# Training Curriculum in Domestic Violence Screening for Health Professionals

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Client: Syracuse Area Domestic Violence Coalition

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**Executive Overview** (Table of Contents)

The Syracuse Area Domestic Violence Coalition (SADVC) trains Onondaga county health professionals in domestic violence recognition and intervention in order to address the increasingly important medical and social problem of domestic violence in this community. The SADVC has requested instructional design assistance in revising their curriculum to best influence provider behavior in screening for domestic violence. The instructional design team for this project consisted of instructional designers with experience in teaching and training and included a subject matter expert (SME) in the field of primary care medicine and domestic violence. A broad front-end analysis was conducted in order to obtain multiple perspectives, but also to counteract the potential bias from the small amount of data in the individual assessments. The analysis first reviewed evaluation data from previous trainings and a telephone survey performed in 2000 which surveyed the training participants. From this data, the team obtained information about new topics learned during the trainings as well as ideas about non-instructional solutions to some of the identified issues in the telephone survey. A participant interview about learning styles and needs was conducted (with nurses and social workers) prior to a training session, and this was supplemented by a learner analysis survey sent to physicians. This data was useful in describing learner characteristics and needs. A goals analysis was performed involving two SADVC coordinating staff who both had extensive experience as trainers. This analysis was performed using a modified Delphi method with two opportunities for revision, and resulted in data that heavily influenced the topic analysis. A survey of area primary care physicians, conducted by researchers from the medical issues committee returned preliminary results that highlighted and confirmed some of the training needs from the

goals analysis. Finally, a review of the medical literature was performed to fill in the gaps concerning existing methods of instruction for domestic violence topics and to provide background material.

The task analysis was performed using a combined procedural and topic analysis to reflect the basic procedural structure of a focused patient-provider interaction while enabling the learner to handle the ultimate complexity of the individual situations encountered in practice. The SME was interviewed in detail for the procedural analysis and produced the topic analysis. These documents were clarified and revised by the team as a whole, and then linked to each other (through coding of the topic analysis) for reference.

From the task analysis and the goals analysis, a comprehensive set of objectives was developed, focusing on the three terminal objectives for the health care provider attending the training: 1) to understand the importance of domestic violence in medical care, 2) to understand how to screen patients for domestic violence, 3) to understand how to refer patients for assistance with domestic violence concerns. These were broken down into numerous enabling objectives, which were formatted using Merrill's performance-content matrix model as a guide. From these, the team developed the initial presentation and generative strategies for each of the enabling objectives. The sequencing of the didactic portion of the instruction was developed using world-related sequencing, aligning the topics of instruction to the flow of the actual screening encounter: background, screening questions, dealing with the answers, documentation and referral.

The overall instructional strategy chosen again attempted to reflect the potential complexity of the encounter while recognizing basic procedural aspects of screening. Reflecting this, the team chose to base the strategy on Reigeluth's elaboration theory – presentation of the simplest form of the encounter (a properly performed screening modeled by the trainers) and then increase the complexity as the learner understands more. Since the trainings are designed as single sessions and are somewhat time-limited (1-2 hours) activities, the team chose to place small-group/didactic work after the initial presentation. Familiar with this new information, learners will then work through increasingly complex patient case vignettes.

The implementation of the curriculum based on the instructional strategies will ultimately rest with the SADVC Medical Issues committee, of which the SME/instructional designer is a member. The design team will present these findings and strategies to the committee and be available for questions and assistance with the curricular design as the committee reviews and revises the instruction. Full implementation of the revised curriculum is expected by summer 2003. Risks to implementation include the short duration of the trainings, limited financial and human (trainer) resources. These are addressed by creating the curriculum to be flexible in terms of both presentation and content and by including resources for self-study. Challenges to the project include the need for summative and confirmative evaluation and motivating provider attendance at the trainings.

## Introduction (Table of Contents)

### *Background and Needs Assessment* (Table of Contents)

Domestic violence is a pervasive problem in society, and is increasingly recognized as a major contributor to morbidity and mortality among adult females. Health professionals have the opportunity to impact this situation given the confidential and caring relationships that are essential in medical practice. Medical research, however, shows that health care providers are uncovering domestic violence at a much lower rate than is reflected by the prevalence estimates from medical research. Studies show that only about 7 – 25% of domestic violence cases are identified (Sugg, 1999). Only 2 – 7% of women treated in ambulatory care facilities report being questioned about abuse (Sugg, 1999). These data are contrasted to reports that 1 in every 4 women treated in ambulatory care facilities are affected by domestic violence (Eisenstat, 1999). Additional data that we collected locally support these identified gaps. The SADVC Medical Issues committee conducted a recent survey looking at the barriers to domestic violence screening. Local health care professionals provided equivocal (equal numbers of agree and disagree) answers to several questions about domestic violence knowledge and attitudes. These answers indicated a number of educational needs. For example, several participants in the survey felt neutral or disagreed with the following statements: they had sufficient training to screen for domestic violence, they could identify the risk factors for domestic violence, or they had enough professional support or resources to deal with domestic violence (Appendix D). Although some of our data shows some non-

instructional barriers to the training (Appendices B and F), much of the needs assessment points to an educational gap that could be corrected with proper training and support.

Many organizations, locally and nationally, have recognized this gap and have advocated more training for health professionals in screening for and diagnosing domestic violence. The SADVC and Vera House, Inc. are two interconnected agencies in the Onondaga County area that have as their missions the education of health professionals about domestic violence. The SADVC Medical Issues committee has conducted domestic violence training for health professionals for the past 4-5 years centered on Domestic Violence Screening Day in October of each year. These training sessions have been well-received by the attendees who requested them, but the Medical Issues committee has been concerned recently that the trainings may not be as effective as they can be in changing health care provider practice. In addition, the training sessions have not been as well-attended by physicians as desired.

A final part of the front-end analysis was the goals analysis conducted with two staff members who served as trainers for the SADVC (Appendix E). The approach for the goals analysis was a modified Delphi technique. Each staff member was independently asked broad questions about the content and objectives of the training curriculum. The results were combined by the design team, and reflected back to the members as single outline for comments and revision. These second comments then were reorganized into the final goals listing. As this analysis was performed somewhat later in the project, its main use was to reinforce the objectives created as a result of the procedural and topic analyses (see Goals/Objectives below).

*Problem Statement* (Table of Contents)

The current domestic violence screening training should be revised in order to improve the efficacy of the training program and to improve attendance by health care professionals. Because of the meager budget of the sponsoring non-profit agency, the training should be adaptable to differences in the availability of training resources – both financial and human.

*Target Audience* (Table of Contents)

The target audience for the screening curriculum consists of the primary care health professionals in the Syracuse/Onondaga County area. The members of this community include family physicians, internists, obstetricians and gynecologists, physician assistants, and nurse practitioners.

Current literature shows that a low percentage (22%) of health professionals has attended a domestic violence training program in the last year (Sugg, 1999). From that same group, less than 40% of the health professionals confident in their abilities to ask questions about domestic violence. Additionally, only 12% of clinicians and 1% of the nurses surveyed believe that domestic violence is common (occurs in 10-15%) of the population (Sugg, 1999). Our learner analysis suggests that a broad range of learning styles, interests, attitude and knowledge will be represented in the training. Interviews with some participants in previous trainings identified that many of the trainees will serve as trainers themselves in their practice environment (Appendix C). They identified the need for high quality reference materials and a preference for video simulations. They also identified a strong dislike for personal role-playing. Physicians in the learner

analysis indicated a wide range of acceptable presentation strategies. They complained of a general lack of time for the training, but stated that continuing medical education credit and an early evening time for the training would likely increase their attendance.

### *Task Analysis* (Table of Contents)

The task analysis (Appendix H) performed for this project started from the idea that domestic violence screening is basically a procedural task, but due to the many factors at work in an interpersonal relationship (in this case the doctor-patient relationship), there is a great deal of potential complexity. Thus, the first analysis performed was a procedural analysis created from an interview of the SME which described an ideal set of statements and options to be used in the setting of domestic violence screening in a primary care physician's office. In order to categorize the background material on domestic violence theory which was deemed necessary in the goals analysis, a topic analysis was created, outlining the basic knowledge of the theory, as well as some mnemonics used to remember key points of screening and domestic violence resources. The topic analysis headings were noted at the appropriate points on the procedure analysis diagram to enable quick reference for the team and to reinforce the idea that the basic procedure may need to be modified at any point using the information from the topic analysis. This analysis may also be useful for the learners as a reference given its structure and detail.

*Goals/Objectives* (Table of Contents)

The objectives for the training curriculum were developed from the procedural and topic analyses and confirmed using the goals analysis. The main goals analysis objectives were (Appendix E):

1. Increase the understanding of the prevalence of domestic violence and the dynamics of domestic violence.
2. Improve health professionals' ability to identify and assess domestic violence.
3. Improve health profession intervention strategies.
4. Identify barriers to screening for domestic violence that health professionals face.

These goals were modified slightly to serve as terminal objectives for the training curriculum (Appendix I):

1. Understand the importance of domestic violence in medical care.
2. Properly screen patients for domestic violence.
3. Understand how to refer patients for assistance with domestic violence concerns.

These terminal objectives of training, although broad, serve as the basis for creating the enabling objectives. The more specific enabling objectives allow us to both develop particular presentation strategies as well as evaluate the knowledge gained as a result of the training.

