Pilot Guidelines on Identifying and Responding to Male Intimate Partner Victimization and Perpetration in the Health Care Setting

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INTRODUCTION

For over a decade, the Family Violence Prevention Fund (FVPF) through its publications, practices, educational programs, and outreach efforts, has promoted routine screening for intimate partner violence and effective responses to victims in health care settings. Other health professionals' organizations including the American Medical Association, American College of Obstetricians and Gynecologists, American Nurses Association, American Academy of Pediatrics, American Academy of Family Physicians, American Psychological Association, the Joint Commission on the Accreditation of Health Care Organizations, and the Institute of Medicine, have promulgated policy statements, position papers, guidelines and monographs about this important health issue.

In 1999, the Family Violence Prevention Fund (FVPF) published its first set of national guidelines on screening and treating intimate partner violence in the health care setting. In 2002, in collaboration with an expert advisory committee, the FVPF developed *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings* [1] to reflect emerging research findings. These guidelines recommend screening of all female and male adolescent and adult patients for intimate partner violence victimization. The addition of screening men for victimization in these revised guidelines reflected new data that suggest that men in same-sex relationships experience intimate partner violence at rates at least equal to that of women in heterosexual relationships, and that some men in heterosexual couples also experience abuse. [2, 3] The FVPF also released important new guidelines addressing intimate partner violence in pediatric settings to expand screening and to address childhood exposure to adult and adolescent intimate partner violence in greater depth.[4]

These pilot guidelines, "Pilot Guidelines on Identifying and Responding to Male Intimate Partner Violence Victimization and Perpetration in the Health Care Setting, are meant to focus specifically on the experience of men with intimate partner violence (IPV). The guidelines address screening, assessing, and treating men for IPV victimization and perpetration. Such interventions with men are critical for reducing not only IPV but also child maltreatment, given the strong correlation between these two phenomena.[5]

Health care research on IPV issues and men is limited. There are few studies that explore the prevalence of IPV in men in the health care setting [6-9], the accuracy and efficacy of screening men in the health care setting [9, 10], the ability of interview procedures to distinguish victimization from perpetration,[10, 11] the efficacy of a health care response to men involved in abusive intimate relationships, or the efficacy of batterer's treatment programs.[12],[13] Yet, there is considerable expert experience in certain sites throughout the country and in other countries in this field. [11, 14, 15], [16],[17], [18, 19]

Therefore, these pilot guidelines are not meant to represent standard of care in this field, but instead to share expert opinion to guide the practice of those providers and institutions that already have familiarity with treating IPV in women or working with men around violence and would like to expand their experience. These pilot guidelines are meant to encourage safe dialogues with men about IPV and to encourage study of this important, unexplored topic.

To develop these pilot guidelines the FVPF built on its guidelines developed in partnership with advisors from the National Health Care Standards Campaign on Domestic Violence and a national Advisory Committee. A new National Advisory Committee assiduously reviewed these pilot guidelines. These recommendations reflect the combined decades of their experience in the field as well as results from current research.

Definitions:

Family violence (FV):

The term family violence has been used to describe acts of violence between family members, including adult and adolescent partners; between a parent and a child (including adult children); between caretakers or partners against elders; and between siblings. While sometimes used interchangeably, the term domestic violence is generally seen as a subset of family violence occurring between intimate partners.

These pilot guidelines focus primarily on intimate partner violence or IPV and use the following definition:

Intimate Partner Violence (IPV):

> *Intimate partner violence is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at maintaining or establishing control by one partner over the other*.

Legal definitions of IPV reference state or federal laws and generally refer specifically to threats or acts of physical or sexual violence including forced rape, stalking, harassment, certain types of psychological abuse and other crimes where civil or criminal justice remedies apply. Laws vary from state to state.

An IPV victim:

Is a person who is being physically, sexually, or psychologically harmed by another person repeatedly. The victim does not hold the bulk of the power or control in an intimate relationship. Power and control refers to physical, sexual, psychological, economic, and social power and control.

An IPV perpetrator:

Is a person who physically, sexually. or psychologically harms another person repeatedly. The perpetrator holds the bulk of the power or control in an intimate relationship. Power and control refers to physical, sexual, psychological, economic, and social power and control.

