online Resources (VAWOR) website. This brochure on domestic violence is designed to provide information to clergy, members of the congregation, battered women's programs, and human service providers. (113099) (rel)

<http://www.welfareinfo.org/domestic.htm>

This site contains a state by state list (inc 12 states) of what's going on, as well as links to other involved organizations.

<http://www.eastside.net/edvp/aboutedvp.htm#top>

In 1996, EDVP provided education and training on domestic violence to 13,867 individuals, including employers, law enforcement personnel and health care and human service providers. Recent outreach and community education efforts have included:

Local police trainings and roll call updates on the law, Medical training, Legal training, Business training - "When Domestic Violence Goes to Work", Human Service providers.

<http://www.vaw.umn.edu/Promise/Vicsvcs.htm#167>

A Tool for Community-Based Victim Service Programs Developing Effective Responses

A Product of the Promising Practices Initiative of the STOP Violence Against Women Grants Technical Assistance Project. Responses to Violence Against Women By Victim Service Provider, also has hyper-links to state programs.

<http://www.puget-sound.med.va.gov/nursing/outreach/outreach.html>

site is an advertisement for “screening days,” where domestic violence is just one of many things participants will / can be screened for.

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

The Minnesota Center Against Violence and Abuse, University of Minnesota, St Paul, is one of the most useful Web sources for information about domestic violence, child abuse, elder abuse, same-sex abuse, human rights abuse, violence in the workplace, men’s issues, school violence, violence in the religious community, media violence, and teen and gang violence. It includes extensive bibliographies, course curricula and training resources, news groups and discussion lists, legal reports, scholarly papers, funding agencies, and written exercises, with links to many of these sites.

<http://www.family.mcw.edu/ahec/ec/medviol.html>

This site, maintained by the Medical College of Wisconsin, provides clinical protocols for screening, interviews, intervention options, and suggestions for working with victims of partner violence. It also suggests proper methods of “SOAP” note documentation and patient safety assessments, and includes discussion rooms concerning issues related to domestic violence, primarily for health care providers but so open to survivors.

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

The Family Violence Prevention Fund is a national, nonprofit organization that focuses on domestic violence education, prevention, and public policy reform. Much of its information is health care oriented; the site includes basic information about domestic violence, updates on health care and legal initiatives, information about the organization’s national health initiative, survivors’ stories, and innovative programs across the United States.

<http://www.sfms.org/domestic.html/>

Domestic Violence: A Practical Approach for Clinicians. This site, maintained by the San Francisco Medical Society, addresses the background of domestic violence, including risks for and forms of domestic abuse, screening, diagnosis, clinical findings, interventions, patient safety issues, continuity of care, and documentation. It also focuses on how domestic violence is reported, which is a requirement in the state of California, although not necessarily in other parts of the country.

MEDICAL SPECIALTY ORGANIZATIONS

Many medical specialty groups maintain professional and public information on domestic violence issues on their Web sites, including practice and policy statements and available resources. These include the American College of Emergency Medicine at <http://www.acep.org/>, the American College of Obstetricians and Gynecologists at <http://www.acog.org/>, the American Academy of Family Practice at <http://www.aafp.org/>, the American Academy of Pediatrics at <http://www.aap.org/>, the American Medical Association at <http://www.ama-assn.org/>, the American Nurses Association at <http://www.ana.org/>, the US Preventative Services Task Force at <http://www.ahcpr.gov/clinic/uspstfix.htm>, American College of Surgeons at <http://www.facs.org/>, and the National Research Council’s Board on Children, Youth and Families at <http://www4.nationalacademies.org/cbsse/bocyfweb.nsf>, and the Centers for Disease

Control and Prevention at www.cdc.org, and the U.S. Department of Health and Human Services at <http://www.hhs.gov/>, and the Joint Commission of Accreditation of Healthcare Organizations at <http://www.jcaho.org/>.

LEGAL SITES (LAW ENFORCEMENT AND PROSECUTION)

<http://www.telalink.net/~police/abuse/index.html>

The Domestic Violence Division of the Metro Nashville Police Department Web page is one of the more useful law-enforcement sites addressing this problem. It includes information about indicators of domestic violence, stress-related problems in children who witness abuse, progression of violence, signs of abuser rehabilitation, common characteristics of the batterer, symptoms of abuse, separation violence, long-term effects of domestic violence, safety plans for victims, information about orders of protection, workplace safety, and a copy of the department's domestic violence policy.

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

The American Bar Association Commission on Domestic Violence. This site includes basic information about domestic violence, important phone numbers, hot links to related sites throughout the country, and updates about legal issues, confidentiality issues, and policies regarding domestic violence.