## Instructional Strategy (Table of Contents)

*Information Presentation and Generative Activities* (Table of Contents)

The didactic instructional strategy for this curriculum is tied to the instructional objectives in the performance-content model. Each enabling objective is analyzed for its content – fact, concept, procedure, attitude, etc. The presentation and generative strategies are then designed to maximize learning of each separate content area according to accepted learning theory and instructional design principles. Appendix I shows the combined matrix of objectives, presentation and generative strategies.

*Training Program Outline* (Table of Contents)

The overall instructional strategy is related to the concepts of the task analysis – there is a basic procedural task (in this case a properly-performed screening encounter), from which complexity will arise given the infinite number of situations and responses possible. To accomplish this, the design team chose to use a variation on Reigeluth's elaboration model to structure the training session. A role-play or videotaped example of a properly performed, relatively simple screening encounter will be shown to the students. Following that, the basic information covered in the topic analysis will be presented using the strategies in Appendix I. Following that presentation, and limited by the time remaining, vignettes of increasingly complex encounters will be presented for discussion and problem-solving by the small group attendees. This format can be modified for large lecture audiences by either splitting the audience into groups with a single vignette each (with subsequent reporting back to the group) or by encouraging large group discussion. Appendix J shows the basic outline of the proposed training session.

### *Evaluation Strategy* (Table of Contents)

The evaluation of the proposed training revision will be primarily formative, beginning with the presentation of this document to the Medical Issues committee. Further formative evaluation will be provided on an ongoing basis by the learners, with questions for this evaluation focusing on the acceptability and usefulness of the presentation strategies, the material resources, and the further educational needs not covered by the sessions.

Ideally, summative evaluation should be performed, but this level of evaluation on a learner population which spans the county faces numerous challenges. These challenges include financial considerations, time and a lack of simple measures to assess changes in primary care practice. One possibility for summative evaluation is to repeat the provider "barriers" survey that was done to assess for change – especially in the domains that were identified as training needs. This assessment would be complicated by contamination of the sample with other domestic violence training activities that occur in the interim and by survey response, which will likely represent a different sample of the population.

## **Resources** (Table of Contents)

### *Design* (Table of Contents)

Staff: Staff members from Vera House, and consulting instructional designers and clinicians are needed to design the training program. Vera House staff members and clinicians should be knowledgeable in domestic violence abuse and in how to screen for

domestic violence abuse in healthy adults. Instructional designers provide the knowledge necessary in designing an effective training program.

Equipment: Equipment required for the design of the domestic violence training program include: computer, pens and paper.

Software: Software needed to design the program includes Microsoft Office™ (MS PowerPoint ™ and MS Word ™).

*Development* (Table of Contents)

Staff: Staff members from Vera House and consulting clinicians are needed to create the training program. These members must be knowledgeable in domestic violence abuse and in how to screen for domestic violence abuse in healthy adults. Equipment: computer, video camera, video editing machine and videos (if making own video of a domestic violence screening taking place).

Software: Software needed to design the program includes Microsoft Office™ (MS PowerPoint ™ and MS Word ™).

Other Resources: If web-based tutorials are planned, additional web-based design software systems as well as web-design consultants will be needed.

*Delivery* (Table of Contents)

Staff: Staff members from Vera House and clinicians are needed to deliver the training program. These members must be knowledgeable in domestic violence abuse and in how to screen for domestic violence abuse in healthy adults. Ideally, there should be at least one staff member from Vera House and one clinician at each training session,

but this is frequently not possible. All the trainers should be trained in delivering this program.

Equipment: Equipment necessary in the delivery of this training program includes a laptop computer, MS PowerPoint™ presentation, LCD Projector, screen, instructor manuals, participant manuals, butcher paper, easel for paper, markers, tape, pens, paper, television, a VCR, tables and chairs.

Software: Software needed to design the program includes Microsoft Office™ (MS PowerPoint ™ and MS Word ™).

## Project Management (Table of Contents)

### *Timeline* (Table of Contents)

The timeline involved in the development and implementation of the project begins with the project's conception and continues through the evaluation and revision phases of its development. The project began with an initial meeting between the design team and the client to learn about the needs of the client. A thorough front-end analysis, including a needs assessment, topic analysis and procedural analysis, was conducted. As the project progressed, the client interacted with the design team leader in maintaining focus to the project. By collaborating with the client, a goal analysis utilizing the Delphi method was conducted. The development of goals, instructional objectives, and instructional strategies provided the foundation for the development of the instructor training program and the participant's training program. The timeline provides the client with recommended milestones and estimated timelines for the continued development, implementation and revision of the domestic violence training program. Milestones are

those events that signify the end of a critical design process. Deliverables refer to those products that are developed during the process. For the domestic violence training project, milestones and deliverables were considered at various phases of the instructional design process. This timeline appears in Table 1.

***Table 1*: Domestic Violence Training Program Timeline**

| Milestone/Activity | Date Completed | Associated Deliverables |
|---|---|---|
| Initial meeting of the client and the design team leader to discuss project | September 3, 2002 | Written project proposal by team leader. |
| Initial meeting of the design team | September 10, 2002 | Written notes from meeting |
| Needs Assessment conducted of medical personnel | September 17, 2002 | Written summary of results of interviews with medical personnel |
| Literature Review completed | October 5, 2002 | Written report of literature review |
| Topic Analysis completed | October 1, 2002 | Written outline of topic analysis |
| Task Analysis completed | October 1, 2002 | Written outline of task analysis |
| Goal Analysis completed | November 10, 2002 | Written and e-mailed to team |
| Instructional objectives finalized by design team | October 22, 2002 | Written report outlined. |
| Instructional strategies developed | November 10, 2002 | Written outline |
| Timeline for implementation completed | November 17, 2002 | Timeline for development of instructional materials developed in written format |
| Budget completed | November 17, 2002 | Budget document. |
| Instructional Training Materials Developed | Estimated February 10, 2003 | |
| Instructional booklet developed for trainers and participant booklet developed for participants | Estimated February 10, 2003 | |
| MS Powerpoint™ Presentation developed | Estimated February 10, 2003 | |
| Training scheduled for instructors | Estimated March 15, 2003 | |
| Participant trainings scheduled for April 2003 | Estimated by April 1, 2003 | |

*Budget* (Table of Contents)

The client requested that the budget needed for the successful development and implementation of the program be kept as low as possible. In meeting this need, the design team provided only the costs for those materials that were deemed absolutely necessary in the delivery of the program by the team. The final budget proposed by the project is $187.00. The final budget appears in Table 1.

Table 1. Domestic Violence Training Program Budget

| ***Item and Description*** | ***Cost*** |
|---|---|
| Participant Booklets/Written Materials:<br>1 booklet of 15 pages with cover:<br>Copies @ $.03/copy x 15 pages = $0.45<br>Bind copies in booklet @ $1.00/binding= $1.00<br>Color cover page @.50/page $0.50<br>One booklet: $1.95<br>Estimated number of booklets is 45 x $1.95 = | $87.85 |
| Instructor Binders:<br>10 binders @ $3.00/binder $30.00 | $30.00 |
| Instructor Manuals:<br>1 booklet of 30 pages with cover bound $2.40<br>Estimated number of manuals is 10 x $2.40= $24.00 | $24.00 |
| Pens:<br>2 boxes of 20 @ $3.00/box $6.00 | $6.00 |
| Butcher Paper:<br>1 pad of paper @ $15.00 $15.00 | $15.00 |
| Markers:<br>1 box of markers @ $5.00 $5.00 | $5.00 |
| Tape:<br>3 rolls of tape @ $3.00 for 3 rolls $3.00 | $3.00 |
| Food :<br>1 dozen donuts for training session @ $3.00/donuts x 4 sessions $12.00 | $12.00 |
| Instructors:<br>Clinicians volunteer for this role | $0.00 |

| | |
|---|---|
| Audio Visual Equipment: Provided by the hospital at no additional charge $0.00 | $0.00 |
| **Total Expenses:** | **$182.75** |

This budget includes costs associated with the development of instructor and participant manuals, pens, paper, and training materials. Vera House has agreed to consider financing the finished curricular revision and materials. The materials needed for the program include the instructor training materials and participant domestic violence information booklets. The instructor training manual includes training goals, objectives, instructional strategies, and domestic violence information resources, and activities to facilitate participants learning how to screen for domestic violence abuse. Participant domestic violence information booklets contain information about domestic violence, steps to conduct an effective domestic violence screening, and information resources about domestic abuse shelters for referral purposes. The instructor manual will be distributed during the instructor training session. The participant booklet will be distributed during the training program sessions.

*Project Status* (Table of Contents)

The needs assessment, topic and procedural analysis, instructional objectives, instructional strategies and implementation plan have been completed for the project. Instructor manuals, participants' manuals, video demonstrating a domestic violence screening, and instructor training curriculum need to be developed utilizing the objectives and content provided during the design process. The MS PowerPoint ™ presentation utilized during the training program needs to be revised based on data gathered during the

process. Finally, the recruitment of instructors, training of instructors, marketing and scheduling of domestic violence training sessions for clinicians needs to be developed.

*Risks* (Table of Contents)

Implementation plans to facilitate change in an organization or system consider the impact of the innovation, of communication systems, of available time and of social systems when developing the implementation strategy. The domestic violence training program is an innovative approach for addressing the issue of the infrequency of domestic violence screening in healthy adults by clinicians. In this case, the innovation - the training program - must be as unobtrusive as possible for clinicians' participation. If it is perceived as getting in the way of routine health care, then they will not participate. The feasibility of using the protocol is influenced by the amount of time the clinician has with the patient, and given the increase in the number of preventive services advocated for these visits, physicians are under increased time pressure.

