HOSPITAL EMERGENCY DOMESTIC VIOLENCE PROTOCOL

The Hospital Emergency
Working Group

Coalition for Woman Abuse
Policy & Protocol
Prince Edward Island

DEDICATION:

For all who struggle to end the cycle of violence, and children who will be voices of change.

June, 2002

This protocol was prepared by the Hospital Working Group as part of the Coalition for Woman Abuse Policy & Protocol. This protocol was adapted from St. Joseph's Health Centre Woman Abuse Protocol, St. Joseph's Women's Health Centre, Toronto, 1996, and credit for and copyright of the majority of the content remains with them.

For information about the Coalition for Woman Abuse Policy & Protocol, and other protocols go to the PEI Woman Abuse Protocols Web site - www.isn.net/cliapei/womanabuse

Acknowledgements

We gratefully acknowledge the work of those who have developed the following protocols, upon which we have based much of our own protocol.

•Especially, St. Joseph's Health Centre Woman Abuse Protocol, St. Joseph's Health Centre, Toronto, 1996

•Protocol for Battered Women, Prince Edward Island Hospital Services Commission, 1985

•Vancouver Hospital & Health Sciences Centre, Domestic Violence Program, June 1993

•Best Practices Guidelines, Metro Woman Abuse Protocol Project, 1994

•Domestic Violence Screening Protocol, Centre de recherche interdisciplinaire sur la violence familiale et la violence faite au femmes, 2001

We are also grateful for the assistance of the Premier's Action Committee on Family Violence Prevention and the generosity of the employers who contributed time and travel.

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1 INTRODUCTION

The Province of Prince Edward Island recognizes domestic violence as a social issue which has very serious health implications for women, children and men. We recognize, however, that the vast majority of victims of domestic violence are women.[1]

Health care providers have a responsibility to identify and respond effectively to domestic violence, and to take steps to prevent further abuse.

The Domestic Violence Protocol will inform and guide health care providers in their work with patients who have experienced and continue to experience violence in their lives.

Domestic violence is a crime which exists in all cultural, religious, economic, social communities, and age groups. A significant percentage of women presenting in the emergency department are there because of abuse, but only a small percentage of cases related to abuse are identified by health care professionals[2]. It is extremely important that health care professionals have the knowledge and the tools necessary to identify and intervene appropriately in abuse cases. Equally important, health care providers must carefully examine societal and personal stereotypes held about particular cultures, religious beliefs, socio-economic classes and victims of domestic violence, since these will have a great impact on the quality of care and intervention provided. Intervention must be sensitive to differences of culture, race, class, sexual orientation, abilities and psychiatric history.

The Domestic Violence Protocol acts as a guide and educational tool in that it provides health care professionals with practical and appropriate screening, assessment and intervention strategies. The protocol also addresses legal and safety issues and resources available in the community.

The health care community is in a unique position to identify and respond to domestic violence. **For most abused women, the health care system is their first and frequently only contact with an agency or program that provides intervention and support.** With the implementation of the Domestic Violence Protocol, the Province of Prince Edward Island is sending a clear message to service providers, patients and the community that it is committed to breaking the cycle of violence.

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[1] Of 22,000 victims of spousal violence reported to police in 1997, 88% were female and 12% were male [Robin Fitzgerald, Family Violence in Canada: A Statistical Profile 1999 (Ottawa: Statistics Canada, Canadian Centre for Justice Statistics, 1999): 11]

[2] Noel, N. and Yam, M. "Domestic Violence: The Pregnant Battered Woman", Women's Health, 27 (4), 1992.

2 PURPOSE and OBJECTIVES

The purpose of the protocol is to ensure consistent screening, identification and effective intervention for domestic violence.

The objectives of the protocol are to:

- facilitate opportunities for victims to reveal abuse
- ensure privacy and confidentiality
- facilitate a multi-disciplinary approach and response which assesses immediate needs and risks to the patient
- provide patient with current resources and referral where appropriate
- provide guidelines for identification, assessment, documentation and referral
- clarify the roles and responsibilities of each party
- document evidence of abuse
- provide a tool for orientation and training of staff

3 STATEMENT OF PRINCIPLES

- Domestic violence is a crime.
- Domestic violence undermines mental and physical well-being. Everyone, especially children, have the right to live free from abuse and violence.
- Domestic violence is a serious health issue that can result in severe physical and psychological harm. It should be viewed as part of a potentially life-threatening pattern regardless of the severity of the present injury.
- Everyone has the right to non-judgmental services and resources. The response to domestic violence must not re-victimize the patient and/or the patient's child(ren).
- All intervention and care must be provided in ways that facilitate a woman's ability to exercise her own choice and enable women to be full participants in the process. Education and support to victims should be provided in a way which will facilitate empowerment of the patient.
- Educational training for service providers is a necessary component to provide effective intervention.
- All staff are responsible for ensuring that victims of domestic violence receive high quality and compassionate care.
- Public awareness about domestic violence and the

services available is a necessary component of this protocol.

- In issues of domestic violence, confidentiality is a safety issue.

4 THE ROLE OF EMERGENCY STAFF

A. Nursing Staff and Physicians

There are five aspects of care that should be provided to victims of domestic violence:

- screening / identification
- assessment / examination
- documentation
- safety planning
- referral

Health care providers must carefully examine personal and societal stereotypes and biases held about particular cultures, religious beliefs, social classes, age groups, and victims of domestic violence, since these will greatly impact the quality of care and intervention provided.