<http://www.ncjrs.org/victdv.htm>

The National Criminal Justice Reference Service Web site is a law-enforcement and social service site with conference transcripts, legislation, and general information about family violence, including intimate partner violence, child abuse, stalking, substance abuse, and female victims of violent crime.

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

The US Department of Justice's Violence Against Women site lists research, legislation, and resources pertaining to violence against women, including violence in the workplace. The full text of this monthly newsletter and its Domestic Violence Awareness Manual are available at this site.

GENERAL AND COMMUNITY SITES

<http://www.s-t.com/projects/DomVio/>

The Standard-Times newspaper of New Bedford, Mass, ran this series of 60 articles about domestic violence in May and June 1995. Topics covered include an overview of domestic violence, survivor stories, police perspective on domestic violence, popular culture and sports in violence, the medical, legal, and religious responses to domestic violence, resources for women, issues about batterers, issues in schools, and suggested solutions.

<http://www.feminist.org/other/dv/dvhome.html>

This site, offered by the Feminist Majority Foundation, provides links to numerous other sites, including phone numbers for each state's Coalition Against Domestic Violence offices, information about the Violence Against Women Act, facts about domestic violence, and general references about domestic violence, self-defense, stalking, sexual harassment, and sexual assault.

<http://computrek.org/xx.htm> (xx=state abbreviation)

This site provides domestic violence articles, stories submitted by perpetrators and survivors, and a bulletin board with chat rooms. It has a comprehensive state-by-state listing of local Coalitions Against Domestic Violence, local hot lines, counseling services, shelters, and victim service organizations. State-by-state listings of resources are available.

<http://www.xq.com/cuav/domviol.htm>

The Community United Against Violence site has general information, bibliographies, and resources about same-sex abuse.

<http://www.tamoore.com/violence/>

The commercial site produced by “Nonviolent Alternatives” counseling services is one of the few geared toward the abuser. It provides general information about domestic violence, warning signs of abuse, and tips on nonviolent conflict resolution. It also provides hot links to numerous domestic violence resources.

<http://www.dgp.utoronto.ca/~jade/safe/>

Stop Abuse for Everyone (SAFE) This site accessed through the University of Toronto server is directed to the public and includes domestic violence resources, ways to become involved in addressing domestic violence, and survivors’ stories. This site has more emphasis than most about violence against men by women.

<http://www.columbia.edu/~rhm5/>

This social service site, based at the Columbia University, School of Social Work, New York, NY, provides online training manuals and participant workbooks for its training program for child protective and other social service professionals.

<http://alpha.acast.nova.edu/health/psy/file-desc/file50.html>

This is a listserv to which people can subscribe to obtain e-mail information about child abuse, sexual abuse, spousal abuse, elder abuse, dating violence, and other similar issues.

<http://www.letswrap.com/mndv/sominn.htm>

This site lists domestic violence resources available in the southern portion of Minnesota.

<http://www.letswrap.com/mndv/nominn.htm>

This site lists domestic violence resources available in Northern Minnesota.

<http://www.letswrap.com/mndv/metro.htm>

This site lists domestic violence resources available in the Twin Cities Metro area.

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

This site provides law, criminal justice, advocacy, and social service professionals with up-to-date information on interventions to stop violence against women.