Social systems influence clinicians' perceptions concerning the benefits of the training program, which will influence whether or not the clinician will choose to participate in it. It is essential that those who influence clinician perceptions be involved and be encouraged to promote actively the benefits of the training program. For this training program, hospital administrators, medical personnel, Vera House coordinators, and NY State Licensing Board must be involved in the marketing of the program because of their ability to communicate the program's objectives and of their ability to influence others to promote the program positively. As the program's reputation grows and becomes more widely known, these influential people can share with others what it is,

why it should be supported, and how it enhances the image of effective medical practice. Time is important in considering the various points at which medical personnel will begin to use the proposed innovative domestic violence training program. Those who are hesitant to believe in the effectiveness of the program will wait until their colleagues have participated in the program and told them about its effectiveness. Thus, it will be important to allow the program's positive reputation to develop over time, as opposed to expecting results in just a few weeks. As there are no negative consequences for clinicians who choose not to participate in this training program, designers must remember that participation is completely voluntary. It is recommended that the media be invited to promote the positive impact of domestic violence screening training programs in the preparation of clinicians. For example, newspaper articles that explain the program and share stories about how the program benefited clinicians and patients can result in increased understanding among both patients and clinicians about the availability of domestic violence screening in healthcare settings.

Risks and threats associated with the implementation of the domestic violence training program include time considerations, administrative policies, and limited finances. According to data gathered from the needs assessment phase, clinicians may not be able to use two hours from their busy schedules to participate in the training. In addition to providing the training program, the client may have to consider offering a web-based tutorial for those clinicians who cannot attend the scheduled training sessions. A second option is to shorten the training to one hour by eliminating didactic training methods and providing reference materials that can be read after the training. Another threat to consider in the implementation of the program is related to the research policies

of the Institutional Review Board. The Institutional Review Boards (IRBs) are concerned with the client using data collected during the patient-provider screening process for the client's need to assess how many domestic violence screening sessions are being conducted. The client will have to work with the IRBs in finding an appropriate method to gather information they need. A final threat to consider is the limited funding available to the program by the client. The training program costs must be limited to the development of instructional materials essential to the program's goals.

**Deliverables** (Table of Contents)

The deliverables from this project as completed to date will include this project report. In it, the resources such as the goals analysis, learner analyses, task analysis and the objectives-presentation-generative strategies matrix will be the most useful for the SADVC to implement these curricular suggestions. The SME will continue to work with the Medical Issues Committee to created the curriculum, and the design team will be available for the presentation of the project report to the committee.

**References** (Table of Contents)

Sugg, N.K., Thompson, R.S., Thompson, D.C., Maiuro, R., Rivara, F.P. (1999). *Domestic violence and primary care: attitudes, beliefs and practices.* Archives of Family Medicine, 8(4): 301-306.

Eisenstat, S.A., Bancroft, L. (1999). *Primary care: domestic violence*. The New England Journal of Medicine, 341(12): 886-892.

**Appendices** (Table of Contents)

A. Domestic Violence Training Evaluations – Summary

B. Screening Day Training – Telephone Survey of Non-participants

C. Interview with participants in domestic violence screening training on 9/14/02

D. DV Screening Barriers – Community Providers Survey

E. Goals Analysis for Vera House Domestic Violence Training

F. Learner analysis - Physicians

G. Medical Literature Review

H. Task Analysis

I. Objective-Presentation-Generative Strategy Matrix

J. Course Outline

Appendix A (Table of Contents)

Domestic Violence Training Evaluations – Summary

39 Medical students (70% female, mostly MS I and II),

1 hour "interactive" lecture – standard training curriculum 10/22/02

**Overall ratings** of presentation: 58% excellent, 39% good, 3% no rating

**New Things Learned at DV Training**:

Specific details

Increased during pregnancy

Vera house as resource

The "healthy cycle" (opposite PC wheel)

All Types of DV, not just physical

Cycles of violence

How to screen/ways to ask questions

ABCD mnemonic

Victims attempt to leave 6-8 times before actually leaving

Power and control wheels

Every 15 seconds statistic

Attempts to leave often increase risk of violence

How often it occurs

Acronyms to evaluate patients – HITS, BATHE

Economic abuse

Prevalence in all socioeconomic levels

Stories (about victims) helped visualize/clarify points

That doctors have a place to call for information

Symptoms/signs of domestic violence

Prevalence in same-sex relationships

**New Resources Learned:**

Vera House – how extensive it is, that doctors could get information there.

Vera House Web site

"general doc's office" {sic}

crisis line

## Appendix B (Table of Contents)

Screening Day Training – Telephone Survey of Non-participants

The original copy of the telephone survey and the results is not currently available. A narrative summary of the results from the SME follows.

SADVC conducted telephone interviews of health care site representatives who had not participated in Domestic Violence Screening Day in 2000. Questions in the survey attempted to elicit information about barriers to participation and ways that the SADVC could enable participation the following year. The problems noted generally dealt with issues for which there was not a clear instructional solution – "forgot about screening day", "provider was absent that day", etc. However some problems related to misunderstandings or lack of knowledge about the recommended process for screening day - how to use the materials, whom to screen, etc. It is in these areas that the instructional design team must concentrate its focus.

Appendix C (Table of Contents)

Interview with participants in domestic violence screening training on 9/14/02

5 participants- nurses and nurse practitioners:

1) What motivated you to participate in this training?

   Response: All participants responded that participation in this training was voluntary.

2) Rate yourself on a scale of 1-5 with 5 being highest in terms of your knowledge of screening for domestic violence abuse (what it is and its symptoms)

   Two participants rated themselves with a "3" in terms of their knowledge of domestic violence. They elaborated they knew what it was and how to recognize signs of abuse.

   Three participants rated themselves with a "4" in terms of their knowledge of domestic violence. They were confident they knew what signs of abuse were and how to identify them, but wanted to learn more.

3) We are trying to learn about the best methods to utilize in a domestic violence screening training. Describe the best methods you recommend for this type of training and why.

   All participants agreed that watching a video of a clinician/nurse interacting with the patient in screening for abuse would be useful. They wanted more written information and an opportunity to discuss various case studies relevant to the

issue. All participants agreed that they would not enjoy or learn from role-playing various scenarios.

4) Describe how domestic violence appears in your daily work?

   Participants explained that many of the domestic violence situations they see are alcohol-related. They encounter women who are controlled verbally and are physically abused. They were very concerned that it is the tendency of hospitals to send abused victims to 5 West (the psychiatric department) because it keeps women from being with their children and from getting them back.

5) How are you recognized for your participation in this training?

   Participants are able to serve as a mentor and resource to other members of their team. In addition, they can share information at various in-service trainings and discussions in their particular unit. They enjoyed the ability to share their information with others.

6) How do you prefer to be recognized for attending this training?

   They had no additional recommendations in regards to additional sources of recognition that could be provided by the hospital.

Appendix D (Table of Contents)

DV Screening Barriers – Community Providers Survey

37% Female, 81.5% Caucasian

Years since specialty training: 0-5-18.5%, 5-10-19.2%, 10-15-19.2%,>15-39%

Specialty: IntMed-22%,FamPract-43%,ObGyn-27%,Other-3%

82% private office or clinic

Formal statistical analysis of the survey is not yet completed. Below are statements that indicate further education in domestic violence is needed. Statements that were consistent with knowledge and attitudes about domestic violence were not included below. The statements were rated on a 5 point Likert scale of agreement (strongly agree, agree, neutral, disagree and strongly disagree). The statements below are separated into those agreed with, equivocal responses (neutral or divided between agree and disagree), and those disagreed with. A copy of the survey is attached for reference to the full versions of the questions.

(DV=domestic violence)

**Agree**

It is difficult to know who's to blame in cases of DV

**Equivocal**

Lack of scientific evidence about DV screening effectiveness

Minorities at higher risk of DV

Specific DV screening policy in office

I have enough time to screen

Practice has strong commitment to screening

Office too understaffed to screen

I have sufficient training to screen

Practice has counseling services available for identified DV victims

I feel frustrated seeing repeat DV injury

I do not know the reporting requirements for DV injury

Low income patients are at higher risk of DV

Patients are willing to discuss DV

Screening is important at each visit

I am afraid of misdiagnosing case of DV

I have access to professional support for DV cases

Don’t screen potential batterers, don’t want to increase the risk for the victim

I provide patient education materials to victims

I’ve received DV education since specialty training

**Disagree**

None

Appendix E (Table of Contents)

Goals Analysis for Vera House Domestic Violence Training

**Initial Goal Identification by Vera House Staff**

Randi Bregman, Executive Director, Vera House

1. Aims of the training for health care providers:
    a. Increase health care providers' understanding of dynamics of domestic violence
    b. Improve health care providers' identification and assessment of domestic violence
    c. Improve health care providers' intervention with domestic violence victims and perpetrators when domestic violence has been identified
2. Specific knowledge, skills and/or attitudes that trainees should have gained:
    a. Increase health care providers' understanding of dynamics of domestic violence:
        i. Understand a broadened definition of domestic violence, that it is much more than physical violence, that it is based on the abuse of power and control, that there is a pervasive climate of fear…
        ii. Understand the continuum of violence – that violence tends to get worse over time
        iii. Understand the cycle of violence that many victims of domestic violence experience, particularly understanding the

"honeymoon"/hopeful period and the need to understand this dynamic to provide effective intervention

iv. Understand the barriers to leaving, including fear, love/loss issues, economics, etc.

b. Improve health care providers' identification and assessment of domestic violence:

i. Increase the comfort level of providers in asking about violence and responding to both positive and negative answers to questions about violence

ii. Help providers recognize more subtle indicators of domestic violence (e.g. frequent, vague complaints, etc.)

iii. Establish routine screening as well as follow-up assessments as indicated

c. Improve health care providers' intervention with domestic violence victims and perpetrators when domestic violence has been identified:

i. Providers will be familiar with community resources for those affected by domestic violence and will be comfortable making referrals

ii. Providers will prioritize safety for victims in their initial responses/intervention

iii. Providers' intervention will incorporate their knowledge of the dynamics of domestic violence discussed above and will accept,

and even expect, that victims' timelines for change may be very different than the provider's

Loren Cunningham, Vera House

*Overall Goals*

1. Educate health care providers about the dynamics of domestic violence and the prevalence
2. Educate health care providers about potential indicators of domestic violence
3. How and why to do routine screening
4. Educate health care providers about how to intervene when domestic violence is occurring
5. Educate health care providers about what local resources are available to assist them and their patients
6. Normalize that this work can be very frustrating/challenging, but there is hope, and they never know if they have planted a seed with someone that eventually may change that person's life.

