Contra Costa County
Health Services Department

Guidelines

for

Domestic Violence Screening
and Reporting

October 1995
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Provider’s Reference Card for Domestic Violence Screening and Reporting

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Provider's Reference Card:

Domestic Violence Screening, Assessment, Intervention, and Reporting:

Below are the key steps involved in the Health Service Department’s model protocol for domestic violence. This protocol, contained in the Department’s Guidelines for Domestic Violence Screening and Reporting, will enable providers to comply with current California laws related to screening for and reporting domestic violence. All forms and reference materials cited in this

Synopsis are available in the Guidelines Appendices. In order to take the following steps you MUST have:

Body Maps (Appendix D)
Domestic Violence Reporting Form (Appendix F)
Battered Women’s Alternatives Referral Information (Appendix I)

1. Designate a KEY STAFF PERSON responsible for implementing the protocol:

Ideally, one health care provider will implement the protocol. However, in some settings, such as the emergency department, a team of professional staff may be responsible for implementation.

2. Designate a PRIVATE SETTING within the health care facility in which to implement the protocol:

Never screen or assess a patient for domestic violence in the presence of her partner. This can put the patient at extreme risk. If there is no private examination room in the facility, find a point in the examination process prior to commencing screening where the patient can be separated from her partner, such as when an x-ray is taken or during lab work. A private office or nursing station where the patient can be interviewed alone can also be utilized if no other setting is available.

3. INFORM the patient of the following points:

Screening for domestic violence is ROUTINE and is conducted with all women. If she has injuries that have been caused by domestic violence, health care providers are REQUIRED BY LAW TO REPORT HER INJURIES to law enforcement and document the injuries in the medical record. Inform the patient that information in the medical record can be useful in criminal proceedings related to domestic violence.

4. SCREEN for exposure to domestic violence:

Administer the recommended Screening Tool (Guidelines, Appendix B), or ask:

“Do you ever feel afraid of or threatened by your partner?” YES NO
“Within the last year, have you been hit, slapped, kicked, or physically hurt by someone?” YES NO
If patient is pregnant, “Since the pregnancy began, have you been hit, slapped, kicked, or physically hurt by someone?” YES NO
If YES, “Who hurt you?” (circle all that apply): Spouse, Former Spouse, Boyfriend, Ex-Boyfriend, Girlfriend, Ex-Girlfriend, Stranger, Sibling, Parent, Other (specify) (OVER)

Reporting Injuries Caused by Domestic Violence

Only physical injuries caused by domestic violence which are observed during the provision of medical services for a physical condition must be reported. Note: If a provider is not treating a patient for a physical condition, the provider is not required to report domestic violence injuries (e.g., advice nurse).

Health care providers can fulfill their legal obligation to report domestic violence while also maintaining patient safety. Police departments may conduct an investigation upon receipt of a health care provider report of injuries. For this reason, the Domestic Violence Reporting Form (Guidelines, Appendix F) has space in which to indicate whether or not the patient is concerned about retaliation from the batterer if police investigate the report, and how she may be contacted safely. Be sure to fill out all of the information on the form.

Reports must be made to a local law enforcement agency (police telephone numbers are listed below) in the jurisdiction in which the injury occurred.

A TELEPHONE REPORT must be made as soon as is practically possible by the provider who treated the patient’s physical condition or by the provider’s designee.

A WRITTEN REPORT must be prepared by a designated person and sent within two working days.

Police Phone Numbers:

<table>
<thead>
<tr>
<th>Alamo</th>
<th>Brentwood</th>
<th>Hercules</th>
<th>Moraga</th>
<th>Pleasant Hill</th>
<th>Unincorporated Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>646-2441</td>
<td>778-2441</td>
<td>724-1111</td>
<td>284-5010</td>
<td>671-4600</td>
<td>646-2441</td>
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<tr>
<td>Antioch</td>
<td>Concord</td>
<td>Kensington</td>
<td>Orinda</td>
<td>Richmond</td>
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</tr>
<tr>
<td>778-2441</td>
<td>671-3333</td>
<td>526-4141</td>
<td>284-5010</td>
<td>233-1214</td>
<td>943-5844</td>
</tr>
<tr>
<td>Bethel Island</td>
<td>Danville</td>
<td>Lafayette</td>
<td>Pinole</td>
<td>San Pablo</td>
<td>Note: to make a report on a DV incident that occurred in an area of Contra Costa County that is not listed here, call the County Sheriff’s office at 646-2441.</td>
</tr>
<tr>
<td>646-2441</td>
<td>646-2441</td>
<td>284-5010</td>
<td>724-1111</td>
<td>233-1214</td>
<td>646-2441</td>
</tr>
<tr>
<td>Blackhawk</td>
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<td>Martinez</td>
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<td>372-3440</td>
<td>646-2441</td>
<td>646-2441</td>
<td></td>
</tr>
</tbody>
</table>
5. If screen is NEGATIVE for exposure to domestic violence:
Note: place Screening Tool in the medical record. Inform the patient of the availability of Battered Women’s Alternatives services: see Step 6, below.

6. IF SCREEN IS POSITIVE AND PATIENT IS NOT PRESENTING WITH INJURIES due to domestic violence:
Note: place Screening Tool in the medical record, and record any additional comments or history of past injury due to domestic violence.
Counsel the patient on the physical and emotional sequelae of domestic violence and validate that the abuse is not her fault but that of the abuser.
Inform the patient that information in the medical record can be helpful to her in a legal or criminal justice action.
Advise the patient that because abuse can escalate in a relationship, you are concerned for her safety and would like to ask her some additional questions.
Administer the Danger Assessment Questionnaire (Guidelines, Appendix C) or ask:
“Has the violence increased in frequency over the past year?” YES NO
“Has a weapon been used or has a threat to use a weapon been made?” YES NO
“Is there a gun in the house?” YES NO
“Does your partner threaten to kill you, or do you believe that he is capable of doing so?” YES NO
“Do you ever believe that you might harm or attempt to kill yourself?” YES NO
Note: place questionnaire in the medical record.
Ask the patient if she would like to discuss options and services that are available to her and if she feels ready to discuss the situation with a domestic violence counselor. Use the answers to gauge her readiness to make decisions that will lead to changing that situation.
Inform the patient that she can talk to an advocate from BWA, either on the phone or in person. Inform the patient that BWA can:
help her assess her safety in her current situation;
link her to ongoing support groups;
provide her with legal advocacy services and
provide her with telephone counseling;
provide her and her children with transportation and shelter;
assist her in making a police report.

7. Access BWA advocacy services:
It is extremely useful to have an advocate from BWA meet with the patient to assess her safety and link her to services. If the patient would like the services of a BWA advocate, CALL THE BWA CRISIS NUMBER and request that an advocate meet the patient in the health care setting.
INFORM BWA IF A LANGUAGE OTHER THAN ENGLISH IS THE PRIMARY LANGUAGE of the patient. Every attempt will be made to dispatch an advocate who speaks the patient’s language.

BWA CRISIS PHONE NUMBERS:
Antioch: 757-8200 Concord: 930-8300 Richmond: 233-2420

If the patient DECLINES BWA SERVICES, offer her a card with BWA service number (be sure the patient can safely have this card in her possession) and/or other referrals as appropriate (see Appendix I, Community Resource List). Assess how safe she will be after she leaves the health care setting: see Step 9, below.

Don’t judge the success of the intervention by the patient’s action. A woman is most at risk of serious injury or even homicide when she attempts to leave an abusive partner, and it may take her a long time to finally do so. It is frustrating for the provider when a patient stays in an abusive situation. Be assured that if you have acknowledged and validated her situation and offered appropriate referrals, you have done what you can to help her.

8. IF SCREEN IS POSITIVE AND PATIENT IS PRESENTING WITH INJURIES due to domestic violence:
TREAT the patient’s physical injuries.
DOCUMENT in the medical record injuries and any statements made by the patient. Document location of injuries on Body Map (Guidelines, Appendix D).
INFORM the patient that because her injuries were caused by domestic violence, the health care provider is REQUIRED BY LAW TO REPORT HER INJURIES to a local law enforcement agency.
COUNSEL/ASSESS FOR LETHALITY of the abuse: see Step 6.
ACCESS BWA advocacy services: see Step 7.

9. Conduct a SAFETY ASSESSMENT:
If a BWA advocate cannot be brought in to assist the patient, it is recommended that health care providers familiarize themselves with safety planning (Guidelines, Appendix E). Determine if the patient has a safe place to stay after she leaves the health care setting or is discharged from the hospital or emergency department. Determine if she can stay with friends and if she has key documents, such as a driver’s license, checking account numbers, and other forms of identification, etc.
Schedule a follow-up appointment with the patient.

10. REPORT INJURIES caused by domestic violence: see box on other side.
Executive Summary

Introduction:

The impact of domestic violence on women's health is significant. Each year, approximately two million women in the United States are battered by their partners. Battering is responsible for a range of health problems, including serious injury, disability, and death. Health care providers have an opportunity to intervene in domestic violence situations, as battered women frequently seek treatment for injuries sustained through battering and abuse. Providers are in the unique position of being able to identify battering as the cause of a woman's injury and refer her to the appropriate services.

The Contra Costa Health Services Department Guidelines for Domestic Violence Screening and Reporting were developed to give Health Department staff resources for assisting patients in domestic violence situations and complying with California law. The materials, which are referenced in the HSD's Domestic Violence Screening, Mandatory Reporting, and Training Policy, reflect current knowledge and expertise about the nature of domestic violence and the role of health care providers in controlling and preventing domestic violence.

Summary of Domestic Violence Screening and Reporting Laws:

Not only is it the goal of the Health Services Department to make screening for domestic violence a routine part of health care delivery, California law now mandates routine screening. Additionally, under state law there are some circumstances in which injuries resulting from domestic violence must be reported to law enforcement. The following paragraphs explain the requirements of these two laws.

The domestic violence screening law requires licensed clinics, general acute care hospitals, psychiatric hospitals, psychiatric health facilities, and chemical dependency recovery hospitals to establish and adopt written policies and procedures for screening patients for spousal and partner abuse by July 1, 1995. These policies and procedures shall include:

• Methods for identifying spousal and partner abuse among patients.

• Documentation in the medical record of the patient's injuries or illnesses attributable to spousal and partner abuse.

• For patients who are positively screened, provision of a current referral list of community agencies that provide, at a minimum, information on shelter services for battered women, counseling, legal services, and how to arrange for restraining orders.

The domestic violence reporting law requires any health practitioner employed in a health facility, clinic physician's office, local or state public health department, clinic, or other facility operated by a local or state public health department to make a report if he or she "provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is":

1. "suffering from any wound or other injury inflicted by his or her own act or inflicted by another where the injury is by means of a knife, firearm, or other deadly weapon," and/or
2. “suffering from any wound or other physical injury inflicted upon the person where the injury is
the result of assaultive or abusive conduct.”

