



Subject	Number	Date Issued	Date Approved	Date Effective
<b>Domestic Violence Protocol</b>	1	10/29/2015		
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# **Domestic Violence Protocol**

## **Definition**

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

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

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

## **Purpose**

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

## **Guiding Principles**

1. Treat patients with dignity, understanding, respect, and compassion.
2. Treat patients of different ages, cultures, and sexual orientation with sensitivity, while remembering that violence is unacceptable in any relationship.
3. Recognize that the process of leaving a violent relationship is often a long and gradual one.
4. Attempt to engage patients in long-term continuity care within the healthcare system, in order to support patients through the process of attaining greater safety and control.
5. Respect the integrity and authority of patients' life choices.
6. Discuss confidentiality issues with all patients.

## **Policy**

This protocol applies to all staff, students, and volunteers working within MayView Community Health Centers. The roles and responsibilities of staff in each clinical are described in **Attachment A**.

## **Process**

This protocol will be reviewed at a minimum of every 2 years by a MayView Community Health Center advocate/team trained in domestic violence and by the medical director. Staff training will be included as part of the review process.

## **Training**

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

## **Supplies**

1. DOMESTIC VIOLENCE BINDER: Purple Binders kept in an agreed upon location be located in each clinic

Contents of binder will be restocked by a patient advocate trained/MA

List locations: MayView Palo Alto

MayView Mountain View

MayView Sunnyvale

2. DOMESTIC VIOLENCE RESOURCE MANUALS: Educational Materials and protocol will be at each location in \_\_\_\_\_.

## **1. SCREENING**

### **Standards:**

- **In all primary care visits, family planning visits, pediatric visits, and pre-natal visits.**

**Screen all women (18 years and older).** Also, screen men and boys presenting with symptoms or signs of domestic violence (See **Attachment B**).

### **Procedures:** (see **Attachment C** for flowchart)

#### **A. Screen for domestic violence in a safe environment.**

- Use your own words in a non-threatening, non-judgmental manner.
- Ask the patient about domestic violence in a private place.
- Separate any accompanying person or child from the patient while screening for domestic violence.
- If it is not possible to screen for domestic violence safely do not screen patient.

Arrange for return visit.

**B.** Use questions that are direct, specific, and easy to understand (See **Attachment D**).

“Are you in a relationship with a person who threatens or physically hurts you?”

- If the patient has a physical injury: “Many people come in with injuries like yours and often they are from someone hurting them. Is this what happened to you?”

**C.** When unable to converse fluently in the patient's primary language:

- Use a professional interpreter or another healthcare provider fluent in the patient's language.
- The patient's family, friends or children should not be used as interpreters when asking about domestic violence.

**D.** Screen verbally, in addition to any written questionnaire forms used.

**E.** Document that screening for domestic violence was done.

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

## **2. ASSESSMENT**

### **A. Essential Assessment**

1. Obtain history of present complaint.
2. Physical examination: Provider should examine for evidence of further injuries or scars.
3. Refer to Advocate to address the following four issues before the patient leaves your site:
  - Immediate risk: “If you return home, will you be in immediate physical danger?”
  - Children: “Is perpetrator (or patient) hurting or threatening patient’s children?”
  - State of mind toward situation and readiness for change: “What type of assistance would you like?” “Are there any changes you would like to make?” “What steps would help you towards those goals?” “What actions are you ready to take?”
  - Suicide: “Have you had suicidal thoughts in response to your situation?”

### **B. Further Assessment**

Advocate will do further assessment with patient and/or in conjunction with community domestic violence experts and counselors.