*For each of the aims you listed above, list some specific knowledge, skills and/or attitudes that the trainees should have gained at the end of the training.*

1. Educate health care providers about the dynamics of domestic violence and prevalence.
    a. Power and Control dynamics

b. The Cycle of Abuse

c. The Continuum of Family Violence

d. Barriers to leaving

d. Causes vs. Factors of domestic violence. Know that the batterer makes a choice to be abusive and is therefore the only person that can make the abuse stop. Substance Abuse/Stress/Anger are factors that influence the abusive person, but they do not cause domestic violence. Know that the victim does not cause the abuse.

e. Local and national stats on domestic violence, law enforcement in Onondaga County responds to ~15,000 domestic violence calls annually, ~500 women and children seek shelter annually in O.C. because of domestic violence. Domestic violence is the leading cause of injury to women age 18-44.

2. Educate health care providers about potential indicators of domestic violence

a. Things to look out for, such as unexplained injuries, injuries in various stages of healing, frequent visits to the doctor, changes in office visit patterns, depression/anxiety/jumpiness, an over solicitous partner, fear of partner...

3. How and why to do routine screening.

a. Know that all different types of people are affected by domestic violence, regardless of race, sex, cultural background, and age.

b. Therefore, we can not easily identify who is a victim and who is not, so routine screening asks the question of everyone
c. Know how to screen, the questions to ask and how to ask them. Ask direct questions in person; use a lead in statement to normalize the questions, ask one question that is broad and one that is very specific.
d. If patient screens "no", then reinforce that if in the event they are impacted by domestic violence, they can come to the health care provider for assistance.
e. If patient screens "yes", let the patient know the abuse is not their fault and that they do not deserve to be abused. Believe what the patient is saying; document the patient's statements and any injuries thoroughly.
f. Know how to ask about safety and either briefly safety plan with the patient or offer referrals and possibly a safe place to call for assistance.
g. Set up a return visit to check in with patient, but do not nag the patient about the choices made. Remember that although it may seem counterintuitive, the safest place for a victim of domestic violence may be at home with the abuser. The victim is the best judge of that and health care providers should know to respect an individual's right to self-determination.
h. Know that if they don't do these things, they may be doing the victim more harm than good

4. Educate health care providers about how to intervene when domestic violence is occurring
    a. See above re: screening
    b. Know that the majority of people in domestic violence situations are not constantly in a state of crisis; so don't let that fear keep them from asking the questions.

5. Educate health care providers about what local resources are available to assist them and their patients
    a. Vera House and its services...not just a shelter, also has outreach services and services for children. 24-hour crisis and support line is not only for those affected by domestic violence, but also for professionals also, so know that they can call us anytime with questions/challenges.

6. Normalize that this work can be very frustrating/challenging, but there is hope, and they never know if they have planted a seed with someone that eventually may change that person's life.

**Initial Refinement**

*Overall goals of domestic violence screening training*

1. Increase the understanding of the relationship dynamics in domestic violence.
2. Improve health professionals' ability to identify and assess domestic violence.
3. Improve health professional intervention strategies.
4. Identify domestic violence resources for use by health professionals.
5. Increase the awareness of the challenges of domestic violence screening to health professionals and patients.

*Subsets of goals*

1. Increase the understanding of the relationship dynamics in domestic violence.
    a. Define domestic violence.
    b. Understand continuum of violence.
    c. Understand the cycle of violence.
    d. Understand barriers to leaving.
    e. Identify the causes and factors of domestic violence
    f. Define domestic violence statistics.

2. Improve health professionals' ability to identify and assess domestic violence.
    a. Identify the indicators of domestic violence.
    b. Understand why screening should be completed on a routine basis.
    c. Understand patient comfort levels.
    d. Understand the process of domestic violence screening.
    e. Brief patients on safety issues.
    f. Establish follow-up assessments.

3. Improve health professional intervention strategies.
    a. Understand crisis levels in patients.
    b. Prioritize safety plans.
    c. Be familiar with domestic violence resources.
    d. Incorporate the dynamics of domestic violence in intervention.

4. Identify domestic violence resources for use by health professionals.
    a. Be familiar with domestic violence resources.

5. Increase the awareness of the challenges of domestic violence screening to health professionals and patients.

**Final Refinement**

*Overall goals of domestic violence screening training*

1. Increase the understanding of the prevalence of domestic violence and the dynamics of domestic violence.
2. Improve health professionals' ability to identify and assess domestic violence.
3. Improve health professional intervention strategies.
4. Identify barriers to screening for domestic violence that health professionals face.

*Subsets of goals*

1. Increase the understanding of the dynamics of domestic violence.
    a. Understand the prevalence of domestic violence
    b. Define domestic violence.
    c. Understand continuum of violence.
    d. Understand the cycle of violence.
    e. Understand barriers to leaving.
    f. Identify the causes of and factors relating to domestic violence.

2. Improve health professionals' ability to identify and assess domestic violence.
    a. Identify the indicators of domestic violence.
    b. Understand why screening should be completed on a routine basis.
    c. Understand the process of domestic violence screening.
    d. Brief patients on safety issues.
    e. Establish follow-up assessments.

3. Improve health professional intervention strategies.
    a. Understand crisis levels in patients; offer supportive, non-blaming messages.
    b. Prioritize safety plans.
    c. Be familiar with domestic violence resources.
    d. Incorporate the dynamics of domestic violence in intervention.

4. Identify barriers to screening for domestic violence that health professionals face.
    a. I.e. Time constraints, discomfort with the subject, fear of offending patients, feeling like they can't do anything to help the person.

Appendix F (Table of Contents)

Learner analysis - Physicians

This survey was delivered by email to a set of 10 family physicians in a single, academic group practice. There were eight responses, but some respondents did not answer each question. The respondents were also asked to fill out the VARK questionnaire to determine their learning preferences.

The responses overall represented a wide range of preferences, learning styles and motivators. Motivating elements suggested include: more time on their schedule for such an activity, belief that the curriculum would benefit them, continuing medical education credit. Items that prevented participation were mainly lack of time and incompatibility of schedule. Both the preferred format of instruction as well as the preferred timing of the instruction was distributed almost equally, indicating no overall preference. Most providers seem to get information about domestic violence from colleagues, which raising the possibility that the effect of training may diffuse through the community by quality training for relatively few providers. The preferred learning style inventory also indicated a range of learning styles.

| Question | Response | Comments |
|---|---|---|
| What would motivate you to participate in a 1 hour domestic violence training session? | 1. Time on my schedule that does not detract from other duties...<br>2. The belief that there was a high likelihood that I would develop important knowledge, skills, and attitude that I would then apply in my practice.<br>3. TIME<br>4. compulsion, interest, | |

| | | |
|---|---|---|
| | group activity, money, food, lots of clinical relevance in practice, practical useful info for practice<br>5. Making this service billable--having easy access to social work to help me with patients in this situation. Having support around how painful it is for me to deal with so many scary situations.<br>6. CME credit; lunch; bring it to the office; making it mandatory thru institution or above.<br>7. Convenient time.<br>8. CME, TIMING, HELP OUT JOHN EPLING, MIGHT BE USEFUL FOR MY PRACTICE | |
| What would prevent you from participating in a 1 hour domestic violence training session? | 1. schedule conflict; potentially the timing of it otherwise (i.e. so early a.m. or late night; depending on the info I may be willing to do weekends; is CME offered?<br>2. Conflicting priorities, lack of time, and the belief that I probably wouldn't get what I wrote above.<br>3. Not enough time for everything<br>4. busy schedule, fact that I have attended such in the past<br>5. Other duties--I think I know it all.<br>6. Time inconvenience; if it were optional instead of mandatory.<br>7. Conflicts in schedule. I don't know enough on this topic and need a booster. | |