"Child Exposure to IPV":

Child exposure to IPV is a term encompassing a wide range of experiences for children whose caregivers are being abused physically, sexually, or emotionally by an intimate partner. This term includes the child who observes a parent being harmed, threatened, or murdered, who overhears these behaviors from another part of the home, or who is exposed to the short- or long-term physical or emotional aftermath of caregiver's abuse without hearing or seeing a specific aggressive act. Children exposed to IPV may see their parents' bruises or other visible injuries, or witness to the emotional consequences of violence such as fear or intimidation, without having directly witnessed violent acts. (for a complete discussion of children who witness violence see [20])

This term also includes children who are used by the perpetrator to intimidate and abuse the adult victim as well as those who are forced by the perpetrator to participate in the abuse of an adult victim. The impact of IPV on children varies greatly depending on the nature and frequency of the perpetrator's abusive tactics, the development stage and gender of the child, and the presence of protective factors. Providers must distinguish child exposure from legally defined and reportable child abuse.[4]

PREPARING A PRACTICE OR HEALTH CARE SETTING FOR SCREENING AND INTERVENING WITH MALE VICTIMS AND PERPETRATORS OF IPV:

1. Establish training that:

- Is interactive, institutionalized, and on-going.
- Emphasizes the safety of victims and children.
- Emphasizes the safety of health care providers and staff
- Addresses the prevalence and dynamics of IPV for both women and men
- Addresses cultural competency with attention to how culture, race, ethnicity, religion, sexual orientation, and gender identity impact IPV screening and treatment.
- Addresses the appropriate identification, assessment, and responses for both victimization and perpetration in the health care setting. Training should specifically address the providers' barriers to an effective response to male IVP patients
- Acknowledges that differentiation between victim and perpetrator will not always be possible and that safety still needs to be kept as the guiding principle.
- Acknowledges that health care providers and staff are also affected by IPV and describes how trainees may access employee assistance.

2. Establish a protocol for IPV screening and treatment that:

- Allows for privacy when doing screening
- Makes clear to all patients that the IPV screening and treatment program is a ROUTINE practice in the healthcare setting so that perpetrators do not assume the topic of IPV is being raised due to a victim's disclosure of violence to a provider. (This is especially important when both members of a couple are patients or potential patients in the same health care setting.)
- Delineates a proper response to IPV
- Allows for proper documentation of the response to screening and treatment
- Establishes procedures for: 1) reporting of child abuse and elder or dependent adult abuse, 2) mandatory reporting of IPV when legally required, 3) warning victim(s) of imminent harm, and 4) intervening in cases of homicidality and suicidality.
- Establishes a security protocol for all staff and patients in the facility in which IPV screening and treatment will occur.

3. Display messages and materials in public and private locations that allow patients to get help with IPV regardless of whether or not they disclose IPV to the healthcare provider. (For eg. Put in the bathrooms, exam rooms, and the lobby--posters, brochures, safety cards, and, even, interactive computer tools)

4. Incorporate the IPV screening and treatment program into existing quality improvement programs

SCREENING AND INTERVENING WITH MALE VICTIMS AND PERPETRATORS OF IPV:

Have you *SAID* it? : Screened, Assessed, Intervened, Documented?[21]

SCREENING

Screening goals:

- Establish rapport through use of non-judgmental questioning and expression of genuine interest in understanding a particular patient's health issues and life circumstances
- Facilitate but do not force disclosure of IPV
- Use environmental aids to encourage both disclosure and help-seeking (posters, brochures, videos, computer screening and assessment tools, marketing of self-referral for IPV services to patients)

Who should do screening?:

A provider who:

- Has been educated about the dynamics of IPV victimization and perpetration, the safety and autonomy of victimized patients, and elements of culturally competent care (including specific training on working with gay male patients)
- Has been trained to ask about both IPV victimization and perpetration and to do basic assessment and intervention appropriately with identified victims and perpetrators
- Is authorized to record in the patient's medical record
- Has established a relationship or some trust with the patient in a primary care setting, or. . .
- Has a clearly defined role with regard to IPV screening in a specialty, urgent care or emergency setting