Screening for Domestic Violence:

It is strongly recommended that providers notify patients prior to screening for domestic violence that health
care providers are legally mandated to report to law enforcement in the event that the patient’s injuries were
caused by domestic violence.

It is very important to conduct screening interviews in private, away from the patient’s partner, children, or
friend, so that the patient can speak frankly. Ask any spouse, partner, friend, or family member accompanying
the patient to leave the treatment area. Questioning the patient about battering in the presence of the abuser
could put the patient in extreme danger.

The issue of battering should be assessed in a straightforward manner. Medical providers should ask
questions in a direct, non-threatening way. Encourage but do not badger the patient to respond to domestic
violence screening and assessment questions. Patients will choose when to share any history of violence with
a health care provider. For some, more time may be necessary. Once the topic of battering has been opened,
the patient must trust the health care provider in order to feel comfortable disclosing domestic violence.

Reporting Domestic Violence Injuries:

Health care providers can fulfill their legal obligation to report domestic violence while also maintaining
patient safety. Police departments may conduct an investigation upon receipt of a health care provider report
of injuries. For this reason, the Domestic Violence Reporting Form (Appendix F) recommended for use by
Health Services Department providers has space in which to indicate whether or not the patient is concerned
about retaliation from the batterer if police investigate the report, and how she may be contacted safely. Be
sure to note in the spaces provided on the form the answers to these questions, as this information will assist
police in investigating without increasing the likelihood of further violence.

Linking Battered Women with Battered Women’s Alternatives:

All patients who report past or current abuse by their partners or spouses should be referred to Battered
Women’s Alternatives (BWA), which provides a network of services for victims of domestic violence. BWA
staff are available to serve in the health care setting as advocates for victims of battering. If a patient declines
services, offer the patient a BWA card listing crisis line numbers.

Working with Diverse Populations:

Particular attention must be paid to issues affecting patients of diverse cultures, ethnicities, linguistic
abilities, age groups, and sexual orientation when addressing domestic violence. Awareness of cultural values
and norms will assist the health care provider when listening to patients, giving them information, and helping
them make decisions and safety plans.
How to Use these Guidelines

The Contra Costa Health Services Department Guidelines for Domestic Violence Screening and Reporting were developed to give Health Department staff resources for assisting patients in domestic violence situations and complying with California law. The materials reflect current knowledge and expertise about the nature of domestic violence and the role of health care providers in controlling and preventing domestic violence. Throughout this document, it is assumed that the victim of domestic violence is female. Although men are battered by male and female partners, 95% of battering victims are women.

The protocol included in Appendix A is intended to lead health care providers through the process of screening and assessing clients for exposure to domestic violence as a routine part of service provision. The protocol provides information on how to link clients to the advocacy services of Battered Women's Alternatives and how to educate patients and refer them to services. In cases where a patient presents with physical injuries due to domestic violence, the protocol will assist providers in fulfilling their legal obligation to report these injuries. Also included in the Guidelines are recommendations for working with the culturally and linguistically diverse patients served by the Health Services Department.

The protocol, tools, and forms prepared for these Guidelines can be found in the Appendices in the back of the guide. They are intended for removal and duplication in individual departments and clinical settings.

Technical assistance on implementing this information is available. If your department would like to refine the protocol presented here, please contact the Contra Costa County Health Services Department Prevention Program at (510) 646-6511, Battered Women's Alternatives at (510) 676-2845, or the Family Violence Prevention Fund's Health Resource Center at 1-800-333-1310. To obtain additional copies of the Guidelines, please contact the Prevention Program.
Introduction

The impact of domestic violence on women's health is significant. Each year, approximately two million women in the United States are battered by their partners. Battering is responsible for a range of health problems, including serious injury, disability, and death. Health care providers have an opportunity to intervene in domestic violence situations, as battered women frequently seek treatment for injuries sustained through battering and abuse. Providers are in the unique position of being able to identify battering as the cause of a woman's injury and refer her to the appropriate services.

Research has demonstrated the lack of a consistent, coordinated response to domestic violence on the part of health care providers, even in settings in which a protocol for treating and referring battered women exists. A recent study of primary care physicians' responses to domestic violence found that physicians expressed a variety of reasons for not assessing domestic violence. For example, physicians feared offending patients when asking about abuse and felt powerless to prevent future violence. Additionally, physicians cited time constraints and fear of identifying with victims as deterrents to asking about abuse.

The study also found that physicians who routinely asked about domestic violence had developed a "...comfortable, neutral, business-as-usual approach to asking questions about violence. They perceived their role as validating a patient's feelings, discussing safety issues, and referring patients to appropriate resources." These physicians realized that the time-frame for recovery from abuse could be lengthy and did not expect one intervention to solve the problem. At the same time, they noted having achieved successful outcomes when addressing the issue of domestic violence in the medical setting.

By incorporating questions regarding battering into routine screening, the health care provider has the opportunity to validate battering as an important cause of injury to women, stress-related disorders, and disability. Broaching the topic can make a battered woman's interaction with health care professionals positive, supportive, and informative. It may also have unintended positive consequences, as in the following case:

When I was 17 and pregnant with my first child, the nurse asked if I was abused. When I said no, she offered me information on abuse and community resources. I took the information because my sister was being abused. Three months later, during an argument the baby's father slapped me across the face. I dialed 911 and he tore the phone out of the wall before I could talk to anyone. The police arrived in four minutes and arrested him. I pressed charges. He was fined for damages, given six months probation and required to attend a treatment program for abusive men. He completed the program. There has been no further violence since that first episode years ago.
Health Services Department Domestic Violence Policy Objectives

• To promote awareness of domestic violence as a public health issue among Health Services Department staff and providers.

• To increase the use of domestic violence screening tools as part of routine preventive health practices and quality care.

• To provide education to patients about the impact that domestic violence can have on their lives and on the lives of their children, for the purposes of preventing further violence and injury.

• To link victims of domestic violence with appropriate community-based agencies and legal services.

• To offer health care providers a methodology for documenting and reporting injuries caused by domestic violence.

• To document the Health Services Department’s compliance with California domestic violence screening and reporting laws.

The Dynamics of Domestic Violence

Behavioral Definition:

Domestic violence is defined as the threat or infliction of physical harm against past or present adult or intimate partners (dating, married, or separating relationships of heterosexuals, gays, lesbians). Physical and sexual assault may be accompanied by psychological abuse, verbal intimidation, destruction of property, threat to significant others, stalking, and/or control over a victim’s access to money, personal items, and friends, family, and children. Domestic violence is a pattern of assaultive and coercive behaviors intended to achieve compliance from or control over the victim.  

Abusive and violent behavior often follows a pattern referred to as the cycle of violence. The cycle of violence contains three phases which can repeat again and again:

Phase One: This phase is marked by a need for power and control on the part of the batterer, as well as by anger and blame directed at the victim.

Phase Two: This phase involves a range of violent behavior, from a slap, push, or punch to repeated beatings, use of weapons to injure or threaten the victim, and sexual abuse.
**Phase Three:** During this phase, the batterer may be apologetic, make excuses for his behavior, and/or attempt to minimize its importance. He may also deny the behavior or blame the woman for causing the battering.

**Domestic Violence Facts:**

Battering affects women of all social classes, races, ethnicities, educational levels, professions, ages, sexual orientations, and religions. The following statistics illustrate the significance and scope of battering and its impact on women's health:

- Battering is responsible for more injuries to women than car accidents, muggings, and rapes combined.\(^7\)

- Approximately 95% of the victims of battering are women.\(^7\)

- According to the FBI, 30% of female homicide victims are killed by their current or former husbands or boyfriends.\(^7\)

- A study of female homicide in San Francisco County found that over 60% of solved murders were due to domestic violence.\(^9\)

- 14% of ever-married women report being raped by their current or former husbands.

- Rape is a significant or major form of abuse in 54% of violent marriages.\(^9\)

**Battering as a Health Problem:**

Battering has been associated with a wide range of health problems, including depression, anxiety, increased alcohol use, emotional problems, illness, pain and injury, temporary and permanent disability, and death.

The impact of domestic violence on the health care system has been demonstrated by numerous studies. According to the American Medical Association, battered women may account for:

- 25 to 30% of injured women seen in emergency departments.\(^9\)

- 14% of women seen in ambulatory care internal medicine clinics (28% have been battered at some time).\(^9\)

- 25% of women who attempt suicide.\(^9\)

- 25% of women utilizing a psychiatric emergency service.\(^9\)
• 23% of pregnant women seeking prenatal care.⁹

• 45% to 59% of mothers of abused children.⁹

• 58% of women over 30 who have been raped.⁹

Battering of pregnant women has been associated with increased risk of low-birth weight babies (less than 5.5 pounds) and delay of prenatal care. One study of 600 postpartum women in public and private hospitals found that abused women were more than twice as likely to deliver a low-

birth weight baby, and that abused women who attended private hospitals had a four-fold risk of delivering a low-birth weight baby.⁹

**Reluctance to Seek Help or Disclose Abuse in a Health Care Setting:**⁹

For many reasons, battered women may have difficulty seeking help or discussing abuse in a health care setting. Some women are literally held captive in their homes; others may lack money or means of transportation to health care facilities. If a battered woman does come to a provider's office, she may have to leave before being seen rather than risk further abuse for getting home late. Childhood experiences of physical or sexual abuse, or witnessing domestic violence, may make it more difficult for a battered woman to recognize a relationship as abusive and take steps to protect herself. Cultural, ethnic, or religious background may also influence a woman's response to abuse and her awareness of viable options. Other reasons for not seeking assistance or mentioning abuse to the provider include:

• Fear that the revelation will jeopardize her safety.

• Shame and humiliation about the way she is being treated, or thinking that she deserves the abuse and does not deserve help.

• Feeling protective of her partner, who may be her sole source of love and affection when not abusive and may provide financial support for her and her children.

• Lack of awareness that her physical symptoms may be the result of the stress of living in an abusive relationship.

• Belief that her injuries are not severe enough to mention.

The experience of abuse is degrading and humiliating. A victim of domestic violence may be reluctant to discuss the issue with someone she feels may not take her seriously, discount her experience, perceive her as deserving the abuse, or blame her for staying with her abuser. A battered woman may fear that disclosing the abuse will jeopardize her safety and eliminate her means of support. She may stay in the relationship hoping that the situation will improve. Her partner may not always be abusive, and she may cling to the hope that he will change.
Legal Requirements for Screening for and Reporting Domestic Violence

Two California laws have a direct impact on how health care providers must serve patients who have experienced domestic violence. While it is the goal of the Health Services Department to make screening for domestic violence a routine part of health care delivery systems, it is also important to understand the legal requirements of domestic violence screening and the circumstances under which a violent injury report must be made to local law enforcement agencies. What follows is a summary and explanation of the domestic violence screening law (AB 890; Health and Safety Code Section 1259.5) and the domestic violence reporting law (AB 1652 and AB 74X; Penal Code Section 11160).