| | 8. TIME DEMANDS | |
|---|---|---|
| Which format would you prefer to use in obtaining further training about domestic violence? (Rank order the following options from 1-3 with 1 being the best option.) | scientific review – 2,3,5,3<br>information by e-mail – 3,3,4,4<br>interactive cd-rom – 2,1,4,3,5<br>web-based training – 1,2,1,2,6<br>small group training – 1,1,1,2,1,2<br>lecture -2,2,5,6,1<br>other (describe) - | 1. I'm not likely to create the time to do this work independently via emails/web based; not sure what you mean by scientific review (i do the review or someone gives me the info from their review???)<br>6. Scientific review - I would want this included in any of the below. |
| From whom do currently obtain information to answer questions about domestic violence? | 1. colleagues; Vera house; social workers<br>2. No one<br>3. wherever I can find it<br>5. No one<br>6. From CME attended or from colleagues. It is something I think a lot about.<br>7. Colleagues on the rare prn basis.<br>8. PERSONAL EXPERIENCE, COLLEAGUES, LOCAL AGENCIES. HOSPITAL SOCIAL WORKERS | |
| Would provision of Continuing Medical Education credits make it more likely that you would attend domestic violence training? | 1. Yup; see above.<br>2. No<br>3. probably not, but would be helpful<br>5. It would really annoy me. The other required curricula are all terrible and I take them every year to keep my license and my job. This is a waste of time. People who don't ask about domestic violence won't ask any more often if they have a required training. Patients tell me that there is a way that some doctors ask about domestic violence that | |

| | | |
|---|---|---|
| | clearly tells them "I don't want you to tell me that your husband/boyfriend beats you." (even though he does)<br>6. In the right setting and at the right time. Adding it to larger courses is good - i.e., NYSAFP Scientific Program in Lake Placid.<br>7. Not really, but it all helps. S<br>8. YES | |
| What times would work best for you to participate in a one-hour domestic violence training session? | 1. Early AM (before work hours) not before 7<br>Early evening (just after work) 5pm ok if i don't have office in the afternoon; otherwise 6pm better...<br>2. Depends on the day. If I didn't have anything else scheduled, I would consider going if it met the criteria in #1. I doubt that I would go after work regardless.<br>3. No one time is good all the time, which is why I chose the options I did<br>5. mid-evening<br>6. Early AM (before work hours) 3<br>AM 4<br>Noon 1<br>Afternoon 5<br>Early evening (just after work) 2<br>Dinner time 6<br>Mid-evening 7<br><br>Or if web-based - could do it anytime. Like the IRB tutorial. Would like to be able to leave and re-enter.<br>7. Early evening (just after work) best<br>8. Early AM (before work | |

| | | |
|---|---|---|
| | hours) 4<br>AM 2<br>Noon 1<br>Afternoon<br>Early evening (just after work) 3<br>Dinner time 5<br>Mid-evening 6 | |
| OPTIONAL - What's your learning style? | 2. My answer to the last question is "mild read-write" - although I think that the questionnaire was not very good. Far too many "it depends".<br>3. Who knows for sure, but I think repetitive visual.<br>5. Mildly Kinesthetic<br>6. I like small group/ PBL format.<br>The website said I was a read/write type of learner. Is this validated?!<br>7. Visual: 4<br>Aural: 3<br>Read/Write: 2<br>Kinesthetic: 4<br>8.<br>Visual: 3<br>Aural: 2<br>Read/Write: 3<br>Kinesthetic: 5<br>You have a<br>mild Kinesthetic learning preference. | |

Appendix G (Table of Contents)

**Literature Review for Vera House Domestic Violence Training**

The following contains information gathered from articles published in several current accredited health care journals as well as culmination and position statement created by the National Resource Center on Domestic Violence.

Eisenstat, S.A. & Bancroft, L. (1999). Primary care: domestic violence. *The New England Journal of Medicine*, 341(12): 886-892.

- Domestic abuse is a pattern or psychological, economic, or sexual coercion of one person in a relationship.
- Abuse is often punctuated by physical harm to an individual.
- 90% of battering cases involve a male abusing their female partner.
- Women are more likely to sustain injury than men.
- There are no profiles or predictors for aggressive behavior.
- Victims of abuse have an increased risk of:
    - physical injury
    - problems with pregnancy/childbirth
    - gynecologic problems

  - exacerbation of medical conditions
  - noncompliance with medical treatment
  - depression, anxiety, and suicide
  - eating disorders
  - alcoholism and substance abuse
  - children with an abused parent have a greater risk of falling into the above risk factors
- Domestic violence is rising in numbers.

| Type of Behavior | Result |
|---|---|
| Aggressive | Destruction of furniture or possessions, injury of pets. |
| Controlling or Coercive | Withholding of money, car, health insurance; refusal to pay bills; sabotaging victims attempts to go to school or work |
| Harassing | Uninvited visits, calls, letters; stalking; embarrassment of victim in public |
| Destructive | Slapping, punching, kicking, pinching, biting, grabbing, choking, restraining, or pulling hair of victim; sexual assault |
| Intimidating | Oral, implicit or direct threats or criticism of victim; use of weapons; throwing objects, standing in doorway, or cornering victim during arguments; shouting; swearing |
| Isolating | Restricting and tracking activities and telephone use of victim |
| Threatening | Threats to seek custody or kidnap children, threats to kill victim or self |

**Statistics**

**Emergency medicine:**

- 1 in 4 women seek emergent care for domestic violence
- 37% of female patients treated in the ER for violent injury are there as a result of domestic violence
- 1 in 3 women with trauma has been injured by their partner

**OB/GYN**

- 1 in 6 pregnant women is abused during pregnancy

**Primary care**

- 1 in 4 women has been abused at some point in their life
- 1 in 7 women report having been abused in the last 12 months

**Psychiatry**

- 1 in 4 women who attempt suicide is a victim of abuse
- 1 in 4 women who are treated for psychiatric symptoms has been battered

**Pediatrics**

- 50 – 70% of the mothers of abused children are also being abuse by their partner
- Acts of physical aggression occur in 1 in 6 homes in the U.S.
- Yearly, 3.3 million children (ages 3-17) are exposed to parental abuse in the U.S.

**Barriers to Screening**

- Domestic violence screening is NOT a part of routine medical visits.
- Barriers include:

    - lack of clinical guidelines
    - brevity of medical visits
    - clinician discomfort
    - lack of access to intervention services to deal with the perpetrator
    - misconceptions about the typical victims of abuse
    - for patients:
        - past failures with the medical system
        - shame about the abuse
        - cultural and language barriers
        - fear of reprisal
- Most victims are HOPING that their clinician will ask about abuse (and in a cring manner)

**Presentation and Indicators of Abuse**

**Physical Findings**

- Dental Trauma
- Injury to the head an neck; fatal injury

**General Findings**

- Chronic abdominal, pelvic, chest pain
- Somatic disorder
- Irritable bowel syndrome
- Chronic gynecologic symptoms
- STDs and exposure to HIV from sexual coercion

- Exacerbation of chronic symptoms from diabetes, asthma, or coronary artery disease
- Chronic joint or back pain, headaches, numbness, and tingling from injuries
- Noncompliance with medical regimen

**Psychological symptoms**

- Depression and suicidal ideation
- Anxiety symptoms and panic disorder
- Eating disorders
- substance abuse
- PTSD

**Findings during pregnancy and childbirth**

- Any of the above
- Unwanted pregnancy
- Complications such as miscarriage, low birth weight of infant, abruptio placentae, Premature rupture of membranes, and antepartum hemorrhage
- Lack of prenatal care

**Incidental findings**

- Delay in seeking treatment or inconsistent explanation of symptoms
- Repeated visits to ER or clinic
- Evasiveness of patient or jumpiness, fearfulness, or crying
- Overly attentive partner or verbally abusive partner
- Identifiable social isolation

**Common Characteristics of Domestic Violence Injuries**

- Central distribution
- Injuries on head, neck, and mouth
- Defensive injuries of the forearms
- Injuries that are not adequately or consistently explained
- Injuries to multiple areas
- Bruises in multiple stages of healing
- Neurologic symptoms: hearing and vision loss, headaches, numbness or tingling
- Unexplained stroke in young woman
- Any injury as a result of sexual assault

**Presentation**

- Symptoms are often ambiguous
- Victim may use medical visit in order to seek help.
- Batterers often interfere with victim's ability to seek help for themselves
- Both partners may have mental health issues.
- Battering often increases during pregnancy.
    - ALL pregnant women should undergo domestic violence screening.
- Domestic violence victims may have a confusing medical history and victims may be evasive or anxious.

**Management**

- Many women will have no signs of abuse; therefore, routine screening is necessary.

- Screening of men is recommended if the patient shows any indicators.
- Ambiguous situations call for good differentiating questions.
- In pediatric cases, screeners should also examine the child for indicators.
- Routine visits provide opportunities for screening.
- Screening should be done in private.
- Under no circumstances should a woman be questioned about domestic violence in the presence of her partner or a non-professional translator.
- Use a general questioning approach at first.
- This approach avoids confrontation.
- Key Questions:
    - "Do you ever feel unsafe at home?"
    - "Has anyone ever tried to harm you in any way?"
    - 71% sensitivity and 85% effective
- If there is a disclosure – document:
    - Nature of abuse
    - date, time, circumstances of event
    - previous assaults
    - resultant injuries

**Documentation**

- Keep contact confidential.
- Revealing information needs to be kept confidential.
- Domestic violence should be included in billing or diagnostic terms.

- A woman with a suspected abuser should not handle her own chart.
- Clear documentation is important.
- Recordings of injuries should include:
  - location
  - depth
  - direction
  - appearance
  - character
- Photographs are vital but require consent.

**Referral**

- Inform patient of available resources and options.
- A common barrier to leaving is a woman's lack of confidence in her own ability

**Safety Planning**

- Screener must decide whether or not it is safe for a victim to leave the premises.
- Follow-up visits are important.