## **3. INTERVENTION DONE BY THE ADVOCATE ON SITE**

### **A. Convey the following messages:**

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

**B. Provide information on domestic violence:**

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

**C. Assist the patient in making a safety plan:**

**1. Ask the following questions:**

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

**2. Contacting the police:**

- Do you want police intervention? If the patient wants official police intervention, assist her/him in filing an official report with the local police department.
- Health Practitioners, patient advocate, or MA should assist the patient in making the report.
- If perpetrator is posing immediate danger to patient, clinicians or the safety of others, **call 911.**
- If perpetrator is not posing immediate danger and patient wants police assistance, **call police dispatch at: MV (650)903-6395**

**PA (650)329-2413**  
**EPA (650)321-1112**  
**Sunnyvale (408) 730-7110**

- Healthcare personnel should remain with the patient during the police interview, if the patient so desires.
- Ensure patient is in safe place while awaiting police.
- Document in the medical record that an official police report was made (include date, time, and officer name and badge number).
- Urge the patient to call the appropriate DV agency or the National Domestic Violence Hotline at 1-800-799-7233 to obtain an advocate to help her or him navigate the criminal justice system.
- ***A separate report of injuries must be submitted by the healthcare provider to law enforcement, as required by California law Attachment E***

### **3. Safety in Clinic:**

- Clinics should discuss and adapt safety strategies. If patient wishes to escape the perpetrator during the clinic visit, use alternative exit to safely escort the patient out of the building. Provide patient with resources. Notify police if the patient or staff is in immediate danger.

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

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

### **D. Referrals:**

All known or suspected victims of current domestic violence should be referred to a Domestic Violence agency, if the patient will accept a referral.

- Refer the patient to available community resources (See **Attachment G**).
- If patient thinks it would be dangerous to take a list of resources offer the phone number of appropriate DV agency or the National Domestic Violence Hotline at 1-800-799-7233
- When the patient is willing, assist her/him in calling a domestic violence hotline during the healthcare visit.
- Tell the patient she/he can always call or come back for support or more information.

### **E. Sexual Assault Intervention:**

- In the case of sexual assault urge the patient to accept a referral to the **Rape Crisis Center** at **1-800-656-4673** for advocacy, counseling, and appropriate information on transfer for evidentiary collection. Currently, San Francisco Law Enforcement recommends that evidentiary collection can be useful for up to 120 hours (5 days) after assault.
- Offer to assist the patient to the appropriate Emergency Department for evidentiary collection.
- If the patient does not wish to go to the Emergency Department, but the provider would like advice on examination, documentation, and treatment, call the Rape Crisis Center for advice.

#### **4. DOCUMENTATION (Provider)**

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

- A description of domestic violence history, including present complaints or injuries, past experiences of physical/sexual abuse and frequency of abuse. Include date, time and location of domestic violence incidents.
- Whenever appropriate use the patient's own words in quotation marks.
- A description of patient's injuries, including type, location, size, color and age. Document injuries on a body map (See **Attachment H** for Body Map Documenting Instructions).
- Alleged perpetrator's name, address, and relationship to patient (and children, if any), if patient is willing to provide this information.
- A description of other health problems, physical or mental, which may be related to the abuse.
- Whenever possible, following patient's consent, take photographs of patient's injuries (see **Attachment H** for photograph consent form). Take photographs of all injuries, including:
  - One full body shot (to link injuries with identified victim).
  - One mid-range to show torso injuries.
  - Close-ups of all wounds and bruises.
- Preserve any physical evidence (e.g., damaged clothing, jewelry, weapons, etc.) which can be used for prosecution. (See **Attachment H** for Receipt of Evidence form).
- Document details of intervention made and all actions taken.
- In the case of rape/sexual assault contact **Rape Crisis Center** at **1-800-656-4673** for advice on transferring patient for appropriate forensic exam/evidentiary collection.
- This documentation process may take place over more than one visit as further history is revealed. Different members of the multidisciplinary team may document different aspects of the abuse.