Screening for Domestic Violence in Health Care Settings:

The domestic violence screening law requires licensed clinics, general acute care hospitals, psychiatric hospitals, psychiatric health facilities, and chemical dependency recovery hospitals to establish and adopt written policies and procedures for screening patients for spousal and partner abuse by July 1, 1995. These policies and procedures shall include:

- Identification of spousal and partner abuse among patients.
- Documentation in the medical record of the patient’s injuries or illnesses attributable to spousal and partner abuse.
- For patients who are positively screened, provision of a current referral list of community agencies that provide, at a minimum, information on shelter services for battered women, counseling, legal services, and how to arrange for restraining orders.

Mandatory Reporting:

The law that mandates reporting of incidents of domestic violence is controversial. Some advocates for battered women fear that the mandatory reporting law could increase a woman’s risk of injury or death due to retribution from her partner and argue that taking the choice away from a woman about when to disclose abuse to law enforcement may further disempower her. Conversely, the benefit of mandatory reporting is that it provides women with a documented record of her injuries that can be used in future legal proceedings.

Controversy about reporting makes it essential that health care providers inform women (prior to asking questions regarding domestic violence) about their legal responsibility to report to local law enforcement agencies any physical injuries they know or reasonably suspect were caused by domestic violence. Following is a summary of the reporting law. For information on implementing the law, please refer to the Model Protocol for Screening, Assessment, Intervention, and Reporting in Appendix A.

CCCHS Guidelines for Domestic Violence Screening and Reporting
Summary of the Domestic Violence Reporting Law:

Any health practitioner employed in a health facility, clinic physician's office, local or state public health department or clinic, or other facility operated by a local or state public health department is required to make a report if he or she "provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is":

1. "suffering from any wound or other injury inflicted by his or her own act or inflicted by another where the injury is by means of a knife, firearm, or other deadly weapon," and/or

2. "suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct."

"Assaultive or abusive conduct" includes a long list of criminal offenses: murder, manslaughter, torture, battery, sexual battery, incest, assault with a deadly weapon, rape, spousal rape, and abuse of spouse or cohabitant.

Who is a Mandated Reporter:

Health practitioners employed in a local or state public health department, health facility, licensed clinic, or physician's office are mandated reporters. Only physical injuries caused by domestic violence which are observed during the provision of medical services for a physical condition must be reported. If a provider is not treating a patient for a physical condition, the provider is not required to report domestic violence injuries (e.g., advice nurse).

How to Make a Report:

A report must be made to the local law enforcement agency that has jurisdiction over the location in which the injury took place. Refer to Appendix F for a copy of the Domestic Violence Reporting Form and Appendix G for a list of local law enforcement agency phone numbers.

- A telephone report must be made as soon as is practically possible.
- A written report must be prepared and sent within two working days.

The report shall include, but is not limited to, the following:

- Name of the injured person;
- Injured person's whereabouts;
- Character and extent of the injuries; and
- Identity and whereabouts of the person who allegedly inflicted the injuries.

A report must be made even if the patient has died, regardless of whether or not the injury contributed to the death or evidence of the conduct of the perpetrator was found during autopsy.
**Documentation of Injuries in the Medical Record:**

Like the screening law, the California mandatory reporting law stipulates that the provider must document in the medical record injuries caused by domestic violence. The law recommends the following guidelines for documenting injuries that must be reported:

- Any comments made by the injured person regarding past domestic violence and/or the name of any person suspected of the assaultive or abusive conduct;

- A map of the injured person's body identifying the injuries and bruises (see Appendix D for a Body Map); and

- A copy of the law enforcement reporting form (see Appendix G).

**Referral:**

The law recommends that health care providers refer people suffering or suspected of suffering from domestic violence to local domestic violence services.

**Confidentiality of Report:**

Health facilities, clinics, physicians' offices, and law enforcement agencies must keep the reports made pursuant to this law confidential. Law enforcement may disclose a report to those involved in investigating the report or in enforcing a criminal law implicated by the report.

*In no case shall the person suspected or accused of inflicting the injury, or his or her attorney, be allowed access to the injured persons' whereabouts.*

**Doctor-Patient Privilege:**

In any court proceeding or administrative hearing, physician-patient privileges do not apply to the information required to be reported.

**Liability:**

Health facilities and health professionals who report a known or suspected instance of assault or battery cannot be held civilly or criminally liable under this law.

**Penalty:**

Violation of this law is a misdemeanor.
Model Protocol for Screening, Assessment, Intervention, and Reporting of Domestic Violence

The Model Protocol in Appendix A provides an outline of the key steps involved in screening for domestic violence, assessing the needs of patients, educating and referring patients, and reporting suspected or confirmed cases of battering to law enforcement. Because the protocol cannot anticipate all intake settings and practice situations, key personnel and department sites must be identified by individual departments. Should your department or program require technical assistance in implementing or modifying the protocol, please contact the Contra Costa County Health Services Department Prevention Program at 646-6511, Battered Women's Alternatives at 676-2845, or the Family Violence Prevention Fund's Health Resource Center on Domestic Violence at 1-800-313-1310.

The Model Protocol, screening tools, forms, body map, restraining order information, and a list of community resources are available for removal and duplication in Appendices A to I. The following sections of the Guidelines provide more information and suggested methods of implementing the protocol.

Guidelines for Screening and Interviewing Patients

Licensed clinics and hospitals are required by law to screen patients for domestic violence. Screening for domestic violence is also recognized as an important aspect of preventive health services and should therefore be made part of routine case history ascertainment.

Women receiving prenatal check-ups should be screened periodically at prenatal visits, since battering often begins or intensifies during pregnancy.

Indicators of Domestic Violence:

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

2. The patient denies physical abuse but presents with unexplained bruises, whip-lash injuries consistent with shaking, areas of erythema consistent with slap injuries, grab marks on arms or neck, lacerations, burns, scars, fractures or multiple injuries in various stages of healing, fractured mandible, or perforated tympanic membranes.

3. Common sites of battering injury are areas hidden by clothing or hair (i.e., face, head, chest, breasts, abdomen, and genitals). Accidental injuries usually involve the extremities, whereas domestic violence often involves both trunk and extremity injuries.
4. The extent or type of injury is inconsistent with the explanation offered by the patient.

5. The woman is pregnant. Violence often begins during a woman's first pregnancy, with injuries to the breasts or abdomen.

6. The patient presents evidence of sexual assault or forced sexual actions by her partner.

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

8. The patient is afraid to return home and fears for the safety of her children.

9. Substantial delay exists between the time the injury occurred and the time at which the patient presents for treatment. The patient may have been prevented from seeking attention earlier or may have had to wait for the batterer to leave.

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

11. The patient has psychosomatic complaints, such as panic attacks, anxiety, choking sensation, or depression.

12. The patient complains of chronic pain (back or pelvic pain) with no substantiating physical evidence (often signifies fear of impending or actual physical abuse).

13. Psychiatric or alcohol or drug abuse history in the patient or partner.

14. History of suicide attempts or suicidal ideation. One in every four women and half of all African American women who attempt suicide have a history of battering.

15. Review of medical record reveals use of Emergency Department or other medical and/or social services. Medical history reveals many "accidents" or remarks by nurse or provider indicating that previous injuries were of suspicious origin.

Medical Findings Associated with Batterings

The following medical findings have been identified by the American Medical Association as associated with battering.

1. Chronic pain, psychogenic pain, or pain due to diffuse trauma without visible evidence.
2. Physical symptoms related to stress, chronic post-traumatic stress disorder, or other anxiety disorders such as:
   - Depression
   - Sleep and appetite disturbances
   - Fatigue, decreased concentration
   - Sexual dysfunction
   - Chronic headaches
   - Abdominal and gastrointestinal complaints
   - Palpitations, dizziness, paresthesia, and dyspepsia
   - Atypical chest pains


4. Frequent use of prescribed minor tranquilizers or pain medication.

5. Frequent visits with vague complaints or symptoms without evidence of physiologic abnormality.

**Responsibility to Inform Patients of Reporting Law:**

When introducing the concept and practice of screening for domestic violence, it is strongly recommended that providers notify patients prior to screening for domestic violence that health care providers are legally responsible to report to law enforcement in the event that the patient presents with physical injuries known or reasonably suspected to have been caused by domestic violence.

**Preparation:**

It is very important to interview the patient in private, away from her partner, so that she can speak frankly. Ask any accompanying spouse, partner, friend, or family member to leave the treatment area. Questioning the patient about battering in the presence of the abuser will put the patient in extreme danger. If the partner is uncooperative, have another provider ask to interview him privately while the patient is being interviewed. Call security only in the last resort, as this may increase the risk of later violent retaliation against the patient.7

If the patient is accompanied by children, do not interview her in their presence. Never ask children to act as interpreters for their mothers. Utilize staff to watch children in order to assure privacy when assessing patients for battering. Children as young as two years old may report back to the partner or other family members that mother discussed the abuse, which could place the woman and her children at risk for further violence.8
Provide an interpreter if necessary, i.e., someone from the facility, preferably a woman, who is trained in medical interpretation and will honor confidentiality. It is not appropriate to expect the woman to bring along a friend or relative to interpret, since that person may be the batterer or someone sympathetic to the batterer.

The disabled patient has a legal right to be accompanied in the treatment area by her personal assistant (PA) or other support person if she so desires. If a patient is disabled and her PA or support person has come to the facility with her, ask the patient in private if she wants her companion to accompany her into the treatment area. This will minimize the chance that the patient will feel coerced into silence by an abusive companion or assistant.

The Interview Process:

In general, maintain eye contact when screening patients for battering. (Note: for some cultures this may be inappropriate.) Battering, as a health problem, should be approached by the provider in the same way as any health problem. If a woman denies being battered or becomes upset at being questioned about domestic violence, the provider should explain that all patients are screened for battering. Providers should explain that health care professionals are concerned about the problem of violence against women, which has a significant impact on women’s health.

Encourage but do not badger the patient to respond to domestic violence screening and assessment questions. Patients will choose when to share any history of violence with a health care provider; for some, more time may be necessary. Once the topic of battering has been opened, the patient must trust the health care provider in order to feel comfortable disclosing domestic violence.

The issue of battering should be assessed in a straightforward manner. Medical providers should ask questions in a direct, non-threatening way. Given that the patient may not be in a heterosexual relationship, it is preferable not to refer to the gender of the perpetrator. Lesbians and gay men are also battered by their partners and may have even more difficulty disclosing abuse if they fear discrimination based on sexual orientation.

Health care providers who fear that they may offend their patients by broaching the topic of battering can preface their questions by stating that since violence is such a significant problem for women, especially those who are pregnant, all women seeking health care are routinely screened.