Sugg, N.K., Thompson, R.S., Thompson, D.C., Mauiro, R. & Rivara, F.P.(1999). Domestic violence and primary care: attitudes, practices, and beliefs. *Archives of Family Medicine*, 8(4): 301-306.

- Most health care experts are uninformed about the risk factors in their patients for spouse abuse and violence.
- Only 7 – 25% of domestic violence cases are identified and only 60 – 90% of cases are handled properly.
- Only 2 – 7% of patients in ambulatory care report physician inquiry about abuse.

**Results of Survey Research**

5 Clinics

240 Providers

92,201 patients

206 respondents

- 71 physicians
- 13 PAs
- 6 NPs
- 58 RNs
- 25 LPNs
- 33 MAs

- 70% women
- 72% worked in health care for at least 10 years

| EVER | PAST YEAR |
|---|---|
| 10% never identified an abuse victim (clinicians) | 30% |
| 55% never identified a batterer | 72% |
| 46% never identified an abuse victim (nurses) | 61% |

61% never identified a batterer 85%

**Perceived Prevalence**

| Clinicians | Nurses | |
|---|---|---|
| 50% | 70% | Believed that domestic violence occurred in less than 1% of their practice site. |
| 12% | 1% | Believed that domestic violence was common (10-15%) of the population. |

**Frequency of Asking about Domestic Violence**

How often do you ask (clinician) in high-risk cases (injury, depression, anxiety, chronic pelvic pain, headache, irritable bowel syndrome)?

Seldom or never 45.2%

Patients with depression, anxiety, or chronic pelvic pain: seldom or never – 60%

Less than 20% always or almost always ask when high risk factors are met.

**Feeling of Offending**

85% feel that asking about domestic violence was not an invasion of privacy.

65% were concerned about offending patients.

**Confidence in Asking**

39.3% were confident about asking questions about domestic violence.

25.8% were not at all confident.

**Previous Education on DOMESTIC VIOLENCE**

22% had attended domestic violence training in the last year.

70% of clinicians and 83% of nurses had no training in the last year.

Nudelman, J. & Trias, H.R. (1999). Building bridges between domestic violence advocates and health care providers. Retrieved October 3, 2001, from http://www.vaw.umn.edu/FinalDocuments/dvcps.asp.

**Why battered women need a strengthened health care response.**

US Justice Dept reports that 37% of women that sought health care as a result of violence received injuries from a current spouse or boyfriend

ER Dept - 28% of women at 3 care centers had experienced domestic violence and 14% were currently experiencing some form of domestic violence

OB/GYN – 10-32% of prenatal patients have a history of abuse

**Health professionals often fail to perceive domestic violence as a part of a patient's life.**

One study in the Midwest: n=394

22.6% had been abused in t he last year, 38.8% had been abused in their lifetime

1.6% have ever been questioned about domestic violence

**State Law**

NY requires all hospitals have some protocol to identify and treat domestic violence

NY requires all physicians to undergo domestic violence training for re-licensure???

**Training**

The most useful training programs are interactive, learner-centered, and utilize role-play. Role-play should enable participants to practice screening and supportive interventions.

Programs should include speakers that can provide basic domestic violence training on nature and the dynamics of domestic violence.

Program trainers should provide resources for legal assistance, child advocacy, job training and referral centers, supervised visitation centers, and other community resources.

Screeners will need to understand their role related to law enforcement.

Be prepared for potential screeners to indicate that they are victims of abuse.

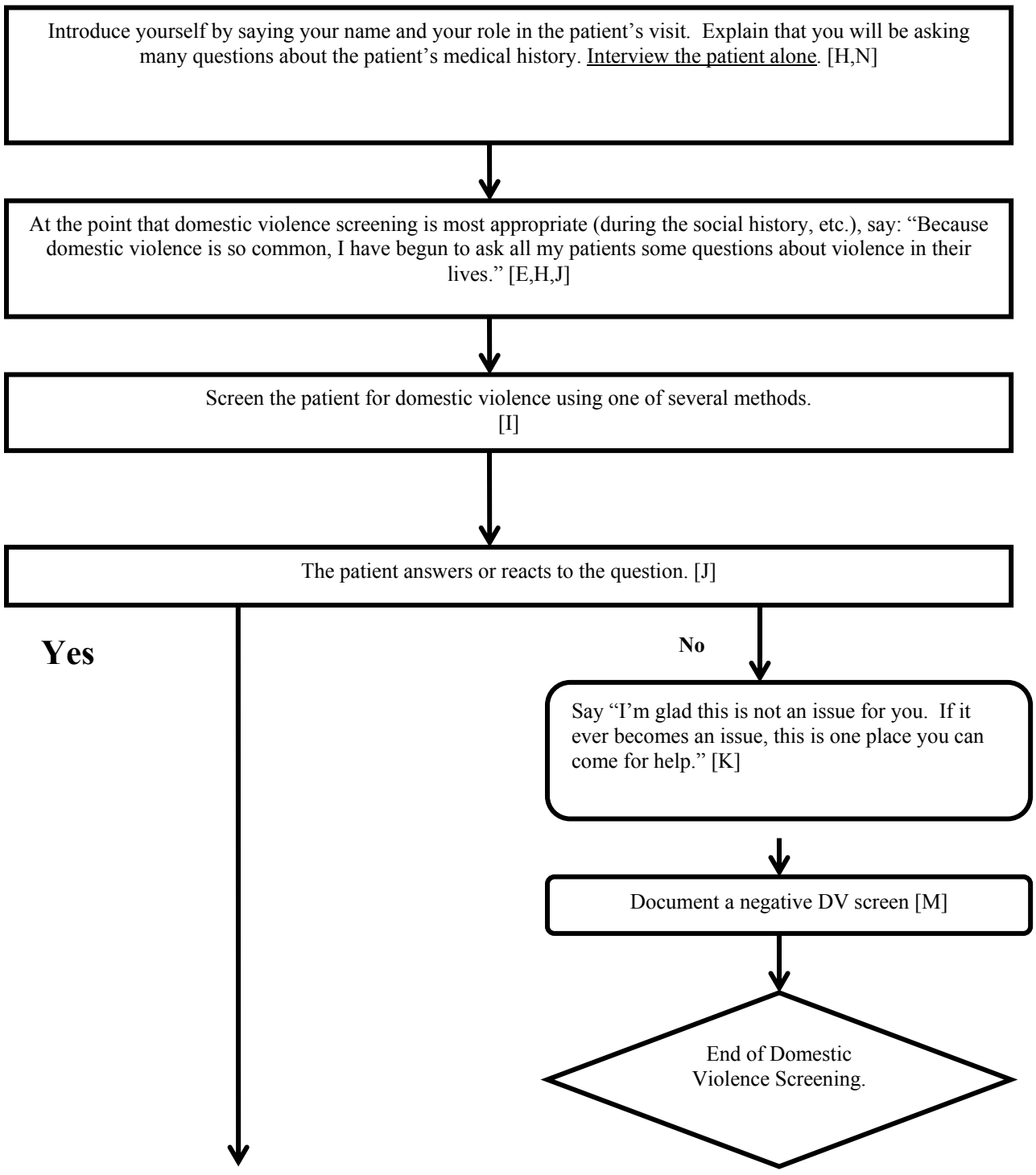
**The importance of combining screening with training, response protocols and service.**

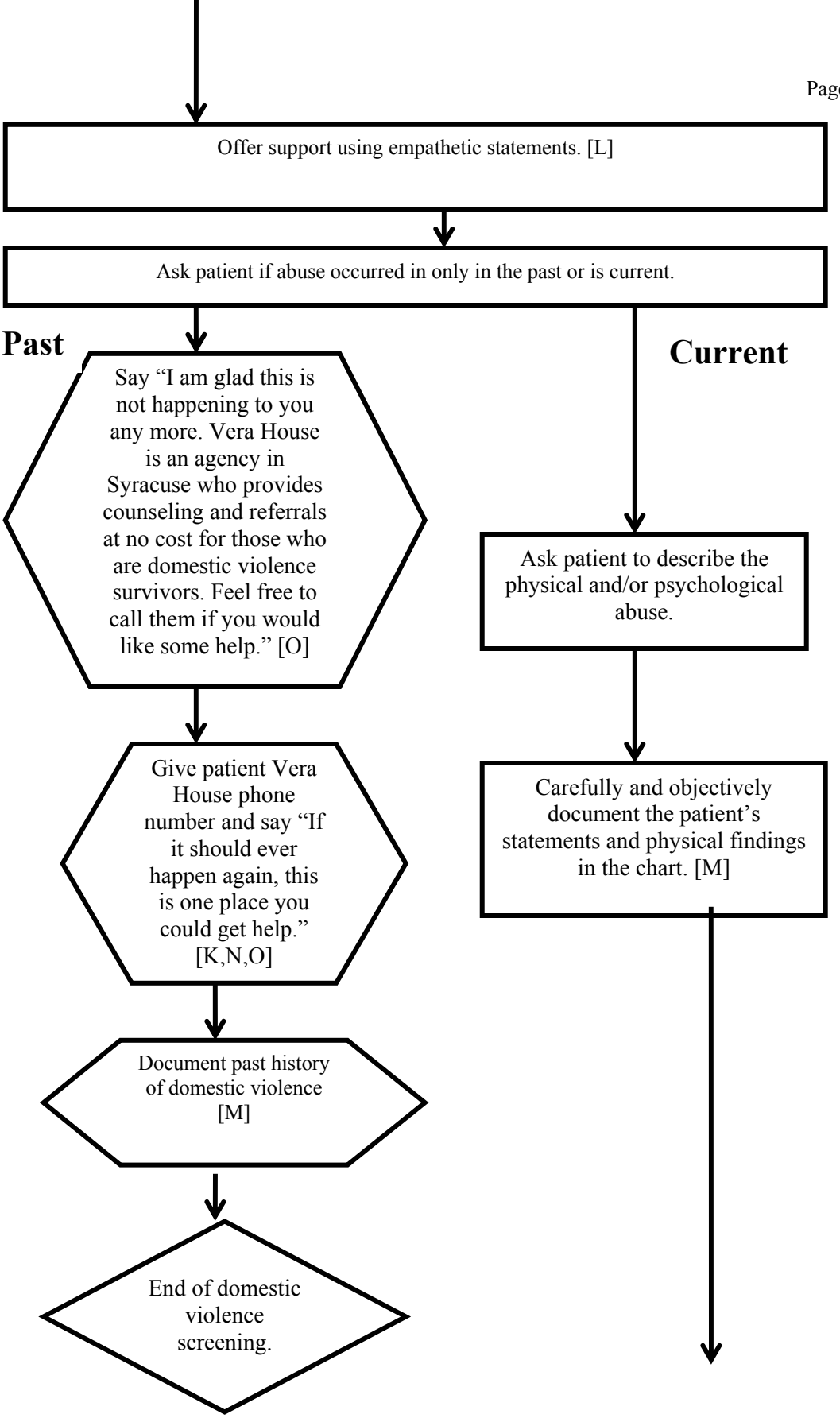
There are risks to the patient if the screener is not properly trained to deal with the situation. Untrained screeners could endanger the patient unduly. This could force inappropriate legal action. Screening needs to go hand in hand with training and case management.