During the screening and assessment process, it is important to be aware of how cultural and religious issues affect the way violence is viewed and how decisions are made regarding safety and separation. While domestic violence exists in all cultural communities, patients from different cultural communities may react differently from each other when in an abusive relationship depending on the views about family violence commonly held in her or his community.

Keeping these factors in mind, the following guidelines

will assist health care providers to implement the domestic violence protocol effectively and sensitively.

B. Receptionists, Clerical Staff, Paramedics, Commissionaires and Volunteers

If you suspect abuse or the patient discloses abuse:

- ✓ Acknowledge the disclosure and reassure the patient that the health care provider is in a position to offer assistance
- ✓ Refer immediately to the health care provider and alert the provider responsible for the patient's care that the possibility of abuse exists or that the patient has disclosed abuse
- ✓ Adhere to hospital standards or practices regarding confidentiality

5 UNIVERSAL SCREENING

A. Principles

To identify those experiencing abuse, all patients who present for care or treatment will be screened for abuse. This can be done discretely by nurses or physicians during the course of the patient's assessment and treatment.

Health care providers should become familiar and proficient in various ways of asking patients about abuse and ways of providing appropriate intervention and support. When asking about abuse;

- ▸ Focus your attention on the patient to increase trust and build rapport. Avoid doing paperwork or other tasks during the screening process.
- ▸ Provide a safe, private and supportive environment within which to screen for abuse. Allow support persons at the patient's discretion, provided their presence is not going to hinder an accurate assessment nor put the patient at further risk.

  CAUTION: DO NOT screen for abuse with the partner OR other family members present

- ▸ Be sensitive to the fact that patients may refuse to give information about abuse or refuse to receive intervention or referral information. (Document on the medical chart if a patient wishes not to give or

receive information.).

B. Procedures

1. When screening, the following questions and statements are to be addressed to every patient in a direct but compassionate manner.

"We know that many people experience problems in intimate relationships which can result in health problems..."

"...so, we ask all patients this question: Are you in a relationship with someone who threatens to or has hurt you in any way?"

"All information disclosed is confidential."
(See section 10, "Confidentiality", pg.24)

2. If the patient appears to not understand the question, provide her/him with examples of ways of experiencing abuse, such as:

"Does your partner push, slap or hit you in any way?"

"Does your partner call you names or threaten you?"

"Are you afraid of your partner?"
"Have you ever been pressured or forced to have

sex with your partner when you did not want to?"

"Has your partner ever forced you to take part in sexual acts that made you feel uncomfortable?"

3. If the patient discloses abuse, proceed to Guidelines for Assessment/Intervention, Section A, pg. 11.

4. If the patient denies abuse, but you strongly suspect abuse, proceed to Assessment/Intervention Guidelines, Section B, pg.14.

5. Document patient's response to screening interview. (Refer to "Documentation and Reporting Procedures" for guidelines, pg. 25)

6. If there is a need for an interpreter, **under no circumstances** should you use the patient's partner, children or other relatives as the interpreter during the screening for abuse. However, since communication is the ultimate goal, it is better to work with a family member or friend than to have no communication. In this instance, be aware of the limitations and ensure that clear communication is occurring. If possible, obtain an interpreter from within the hospital, ensure that the interpreter is aware of issues of confidentiality and ensure that the patient is comfortable with that person.

6. ASSESSMENT and INTERVENTION GUIDELINES

A. When There Is Disclosure of Abuse

DO:

✓ Immediately provide a safe, private and supportive environment.

✓ Attend to immediate medical needs.

✓ Assess danger level and safety of patient and her/his children. (See pages 17-20 for guidelines.)

✓ Alert security if abuser becomes violent / disruptive.

✓ Acknowledge the disclosure and affirm clearly that **domestic violence is wrong.** Reassure the patient that s/he is doing the right thing by talking with you.

✓ Ensure confidentiality (ie. partner, family members, friends **do not** have access to patient's medical treatment / records without the patient's consent.) (See section entitled "Confidentiality", pg. 24)

✓ Offer support and information in a non-judgmental and sensitive manner.

✓ Inform the patient of rights and options:
- Everyone has the right to live free of abuse.
- The patient is not to blame for the abuse.
- Domestic violence is a crime.
- Everyone has the right to stay in a safe place
- A patient who is being abused has the right to file a report with the police
- The patient may have the right to make an application under the Victims of Family Violence Act.

✓ Provide the patient with brochures, pamphlets and emergency numbers as well as the safety plan information which can be found at page 21. Review the information with the patient to ensure understanding**.**

Determine with the patient whether it is safe for the patient to take written materials home. Whenever possible, provide information in the patient's first language.

✓ **MANDATORY REPORTING OF CHILD ABUSE**
On PEI, you are required by law to report child abuse. If a minor patient (under 18 years of age) discloses abuse, or if an adult patient discloses abuse or you *suspect* abuse and there are children living in the home, you are required by law to report to Child Protection. Children are considered "in need of protection" when they are being abused *AS WELL AS* when they are

witnessing abuse. Child Protection can be reached at 1-800-341-6868. For local numbers, refer to Appendix A.

✓ With patient's consent refer to the Family Violence Outreach Worker, a Social Worker, Child and Family Services or Transition House Association.

✓ Be aware of your own reaction to the situation and debrief with colleagues or a supervisor.

Where questions of safety, confidentiality and competency exist, please refer to your profession's guidelines. These are complex areas of law and the provider should be guided by a balance between the demands of their profession and respect for the dignity of individual choice.

DON'T:

X Don't ignore the disclosure of abuse.

X Don't minimize the patient's experience. (eg. *"Don't worry, it will all work out"*.)