Domestic Violence Screening Tool:

A screening tool adapted from the March of Dimes (see Appendix B) is suggested for use in the assessment of domestic violence. The instrument has enabled providers to successfully identify victims of battering and has been found to be reliable in assessing physical abuse in intimate relationships. Use of the survey will provide the basis for periodic preventive health screening.
for domestic violence and will ensure compliance with California's domestic violence screening requirements. Consistently gathered information will enhance the Health Services Department's ability to document the extent of the problem of domestic violence locally.

In addition to the questions presented in the screening tool, other appropriate introductory questions include:

- I ask all women patients if they are in a relationship with someone who may be hurting them or controlling them.

- Is anyone in your life hurting you?

- Was this done by someone you are in a relationship with?

- You seem frightened by your partner; has your partner hurt you?

- I'm concerned because I know that if you're in a relationship and violence occurs, it is likely to get worse. How can we help you?

Working with Diverse Populations

Health care providers must pay specific attention to issues of cultural diversity when addressing domestic violence. Awareness of cultural values and norms will assist the health care provider when listening to women, giving them information, and helping them make decisions and safety plans. While cultural differences must be considered when dealing with battering, differences must never be used to deny or excuse the violence. The attitude that certain cultures or socio-economic groups are inherently more violent than others is uninformed and helps to create a climate in which violence toward women is considered “normal” or minor, hence, unimportant and invisible.

Women of all races, classes, ethnicities, ages, religions, sexual orientations, and physical abilities must have access to information and services that can help ensure their safety. However, what feels safe and validating differs from culture to culture. Following are some guidelines to enhance providers’ effectiveness in dealing with abused women from cultures different from their own.

Racial Oppression: Stereotypes held by the dominant culture about communities of color affect the type of help a woman can expect to receive, thus making it more difficult for women of color to escape from abusive situations. It is imperative to examine your own stereotypes toward others and realize that the woman before you is an individual.

Language: What is the woman's primary language? Is English a second language, don't
assume that she “doesn’t mind” speaking English. If she doesn’t speak English, it is important to use an appropriate interpreter, i.e., someone from your facility, preferably a woman who is trained in medical interpretation and will honor confidentiality. Remember to address the woman when you speak, not the interpreter. It is not appropriate to expect the woman to bring along a friend or relative to interpret, since that person may be the batterer or someone sympathetic to the batterer. It is never appropriate to use a child as an interpreter. In an emergency situation, when no interpreter is immediately available, use your best judgment.

**Health Care Institutions:** Every organization has its own cultural atmosphere which makes it accessible and comfortable to some communities and alienating to others. Health care settings can be particularly threatening to newly arrived refugees and immigrants. Take stock of your particular setting and the atmosphere it projects. Does it feel alienating to those who are not part of the dominant culture, and if so, what can be done to make it more welcoming?

**Family and Community Values:** When working with an individual woman, it is helpful to be aware of the customary family and sex roles in her community. This includes how divorce is perceived, how single mothers are treated, and whether the role of family members is to confront or protect batterers. In some communities, a strong emphasis is placed on keeping the family together. Divorce and separation are frowned upon, and the blame is generally placed on the woman, who may be socially ostracized. The challenge in this situation is to help the woman begin to think about personal empowerment in the context of family or community.

**Shame:** All battered women experience degrees of shame, which usually arises from the belief that the violence is a result of their behavior. Cultural values and religious beliefs can heighten this sense of shame to the point where some women take the ultimate step toward ending the violence by taking their own lives. To reduce the self-blame that accompanies battering, it is important to remind the woman that cultural and religious values emphasizing compassion, respect, patience, and responsibility are being violated by the batterer.

**Help-Seeking Behaviors:** It is important to know how the woman's community views seeking help from outsiders. Is it acceptable or is it considered a betrayal? Cultural norms such as these may be related to a reluctance to seek a restraining order or contact a battered women's shelter. Helping the woman to identify these values and her fears about betraying them may assist her in the decision-making process.

**Body Language:** What are the traditions in the woman's community for speaking about personal problems? Many people will not speak directly about problems but will begin by talking about other, less personal issues. A woman's body language may also be different from yours. She may avoid direct eye contact if it is a sign of disrespect in her culture. Sitting close or far away, smiling after every comment, talking loudly or softly, getting angry quickly, or staring emphatically are all behaviors that may be related to a woman's culture and the way in which its members communicate. To avoid misunderstandings, ask the woman to tell you, in her own words, what she understands from her meeting with you and what her plans are.
Battered Teens: Because of their lack of experience, teenagers may be particularly susceptible to the stereotypical and unequal sex roles presented in our society. The socialization of girls tends to reinforce their submission to males. This occurs to varying degrees within different cultures and can contribute to a girl’s inability to comprehend that her partner’s abusive behavior is out of line. The isolation that results from abuse makes it more difficult for girls to compare their experiences with others. Gay and lesbian teenagers, who are further isolated because of their sexual orientation, will probably be even more reluctant to talk about an abusive relationship.

The health care provider faces special problems in the treatment of battered teenagers. Teenagers are typically struggling for independence and are reluctant to turn to authority figures for help. Fearing their parent’s potential involvement may cause them to avoid seeking medical treatment or revealing the true cause of their injuries. Adolescents need to be reassured that the abuse is not their fault. Educating young women about the options and resources available to them will help them to get out of abusive relationships.

Abuse Against Persons with Disabilities: “Disabilities” covers a wide range of physical, psychological, emotional, sensory, cognitive, and communication difficulties. “Disability” also encompasses many types of chronic health conditions and impairments that may or may not be immediately apparent to the provider. If a person identifies herself as having a disability and requests some type of accommodation to facilitate her examination or treatment, her request should be respected.

Persons with disabilities, both female and male, are at increased risk of abuse. This risk is heightened by their reliance on care givers and others for some life support. Abuse can occur at home or in institutional settings such as group homes, state schools, nursing homes, and hospitals. A companion should be allowed to accompany the patient during an interview or exam only if the patient identifies herself as having a disability and requests that her personal care attendant or support person accompany her. The patient’s wish to be accompanied should be ascertained in private in order to lessen the chance that the patient will feel coerced by her personal care attendant or support person.

Lesbians: Although women who are abused by their female partners experience the same physical and emotional strain as women abused by their male partners, they also face some unique problems to which health care providers must be sensitive.

If a lesbian is being battered and has not come out publicly about being a lesbian, she may be very reluctant to discuss with a provider the battering relationship. The battered lesbian may be uncomfortable revealing her sexual orientation in a health care setting. Additionally, her partner may have threatened to expose her sexual orientation if she talks about the abuse, and she may fear losing her friends, custody of her children, or job as a result.

Finding safe shelter may be more difficult for lesbians than it is for heterosexual women because women are usually automatically trusted within the shelter system; anywhere the battered lesbian...
can go, her partner can go as well. It is sometimes difficult for women who work with battered women to admit that women themselves can be abusers. That denial, coupled with homophobia, often prevents an adequate response to battered lesbians seeking shelter or other assistance.

**Gay Men**: Domestic violence is a serious problem in the gay/bisexual male community. While providers may tend to assume that violence in male relationships is mutual, domestic violence among gay men, like that among heterosexuals, involves one man using intimidation and force against his partner.

Gay men who have not come out publicly about their homosexuality face will share the same concerns about disclosing abuse in a health care setting as lesbians who are not out. When a gay man does disclose domestic abuse, the provider must be sure to follow the same procedures (e.g., danger assessment, safety planning, reporting, and referral) that are in place for women victims of domestic violence. Finally, community resource lists must include agencies that provide services to gay men, lesbians, and bisexuals.

**Substance Abusing Battered Woman**: Women who have been assaulted sexually, were victims of incest or sexual abuse as children, or who have experienced physical abuse by a spouse or partner are at high-risk for alcohol and other drug abuse. Treatment programs estimate that 75% to 90% of women in substance abuse treatment have histories of physical or sexual abuse, or both.

The coexistence of battering and substance abuse represents a unique dilemma for the client seeking help, often jeopardizing her efforts to obtain treatment. Substance-abusing women who seek safety at battered women's shelters or rape crisis centers may be denied access because of drinking or drug use. Chemical dependency treatment programs cannot accommodate children, often do not identify violence as a treatment issue, and do not want to place their staff and other clients in any danger.

Female substance abusers are often locked into cycles of victimization and intoxication. A two-tiered approach is necessary when developing an appropriate intervention for a chemically addicted woman who is also a victim of domestic violence. The defenses used to cope with the addiction and abuse (secrecy, denial, and minimization) result in an inability to identify and resolve each problem. A treatment plan that incorporates an intervention for addiction, unresolved trauma and domestic violence is recommended. Increased communication between provider systems will ensure that clients are appropriately and adequately served. Specialized counseling arrangements are required for the clinical treatment of all three issues.

**Documentation in the Medical Record and Collection of Physical Evidence**

Thorough, well-documented medical records are essential for preventing further abuse. Both the California screening and reporting laws require the documentation of domestic violence in
medical records. Furthermore, well-documented medical records provide concrete evidence of violence and abuse and may prove crucial to the outcome of any court proceeding or administrative hearing. If the medical record and testimony at trial conflict, the medical record may be considered more credible.

Records should be kept in a precise, professional manner and should include the following:

- Chief complaint and description of the abusive event, using the patient’s own words whenever possible rather than the provider’s assessment. For example, a statement such as “my husband hit me with a bat” is preferable to “patient has been abused.”
- Complete medical history.
- Relevant social history.
- A detailed description of the injuries, including type, number, size, location, resolution, possible causes, and explanations given. Where applicable, the location and nature of the injuries should be recorded on a body map (Appendix D).
- Copies of screening tools (Appendices B and C).
- An opinion on whether the cause of the injuries was adequately explained.
- Results of all pertinent laboratory and other diagnostic procedures.

In addition to complete written records, photographs are particularly valuable as evidence. The provider should ask the patient for permission to take photographs, and, if consent is given, should follow these procedures:

- When appropriate, take photographs before medical treatment is given.
- Use color film, along with a color standard.
- Photograph from different angles, full body and close-up.
- Hold up a coin, ruler, or other object to illustrate the size of an injury.
- Include the patient’s face in at least one picture.
- Take at least two pictures of every major trauma area.
- Mark photographs precisely and as soon as possible with the patient’s name, locations of injuries, and names of the photographer and others present.

For medical records to be admissible in court, the provider should be prepared to testify that:

- The records were made during the regular course of business at the time of the examination or interview.
- The records were made in accordance with routine procedures.
- The records have been properly stored, with access limited to professional staff.

**Intervention and Referral**

When domestic violence is recognized, a number of interventions are possible. Even if a woman
is not ready to leave the relationship or take other action, the provider's recognition and validation of her situation is an important intervention in and of itself. Silence, disregard, or disinterest convey tacit approval or acceptance of domestic violence. In contrast, recognition, acknowledgment, and concern confirm the seriousness of the problem and the need to solve it.

Interventions that can be initiated in the health care setting include:

- Patient education;
- Assessment for increased risk of abuse;
- Linking the patient to the services of Battered Women's Alternatives; and
- Safety planning.