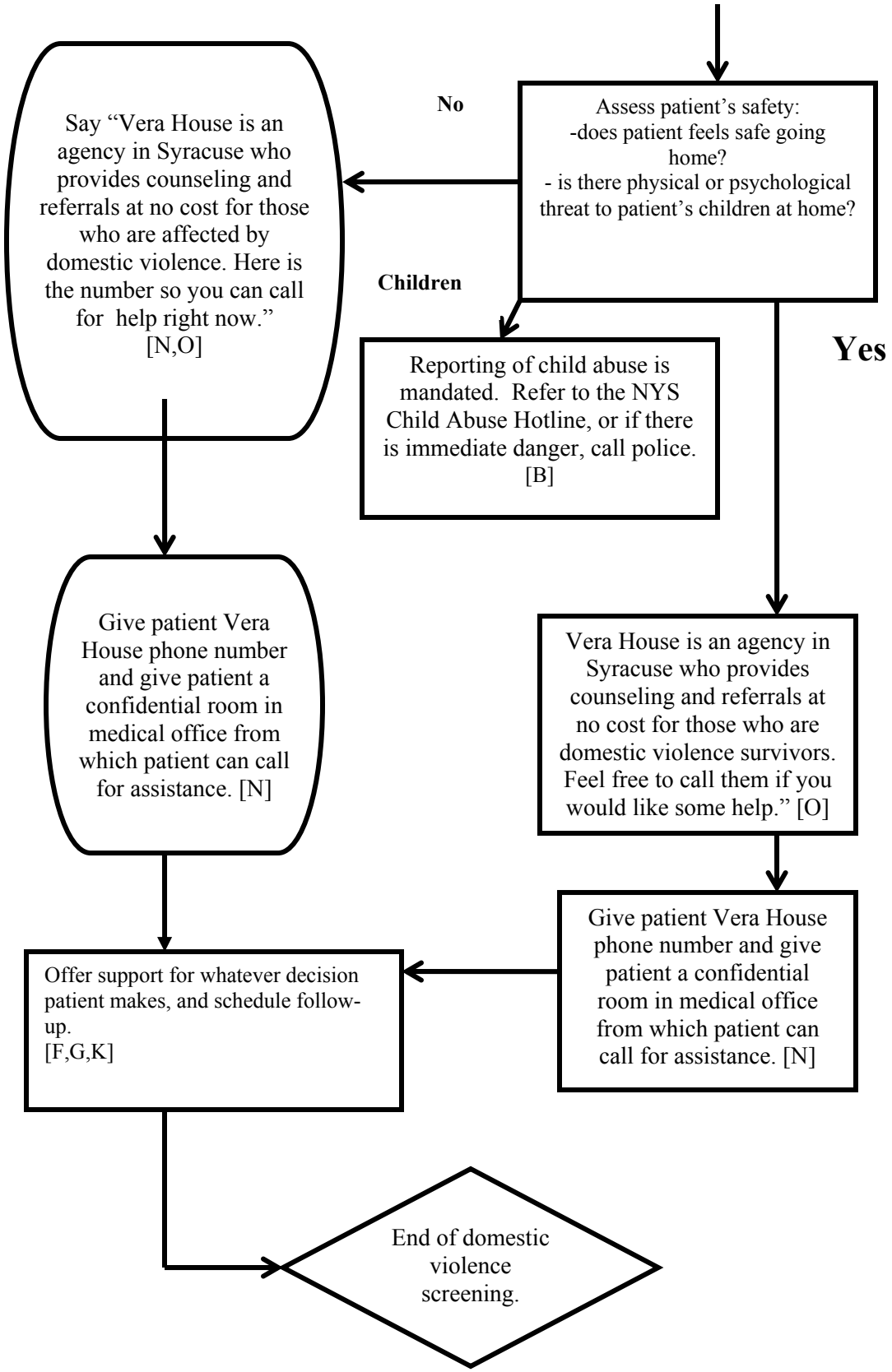
Appendix H (Table of Contents)

Task analysis for health care personnel screening for domestic violence

Screening may occur during a doctor's visit for a routine physical examination, women's health examination, or any routine pregnancy visit. Analysis begins from point at which medical personnel meets patient in the exam room.
Variations or choices occur at lettered ([X]) points – see the topic analysis below for explanations.
.




Offer support using empathetic statements. [L]
Ask patient if abuse occurred in only in the past or is current.
Past
Current
Say "I am glad this is not happening to you any more. Vera House is an agency in Syracuse who provides counseling and referrals at no cost for those who are domestic violence survivors. Feel free to call them if you would like some help." [O]
Give patient Vera House phone number and say "If it should ever happen again, this is one place you could get help." [K,N,O]
Document past history of domestic violence [M]
End of domestic violence screening.
Ask patient to describe the physical and/or psychological abuse.
Carefully and objectively document the patient's statements and physical findings in the chart. [M]


Assess patient's safety:
-does patient feels safe going home?
- is there physical or psychological threat to patient's children at home?
No
Say "Vera House is an agency in Syracuse who provides counseling and referrals at no cost for those who are affected by domestic violence. Here is the number so you can call for help right now." [N,O]
Children
Reporting of child abuse is mandated. Refer to the NYS Child Abuse Hotline, or if there is immediate danger, call police. [B]
Yes
Give patient Vera House phone number and give patient a confidential room in medical office from which patient can call for assistance. [N]
Vera House is an agency in Syracuse who provides counseling and referrals at no cost for those who are domestic violence survivors. Feel free to call them if you would like some help." [O]
Give patient Vera House phone number and give patient a confidential room in medical office from which patient can call for assistance. [N]
Offer support for whatever decision patient makes, and schedule follow-up. [F,G,K]
End of domestic violence screening.

TOPIC ANALYSIS – Intimate Partner Violence Screening

A. Terms
    a. Spouse Abuse
    b. Battering
    c. Domestic Violence
    d. Intimate Partner Violence (IPV)
        i. This is preferred because of inclusiveness.
B. Spectrum of Family Violence
    a. Child Abuse
    b. Teen Dating Violence/Date Rape
    c. Elder Abuse
    d. IPV does not involve mandated reporting by health professionals
        i. Health professionals provide resources for patient to help themselves
    e. Abused elders and children are in a dependent situation with abusing caregivers, therefore require mandated reporting.
        i. NYS Child Abuse Hotline - 1-800-342-3720
    f. In most heterosexual couples with IPV, the female is the victim (95% of time)
C. Background Statistics on IPV
    a. 76% of women raped or assaulted (after age 18) were victimized by intimate male significant other. (National Violence against Women Survey 1998)
    b. 1 million women per year seek medical assistance for injuries caused by battering. (US Dept of HHS, 1991)
    c. over 22% of women are assaulted by an intimate partner in their lifetime.
    d. Domestic violence is the leading cause of injury to women between the ages of 15 and 44 – more than auto accidents, muggings and rapes combined. (Uniform crime reports, FBI, 1991)
    e. Medical expenses from domestic violence – $3-5 billion/year (Domestic Violence for Health Care Providers, 3e, Colorado Domestic Violence Coalition, 1991)
D. Power and Control Dynamics
    a. IPV is primarily a result of relationships based on power and control over the partner rather than respect for and negotiation with her.
    b. See: http://www.jwejr.net/familymed/dv/Domestic%20Violence%20and%20Health%20Care_files/frame.htm for the power and control wheel and the equality wheel (both with examples of the dynamics).
E. Continuum of IPV leading to consequences
    a. Physical→Death
    b. Verbal/Emotional→depression and suicide
    c. Sexual→forced sex/rape
F. Cycle of Violence
    a. Tension→Violent Act→Remorse→"Honeymoon"→Tension
    b. Over time, cycle contracts: Tension→Violence→Tension
    c. Honeymoon period reminds victim of why they are in the relationship to begin with – there is hope that the situation will improve.
        i. But over time, the honeymoon periods shrinks to nothing.
G. Barriers to Leaving
    a. Power and Control Methods/Non-violence and Equality Methods
        i. Coercion and Threats/Negotiation and Fairness
        ii. Intimidation/Non-Threatening Behavior
        iii. Emotional Abuse/Respect
        iv. Isolation/Trust and Support
        v. Minimizing, Denying, Blaming/Honesty and Accountability
        vi. Using Children/Responsible Parenting
        vii. Social Power/Shared Responsibility
        viii. Economic Abuse/Economic Partnership

   b. Leaving is the most dangerous time in IPV relationship
      i. Women who leave batterers are at a 75% greater risk of being killed than those who stay. (Hart B., National Coalition against Domestic Violence 1988)
   c. Honeymoon is a reason women do not leave right away.
   d. Social, economic and personal entanglement makes leaving difficult, even for victims who are motivated to do so.