What are appropriate opportunities for screening?:

- Adult primary care
- Pediatric primary care
- Family Practice
- Geriatrics
- Urgent and Emergency Care
- Mental Health
- STI and Family Planning Clinics
- Public Health settings
- Dental care settings
- Orthopedic Surgery
- Inpatient services
- Substance abuse treatment
- School health settings
- Rehabilitation/Occupational Health
- Other specialty practices

When should screening NOT occur?:

- If the provider cannot secure a private space in which to conduct screening. (Only the patient and children under 3 should be present).
- If there are concerns that screening the patient is unsafe for either the patient or the provider.
- If the provider is unable to secure an appropriate interpreter
- If a patient who is being victimized by another patient in the practice or clinical setting requests that screening for perpetration not occur because she/he believes it would cause increased danger for her/himself or her/his children
- If the patient is incapacitated, demented, or obviously intoxicated with drugs or alcohol

How should screening be done?:

- Conducted routinely, regardless of the presence or absence of indicators of abuse
- Conducted verbally as part of a face-to-face health care encounter
- Included in written or computer based health questionnaires
- With direct and nonjudgmental language that is culturally and linguistically appropriate
- Conducted in private: no friends, relatives (except children under 3), caregivers, or others should be present
- Confidential: prior to screening, patients should be informed of any reporting requirements or other limits to provider/patient confidentiality
- Assisted, if needed, by interpreters who have been trained to ask about abuse and who do not know the patient or the patient's partner, caregiver, friends or family socially

Screening procedures:

Because screening men for IPV victimization and perpetration is relatively unexplored in the scientific literature and general practice, a variety of approaches and questions are included below. Providers doing screening should choose questions that feel most appropriate to them. Indirect questions may be used to establish rapport and gather useful information. It is recommended, however, that direct questions always be included in the screening process.

Screening questions for Adulthood IPV:

- Are you currently in a relationship now? Yes or No

- Do you have relationships with women, men, or both? _____

All couples have different ways of relating. All couples argue or disagree. I'm going to ask you some questions about your relationship. I'm going to ask you some questions about how you and your current or past partners have handled arguments or disagreements.

*(See **Appendix C** for recommendation on **Screening for Lifetime Exposure to Abuse**)*

Indirect questions about IPV (the same questions can be asked for past relationships):

- How do you feel your partner treats you?
- How do you feel you treat your partner?

Direct screening questions about violent behaviors:

Are you, or have you ever been, in a relationship where:

- Your arguments ever become/became physical? What happened?
- Have you ever been hit, hurt, or threatened by your partner?
- Have you ever hit, hurt, or threatened your partner?
- Has your partner ever forced you to do sexual things you did not want to do?
- Have you ever forced your partner to do sexual things she/he did not want to do?
- Tell me about the worst fight you ever had with your partner. (Guide your patient to give a behavioral description about what each person did rather than focusing on the patient's perception of the causes of the fight)

Caution for clinicians and practices treating couples*:*

Precautions need to be taken to ensure safety and confidentiality when both members of a couple experiencing IPV are seen by the same provider or in the same practice. There are published guidelines on working with couples experiencing IPV in both medical and mental health practices[22 1997, 23, 24]

We recommend that providers and practices establish a standard of care that always includes, at least periodic, individual meetings with each member of a couple during the course of care. Steps should be taken to establish safe ways to contact each member of the couple privately. We also recommend that providers should always privately offer to connect the victimized member of the couple with independent assistance and advocacy services. If the victimized patient does not feel safe discussing ongoing abuse with a provider who is also caring for the perpetrator, she/he will still have knowledge of victim-centered services. Providers should clearly describe the limits of confidentiality to each member of the couple.