X Don't blame the patient. (eg. *"What did you do to cause this?" or "Why do you stay?"*)

X Don't give the patient advice. (eg. *"You should leave your partner immediately."*)

X Don't make decisions for the patient, eg. calling the police or calling a relative, except where Child Protection must be called.

X Don't confront the abuser.

X Don't make excuses for the abuser. (eg. *"Your partner is probably under a lot of stress."*)

B. When Abuse is Suspected but not Disclosed:

Provide further opportunity for disclosure. Continue with gentle but direct questioning. Be attentive to patient's response to additional questioning, for example, **if the patient is becoming angry, hostile, non-communicative, do not pursue further questioning.** Some examples of additional questions are:

"I'm concerned about how you got these injuries. Did someone do this to you?"

"We often see injuries or symptoms like yours when a patient has been hurt by her/his partner. Has this happened to you?"

Educating all patients about abuse is a necessary means of prevention, therefore if the patient **does not** disclose abuse, proceed to ask the following question:

"If this were ever to happen to you, would you know where to go for help?"

Provide the patient with information about resources available, eg. Anderson House, Victim Services, the hospital. See Appendices A and B for a more detailed list of resources.

The following intervention strategies can be helpful for a victim of domestic violence who at this point is not ready to disclose abuse or needs reassurance that the hospital is a safe place to disclose abuse.

✓ Assure patient that any information discussed is confidential. (See section on "Confidentiality", pg. 24)

✓ Review patient's old charts from this hospital (or others) to determine if there is a pattern of abuse and/or suspicious injuries or symptoms. This information may be useful during the screening interview. For example, *"I noticed that last month you were in Emergency for a fractured collar bone and this time for a broken rib."*

✓ Offer the patient a brochure about domestic violence. Provide the information in the patient's first language whenever possible. If the patient refuses to take the literature, respect that decision.

✓ Inform patient of crisis hotline numbers and encourage patient to return to hospital if s/he is ever in the position of needing to speak to someone.

✓ If patient continues to deny abuse, record in chart that the patient's explanation of injuries is inconsistent with the physical findings.

7. ASSESSING THE DANGER LEVEL

If the patient discloses abuse, continue with the following questions. Reassure the patient that your conversation is confidential.

1. When was the last time you were abused? Can you tell me what happened?

2. When did the abuse start? How often does the abuse occur?

3. Is the abuse getting worse? More frequent?

4. Has your partner ever threatened to kill you or him or herself? Has your partner ever used a weapon?

5. Are there children living in your home? How many and how old are they?

6. Are there any weapons in the home?

7. Has your partner ever threatened or hurt your children, pets or property?

8. Are you sometimes afraid of your partner? Are you afraid for your life or for the lives of your children? What are you most afraid of if you return home? If you don't return home?

9. Have the police ever been called to your home?

10. Are drugs or alcohol a factor in the abuse?

11. What do you think will work best for your situation?

8. ASSESSING THE SAFETY OF CHILDREN

Children who are exposed to domestic violence or the threat of violence are at risk and in need of protection.

MANDATORY REPORTING OF CHILD ABUSE

You are required by law to report child abuse. If there are children living in the home and abuse is disclosed *or suspected,* you are required by law to report to Child Protection. Children are considered "in need of protection" when they are being abused *AS WELL AS* when they are witnessing abuse. Child Protection can be reached at 1-800-341-6868. For local numbers, refer to Appendix A.

It is imperative that the children's safety be assessed. The following are supplemental questions which should be asked of patients with children who are living with violence in their home.

- ✓ Ascertain the whereabouts of the children. Are they here at the hospital? Are they with the abuser? Are they with family or friends? Are they safe?
- ✓ Is the patient concerned about the child (ren)'s well being?
- ✓ If the patient is being hospitalized, can children be cared for by supportive family or friends?
- ✓ Has the family received or is currently receiving

help from Child Protection?

9. SAFETY PLANNING AND REFERRAL GUIDELINES

The following is a guideline for assisting the patient to develop a safety plan. It is important to understand that **leaving an abusive relationship is a process** which may take years just as the abuse has taken place over a lengthy period of time. Therefore, remember that the health care provider's role is to inform the patient of all options but the decision about going home or not going home must ultimately be made by the patient and respected by the health care provider. **A crucial component of developing a safety plan with the patient is helping the patient take control of the situation.**

It is recommended that all health care providers be familiar with emergency resources that address the needs of victims of family violence, eg. Anderson House, support groups, counselling, etc. See Appendix A for more information about emergency resources and Appendix B for information about non-emergency community resources.

Safety Planning Tips:

✓ If the patient chooses to return to and remain in the relationship encourage the patient to develop an Emergency Escape Plan.

✓ Provide the patient with emergency phone numbers, list of resources, and brochures in her/his language.

✓ Assist the patient in seeking immediate safety (eg.

Anderson House, staying with supportive family or friends, admission to hospital, hotel room, etc.)

✓ Explore how the patient will take the children out of danger, especially in the middle of the night.

✓ Inform the patient of legal rights (eg. calling the police, Victims of Family Violence Act, etc.)

✓ Help the patient to develop an **Emergency Escape Plan**

Tips for creating an Emergency Escape Plan

Put the following in a safe place:

- a small amount of money
- keys
- medication
- children's favourite toy or blanket
- your identification
- children's identification
- bank book
- mortgage
- passport
- health card
- lease papers
- other important documents

Alert a supportive family member or friend of your situation.

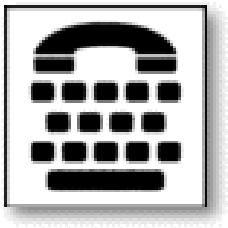
Ask a neighbour to call 911 on your behalf when you give them a pre-determined signal.