**DOCUMENT POSITIVE OR SUSPECTED DOMESTIC VIOLENCE THAT IS OCCURRING**

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

## **5. MANDATORY REPORT OF INJURY (SEE Attachments E, I, & J)**

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

1. Report to the local law enforcement agency when providing medical services to a patient who has a physical condition that you know or reasonably suspect is a result of a firearm or assaultive or abusive conduct.
2. Discuss reporting requirements and solicit cooperation from the patient. Patient consent, however, is not required.
3. Reporting healthcare provider should telephone a report of domestic violence as soon as possible to the Police Department by calling **MV (650)903-6395**

**PA (650)329-2413**

**EPA (650)321-1112**

**Sunnyvale (408) 730-7110**

Document in the medical record that the call was made.

4. Reporting healthcare provider should complete the **OES 2-920** form. (See **Attachment E, I, & J** for form, reporting procedure and other relevant information.) Mail this form within 2 working days to the appropriate police department according to the city where the incident occurred. File a copy of report in “confidential” section of the chart.
5. **If the provider or the patient wants police intervention or follow-up, you must call 911 for emergencies or to make an official police report call:**

**MV (650)903-6395**

**PA (650)329-2413**

**EPA (650)321-1112**

**Sunnyvale (408) 730-7110**

**Your mandatory report is not an official police report.**

6. **Abuse of a minor and elder/dependent adult abuse require different reporting procedures:**

- *For patients under the age of 18, report in accordance with Child Abuse & Neglect Reporting (Article 2.5 of Penal code, commencing with Section 11164), even if alleged perpetrator is also a minor.*
- *For patients age 65 and older and for dependent adults, report in accordance with Elder Abuse and Dependent Adult Civil Protection Act (Chapter 11 of Part 3, Division 9 of Welfare and Institutions Code, commencing with Section 15600).*
- ***Child and elder mandatory reports may result in further investigation by Child Protective Services or Adult Protective Services.***

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

## **6. CONTINUITY OF CARE**



- A. At each visit, for patients with known or suspected domestic violence:
1. Ask about history of violence since last visit.
  2. Ask about coping strategies.
    - Emotional status?
    - Called hotline?
    - Told any family or friends?
    - Attempts to leave?
  3. Ask about any abuse of children since last visit.
  4. Give messages of support and your concern.
  5. Reiterate options to patient (Emergency Protective Order, Temporary Restraining Order, friend's home, shelter, hotline, support groups).
- B. For patients with no suspected domestic violence when screened at your site in the past: There are no studies that address appropriate rescreening intervals. You might consider rescreening the patient at the following times (whichever occurs first):
- Patient starts intimate relationship with new partner.
  - Patient presents with symptoms or signs of domestic violence.
  - Periodic intervals (at provider's discretion).

# Attachment A

## Roles & Responsibilities

### Clerical Staff:

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

### Nurse (RN):

- Does not routinely screen patients for domestic violence during walk-in IZ clinic days or triage telephone calls
- Privately and immediately reports suspicion of domestic violence, a witnessed act of domestic violence or a patient's mention of domestic violence primary provider or patient advocate if patient is at the clinic.
- Nurse may assist patient advocate or primary provider as needed.

### Medical Assistants (MA):

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

### Medical Provider (NP or MD):

- Screens routinely for domestic violence and treats patients as outlined in this protocol.
- Determines whether perpetrator is in clinic if not already informed by RN/MA.

- Urges all patients with known or suspected domestic violence to accept referral to DV agency.
- If provider is not the primary provider for the patient, notifies primary provider of known or suspected domestic violence promptly (only in primary provider is internal within MayView Community Health Center).