Clearly, the injury or complaint that precipitated the patient's health care encounter requires evaluation and appropriate treatment. In addition, the provider should ask about the patient's use of pain, sleeping, or anti-anxiety agents. Psychiatric problems, including severe depression, panic disorder, suicidal tendencies, or substance abuse, may hinder the battered woman's ability to assess her situation or take appropriate action. When serious psychiatric conditions are present, an appropriate treatment plan includes psychiatric evaluation and treatment. On the other hand, emotional, behavioral, and cognitive symptoms of abuse can be misinterpreted as psychiatric in origin. The health care provider must make sure that the mental health professional to whom they refer the patient is sensitive to these issues.

Alcohol or drugs may be used by the abuser to rationalize violent behavior. Perpetrators and family members may insist that substance abuse, not domestic violence, is the problem. Evidence indicates, however, that while substance abuse and violent behavior frequently coexist, the violent behavior will not end unless interventions address the violence as well as the addiction. Similarly, mental illness is rarely the cause of domestic violence, although mental illness in a batterer can lead to loss of control and increased frequency and severity of violence. Treating the mental illness alone will not end the violence; both issues must be addressed.

Couples counseling or family intervention is generally contraindicated in the presence of domestic violence. Attempts to implement family therapy in the presence of ongoing violence may increase the risk of serious harm. The first concern must be for the safety of the woman and her children.

Women are often not the only victims at home. Child abuse has been reported to occur in 33% to 54% of families in which adult domestic violence occurs. In situations in which children are also being abused, liaisons between advocates for victims of domestic violence and child protective service agents should be coordinated to ensure the safety of both the mother and her children.

Patient Education and Counseling:

In a majority of cases, unless violence is stopped it will continue, possibly escalate, and put the
woman and her children at high risk of serious injury or death. Even if children are not directly involved in the violence, exposure to violence in the home can cause lasting emotional and psychological damage. The woman should be informed of these dangers, as well as of the typical behavioral patterns of batterers, described in the cycle of violence (see page 7). Providers must emphasize that the abuser, not the woman, is responsible for the violence.7

Danger Assessment:13

Patients should be assessed for the risk of further violence and homicide before leaving the health care setting. The primary provider, or an advocate from BWA, can assess women for danger. For a copy of the Danger Assessment Questionnaire, please see Appendix C.

After reviewing the assessment questions with the patient, ask her if she thinks she is in danger of being seriously injured or killed. If she says yes, urge her to speak with an advocate from BWA. Provide her with the phone number and a safe, private place from which to call. If requested, a BWA advocate will come to the health care setting to help the woman assess the safety of her current situation.

If the patient is in a high risk situation and is planning to leave the relationship, tell her that she should seriously consider leaving without letting her batterer know. Ask her if she has a safe place where she and her and children can go.15 Tell her that an advocate from BWA can help her find a safe place to go, assist her in developing a safety plan, and provide her with many other supportive and practical services.

If the patient says no but her assessment indicates that she is in danger, explain to her that she is at risk for increased violence and homicide. Express your concerns about these risks, and again suggest that she contact BWA and offer her a BWA card with crisis line number listed.

Don’t judge the success of the intervention by the patient’s action. A woman is most at risk of serious injury or even homicide when she attempts to leave an abusive partner, and it may take her a long time to finally do so. It is frustrating for the provider when a patient stays in an abusive situation. Be assured that if you have acknowledged and validated her situation and offered appropriate referrals, you have done what you can to help her.

Battered Women's Alternatives (BWA) Summary of Services:

All patients who report past or current abuse by their partners or husbands should be referred to Battered Women's Alternatives (BWA). BWA provides a network of services to help women deal with many aspects of domestic violence. BWA staff are available to serve in the health care setting as advocates for women who are victims of battering. BWA offers over a dozen service programs. All are provided free of charge or at low cost, and no one is denied services because of an inability to pay. Following is a list of BWA services:
Shelter:

- Emergency Shelter: Up to six weeks of emergency housing, food, clothing, medical assistance, and counseling is available to battered women and their children.
- Safe Homes: Housing to protect women in life-threatening situations. Trained volunteers open their homes to shelter families in crisis.
- Transitional Housing and Employment Center: Long-term, low-cost apartments to give battered women and their children more time to rebuild their lives.

Support Services:

- 24-Hour Crisis Line: Provides crisis intervention and peer support by telephone 24-hours a day, seven days a week. The telephone number is (510) 930-8300.
- Drop-In Counseling: Counseling to facilitate women receiving support and exploring alternatives to remaining in battering relationships.
- Living Skills: Training for women in money management, employment, establishing a support network, and parenting skills.

Children's Services:

- Children's Program: Assessment and group therapy for children of battered women. Staff and volunteers teach children how to resolve conflicts without violence and how to enjoy non-competitive play.
- Parenting Program: Teaches battered women about child development, age-appropriate behavior, and parenting skills.

Counseling Services:

- Support Groups: Provides a safe environment in which battered women can share their experiences.
- Individual Counseling: Interns counsel battered women and their children.
- The Men's Program: Helps men stop the violence. Through individual and group counseling, men learn to express themselves in non-abusive ways.
Legal Services:

- Legal Advocacy Program: Assists battered women with obtaining restraining orders and dissolutions and solving property and child custody disputes. Attorneys provide legal services for low income residents through the Pro Bono Family Law Panel.

Safety Planning:

If the patient does not wish to contact BWA, an attempt to plan for her safety should be made before she leaves the health care provider's office. Appendix F provides a comprehensive Safety Planning Form that can guide providers in discussing safety planning with patients. It is recommended that providers familiarize themselves with the options outlined in the Safety Planning Form. Various options and questions should be considered by the patient:

- Does she have friends or family with whom she can stay?
- If none are available, can she be admitted to the hospital?
- If she doesn't need immediate access to a shelter, give her written information about shelters and other resources. Make sure to ask the woman if she can safely possess such materials.
- Does she want to return to her partner and schedule a follow-up appointment at a later date?

A Word of Caution About Prescribing Tranquilizers:

Studies indicate that tranquilizers and pain medication are more likely to be prescribed in emergency department settings to battered women than to non-battered women. Primary care physicians may also prescribe tranquilizers, believing that they may help and cannot hurt the situation. Tranquilized women are far less able to understand their options or make the decisions necessary to protect themselves. Unnecessary use of tranquilizers can be dangerous to the battered woman and should be discouraged.

Reporting Injuries Resulting from Domestic Violence:

Health care providers can fulfill their legal obligation to report domestic violence while also maintaining patient safety. Police departments may conduct an investigation upon receipt of a health care provider report of injuries. For this reason, the Domestic Violence Reporting Form (Appendix F) recommended for use by Health Services Department providers has space in which to indicate whether or not the patient is concerned about retaliation from the batterer if police investigate the report, and how she may be contacted safely.
In addition to the mandatory provider report of domestic violence, the patient may herself wish to file a police report. When filling out the Domestic Violence Reporting Form, ask the patient if she would like to press charges on the perpetrator. Also ask her how a law enforcement representative can contact her at a safe phone number and/or address. Be sure to note in the spaces provided on the form the answers to these questions, as this information will assist police in investigating without increasing the likelihood of further violence.

As noted previously, a report must be made to the local law enforcement agency that has jurisdiction over the location in which the injury occurred:

- A telephone report must be made as soon as is practically possible.
- A written report must be prepared and sent within two working days.

The report shall include, but is not limited to, the following:

- Name of the injured person;
- Injured person’s whereabouts;
- Character and extent of the injuries; and
- Identity of the person who allegedly inflicted the injuries.

A report must be made even if the person has died, regardless of whether or not the injury contributed to the death or evidence of the conduct of the perpetrator was discovered during an autopsy.

Health facilities and health professionals who report a known or suspected instance of assault or battery cannot be held civilly or criminally liable under this law.
References


10. Neighborhood Legal Foundation


Appendix A:

Model Protocol for Screening, Assessment

Intervention and Reporting of Domestic Violence
Model Protocol for Screening, Assessment, Intervention, and Reporting of Domestic Violence

The following protocol provides an outline of the key steps involved in screening for domestic violence, assessing the needs of patients, educating and referring patients, and reporting suspected or confirmed cases of battering to law enforcement. Because the protocol cannot anticipate all intake settings and practice situations, key personnel and department sites must be identified by individual departments. Should your department or program require technical assistance in implementing or modifying the protocol, please contact the Contra Costa County Health Services Department Prevention Program at 646-6511, Battered Women's Alternatives at 676-2845, or the Family Violence Prevention Fund's Health Resource Center on Domestic Violence at 1-800-313-1310.

1. **Designate a KEY STAFF PERSON responsible for implementing the protocol:**

   Ideally, one health care provider will implement the protocol. However, in some settings, such as the emergency department, a team of professional staff may be responsible for implementation. Staff can include: primary care or emergency department physician, nurse or public health nurse, or medical social worker.

2. **Designate a PRIVATE SETTING within the health care facility in which to implement the protocol:**

   Never screen or assess a patient for domestic violence in the presence of her partner. This can put the patient at extreme risk.

   If there is no private examination room in the facility, find a point in the examination process prior to commencing screening where the patient can be separated from her partner, such as when an x-ray is taken or during lab work. A private office or nursing station where the patient can be interviewed alone can also be utilized if no other setting is available.

3. **INFORM the patient of the following points:**

   Screening for domestic violence is ROUTINE and is conducted with all women.

   If she has injuries that have been caused by domestic violence, health care providers are REQUIRED BY LAW TO REPORT HER INJURIES to law enforcement and document the injuries in the medical record. Inform the patient that information in the medical record can be useful in criminal proceedings related to domestic violence.

4. **SCREEN for exposure to domestic violence:**

   Administer the recommended Screening Tool (Appendix B).

5. **If screen is NEGATIVE for exposure to domestic violence:**

   Note and place Screening Tool in the medical record.

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Appendix A: Model Protocol for Screening and Reporting Domestic Violence
Inform the patient of the availability of BWA's services.

6. **IF SCREEN IS POSITIVE AND PATIENT IS NOT PRESENTING WITH INJURIES due to domestic violence:**

   Note and place Screening Tool in the medical record.

   Record any additional comments or history of past injury due to domestic violence in the medical record.

   Counsel the patient that the abuse is not her fault but that of the abuser.

   Counsel the patient on the physical and emotional sequelae of domestic violence (see 5, C:HSD Guidelines for Domestic Violence Screening and Reporting).

   Inform the patient that information in the medical record can be helpful to her in a legal or criminal justice action.

   Advise the patient that because abuse can escalate in a relationship, you are concerned for her safety and would like to ask her some additional questions.

   Assess for the lethality of the abuse:

   - Administer the Danger Assessment Questionnaire (Appendix C) to assess the risk of homicide, suicide, or serious injury and place copy of the questionnaire in the medical record.