Consider the following when developing a safety plan

with disabled patients who are being abused:

- when making referrals to community agencies and shelters, find out if it is accessible (ie. wheelchair, access to interpreter for the deaf).

- explore transportation options if the patient needs to leave in an emergency



10. CONFIDENTIALITY

Confidentiality is an important part in developing trust in a relationship. The issue of confidentiality should be discussed with the patient to ensure awareness of its meaning in the context of this hospital and the domestic violence protocol.

Inform patient of standards of practice regarding confidentiality, using professional judgement in terms of timing and delivery in keeping with the spirit of this protocol.

The following is a guideline to help facilitate a conversation about confidentiality.

- Reassure the patient that your conversation will not be discussed with the patient's partner, nor will it be discussed with any other member of the family, without the patient's consent.

- If the patient voices concern about documentation, inform patient of the benefits of full documentation. (See Documentation and Reporting Procedures, pg 25)

- Inform the patient about the mandatory reporting of child abuse or suspected child abuse and other limits to confidentiality.

11. DOCUMENTATION AND REPORTING PROCEDURES

Document identification or disclosure of abuse on the patient's medical chart with the assistance of the Domestic Violence Assessment/Documentation Form (see Appendix D).

Documentation is important for future medical and legal assessments. Proper medical documentation is beneficial to the patient in the event that the police lay charges against the abuser and / or the patient is pursuing legal custody and access issues related to children.

A. Written Documentation

When documenting domestic violence, it is suggested that the service provider:

- Be **objective**, accurate and pay attention to details of what was said, done and observed. Accurate and objective documentation is essential to avoid misinterpretation. For example, use wording such as "the patient states..." when describing the situation.

- Record the injuries on a **body map**. A precise description of injuries must be recorded for legal purposes. Include signs of restraint marks or sexual assault or abuse.

- Record any inconsistencies between patient's explanation of how injury was sustained and medical findings.

Provide the patient with the option of having injuries photographed as supplementary documentation. Follow procedures for photographing patient injuries. (pg 27)

Review documentation with the patient to ensure the accuracy of the information recorded.

Inform the patient that this information is typically shared with the patient's family physician and encourage the patient to follow up with the family physician.

Inform the patient that a report can be filed with the police and the police may lay charges against the abuser. This process will provide the patient with additional documentation and it is beneficial to do this as soon as possible.

Provide the option of calling the police while at the hospital. Having a supportive person there will make the process less intimidating. Be sensitive to patients historical relations with the police. **Police involvement may not be a viable option.**

B. Photographing a Patient's Injuries

- Inform the patient of the legal benefits of photographing injuries (ie. provides supplementary evidence to medical documentation).

- If there is police involvement, *they* should photograph the patient's injuries.

If police are not involved or are unavailable:

- Obtain the patient's consent to take photographs of the injuries. Written consent is mandatory.

- Explain thoroughly to the patient what the patient is consenting to. The patient has the option of agreeing to all of or only part of the consent card. NOTE: The witness signature must be that of someone other then the "photographer" (eg. another nursing staff).

- Take a photo of the consent card to ensure proper identification of the photographs.

- When photographing the injury, begin with an "orientation" photo for example the entire arm, leg, etc. Then, take a "close-up" photo of the injury. Take two sets of photos of each injury. Offer the patient a copy of the photos.

- Take two (2) sets of photographs, using a Polaroid camera, sign each photo on the back including the

patient's name, hospital identification number and the date. Photograph should also be signed by the patient. Offer the patient one set; keep the other in the patient's file.

12. COLLECTING FORENSIC EVIDENCE

If the patient has made the decision to take legal action against the abuser, evidence related to the assault should be collected and labelled to ensure that it is useful to the patients case. When specific questions arise concerning handling and collecting forensic evidence, the attending police officer should be consulted concerning the specific protocol to follow for such material.

If the patient has not made a decision about taking legal action at the time, encourage her/him to allow the collection of forensic evidence in the event that s/he chooses to do so at a later date.

13. LEGAL ISSUES

A. The Law

Domestic Violence is a criminal offence. Police are expected to lay charges whenever there are legal grounds to do so. The law applies equally to married couples, common-law relationships, same sex relationships and to separated / divorced individuals.

B. MANDATORY REPORTING OF CHILD ABUSE

On PEI, you are required by law to report child abuse. If there are children living in the home and abuse is disclosed *or suspected*, you are required by law to report to Child Protection. Children are considered "in need of protection" when they are being abused *AS WELL AS* when they are witnessing abuse. Child Protection can be reached at 1-800-341-6868. For local numbers, refer to Appendix B.

C. Role of Health Care Professionals

Unlike child abuse, reporting abuse of adults is not mandatory. However, health care providers are in the unique position of being able to intervene and provide support in many different ways. It is important that the health care provider be aware that in many circumstances the act of reporting will increase the risk of danger to the patient.

Where questions of safety, confidentiality and competency exist, please refer to your profession's guidelines. These are complex areas of law and the provider should be guided by a balance between the demands of their profession and respect for the dignity of individual choice.

D. Medical Legal Documentation

Physicians have a responsibility to keep patient medical records according to professional standards. Attending physicians may be subpoenaed to appear in court to support their documentation of a patient's physical injuries.

14. SELF -CARE FOR THE HEALTH CARE PROVIDER

There are three components to self-care for the health care professional: personal safety, self-care, and setting realistic expectations for interventions.

A. Personal Safety

It is crucial that attending health care providers be aware of certain personal safety issues when assisting victims of domestic violence.