**Medical Records Staff:**

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

## **Attachment B**

### **Symptoms and Signs of Domestic Violence**

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

*I. History suggesting domestic violence:*

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

*II. Physical clues:*

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

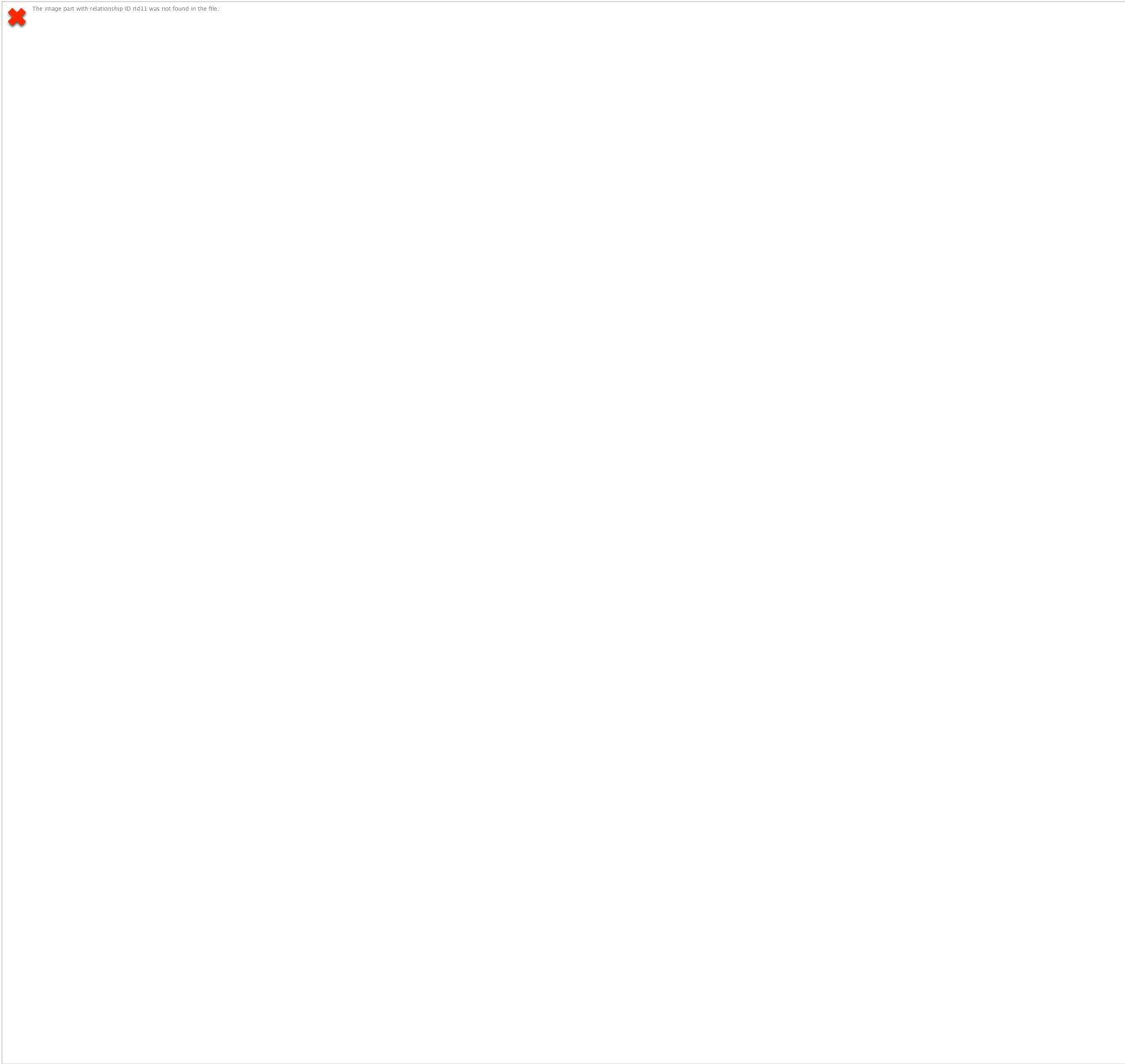
*III. Behavioral clues:*

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

*IV. Verbal clues:*

- Directly or indirectly brings up the subject of abuse

# Attachment C



# Attachment D

## Approaches for Interviewing the Patient

### Screening Questions by MAs:

- “Within the past year, or since you have been pregnant, have you been slapped, kicked or otherwise physically hurt by someone?”
- “Are you in a relationship with a person who threatens or physically hurts you?”
- “Has anyone forced you to have sexual activities that made you feel uncomfortable?”  
\*

### Framing Questions:

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

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

Open ended questions should always be followed by direct questions.