H. Rationale for Screening
   a. True prevalence is unknown
   b. Low harm of screening questions if done correctly
   c. There is no proven overall benefit from screening (USPSTF "C" recommendation, 1996)

I. Methods of screening
   a. Vera House Questions
      i. Have you ever been in a relationship with a person who hurts or threatens you or makes you feel bad about yourself?
      ii. Have you ever been hit, kicked, slapped, pushed or forced or forced to have sex by anyone?
   b. JAMA 1997 – Three Brief Screening Questions
      i. Have you ever been hit, kicked, punched or otherwise hurt by someone within the past year?
      ii. Do you feel safe in your current relationship?
      iii. Is there a partner from a previous relationship who is making you feel unsafe now?
   c. HITS Questions
      i. How often does your partner:
         1. physically HURT you?
         2. INSULT you or talk down to you?
         3. THREATEN you with harm?
         4. or SCREAM and curse at you?

J. Dealing with reactions
   a. Rarely is screening perceived by the patient as offensive.
   b. Patients may attempt to laugh it off or dodge answering the question – politely ask again – if no answer this time, move to "open door" statements [K]

K. "Open door statements"
   a. many women may not be ready to disclose violence[G], others will not be affected by violence at the time
   b. important to "leave the door open" so that patients will have a resource when they're ready to or need to discuss IPV in their lives.
   c. Avoid "nagging" or pressuring the patient into a course of action – equivalent of intimidation and emotional power and control

L. Empowering Statements and post-screening counseling
   a. "**ABCD**" Method – reinforce each with the patient
      i. "You are not **A**lone."
      ii. "You are not to **B**lame for partner's acts."
      iii. "You are not **C**razy. Domestic Violence is a **C**rime
      iv. "You do not **D**eserve to be abused."
   b. **BATHE** Method
      i. **B**ackground – What's been happening?
      ii. How has it **A**ffected you?
      iii. What kind of **T**rouble is it causing in your life?
      iv. How are you **H**andling it?
      v. Use **E**mpathy

M. Documentation issues
   a. Best to place on problem list – positive or negative – BUT confidentiality of chart is important.
   b. Document suspicion, even if not confirmed

   c. Document patient's statements exactly, including date, time, place, and persons involved with full name.
   d. Document injuries with detail. Photos and diagrams add to value of documentation.

N. Safety
   a. Interview the patient alone (without children who can talk, friends, or parents) – respect confidentiality and decrease chance that someone will tell perpetrator about her contact with you.
   b. Provide office phone and space to allow patient to contact shelters/crisis lines.
   c. Do not give literature/cards, etc. with IPV shelter phone numbers or information on it.
   d. Attend to appropriate safety measures when patient informs you that she's in immediate danger – hospitalization, arrangement of safe haven from office, etc.

O. Resources
   a. Vera House Crisis Line (24 hours) – 468-3260
   b. Vera House Administrative Offices – 425-0818
   c. Family Violence Prevention Fund – www.endabuse.org
   d. NYS DV Hotline – 1-800-942-6906

# Appendix I (Table of Contents)

## Objective-Presentation-Generative Strategy Matrix

**1. Understand the importance of domestic violence in medical care.**

| Objective | Content Type | Strategy | Presentation | Generative Strategy |
|---|---|---|---|---|
| Define domestic violence | Concept | Concept learning – organizational | Present the definition, examples and non-examples | Students practice classifying types of abuse as domestic violence or not. |
| Articulate background statistics on intimate partner violence | Fact – Application | Presentation | Present the statistics in percentage format | Calculate the number of people in the room (from the percentages) possible affected by IPV. |
| Describe the ways in which domestic violence theories impact patient-provider interactions (e.g. power and control dynamics, continuum of IPV, etc.) | Rules – Application | Example theories and elaboration | Visual aids (power and control wheel, continuum) describing theories (rules) | Students think of ways in which patient-provider relationships can be affected by these theories (examples by instructor if needed.) |
| Articulate the rationale for screening for IPV in healthy patients | Interpersonal/Attitude | Elaboration | Present national recommendations for IPV screening | Students discuss pros and cons of screening for IPV and difference between screening and diagnosis. |

**2. Properly screen patients for domestic violence.**

| Objective | Content Type | Strategy | Presentation | Generative Strategy |
|---|---|---|---|---|
| A. Identify the appropriate conditions under which to screen (i.e. alone, office space, etc.) | Facts | Recall Application – Practice/Rehearsal | Present the students with the ideal conditions as they would apply to screening a patient for domestic violence | Allow the students time to practice/rehearse the information. Have the students set up a screening atmosphere |

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| | | | | working in groups of two or with the whole class. |
| B. Articulate the methods for questioning patients for abuse. | Procedure | Cognitive Procedures Application | Present the students with a demonstration that models the methods of questioning patients for domestic violence. | Students will complete a worked example in different small groups. The worked example will walk the students through the problem-solving process. During this process the students will either paraphrase or elaborate on the procedure. Next, The students will work other examples. The instructor will help (model) answers for the groups. |
| C. Articulate the reasons why patients do not admit to domestic violence. | Rule | Rule – eg Integration | Present the students with the definition of the rule (domestic violence victims do not always disclose violence). | The definition is followed by several examples of patients that do not disclose violence. Learners will then generate situations where victims will not disclose abuse. |
| D. React to patients' disclosing domestic violence abuse. | Interpersonal Procedural | Demonstration – Modeling<br><br>Practice | Four Steps:<br>1. Present the model to the learner.<br><br>2. Students work with a verbal model that helps to produce a positive reaction from the screener.<br>3. Mental rehearsal | 1. Students observe a video that models a positive example of reacting to disclosure.<br><br>2. Students learn the mnemonics that relate to disclosure (ABCD and BATHE). |

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| | | | 4. Practice | 3. Students will look at some examples and case studies.<br>4. Students will role play a disclosure event. |
| E. Document disclosures completely and appropriately. | Procedural | Cognitive Procedure Recall | Present the students with a demonstration that models the documentation procedure. | Students will complete a worked example that allows the students to practice the process of documenting domestic violence abuse. |

**3. Understand how to refer patients for assistance with domestic violence concerns.**

| Objective | Content Type | Strategy | Presentation | Generative Strategy |
|---|---|---|---|---|
| Identify power-control dynamics to avoid in the medical practitioner relationship | Concept<br><br>Attitude | Application Concept learning-integration<br><br>Developing verbal and imaginal model/organization | Present the power-control dynamic concept and the verbal/image figure that explains it, as well as examples of how the dynamic appears in healthcare settings and is handled properly and improperly. | Students draw the figure that represents the power-control dynamic and explain it. Students look at case studies and explain how the clinician properly or improperly handled the power-control dynamic. |
| Identify domestic violence services provided by local resources/agencies | Facts | Recall | Present a list of domestic violence shelters and agencies, a description of what each does, and how to contact each agency. | Allow for practice/rehearsal by having them list each agency and describing what each does and how to contact them. |
| Understand how and when to provide domestic violence resources to patients. | Procedure | Recall, demonstration, practice | Present a list of statements that the clinician should offer the | Students watch a videotape that shows a clinician interacting with a |

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| | | | patient of what to say when the patient articulates they are a victim of abuse. | patient who has articulated they have been abused. They are referred to a specific point in the video during which the clinician tells the patient the resources that are available to him or her. After the videotape, students are asked to paraphrase what steps were taken and what they should say. |
| Articulate how to assist patient in obtaining assistance from domestic violence agencies. | Cognitive Domain Procedure<br><br>Attitude<br><br>Interpersonal | Recall, demonstration, practice, role-modeling | (same as above) Present a list of statements that the clinician should offer the patient of what to say when the patient articulates they are a victim of abuse. | (same as above) Students watch a videotape that shows a clinician interacting with a patient who has articulated they have been abused. They are referred to a specific point in the video during which the clinician tells the patient the resources that are available to him or her. After the videotape, students are asked to paraphrase what steps were taken and what they should say. |
| Plan appropriate follow-up for patients who do and do not disclose domestic violence abuse | Interpersonal<br><br>Rule | Rule-eg (statement of rule followed by several examples), model | Present the rule of what must be done and written into chart if patient does or does not disclose being a victim of domestic violence abuse. Show some written examples of what was written into chart. Instructors | On an overhead, instructors present the rule of what must be written in chart if patient does or does not disclose domestic violence abuse. Students watch a videotape of clinician speaking with a patient after the patient has and has not disclosed being a victim of abuse. Students are asked to paraphrase what |

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| | | | explain legalities around having to document accurately alleged abuse. | must be done and why it must be done. |

Appendix J (Table of Contents)
Domestic Violence Training Session – Outline