The following guidelines should be adhered to by all health care providers:

- Do not place yourself physically between arguing people.
- Do not confront an alleged abuser. Police or security should be notified if the abuser becomes violent or disruptive.
- When an abuser is present in the room with you and you sense hostility, position yourself so that a quick exit is possible.
- To avoid threats or harassment from the abuser, hospital staff should never release over the telephone or in person, the home phone, address, or shift schedule of any staff members.

B. Self-Care For The Health Care Provider

It is important to acknowledge that providing support to victims of domestic violence often triggers our own feelings and attitudes about domestic violence. Common feelings range from disbelief to rage to helplessness to frustration. It is important to talk about these feelings with colleagues or your supervisor.

Sometimes these reactions are in response to personal experiences of having lived with violence. If you are living in an abusive situation, seek support from a trusted friend, colleague, family member or community agency. As well, there are resources available to employees through the Employee Assistance Program which is confidential and free. You can reach the Employee Assistance Program at 1-800-239-3826 or 368-5736 in Charlottetown.

C. Setting Realistic Expectations For Intervention

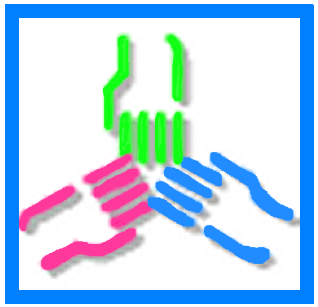
Often times, bearing witness to domestic violence can make us feel powerless in our attempts to make any real impact or change. We may inadvertently be giving messages that the patient is to blame or should be following our advice. These feelings are not uncommon. However, they are not helpful to the person in crisis. Therefore, it is recommended that health care teams create time in their schedule to de-brief and problem-solve on a regular basis through staff meetings or one-to-one with colleagues.

Remember the following when providing support to a victim of domestic violence:

- Acknowledge any steps taken towards safety and change, no matter how small, including the disclosure to you.
- Do not judge the patient's inability to take action at that moment.
- Do not express your feelings of frustration and helplessness to the patient.
- De-brief and problem-solve with colleagues.
- Acknowledge what you were able to do:
  - ✓ provide patient with vital information that could save the patient's life
  - ✓ help the patient feel less alone and isolated

Understand that leaving an abusive relationship is a process that takes time. Health care providers can become part of the process of a victim liberating her or himself, although they may never know. It is important to remember that providing a compassionate and understanding response to disclosure about abuse will have a positive lifetime impact on the patient.

Count Contact as Success!



Notes:

Emergency Resources Appendix A

For Police and Medical Emergencies **911**

Crime Stoppers . . . . (toll free) **1-800-222-8477 (TIPS)**
(Anonymous reporting. No need to give your name.)

Anderson House (emergency) **1-800-240-9894**
within Charlottetown **892-0960**

Family Violence Outreach Workers:
Family Violence Prevention - Eastern PEI **838-0795**
East Prince Transition and Support Services **436-0517**
West Prince Transition and Support Services **859-8849**
Queens County Outreach **566-1480**

PEI Rape and Sexual Assault Crisis Centre **566-8999**
toll-free **1-800-289-5656**

Child Protection:
Charlottetown **368-5342**
Montague **838-0702**
O'Leary **859-8811**
Souris **687-7060**
Summerside **888-8100**
Toll-free **1-800-341-6868**

Community Resources Appendix B

Island Help Line (toll free) 1-800-218-2885
24-hour free, confidential service for all Islanders providing information, support, crisis counselling on family matters, child abuse, alcohol and drugs, parenting and suicide.

Child and Family Services
Charlottetown 368-5330
Souris 687-7060
Montague 838-0700
Summerside 888-8100
O'Leary 859-8811
Financial assistance; homemakers and home helpers; child protection services; general counselling; transportation in cases of special need; day-care subsidy; and other social services.

Home Care and Support
Charlottetown 368-4790
Montague 838-0772
O'Leary 859-8730
Souris 687-7096
Summerside 888-8440
Adult protection; home care nursing; visiting homemakers; occupational therapists; community support workers.

Victim Services
Charlottetown 368-4582
Summerside 888-8217
Assists victims of crime across the province. Services include: information and referral; short-term counselling; assistance through the Court process; victim impact statements; and criminal injuries compensation.

Community Legal Information Association 892-0853
toll free 1-800-240-9798
Provides basic legal information including free pamphlets on a wide variety of legal topics to the general public.

Crown Attorneys
Charlottetown 368-4595
Summerside 888-8213
The Crown Attorneys represent the Attorney General in the prosecution of all criminal cases under the Criminal Code of Canada and Provincial Statutes. In cooperation with Victim Services, Crown Attorneys assist victims with Court preparation upon request.

PEI Community Justice Resource Centre 368-6390
Programming of the Centre focuses upon the delivery of services which will develop and reinforce positive lifestyles. Programs include the Turning Point Program which is a men's group counselling program aimed at helping men to stop violence against their female partners; the Female Anger Management Program; the Male Anger Management Program; and the Sexual Deviance Assessment / Treatment Program.

Family Legal Aid
Charlottetown 368-6043
Summerside 888-8219
Services to low-income clients in family law matters such as separation, divorce, custody, for victims of family violence; also for child protection cases.

Family Court Counsellors
Charlottetown 368-6056
Reports to the Court, e.g. custody reports ordered by Supreme Court Justices; family and marital counselling; and referral to appropriate legal and other agencies.

Consumer Services (toll free) 1-800-658-1799
Charlottetown 368-4580
Assistance and counselling is available to any consumer with a debt-related problem.