For providers caring for couples:

- When provider learns of IPV through victim history but alleged perpetrator denies IPV:
    - Continue to screen respectfully at regular intervals while being very careful to frame screening as completely routine. ("We now ask every single patient the following questions regularly because abuse is so common in relationships and we think it can be so harmful to our patients' health"). Do NOT continue to screen if the victim requests that screening cease or reports that screening results in increased danger to him/her.
- When provider learns of IPV through perpetrator history but alleged victim denies IPV:
    - Continue to screen respectfully at regular intervals while framing screening as completely routine. ("We now ask every single patient the following questions regularly because abuse is so common in relationships and we think it can be so harmful to our patients' health").
    - Offer referral to IPV advocate or to another provider. ("Sometimes patients don't feel comfortable discussing their relationship with the same provider who cares for their partner. If you ever feel this way, I can help you find another provider/social worker/advocate to talk with")

ASSESSMENT

Assessment should occur with a patient who either directly discloses exposure to IPV or whom the provider suspects is or has been exposed to IPV. Even when a patient denies personal exposure to IPV and the provider does not suspect IPV exposure, the provider can use the opportunity to provide brief preventive education about the high prevalence of IPV, its warning signs, and its importance as a public health issue.

Assessment Goals:

- Create a supportive environment in which the patient can discuss abuse
- Enable the provider to gather information about health problems related to the abuse
- Assess immediate and long term safety needs for the patient and the patient's family in order to develop and implement a response
- Attempt to empower and motivate the patient to make changes
- Determine the effects of IPV on exposed or potentially exposed children
- Attempt to distinguish victimization from perpetration

Assessment Process:

Treating men with IPV appropriately requires that the health care system assess any men who admit to being exposed to IPV or are suspected to be exposed to IPV more fully in order to attempt to distinguish IPV victimization from perpetration. While a provider who meets the criteria in "Screening" may screen a patient, she/he may not have the time or the expertise to do a full assessment of the dynamics of IPV for this patient. If this is the case, the provider should refer the patient for more in depth assessment with another clinician or advocate who meets the criteria below.

Who should do assessment and intervention?:

- Providers should meet all the criteria listed in screening section and should also have direct experience in distinguishing victimization from perpetration (in homosexual as well as heterosexual men).
- Providers doing assessments with men should have direct experience treating both male victims and perpetrators.

How should assessment and intervention be done?

- Conducted orally as part of a face-to-face health care encounter
- With direct and nonjudgmental language that is culturally and linguistically appropriate
- Conducted in private: no friends, relatives (except children under 3), caregivers, or others should be present
- Confidential: prior to assessment, patients should be informed of any reporting requirements or other limits to provider/patient confidentiality
- Assisted, if needed, by interpreters who have been trained to ask about abuse and who do not know the patient or the patient's partner, caregiver, friends or family socially

When should assessment and intervention occur?:

- Initial assessment should occur immediately after disclosure of IPV
- Repeat and/or expanded assessments should occur during follow-up appointments on site or with community service providers
- After disclosure of current or past abuse the patient should be offered at least one follow up visit with a trained health care provider, social worker or IPV advocate

When should assessment and intervention not occur?:

- If the provider cannot secure a private space in which to conduct assessment. (Only the patient and children under 3 should be present).
- If there are concerns that assessing the patient is unsafe for the patient or the provider and other health care staff
- If the provider is unable to secure an appropriate interpreter
- If the patient is incapacitated, demented, or obviously intoxicated with drugs or alcohol

Assessment procedures:

The assessment process has not been studied empirically. The questions that follow are based on expert opinion and can be adapted as appropriate to different health care settings. Direct questions about safety always should be included in the assessment.

Distinguishing perpetration from victimization:

During the assessment process a provider or advocate will attempt to distinguish whether a particular patient is primarily experiencing victimization or primarily perpetrating IPV and what the level of control of one partner over the other is. This process is hampered by many factors including: perpetrator minimization and denial of violence, perpetrator perception that he is a victim, the possibility of bi-directional violence, provider lack of training in discussing socially unacceptable behaviors in non-judgmental terms, lack of time and staff available for assessment, lack of research on this topic, and a lack of validated tools to use for this purpose.