SCREENING TOOLS INVENTORY

Tool Name	Developed by, year	Brief Description
Abuse Assessment Screen (AAS)	McFarlane & Parker	Brief, 3-question survey including a body map.
March of Dimes Abuse During Pregnancy Protocol	McFarlane & Parker	Includes the AAS and the Danger Assessment.
Survey of Exposure to Community Violence (SCECV)	Richters & Saltzman, 1990	Survey examines the environmental and systems-level exposure to violence. Includes arrest experience, home break-ins, and specific weapons-related violence
Conflict Tactics Scale	Straus, Hamby, Boney-McCoy, & Sugarman, 1979	Measures both the extent to which partners engage in psychological and physical attacks on each other and also their use of reasoning or negotiation to deal with conflicts.
Revised Conflict Tactics Scales (CTS2)	Straus, Hamby, Boney-McCoy, & Sugarman, 1996	Measure of conflict resolution events that involve violence. Scales measure psychological abusiveness and the use of negotiation and reasoning by either partner to reduce violence.
Diagnostic Interview Schedule-III-Revised	Robins, Helzer, Cottler & Goldring, 1988	A structured clinical interview, includes a listing of traumatic events intended to prime respondents to describe their own trauma history.
NWS Event History-PTSD Module	Nat'l Crime Victims Research and Treatment Center, Medical Univ of SC	Interview comprehensively assesses lifetime occurrence of civilian crime.
Diagnostic and Treatment Guidelines on Domestic Violence	American Medical Association, 1992	"Recommended questions for clinicians to ask women who may be victims of abuse."
Danger Assessment	Campbell, 1986	14 yes, no questions getting at risk factors for homicides for both victim and batterer in situations where abuse has been disclosed,
North Carolina PRAMS (Pregnancy Risk Assessment Monitoring System)	CDC – Annual Survey	Interview (by mailed survey or telephone interview) contains questions concerning the identification of patients with histories of partner violence, uses a series of questions of the AAS.
RADAR	Alpert, 1992	R outine screening, emphasis on routine, A sk direct questions, D ocument, A ssess safety R efer to appropriate services
RADAR-F	Weiss & Kripke, 2000	RADAR + Follow Up
"The Relationship Chart"	Wasson, et al. 2000	A word and picture chart where patients are asked to choose, from five responses, the answer to the question "During the past four weeks, how often have problems in your household led to: Insulting or swearing? Yelling? Threatening? Hitting or Pushing?" The five choices, with pictures to match are, "None of the time," "A little of the time," "Some of the time," "Most of the time," or "All of the time."
6 Question Screening Tool	American Medical Association, 1999	6 direct questions assess the presence of violence in a relationship. "Are you now or have you ever been in a relationship in which you have been harmed or felt afraid of your partner?" "Has your partner ever hurt any of your children?"
Partner Violence Screen (PVS)	Feldhaus, 1997 (?)	3-question tool "Have you been hit, punched, or otherwise someone in the last year?" "If yes, who?" "Do you feel safe in your current relationship?"
Index of Spouse Abuse	Coker, 2000	30-item oral or written survey. Measures the severity of physical and nonphysical abuse inflicted on a woman by her partner. Notes frequency and correlates of intimate partner abuse by type: physical, sexual, and psychological.
Colorado BRFSS Violence Screen	Koziol-McLain, 1998	3-question tool "Thinking back over the past year, on any occasion were you hit, slapped, kicked, raped, or otherwise physically hurt by someone you know or knew intimately, such as a spouse, partner, ex-spouse, ex-partner, boyfriend, girlfriend, or date?" "Considering your current partners or friends, or and past partners or friends, Is there anyone who is making you feel unsafe right now?" "In the past year, have the police ever been called to your home because of a fight or argument, no matter who was fighting or who was at fault?"
HITS Scale	Sherin, 1998	Screening tool for use in family practice.
Straus Home Violence Questionnaire	Straus, 1987	Intellectual functioning and aggression

APPENDIX C

Relevant 2002 Minnesota Legislation

RELEVANT MINNESOTA LEGISLATION

Minnesota Session Laws of 2002, Chapters as listed below

Compiled by Attorney Anne Spencer-Tretinyak, Sexual Violence Justice Institute, Minneapolis, MN 612/313-2797.

CRIME VICTIM RIGHTS ENFORCEMENT

- › Functions of the Office of the Crime Victim Ombudsman funding transferred to the Commissioner of Public Safety as the Crime Victim Oversight Act. (Chapter 220)

PREDATORY SEX OFFENDERS

- › Predatory offenders to register for lifetime after 2nd offense regardless of the age at 1st offense. (Chapter 222)
- › Department of Corrections given access to an offender's private / confidential medical, court, treatment and corrections information for use in assessment and referral for civil commitments as sexual psychopathic personality or sexually dangerous person. (Chapter 273)
- › Owners / property managers of building / facilities (including hotels / motels) used to house domestic abuse victims cannot rent to level 3 offenders. Department of Corrections to report on the impact of several level 3-offender issues. (Chapter 385)
- › Community notification of the release of sex offenders now directs the adult members of the offender's immediate household be notified of the offender's risk level. This applies to Level I, II, III offenders.
- › Cities may determine when and if materials regarding the notification of the release of sex offenders must be presented, orally and/or in writing, in languages other than English.
- › Department of Corrections is directed to report to the legislature by January, 2003, regarding the issues of Level III sex offenders returning to communities. The report will address, among other things, housing, concentration of Level III offenders, and policies adopted in other states that address residential concentrations of offenders assessed to be at high risk of reoffense.