Lawyer Referral Service (toll free) 1-800-240-9798
Charlottetown 892-0853
Legal advice provided early before your problems become complicated or expensive. Nominal fee for one half-hour of advice. Monday to Friday, 9a.m. - 4p.m.

Maintenance Enforcement 368-6010
Enforcement of provincial orders and agreements and contact for out-of-province enforcement for the benefit of child and spousal support.

COUNSELLING

Community Mental Health Services

Charlottetown	368-4430
Summerside	888-8180
Montague	838-0782
Souris	687-7096
West Prince	888-8180

Treatment, assessment and consultation services.

COMMUNITY SERVICES

Community and Family Services of PEI 892-2441
Individual, family and marital counselling; information and referral; family life education; family advocacy; and specializes in anger management for victims and abusers. Ladies' Auxiliary provides a Christmas shop for low-income clients.

Catholic Family Services Bureau 894-3515
Individual, marital and family counselling; support and self-help groups; family life education program; and advocacy on behalf of clients.

Prince County Family Services Bureau 436-9171
Supportive counselling and referrals for families of limited income and for unmarried mothers.

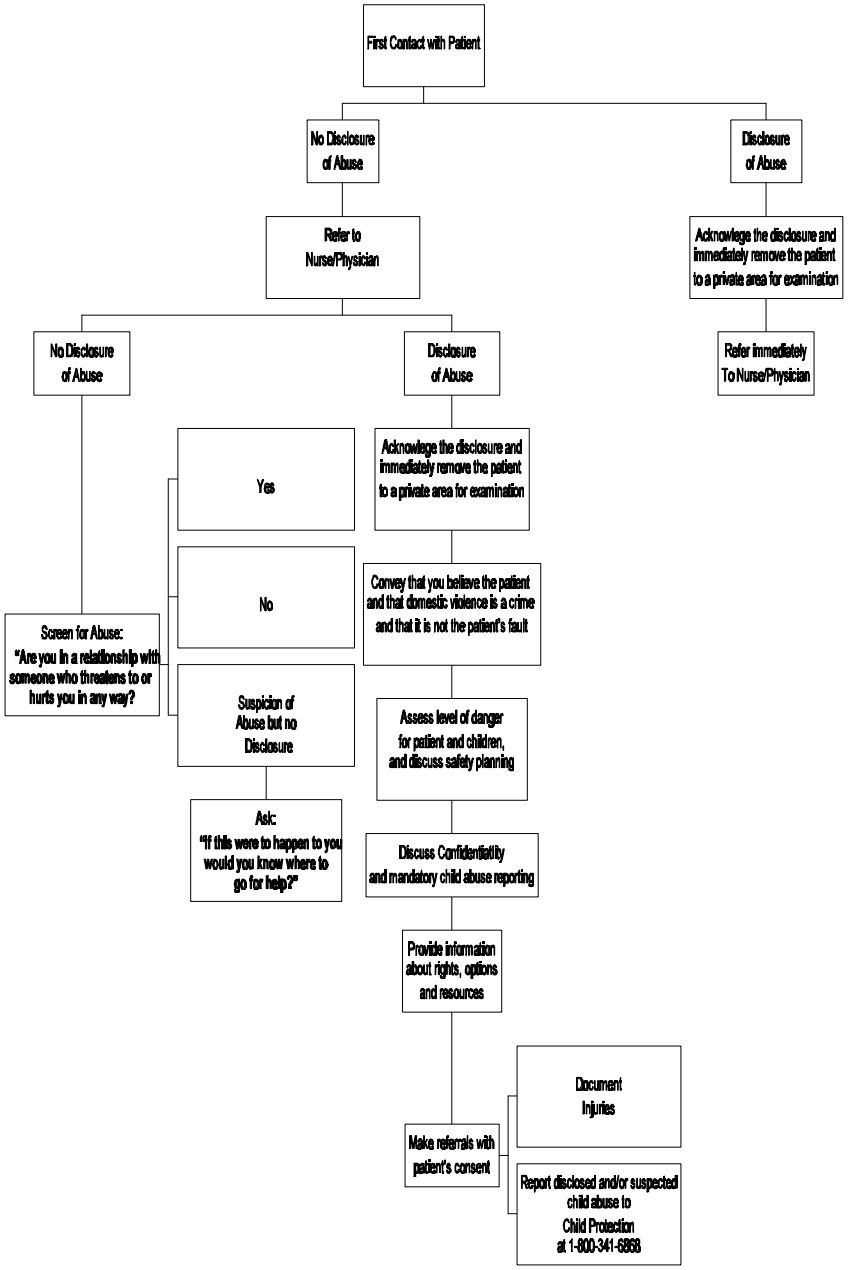
Salvation Army

Charlottetown	892-8870
after hours	566-9982
Summerside	888-3870
after hours	436-6044

24-hour service. Emergency shelter, food and clothing; transportation in emergency cases if needed; pastoral counselling; operation of a senior citizen home; and provision of a chaplain to the Correctional Centre.

East Prince Women's Information Centre 436-9856
Information and referral for women on issues such as employment, wife-battering, addictions, legal rights, sexual harassment, etc.

Domestic Violence Flow Chart Appendix C



Domestic Violence Assessment/Documentation Form Appendix D

Date:_____ Time:____Hrs.

Information:

Safe Contact Name _____Phone Number : _____

Children: Number _____Ages _____

Whereabouts:_____

_____

Police Involvement Prior to Arrival: Yes No

Officer's Name: _____Detachment:_____

History of Incident:

Location of Incident: _____

Date: _____ Time: ____Hrs.