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

### Sexual Abuse questions will be asked by Providers or Advocate:

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

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

### Suspected Domestic Violence questions will be asked by Providers or Advocate:

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

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

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

- **If screening negative Ma's offer pocket card w/1800-# in case pt knows somebody w DV.**

# Attachment E



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# Attachment F

## Safety Planning

When a patient has been identified as a victim or suspected victim of domestic violence it is important to speak with the patient about immediate and future safety. The severity of current abuse or past injury is not always an accurate predictor of future violence. Patients may minimize the danger they face. Assisting the patient in making a safety plan can increase the patient's awareness of options for increasing her/his safety. Also, safety planning will help the provider assess the situation and better support the patient. A patient may choose different options such as returning to the abuser, evicting the abuser or leaving the abuser. A patient may choose to remain in a relationship with the perpetrator for many different reasons. Provide messages of support and discuss the dangerous, harmful consequences of domestic violence but respect the patient's choice and work with the patient to help increase safety as much as possible. Also, remember that leaving a violent relationship may be a very dangerous time for the victim.

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

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

B. If patient is planning to stay in relationship:

- What kind of strategies have worked in the past to minimize injuries? Does patient think these strategies would continue to work?
- Can patient anticipate escalation of violence and take any precautions?
- Would patient call the police if perpetrator becomes violent? If patient couldn't get to phone could she/he work out a signal with a neighbor to call police and/or teach her/his children to call 911?

- Does patient have a support network of friends or family that lives nearby and would provide help if needed?
- Does perpetrator have or use weapons? Can they be removed from perpetrator or can ammunition be separated from weapon?

### C. Escape Plan

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

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

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

# Attachment G

## Referrals

### **POLICE**

- **Emergency**.....**911**
- Non-Emergency MV..... (650) 903-6395
- Non-Emergency PA..... (650) 329-2413
- Non-Emergency EPA..... (650) 321-1112
- Non-Emergency SV..... (408) 730-7110

### **24 HOUR CRISIS LINES**

- National Hotline..... (800) 799-7233
- San Francisco Domestic Violence Hotline (Woman, Inc.)..... (415) 864-4722  
(Spanish spoken 24 hours)
- 211 (referral specialist) ..... 211 or 248-4636
- Community Overcoming Relationship Abuse (CORA)-San Mateo ..... (800) 300-1080
- Asian Women’s Home (AACI)..... (408) 975-2739
- Maitri ..... (888) 862-4874
- Hearing Impaired Hotline ..... (805) 656-4439
- Teen Crisis Line..... (888) 247-7717
- Suicide Crisis Hotline of Santa Clara County ..... (855) 278-4204 (toll free)
- Rape Trauma Services of San Mateo County ..... (650) 692-7273
- YWCA: 24- hour rape crisis line (Santa Clara County)..... (408) 287-3000
- Victims of Crime Resource Center..... (800) 842-8467

### **WOMEN’S SHELTERS**

- Asian Women’s Home (AACI)- San Jose..... (408) 975-2739  
(Various Asian Languages and dialects)
- Support Network – Sunnyvale..... (800) 572-2782
- Next Door Solutions to Domestic Violence – San Jose (24-hour hotline)..... (408) 279-2962
- Community Overcoming Relationship Abuse (CORA)-San Mateo (24-hour hotline/shelter) (800) 300-1080
- WOMAN, Inc. (tracks all shelter bed openings)..... (877) 384-3578

### **FAMILY SHELTERS**

- Family Supportive Housing Inc. (San Jose Family Shelter)..... (408) 926-8885
- EHC Boccardo Regional Reception Center (BRC)-SV..... (408) 294-2100 Or Main: (408) 510-7502
- Bill Wilson Center (youth) -SC..... (408) 243-0222