   Ask the patient if she would like to discuss options and services that are available to her and if she feels ready to discuss the situation with a domestic violence counselor. Use the answers to gauge her readiness to make decisions that will change that situation.

   Inform the patient that she can talk to an advocate from BWA, either on the phone or in person. Inform the patient that BWA can:

   - Help her assess her safety in her current situation;
   - Provide her with telephone counseling;
   - Link her to ongoing support groups;
   - Provide her and her children with transportation and shelter;
   - Provide her with legal advocacy services; and
   - Assist her in making a police report.

7. **Access BWA advocacy services:**

   It is extremely useful to have an advocate from BWA meet with the patient to assess her safety and link her to services. Health care providers should familiarize themselves with the range of services offered by BWA so that they can accurately educate and refer patients.

   If the patient would like the services of a BWA advocate, CALL THE BWA CRISIS
NUMBER and request that an advocate meet the patient in the health care setting.
INFORM the BWA IF A LANGUAGE OTHER THAN ENGLISH IS THE PRIMARY
LANGUAGE of the patient. Every attempt will be made to dispatch an advocate who
speaks the patient’s language.

BWA crisis phone numbers:  
Antioch: 757-8280  
Concord: 930-8390  
Richmond: 233-2420

BWA will consult with the patient’s health care provider and conduct a safety assessment
with the patient. BWA will assist the patient in obtaining legal and shelter services, if
necessary.

If the patient DECLINES BWA SERVICES, offer her a card with BWA service numbers
(be sure the patient can safely have this card in her possession) and/or other referrals as
appropriate (see Appendix I, Community Resource List). Assess how safe she will be after
she leaves the health care setting (see Step 9, below).

Don’t judge the success of the intervention by the patient’s action. A woman is most at risk
of serious injury or even homicide when she attempts to leave an abusive partner, and it may
take her a long time to finally do so. It is frustrating for the provider when a patient stays in
an abusive situation. Be assured that if you have acknowledged and validated her situation
and offered appropriate referrals, you have done what you can to help her.

8. IF SCREEN IS POSITIVE AND PATIENT IS PRESENTING WITH INJURIES due to
domestic violence:

TREAT the patient’s physical injuries.

DOCUMENT in the medical record injuries and any statements made by the patient.
Document location of injuries on Body Map (Appendix D).

INFORM the patient that because her injuries were caused by domestic violence, the health
care provider is REQUIRED BY LAW TO REPORT HER INJURIES to a local law
enforcement agency.

ASSESS FOR LETHALITY of the abuse: see Step 6.

ACCESS BWA advocacy services: see Step 7.

9. Conduct a SAFETY ASSESSMENT:

Again, it is strongly recommended that a BWA advocate be brought in whenever
possible to assist the patient. If this cannot be done, it is recommended that health care
providers familiarize themselves with safety planning, as described in Appendix E.

Determine if the patient has a safe place to stay after she leaves the health care setting or is
discharged from the hospital or emergency department. Determine if she can stay with

Appendix A: Model Protocol for Screening and Reporting Domestic Violence
friends and if she has key documents, such as a driver's license, checking account numbers, and other forms of identification, etc.

Schedule a follow-up appointment with the patient.

10. **REPORT INJURIES CAUSED BY DOMESTIC VIOLENCE:**

Only physical injuries caused by domestic violence which are observed during the provision of medical services for a physical condition must be reported. Note: If a provider is not treating a patient for a physical condition, the provider is not required to report domestic violence injuries (e.g., advice nurse).

Health care providers can fulfill their legal obligation to report domestic violence while also maintaining patient safety. Police departments may conduct an investigation upon receipt of a health care provider report of injuries. For this reason, the Domestic Violence Reporting Form (Appendix F) recommended for use by Health Services Department providers has space in which to indicate whether or not the patient is concerned about retaliation from the batterer if police investigate the report, and how she may be contacted safely.

In addition to the mandatory provider report of domestic violence, the patient may herself wish to file a police report. When filling out the Domestic Violence Reporting Form, ask the patient if she would like to press charges against the perpetrator. Also ask her how a law enforcement representative can contact her at a safe phone number and/or address. Be sure to note in the spaces provided on the form the answers to these questions, as this information will assist police in investigating without increasing the likelihood of further violence.

Reports must be made to a local law enforcement agency (police telephone numbers are listed in Appendix G). Police practice recommends that reports be made to the police department in the jurisdiction in which the injury occurred.

A **TELEPHONE REPORT** must be made as soon as is practically possible (by the provider who treated the patient's physical condition or by the provider's designee).

A **WRITTEN REPORT** must be prepared by a designated person and sent within two working days.
Appendix B:

Domestic Violence Screening Tool
Domestic Violence Screening Tool

Because domestic violence is a serious public health problem, and because California law outlines the role of the health care provider in addressing domestic violence, I now ask all of my women patients the following questions:

1. Do you ever feel afraid of or threatened by your partner? Yes No (circle one)
2. Within the last year, have you been hit, slapped, kicked, or physically hurt by someone? Yes No (circle one)
   
   2a. IF PATIENT IS PREGNANT: Since the pregnancy began, have you been hit, slapped, kicked, or physically hurt by someone? Yes No (circle one)

3. If YES, who hurt you? (circle all that apply)
   Spouse, Former Spouse, Boyfriend, Ex Boyfriend, Girlfriend, Ex Girlfriend, Stranger, Sibling, Parent, Other (ask patient to specify)

4. Can you tell me the total number of times you have been hit?

5. Has the person who hurt you threatened to use a weapon against you? Yes No (circle one)

6. Has the person who hurt you used a weapon to do so? Yes No (circle one) If yes, what kind of weapon(s)?

7. Can you show me where you have been hurt on this body map? (Allow patient to mark the area on the Body Map, Appendix E).

8. How long have you been in this relationship? When did the abuse begin?

   Place a copy of the completed tool in the patient's medical record.

Abuse Severity Score:

1 = Verbal threats of abuse, including threats to use a weapon.
2 = Slapping or pushing with no injuries or lasting pain.
3 = Punching, kicking with bruising, cuts and lingering pain.
4 = Beating with severe contusions, burns, sprains, broken bones.
5 = Head injury, internal injuries, permanent disability.
6 = Use of a weapon or wounds from weapon (other than fists).

Appendix B: Domestic Violence Screening Tool
Appendix C:

Danger Assessment Questionnaire
Danger Assessment Questionnaire

These questions are intended to be administered after a patient's exposure to domestic violence has been established. The questionnaire will assist the provider in assessing for the lethality of the abuse and the overall risk to the patient.

Check yes or no after each question is answered:

YES  NO

1. Has the violence increased in frequency over the past year?
2. Has the violence increased in severity over the past year, and/or has a weapon or threat with a weapon been used?
3. Is there a gun in the house?
4. Does your partner threaten to kill you, or do you believe that he is capable of doing so?
5. Does your partner use drugs or frequently get drunk?
6. Is your partner violent: outside of the home?
7. Does your partner try to control most of your daily activities, such as money, friendships and activities?
8. Has your partner ever forced you into sex?
9. Has your partner ever beaten you while you were pregnant?
10. Is your partner violently and consistently jealous?
11. Do you ever believe that you might harm or attempt to kill yourself?
12. Has your partner ever threatened to commit suicide?

Appendix C: Danger Assessment Questionnaire
Appendix D:

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

signature

Date
Appendix E:

Safety Planning Form
SAFETY PLANNING

It is a myth that battered women do not leave their partners. The reality is that 60% of battered women do leave. While 20% leave after the first battering incident, 40% leave after leaving and returning many times or waiting for the safest time to leave. Leaving is very dangerous. In fact, most battered women who are killed by their partners are killed while they are in the process of leaving or after they left. Therefore, it is important that women who are planning to leave develop a safety plan.

Following is a personalized safety plan worksheet to assist women in different stages of leaving:

PERSONALIZED SAFETY PLAN

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I do not have control over my partner’s violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.

STEP 1: Safety during a violent incident. Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.

I can use some or all of the following strategies:

A. If I decide to leave, I will ________________. (Practice how to get out safely. What doors, windows, elevators, stairwells or fire escapes would you use?)

B. I can keep my purse and car keys ready and put them in ________________ in order to leave quickly.

C. I can tell ________________ about the violence and request they call the police if they hear suspicious noises coming from my house.

I can also tell ________________ about the violence and request they call the police if they hear suspicious noises coming from my house.

D. I can teach my children how to use the telephone to contact the police and the fire department.

E. I will use ________________ as my code word with my children or my friends so they can call for help.

F. If I have to leave my home, I will go ________________ (Decide this even if you don’t think there will be a next time.)
If I cannot go to the location above, then I can go to ______________________
or ________________________.

G. I can also teach some of the strategies to some/all of my children.

H. When I expect we are going to have an argument, I will try to move to a space that
   is lowest risk, such as _________________________.
   (Try to avoid arguments in the bathroom, garage, kitchens, near weapons or in
   rooms without access to an outside door.)

I. I will use my judgement and intuition. If the situation is very serious, I can give
   my partner what he/she wants to calm him/her down. I have to protect myself until
   I/we are out of danger.

STEP 2: Safety when preparing to leave. Battered women frequently leave the residence they
   share with the battering partner. Leaving must be done with a careful plan in order to increase
   safety. Batterers often strike back when they believe that a battered woman is leaving a
   relationship.

I can use some or all of the following safety strategies:

A. I will leave money and an extra set of keys with ______________________
   so I can leave quickly.

B. I will keep copies of important documents or keys at
   _________________________.

C. I will open a savings account by ________________________ to increase my
   independence.

D. Other things I can to increase my independence include:
   __________________________________________
   __________________________________________
   __________________________________________

E. The domestic violence program's hotline number is _____________________. I can
   seek shelter by calling this hotline.

F. I can keep change for phone calls on me at all times. I understand that if I use my
   telephone credit card, the following month the telephone bill will tell my batterer
   those numbers that I called after I left. To keep my telephone communications
   confidential, I must either use coins or I might get a friend to permit me to use
   their telephone credit card for limited time when I first leave.

Appendix E: Safety Planning Form
G. I will check with _______________ and _______________ to see who would be able to let me stay with them or lend me some money.

H. I can leave extra clothes with ________________.

I. I will sit down and review my safety plan every ________________ in order to plan the safest way to leave the residence. _______________ (domestic violence advocate or friend) has agreed to help me review this plan.

J. I will rehearse my escape plan and, as appropriate, practice it with my children.

STEP 3: Safety in my own residence. There are many things that a woman can do to increase her safety in her own residence. It may be impossible to do everything at once, but safety measures can be added step by step.

Safety measures I can use include:

A. I can change the locks on my doors and windows as soon as possible.

B. I can replace wooden doors with steel/metal doors.

C. I can install security systems including additional locks, window bars, poles to wedge against doors, and electronic systems, etc.