Alleged Assailant: Known Unknown

If Known, Relationship to Patient:

Spouse Common-law Boyfriend Caregiver

Same Sex Partner Former Spouse Other

Description of Events: (use patient's words)

_____

_____

_____

_____

Nature of Abuse

Physical	Pushing	Use of weapons
Kicking	Choking	Over-medication
Hitting	Burning	

Withholding food, medical attention
Other:

Economic
Withholding money
Taking her money
Complete control of financial decisions
Other: _____

Emotional / Psychological
Name calling
Use of intimidation
Yelling / Shouting
Homicidal threats
Suicidal threats
Restricting contact with family/friends
Other: _____

Sexual
Control over sexuality
Forced prostitution
Forced / unwanted touching, sexual acts
Infidelity
Denies protection from STD's and AIDS
Other: _____

Emotional Assessment:

Agitated	Suicidal Ideations	Communicative
Fearful	Crying	Non-communicative
Withdrawn	Anxious	Silent
Apprehensive	Nervous	Minimizing Illness / Injury

Medical Information: Is patient pregnant? Yes : # week
No Uncertain

Medical Abuse History:

1. Any evidence of past injuries? Yes No
Was treatment received at time of previous injury? Yes No

Past injuries: (describe)

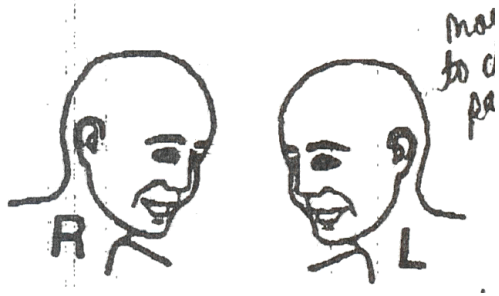
2. Other Medical history (include insomnia, pain, headaches or signs of stress):

Physical Examination:

1. Clothing: Examine for Evidence of Trauma / Assault:

2. Physical Injuries: Indicate, as accurately as possible, ALL injuries sustained. Record type, shape, size and colour of injuries - see chart following page:

Impressions and Comments: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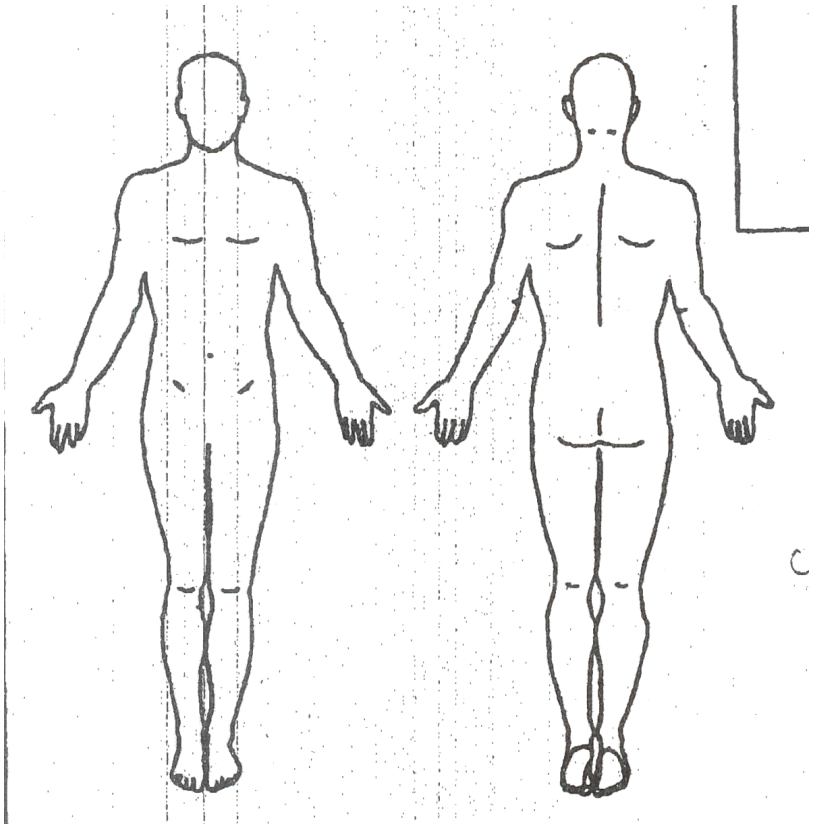


Risk Assessment:

A	Yes	No	B	Yes	No
Was there use or threat of a weapon?			Has there been a history of abuse in the relationship?		
Has the abuse increased in frequency / severity?			Is the abuser presently in the home?		
Does the patient perceive living arrangements unsafe to return to?			Was police intervention needed?		
Has the patient planned or attempted suicide?			Is no one else aware of the abuse?		
Have the children ever been threatened or hurt?*			Did the abuse start or escalate during pregnancy?		
			Will the patient require medical treatment?		

RISK RATING:
If "yes" to any of questions in column A, share concern with patient and assist her/him in developing a safety plan (eg. staying at a shelter, friend, family member)

If "yes" to one or more from column B, explore options, provide emergency numbers, referral and written information etc.

Referrals Made:

Medical Follow-up
Social Work Consult
Family Violence Outreach
Anderson House
Police
Ethno-Specific Agency
Social Assistance
Legal Aid
Psychiatry
Home Care
Public Health Nurse
Other: _____

Information Provided:

Affirmation that domestic violence is a crime.

The patient is <u>not</u> to blame for the abuse.

Telephone number of Anderson House or other crisis lines

Brochures / pamphlets on domestic violence.