### **MEN’S SHELTERS**

- West Valley Community Services (Cupertino) ..... (408) 255-8033

### **TRANSITIONAL HOUSING**

- YWCA of Silicon Valley..... (408) 295-4011

**COUNSELING & SUPPORT GROUPS**

- Alum Rock Counseling Center- SJ ..... (408) 294-0579 (hotline)
- Asian Americans for Community Involvement (AACI)- SJ ..... (408) 975-2730
- Bill Wilson Center (Youth Focused)- SC ..... (408) 243-0222
- Community Health Awareness Council-MV ..... (650) 965-2020
- John F. Kennedy University- Sunnyvale Counseling Center..... (408) 524-4900
- Fair Oaks Mental Health (SCC)..... (408) 992-4800
- The Gronowski Center (Palo Alto University) ..... (650) 961-9300
- Momentum/ La Selva (PA) ..... (650) 617- 8340
- Santa Clara County Mental Health Call Center ..... (800) 704-0900
- Grupo de Apoyo para Mujeres Victimas de Abuso Domestico- Spanish only (SV)..... (408) 730-7800

**BATTERER'S AND MARRIAGE COUNSELING**

- Process Therapy Institute-LG ..... (408) 358-2218
- Family and Children Services ..... (408) 292-9353
- Man Alive (for batterers)- SF ..... (415) 552-1361

**ELDER ABUSE RESOURCES**

- Adult Protective Services (APS) ..... (408) 975-4900
- Senior Adults Legal Assistance ..... (408) 295-5991
- Santa Clara County Department of Aging and Adult Services ..... (408) 755-7600

**CHILD ABUSE RESOURCES**

- Child Protective Services- Palo Alto (CPS)..... (650) 493-1186
- Child Protective Services- Santa Clara (CPS)..... (408) 758-3600
- Child Abuse Council of Santa Clara County ..... (408) 293-5450
- CHAT- at Bill Wilson Center ..... (408) 278-4913

**LEGAL ASSISTANCE**

- Community Overcoming Relationship Abuse (CORA)..... (650) 259-1855
- Immigration Services of Mountain View ..... (650) 938-4911
- Bay Area Legal Aid (DV) ..... (888) 330-1940
- LACY (Legal Advocates for Children and Youth) ..... (408) 280-2416
- Legal Aid Society of Santa Clara County..... (408) 998-5200
- Maitri ..... (888) 862-4874
- CNC Legal Clinic (SV)..... (408) 730-7800

**FOOD SERVICES**

- West Valley Community Services (Cupertino) ..... (408) 255-8033
- Second Harvest Food Bank (SJ/SM) ..... (800) 984-3663
- Sunnyvale Community Services ..... (408) 738- 4321
- Manna Food Distribution (SC)..... (408) 295- 2326
- Family Harvest Program at CNC (SV)..... (408) 730-7800

**NATIONAL HOTLINES**

- National Hotline for Domestic Violence..... (800) 799-7233
- National Human Trafficking Resource Center Hotline ..... (888) 373-7888
- Face to Face National Domestic Violence Project..... (800) 842-4546

## **Attachment H**

### **Injury Location Record (Body Map)**

- In EHR, click on “Patient History”
- Click on “Images”
- Under “Open Image File” ensure the drop down menu reads “ImageBoiler”
- Search “Body” and “3Heads”
- Choose appropriate image (ex: male/female, race/ethnicity, adult/child, etc.)
- Document findings

## **Consent to Photograph** (Place patient label here).

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

The undersigned hereby authorizes \_\_\_\_\_ and the attending  
(Name of Agency)  
clinician to photograph or permit other persons in the employ of this facility to photograph  
\_\_\_\_\_ while under the care of this facility, and agrees

(Name of Patient)

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

Date

Patient's Signature

Street Address

City

State, Zip

Witness

Parent or Legal

Guardian

# Receipt for Evidence

(Place patient label here).