D. I can purchase rope ladders to be used for escape from second floor windows.

E. I can install smoke detectors and purchase fire extinguishers for each floor in my house/apartment.

F. I can install an outside lighting system that lights up when a person is coming close to my house.

G. I will teach my children how to use the telephone and to make a collect call to me and to _______________ (friend, minister, other) in the event that my partner takes the children.

H. I will tell people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I will inform about pick-up permission include: _______________(school), _______________(day care staff, located at _______________).
I. If my partner violates the protection order, I can call the police and report a violation, contact my attorney, call my advocate, and/or advise the court of the violation.

J. If the police do not help, I can contact my advocate or attorney and will file a complaint with the chief of the police department.

K. I can also file a private criminal complaint with the district justice in the jurisdiction where the violation occurred or with the district attorney. I can charge my battering partner with a violation of the protection order and all the crimes that he commits in violating the order. I can call the domestic violence advocate to help me with this.

STEP 4: Safety on the job and in public: Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family and co-workers can help to protect women. Each woman should consider carefully which people to invite to help secure her safety.

I might do any or all of the following:

A. I can inform by boss, the security supervisor and ____________ at work, of my situation.

B. I can ask ____________ to help screen my telephone calls at work.

C. When leaving work, I can ________________.

D. When driving home if problems occur, I can ________________.

E. If I use public transit, I can ________________.

F. I can use different grocery stores and shopping malls to conduct my business and shop at hours that are different from when residing with my battering partner.

G. I can use a different bank and take care of my banking at hours different from those I used when residing with my battering partner.

H. I can also ________________.

STEP 5: Safety and drug or alcohol use: Most people in this culture use alcohol. Many use mood-altering drugs. Much of this use is legal and some is not. The legal outcomes of using illegal drugs can be very hard on a battered woman, may hurt her relationship with her children.

Appendix E: Safety Planning Form
and put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. But beyond this, the use of any alcohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him/her an excuse to use violence. Therefore, in the context of drug or alcohol use, a woman needs to make specific safety plans.

If drug or alcohol use has occurred in my relationship with the battering partner, I can enhance my safety by some or all of the following:

A. If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.

B. I can also ____________________________.

C. If my partner is using, I can ____________________________.

D. I might also ____________________________.

E. To safeguard my children, I might ____________________________ and ____________________________.

STEP 6: Safety and my emotional health: The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life for myself takes much courage and incredible energy.

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

A. If I feel down and ready to return to a potentially abusive situation, I can ____________________________.

B. When I have to communicate with my partner in person or by telephone, I can ____________________________.

C. I can try to use "I can ..." statements with myself and to be assertive with others.

D. I can tell myself:
   ____________________________, whenever I feel others are trying to control or abuse me.

E. I can read ____________________________ to help me feel stronger.

F. I can call ____________________________ and ____________________________, as other resources to be of support to me.

Appendix E: Safety Planning Form
G. Other things I can do to help me feel stronger are
________________________________________________________________________
________________________________________________________________________

H. I can attend workshops and support groups at the domestic violence program or
________________________________________________________________________ or ___________________________________________________________________ to gain
support and strengthen my relationships with other people.

STEP 7: Items to take when leaving: When women leave partners, it is important to take certain
items with them. Beyond this, women sometimes give an extra copy of papers and an extra set of
clothing to a friend just in case they have to leave quickly.

Items with asterisks on the following list are the most important to take. If there is time, the other
items might be taken, or stored outside the home.

These items might best be placed in one location, so that if we have to leave in a hurry, I can grab
them quickly.

When I leave I should take:

*Identification for myself
*Children's birth certificates
*My birth certificate
*Social Security cards
*School and vaccination records
*Money
*Checkbook, ATM card
*Credit cards
*Keys - House/Car/Office
*Driver's license and registration
*Medications
*Welfare Identification
*Work permits
*Green Card
*Passport(s)
*Divorce papers
*Medical records - for all family members
*Lease/rental agreement, house deed, mortgage payment book
*Bank books
*Insurance papers
*Small saleable objects
*Address book
*Pictures
*Jewelry
*Children's favorite toys and/or blankets
*Items of special sentimental value
Telephone numbers I need to know:

Police department - home

Police department - school

Police department - work

Battered women's program

County registry of protection orders

Work number

Supervisor's home number

Minister

Other


Appendix E: Safety Planning Form
Appendix F:

Domestic Violence Reporting Form
# Domestic Violence Reporting Form: Injury or Suspected Abuse

To be completed by Health Practitioners pursuant to Penal Code Section 11160.
The information or this form shall be kept confidential pursuant to Penal Code Section 11163.2.

<table>
<thead>
<tr>
<th>NAME/TITLE OF PERSON MAKING REPORT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS:</td>
</tr>
<tr>
<td>PHONE: ( )</td>
</tr>
<tr>
<td>DATE OF REPORT</td>
</tr>
<tr>
<td>SIGNATURE OF REPORTING PARTY:</td>
</tr>
<tr>
<td>IS VICTIM CONCERNED ABOUT RETALIATION AS A RESULT OF POLICE INVESTIGATION OF THIS REPORT?</td>
</tr>
<tr>
<td>□ YES □ NO □ UNKNOWN</td>
</tr>
<tr>
<td>HOW CAN LAW ENFORCEMENT REP. CONTACT VICTIM WITHOUTJEOPARDIZING VICTIM'S SAFETY?</td>
</tr>
<tr>
<td>DOES VICTIM WISH TO FILE HER OWN POLICE REPORT ABOUT THE INCIDENT OF DOMESTIC VIOLENCE?</td>
</tr>
<tr>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>WAS VICTIM REFERRED TO OUTSIDE SUPPORT AGENCY(S)?</td>
</tr>
<tr>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>VICTIM NAME:</td>
</tr>
<tr>
<td>BIRTH DATE:</td>
</tr>
<tr>
<td>SEX:</td>
</tr>
<tr>
<td>RACE:</td>
</tr>
<tr>
<td>ADDRESS (Keep confidential):</td>
</tr>
<tr>
<td>PHONE (confidential) ( ):</td>
</tr>
<tr>
<td>ADDRESS WHERE VICTIM CAN BE CONTACTED (confidential):</td>
</tr>
<tr>
<td>SAFE PHONE (confidential): ( )</td>
</tr>
<tr>
<td>SUSPECT NAME:</td>
</tr>
<tr>
<td>BIRTH DATE:</td>
</tr>
<tr>
<td>SEX:</td>
</tr>
<tr>
<td>RACE:</td>
</tr>
<tr>
<td>ADDRESS:</td>
</tr>
<tr>
<td>PHONE:</td>
</tr>
<tr>
<td>PRESENT LOCATION (IF KNOWN):</td>
</tr>
<tr>
<td>WAS SUSPECT PRESENT WITH VICTIM AT TIME OF TREATMENT?</td>
</tr>
<tr>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>DATE/TIME OF INCIDENT:</td>
</tr>
<tr>
<td>LOCATION OF INCIDENT:</td>
</tr>
<tr>
<td>□ UNKNOWN</td>
</tr>
<tr>
<td>WAS ASSAULT RELATED TO AN INCIDENT OF DOMESTIC VIOLENCE?</td>
</tr>
<tr>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>DESCRIPTION OF INJURIES:</td>
</tr>
<tr>
<td>DID INJURY RESULT FROM USE OF A WEAPON?</td>
</tr>
<tr>
<td>□ YES □ NO</td>
</tr>
<tr>
<td>IF YES, SPECIFY TYPE OF WEAPON:</td>
</tr>
<tr>
<td>VICTIM SUMMARY OF HOW INCIDENT OCCURRED:</td>
</tr>
<tr>
<td>LAW ENFORCEMENT AGENCY WHERE INJURY WAS SUSTAINED:</td>
</tr>
<tr>
<td>ADDRESS:</td>
</tr>
<tr>
<td>OFFICE CONTACTED:</td>
</tr>
<tr>
<td>PHONE: ( )</td>
</tr>
<tr>
<td>DATE/TIME:</td>
</tr>
</tbody>
</table>

Appendix F: Domestic Violence Reporting Form
Appendix G:

Contra Costa County Police Phone Numbers
<table>
<thead>
<tr>
<th>Location</th>
<th>Police Phone Number</th>
<th>Location</th>
<th>Police Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alamo</td>
<td>646-2441</td>
<td>El Cerrito</td>
<td>237-3233</td>
</tr>
<tr>
<td>Antioch</td>
<td>778-2441</td>
<td>Hercules</td>
<td>724-1111</td>
</tr>
<tr>
<td>Bethel Island</td>
<td>646-2441</td>
<td>Kensington</td>
<td>526-4141</td>
</tr>
<tr>
<td>Blackhawk</td>
<td>646-2441</td>
<td>Lafayette</td>
<td>284-5010</td>
</tr>
<tr>
<td>Bradford Island</td>
<td>646-2441</td>
<td>Martinez</td>
<td>372-3440</td>
</tr>
<tr>
<td>Brentwood</td>
<td>778-2441</td>
<td>Moraga</td>
<td>284-5010</td>
</tr>
<tr>
<td>Byron</td>
<td>646-2441</td>
<td>Oakley</td>
<td>646-2441</td>
</tr>
<tr>
<td>Clayton</td>
<td>229-1212</td>
<td>Orinda</td>
<td>284-5010</td>
</tr>
<tr>
<td>Clyde</td>
<td>646-2441</td>
<td>Pacheco</td>
<td>646-2441</td>
</tr>
<tr>
<td>Concord</td>
<td>671-3333</td>
<td>Pinole</td>
<td>724-1111</td>
</tr>
<tr>
<td>Crockett</td>
<td>646-2441</td>
<td>Pittsburg</td>
<td>646-2441</td>
</tr>
<tr>
<td>Danville</td>
<td>646-2441</td>
<td>Pleasant Hill</td>
<td>671-4600</td>
</tr>
<tr>
<td>Diablo</td>
<td>646-2441</td>
<td>Port Costa</td>
<td>646-2441</td>
</tr>
<tr>
<td>Discovery Bay</td>
<td>646-2441</td>
<td>Richmond</td>
<td>233-1214</td>
</tr>
</tbody>
</table>

Note: to make a report on a DV incident that occurred in an area of Contra Costa County that is not listed here, call the County Sheriff's office at 646-2441.
Appendix H:

Obtaining a Restraining Order
PROCEDURES FOR OBTAINING A RESTRAINING ORDER

You will need to go through 3 procedures (which are described in detail below), to obtain a permanent restraining order. You will also have to work with several forms, which are listed below.

THE SIX FORMS: (if you and the batterer related by blood, marriage, adoption, live together now, or lived together in the past, or have a dating or engagement relationship). Must have a recent incident of physical violence or recent threat of physical violence.

1. Order to Show Cause and Temporary Restraining Order
2. Application and Declaration
3. Ex Parte Order
4. Proof of Service
5. Blank Responsive Declaration (to be attached to Defendants copy of Restraining Order)
6. Order After Hearing (CLETS)

THE EIGHT FORMS: (if you and the batterer already have a pending case with the court. i.e. Divorce, Custody matter etc.) Must have a recent incident of physical violence or recent threat of physical violence.