Other: _____

* Where child abuse is disclosed or suspected, the health care provider is required by law to report the case to Child Protection at 1-800-341-6868.

SAFETY PLANNING

Outline Patient's Options:

- Secure personal documents in safe place(or facsimile - bank book, passport(s), birth certificate(s), address book, health card, etc.)
- Call Transition House Association
- Contact family member
- Contact friend
- Contact Police
- Contact agency (specify):_____
- Return to hospital
- Other: (specify) _____

Physician's Signature: _____

Nurse's Signature: _____

Quick Reference Guide Appendix E

(This guide is a supplement to the Domestic Violence protocol and only serves as a reminder. It is essential that all health care providers familiarize themselves with the details of the protocol to ensure a consistent and appropriate response.)

Five aspects of care should be provided to women who have been abused:

- screening, identification
- assessment, examination
- documentation
- safety planning
- referral

✓ ASK all women about abuse/violence in routine assessment, treatment

✓ Interview the patient ALONE

✓ Convey that you BELIEVE the patient

✓ Convey an attitude of CONCERN, RESPECT and CONFIDENTIALITY

✓ Let her know that WOMAN ABUSE IS A CRIME, she is NOT ALONE and it is NOT HER FAULT

✓ Assess IMMEDIATE SAFETY of the patient and DEVELOP SAFETY PLAN

✓ Provide patient with list of COMMUNITY RESOURCES

✓ DOCUMENT information on patient's charts and complete Documentation Form with patient's consent

Remember:

DO NOT BLAME OR SHAME the patient

DO NOT MINIMIZE her experience

DO NOT IGNORE the disclosure of abuse

DO NOT ALIGN yourself with the abuser

DO NOT AS, "*Why don't you leave?"*

DO NOT MAKE DECISIONS without the patient's knowledge or consent (except where mandatory reporting of child abuse is required)

Woman Abuse Screening Questions:

" We know that many women experience problems in relationships, which can result in health problems. ***Are you in a relationship with someone who threatens to or has hurt you in any way?****"*

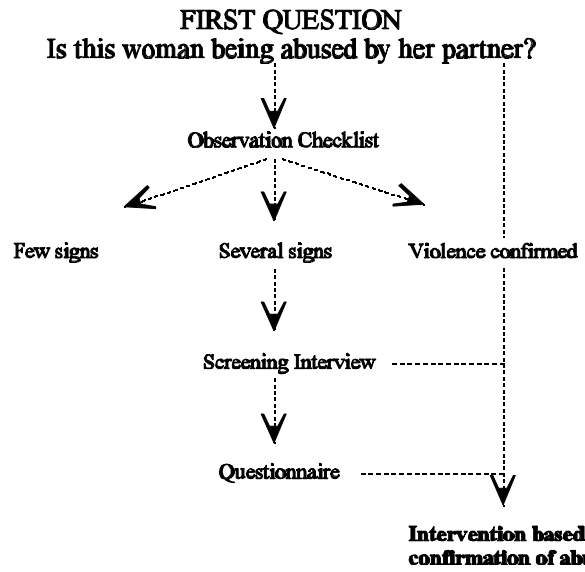
"We often see injuries/symptoms like yours when a patient has been hurt by her husband/partner. Is this happening to you?"

Questions to Ask if you Strongly Suspect Abuse:

"I'm concerned about how you got these injuries. Did someone do this to you?"

COUNT CONTACT AS SUCCESS

Example of Another Protocol [3] Appendix F



Observation Checklist - provides a record of the signs that may lead to suspicions of violence. At this point abuse may be confirmed by the women herself or by her partner or a family member.

Screening Interview - when several signs are observed without confirmation of abuse, the screening interview opens the discussion with the woman on the difficulties she experiences in her relationship with her partner. Abuse may be confirmed at any stage of the interview.

Questionnaire - lists precise questions to ask the woman about how her partner behaves with her, if abuse has not been confirmed and if doubts persist after the interview.

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[3] Centre de recherche interdisciplinaire sur la violence familiale et la violence faite aux femmes 2001

Questionnaire (Some sample questions)

A. Non-Physical Behaviour
(After three positive responses, you may skip to Question 14)
1. Has your partner ever said or done things to hurt of humiliate you?
2. Has he every threatened to his you or throw something at you?
3. Has he ever stomped out of the room or the house?
4. Has he every forbidden you from leaving a room or house?
5. Has he every yelled at you?
6. Has he ever smashed, hit or kicked something
7. Has he ever pushed or hit the dog, car or other pet?
8. Has he ever prevented you from taking a job outside the home?
9. Has he ever forbidden you from seeing certain persons?
10. Has he ever driven dangerously to scare you?
11. Has he ever threatened to leave you or have an affair?
12. Has he ever threatened to take the children away from you?
13. Has he ever threatened to commit suicide?

B. Physical Behaviour (After one positive response, you may skip to Question 24)
14. Has your partner ever slapped you?
15. Has he ever pushed, grabbed, lifted, shaken or immobilized you?
16. Has he ever thrown something at you?
17. Has he ever kicked, bitten or punched you?
18. Has he ever thrown you to the floor or against a wall or furniture?
19. Has he ever burned you?
20. Has he ever struck or attempted to strike you with an object?
21. Has he ever beaten you up (hit you several times)?
22. Has he ever tried to strangle you?
23. Has he ever used a knife, firearm or other weapon against you or threatened you with a weapon?

C. Sexual Behaviour (One positive response is enough)
24. Has your partner ever pressured you to have sex?
25. Has he ever forced you to submit to or perform a sexual act you did not want
26. Has he ever used force to make you have sex with him?

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