DOMESTIC ABUSE

- › Hennepin County Domestic Fatality Review Team pilot project extended. (Chapter 242)
- › Order For Protection and domestic No Contact Orders amended – including misdemeanor violations if you know “of the existence” of the OFP. (Chapter 282)
- › Changes relating to hearings on petitions for OFPs, allows the continuance of an exparte OFPs and provides notice to law enforcement of the continuance. (Chapter 314)

- › Introduction of evidence of similar abusive conduct by a domestic abuser that occurs after acts forming the basis of a criminal charge will be allowed. (Chapter 314)

SEXUAL ASSAULT AND VULNERABLE ADULTS

- › Definitions of CSC3 and CSC4 amended to include persons who sexually penetrate vulnerable adults under certain conditions when the offenders are agents of special transportation providers. (Chapter 381)
- › Establish 90-month executed presumptive sentence for certain CSC2 offenses with any lower sentence given being a departure from the sentencing guidelines. (Chapter 381)
- › Costs for sexual assault exams responsibility of the county in which the alleged offense occurred. Costs include rape kit and any associated pregnancy or STD tests. (Chapter 381).
- › Department of Human Services to recommend changes needed on current background checks policies and disqualifiers for those working with vulnerable adults and maltreatment findings against people with criminal histories who have been allowed to provide services to children and vulnerable adults. (Chapter 292)
- › The Supreme Court will study and make recommendations regarding methods for tracking the filing and status of civil actions for damages resulting from sexual abuse. (Chapter 292)

JUVENILE COURT

- › Juvenile court jurisdiction for juveniles who miss hearings or flee adjudication before being adjudicated expanded (Chapter 314)
- › Hennepin / Ramsey Counties authorized to assign single judge / referee to hear related family, probate and juvenile court proceedings with the exception of juvenile delinquency cases (Chapter 242)
- › Department of Corrections statewide supervision system to receive juvenile offender data. (Chapter 233)

HARASSMENT / STALKING

- › Penalty for aggravated harassment set as 5 year felony, 10 year felony for harassment against a minor done with sexual or aggressive intent by an actor who is 36 months older than the victim. (Chapter 248)
- › Aggravated harassment penalty set at 5 years/\$10,000 fine.
- › Under the harassment and stalking laws, a pattern of harassment was amended to include attempted violations of the cited statutes and those statutes now include the five levels of criminal sexual conduct.

CHILDREN / FAMILY LAW

- › Childcare providers must develop policies / procedures for reporting suspected child maltreatment. (Chapter 248)
- › Process established for a “de facto custodian” or an interested third party to seek custody of a child. No preference for gender or parents of child. (Chapter 304)
- › Child endangerment crime of exposure to drug activity expanded – 5 year felony for permitting a child to be present where drugs are sold, manufactured or where the immediate precursors / chemical substances intended for use in making drugs are present. (Chapter 314)

- › Failure to report when a mandated reporter has reason to believe a sex offender has, in the previous 10 years, perpetrated on two or more children not related to the offender, can result in a gross misdemeanor.

MISCELLANEOUS NEW CRIMINAL PROVISIONS

- › Crime of intentionally obstructing an emergency vehicle created. (Chapter 319)
- › New gross misdemeanor offense of taking responsibility for a criminal act if done with the intent to obstruct, impede or prevent a criminal investigation. (Chapter 232)
- › Beer keg sellers will now be required to place identification tags on all kegs sold and keep details about the sale of the keg for 90 days. (Chapter 232)
- › Electronic signatures on blood sample lab reports authorized in criminal cases and DWI-related license revocation hearings. (Chapter 301)
- › New crime of fleeing electronic monitoring or removing and electronic monitor created. (Chapter 314)

July 2003

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(Footnotes)

¹ The American Medical Association, the American College of Obstetricians and Gynecologists, the American Nurses Association, the American College of Nurse Midwives, the American Psychological Association, the American Academy of Pediatrics, the American Association of Colleges of Nursing, the American College of Emergency Physicians, the Emergency Nurses Association, the American College of Surgeons, the American Academy of Family Physicians, the Family Violence Prevention Fund, and Physicians for a Violence-free Society.

² The Institute of Clinical Systems Improvement (ICSI) is a collaboration of health care organizations dedicated to championing health care quality and to helping accelerate the implementation of best clinical practice for their patients. www.icsi.org.

³ JCAHO, the board that accredits all hospitals and clinics across the nation, requires institutions have objective criteria for identifying and assessing possible victims of abuse and neglect. The criteria should focus on observable evidence and not on allegation alone, and address at least the following: physical assault, rape or other sexual molestation, domestic abuse and abuse or neglect of elders and children. The criteria must be used throughout the organization and staff must be trained in their use.

⁴ *Domestic and Sexual Violence in Minnesota: Strategies for Prevention and Intervention, Five-Year Objectives Health Care and Public Health*. Minnesota Department of Health: 2002