1. Order to Show Cause (green family law form)
2. Temporary Restraining Order (white family law fcm)
3. Application and Supporting Declaration (white family law form)
4. Ex Parte Order (same as above)
5. Proof of Service (same as above)
6. Blank Responsive Declaration (to be attached to Defendant/Respondent copy of Restraining Order) (same as above)
7. Application and Order for Fee Waiver (if indigent)
8. Order After Hearing (CLETS)

THE SEVEN FORMS: (if you and the batterer are not related or do not have a personal relationship i.e. co-worker, neighbor etc.) Must have a recent incident of physical violence or recent threat of physical violence or stalking/harassment.

1. Order to Show Cause and Temporary Restraining Order (Harassment)
2. Petition for Injunction Prohibiting Harassment
3. Ex Parte Order (same as above)
4. Proof of Service (same as above)
5. Blank Responsive Declaration (to be attached to Defendant copy of Restraining Order)
6. Application and Order for Fee Waiver (if indigent)
7. Order After Hearing (CLETS)
THE FOUR PROCEDURES:
1. Obtaining the Temporary Restraining Order
2. Serving the Temporary Restraining Order
3. Obtaining the Order After Hearing (3 Year) Order
4. Serving the Order After Hearing

THE SIX STEPS TO OBTAIN A TEMPORARY RESTRAINING ORDER:

1. Get the proper Documents from the Superior Court (725 Court St., Martinez, Ca) County Clerk’s Office Room 103. Window A, B or C.
2. Fill out the applicable forms (see forms section)
3. Go back to County Clerk’s office and get to any numbered window (1-7). Give the Clerk your paper work, they will assign a case number and tell you which court room to go to and obtain a judges signature.
4. Go to assigned court room, drop off paperwork in designated box and have a seat, either in the court room or in the hall. The legal Tech’s will come and speak with you when necessary.
5. Once the paperwork had been signed by the Judge, go to Room 127 and they will make copies of the Restraining Order for you (up to 5 copies are free). You will need at least:
   - a copy for yourself
   - a copy for the police
   - a copy for the Batterer to be served with
6. Take the original and all the copies back to the County Clerk’s Office Room 103. Give the Clerk the original and all the copies, they will file them for you, assign a court date and give the copies back to you. **THIS IS YOUR TEMPORARY RESTRAINING ORDER (TRO) !! (It is valid until the day of your hearing).**

THE FOUR STEPS TO SERVE THE TEMPORARY RESTRAINING ORDER:

1. You need to take a copy of the TRO to the Police Depts. indicated on your TRO.
2. You need to have someone over 18 (other than yourself) give a copy of the TRO to the Batterer. This person must be served with the TRO at least 5 days prior to the hearing date.
3. The server (person who serves the batterer the TRO) must fill out the bottom portion of the Proof of Service, sign it and give it back to you.
4. Make copies of the Proof of Service and take the original and all the copies back to the County Clerks Office Room 103, go to any of the numbered windows (1-7) and the clerk will file the Proof of Service for you.
THE EIGHT STEPS TO OBTAINING THE ORDER AFTER HEARING (3 yr. Order):

1. Collect any relevant documentation (police reports etc., and copy of the Proof of Service).
2. Make sure you are at your hearing at least 15 min early.
3. Check in with the Bailiff when you arrive.
4. When you case is called, go up to the Plaintiff table (will be marked) It is best to speak directly to the Judge. Try not to speak to the Defendant. Try not to argue back and forth.
5. Once your hearing is over the court will prepare the Order After Hearing for you (it should take 15-30 min to complete the form.)
6. Take the OAH to room 127 and they will make copies for you (up to 5 copies are free)
7. Make sure the police get a copy of the OAH.
8. Make sure the batterer gets a copy of the OAH. If they were at the TRO hearing, mail them a copy. If they were not at the hearing the batterer must be served again (just as you did with the temporary order)

CONGRATULATIONS YOU NOW HAVE A LONG TERM
RESTRAINING ORDER, GOOD FOR THREE YEARS !!
Appendix I:

Community Resource List
## Contra Costa County Community Resources for Domestic Violence

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Description</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shelter</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Battered Women’s Alternatives (B.W.A.)</td>
<td>For battered or formerly battered women and their children. May stay from six months to two years. Counseling, case management and employment services available.</td>
<td>24-Hour Lines &lt;br&gt; West County: 233-2420 &lt;br&gt; Central County: 930-8000 &lt;br&gt; East County: 757-8200</td>
</tr>
<tr>
<td><strong>Housing and Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loma Vista Adult Center, Project Self-Sufficiency</td>
<td>Provides training and technical assistance to locate housing, job training, educational programs, child care and transportation to assist single parents to become self-sufficient.</td>
<td>Countywide: 685-7340</td>
</tr>
<tr>
<td><strong>Rape</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape Crisis Center</td>
<td>Services for adult and child victims of sexual assault and their families. Prevention programs, 24-hour crisis line, medical and legal advocacy and accompaniment, therapy and education.</td>
<td>24 Hour Lines &lt;br&gt; West County: 236-7273 &lt;br&gt; Central County: 798-7273 &lt;br&gt; East County: 439-7273</td>
</tr>
<tr>
<td><strong>Suicide</strong></td>
<td></td>
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<tr>
<td>Crisis and Suicide Intervention of CCC</td>
<td>Crisis hotline, grief counseling and community education programs.</td>
<td>24 Hour Lines &lt;br&gt; West County: 620-0174 &lt;br&gt; Central County: 939-3332 &lt;br&gt; East County: 754-7080</td>
</tr>
<tr>
<td><strong>Child Abuse/Parenting</strong></td>
<td></td>
<td></td>
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<tr>
<td>Child and Family Therapy Center</td>
<td>Professional treatment for child sexual abuse victims, particularly for those who are low-income.</td>
<td>Countywide: 686-2700</td>
</tr>
<tr>
<td>Children’s Protective Services (CPS)</td>
<td></td>
<td>24 Hour Lines &lt;br&gt; West County: 374-3321 &lt;br&gt; Central County: 646-1580 &lt;br&gt; East County: 427-8811</td>
</tr>
<tr>
<td>Parenting Today and Tomorrow (B.W.A.)</td>
<td>Provides prevention education and referral services for adults on family issues, interpersonal violence and substance abuse.</td>
<td>Countywide: 676-7748</td>
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<tr>
<td><strong>Counseling Services</strong></td>
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<tr>
<td>Mental Health Information and Referral</td>
<td>Provides referrals to community programs and low-cost sliding-fee scale individual and family counseling.</td>
<td>Countywide: 313-6101</td>
</tr>
<tr>
<td>Mental Health Crisis Services</td>
<td>Psychiatric emergency and crisis services.</td>
<td><strong>24-Hour Line</strong></td>
</tr>
<tr>
<td></td>
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<td>370-5700</td>
</tr>
<tr>
<td>Mental Health Referrals, Contra Costa Health Plan (CCHP) Members</td>
<td>Provides referrals and authorization for mental health services for CCHP members.</td>
<td>Countywide: 313-6131</td>
</tr>
<tr>
<td><strong>Substance Abuse Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol and Drug Abuse Council of Contra Costa, Inc. (ADACCC)</td>
<td>Information and referral services covering all substance abuse issues, including prevention and treatment for adults, children, and youth.</td>
<td>West County: 231-0788</td>
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<td></td>
<td></td>
<td>Central County: 932-8000</td>
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<td></td>
<td></td>
<td>East County: 778-8100</td>
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<tr>
<td><strong>Resources for People with Disabilities</strong></td>
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<td></td>
</tr>
<tr>
<td>Independent Living Resources of CCC</td>
<td>Provides services for people with disabilities, including personal care assistance and housing referrals, individual and systems advocacy, benefits/peer counseling services, pre-employment, and independent living skills training.</td>
<td>Countywide: 229-9200</td>
</tr>
<tr>
<td></td>
<td></td>
<td>West County: 232-4941</td>
</tr>
<tr>
<td><strong>Resources for Lesbians and Gay Men</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Battered Women's Alternatives (B.W.A.) Lesbian Services</td>
<td>All B.W.A. services are available to lesbians who have been battered. Lesbian advocates are on staff to address lesbian-specific issues.</td>
<td><strong>24-Hour Lines</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>West County: 233-2420</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Central County: 930-8800</td>
</tr>
<tr>
<td></td>
<td></td>
<td>East County: 757-8200</td>
</tr>
<tr>
<td>Community United Against Violence (CUAV)</td>
<td>Offers gay male victims of domestic violence 24-hour crisis intervention and telephone counseling, short-term counseling, support groups, assistance with restraining orders, emergency assistance, and criminal justice and other advocacy.</td>
<td><strong>24-Hour Line</strong></td>
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<tr>
<td></td>
<td></td>
<td>(Located in San Francisco) 415-333-HELP</td>
</tr>
</tbody>
</table>

Appendix I: Community Resource List
<table>
<thead>
<tr>
<th><strong>Legal Services</strong></th>
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<tbody>
<tr>
<td><strong>Victim/Witness Program</strong></td>
<td>Crisis intervention for victims of crime; provides court status information and court support. Victims of Crime Program may pay for medical, counseling, or dental expenses, or for loss of income or support due to crime.</td>
</tr>
<tr>
<td><strong>Battered Women's Alternatives (B.W.A.)</strong></td>
<td>Provides services to individuals and families involved in domestic violence, including assistance with temporary restraining orders, information about criminal charges, court accompaniment and referrals to attorneys.</td>
</tr>
<tr>
<td><strong>Legal Assistance for the Elderly</strong></td>
<td>Provides free legal services to abused CCC elders 60 and over who are threatened with loss of shelter, income and access to medical care.</td>
</tr>
<tr>
<td><strong>Contra Costa Legal Services Foundation</strong></td>
<td>Free legal services on a range of issues related to domestic violence. No legal advice is given by phone.</td>
</tr>
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<tr>
<th><strong>Men's Programs</strong></th>
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<tbody>
<tr>
<td><strong>Battered Women's Alternatives (B.W.A.)</strong></td>
<td>Groups for abusers to help men stop the violence.</td>
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<thead>
<tr>
<th><strong>Teen Services and Programs</strong></th>
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<tbody>
<tr>
<td><strong>Teen Moms' Shelter, San Francisco</strong></td>
<td>Emergency shelter for battered pregnant or parenting teens from all Bay Area counties and their ch. children. Also offers legal advocacy and comprehensive case management.</td>
</tr>
<tr>
<td><strong>Youth Education and Support Services (YESS), a program of B.W.A.</strong></td>
<td>Offers peer training and classes on family and relationship violence prevention, as well as conflict resolution services in targeted high schools.</td>
</tr>
</tbody>
</table>