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

Date: \_\_\_\_\_

Received From: \_\_\_\_\_

Medical Facility: \_\_\_\_\_

Photograph of or items from:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Items (List) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signed: \_\_\_\_\_

Police Officer:

Name (Print or Type) \_\_\_\_\_

Department Badge # \_\_\_\_\_

Prosecutor's Office:

Name \_\_\_\_\_

Title \_\_\_\_\_



# Attachment I

## Reporting Procedure

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

- Inform the patient of clinician's duty to report
- Inform patient that if she/he wants police intervention or follow-up, she/he must call 911 for emergencies or for non-emergency situations and to make an official police report call: **MV (650)903-6395**  
**PA (650)329-2413**  
**EPA (650)321-1112**  
**Sunnyvale (408) 730-7110**
- Make a telephone report to the appropriate police department as soon as possible
- Complete an **OES 2-920** form (see **Attachment E**) and send within two working days to the appropriate police department
- When two or more healthcare providers have knowledge of a known or suspected instance of violence requiring reporting, only one person is required to submit the report.
- All healthcare providers involved are equally responsible to see that the report is made according to State requirements.
- File a copy of the report in the patient's medical record in the correspondence section.
- Maximize role of patient's input; advocate for the patient's needs with authorities.
- Keep the report confidential; it cannot be accessed by friends, family, or other third parties without the patient's consent.

## **Attachment J**

### **Common Questions and Answers about Mandatory Reporting Requirements for Health Practitioners**

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

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

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

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

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

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

The report must include the following:

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

#### **4. How do I make my health practitioner report?**

Telephone the Police Department at: **MV (650)903-6395**

**PA (650)329-2413**

**EPA (650)321-1112**

**Sunnyvale (408)730-7110**

Call as soon as possible and leave a voice mail message. Provider is to document the phone call in the Medical Record. Within 48 hours, mail the confidential mandatory healthcare reporting form to: Police Department Domestic Violence Unit

#### **5. What happens to the health practitioner report once it is made?**

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

There may be exception to the above procedure. In Emergency Room cases, the police may already be involved. Either they were at the scene of the crime or they have been called to the hospital to conduct an investigation, make a report, and possibly make an arrest. In addition, if you do not use the correct telephone number or address listed above, police response may vary. For example, police intervention may occur regardless of patient wishes if you call a different police number.

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

If you or the patient wants police intervention or follow-up, you must call 911 for emergencies or to make a police report call: **MV (650)903-6395**

**PA (650)329-2413**

**EPA (650)321-1112**

**Sunnyvale (408)730-7110**

An officer will come to your location to make the report. Your medical mandatory report is not an official police report. Depending on the circumstances, the police report may lead to arrest, prosecution, and/or incarceration.

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

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

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

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

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

The law does not specify any particular procedure. On the one hand, informing patients of the reporting law prior to screening may enhance their autonomy; if patients believe they will be in more danger if a report is made, they can decide to refrain from discussing the abuse or even leave the facility. On the other hand, healthcare providers can provide lifesaving care and information to patients they identify as being battered, and such prescreening warnings may only provide obstacles to that end. Providers must not let their misgivings about reporting laws prevent them from routinely inquiring about domestic violence and providing appropriate care to patients. Each facility should have a discussion and form its own protocols around this issue.

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

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

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

Providers should be aware of the potential harmful consequences mandatory reporting presents for battered patients. Reporting may put battered patients at risk for retaliation if police intervene against patients' wishes. It may deter patients from seeking healthcare or being candid with their clinicians about the causes of their injuries. There may be an ineffective response to reports of abuse. Reporting without patient consent infringes on personal autonomy, and may also re-victimize patients by controlling their life decisions. The abrogation of provider-patient confidentiality that may result from reporting is also harmful and may undermine the patients' trust in their providers.

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

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

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

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

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

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