There is expert advice on distinguishing victimization from perpetration ***(see Appendix C in http://endabuse.org/programs/healthcare/files/Consensus.pdf)***. Tools have been proposed that assess for power and control in relationships, but these have not been validated in men. [25-28]**.**

Assessment: Phase 1:
Questions about power and control in a relationship:

Ask the following questions about present and past relationships:

- Are you afraid of your partner?
- Do you think your partner is afraid of you?
- Do you need your partner's permission to spend money, go out, or socialize with others?
- Does your partner need your permission to spend money, go out, or socialize with others?
- How do you and your partner decide when and how to have sex?
- Have you ever held or locked up your partner against her/his will somewhere?
- Has your partner ever held or locked you up somewhere against your will?
- Have you ever been injured in a fight with your partner?
- Describe your worst injury to me
- Do you think your children are afraid of you?
- Do you think your children are afraid of your partner?

For patients who identify as gay, bisexual, transgender, and/or have a same-sex male partner, consider asking additional questions about power and control:

- Has your partner ever threatened to "out" you to family, friends, or others?
- Have you ever threatened to "out" your partner to family, friends, or others?
- Do you know your HIV serostatus and that of your partner?
- Has your partner ever threatened or forced you to have unprotected sexual practices when you didn't want to? Have you ever done this to your partner?

Even after the use of all these questions it may be unclear to the provider whether the patient is primarily being victimized or perpetrating violence or whether there is an unequal power and control dynamic in the relationship. Continued exploration of relationship history and dynamics should be pursued over time. Assessment and intervention can be tailored to whether patient is the suspected perpetrator, victim, or indeterminate.

Assessment: Phase 2:
Assessment of Adult Perpetrator, Victim, and Indeterminate Involvement in IPV:

If patient is perpetrator of IPV

Assess the Immediate Safety of Patient and Partner/children

- Where are your partner and children now?
- Do you plan to hurt your partner or children after you leave here?
- Do you have access to a weapon? (Providers should ask about access to weapons routinely in non-IPV safety assessments as well)
- Have you ever threatened your partner with a weapon or used a weapon against your partner?
- Have you ever choked your partner?
- Do you follow or monitor your partner constantly and feel like you need to know where she/he is at all times?

Assess the impact of the IPV (past or present) on the patient's health:

There are new data to suggest that there are physical and mental health problems associated with perpetration of IPV.[29, 30] IPV is also a risk factor for combined suicide-homicide.[31] Disclosure should prompt providers to consider these health care risks and assess:

- How the (current or past) IPV perpetration affects the presenting health issue
- How the (current or past) IPV perpetration relates to other associated health issues
- Specifically address concurrent mental health and substance use problems
    - "Do you ever hurt your partner while using drugs or alcohol?"
    - "Do you ever feel so desperate or depressed that you want to kill yourself, your partner, or your children?" (see ***Appendix B on Duty to Warn***)

Assess the Pattern and History of IPV:

- "When was the first time you used physical force with your partner?"
- "Has your partner ever been injured from your use of physical force?
- "Have you ever been injured in a situation in which you have used physical force with your partner?"
- "Describe your partner's worst injury to me"
- "Describe your worst injury to me"
- "Have you ever been arrested or incarcerated for domestic violence or other violence?"
- "Have you ever been in a treatment program for domestic violence or other problems associated with violence?"

Assess for Effects of IPV on children:

- o "Where are your children during a situation when you use physical force with your partner?"
- o "Sometimes children can get caught in the middle of a physical fight and get hurt. Have your children ever been hurt by you or your partner?"
- o "Have you ever hit, slapped, burned, shaken or otherwise hurt your children?"

- Ask about developmentally appropriate behaviors in children that might be affected by abuse. There is new information emerging that suggests that perpetrators of IPV may be motivated to change their behavior when they understand that witnessing IPV is affecting their children adversely. There is good evidence that witnessed IPV is an important cause for disturbed behavior in children.[32] Many other stressors unrelated to IPV also may adversely affect the attainment of developmental milestones and child behavior. Assess for potential effects of IPV on childhood development and behavior:
  - o For infants, "How is your baby feeding, growing, and sleeping?"
  - o For toddlers, "How is your child doing learning to walk and talk?" "Describe your toddler's play to me"
  - o For school age children, "Do your children have nightmares, headaches, stomachaches? How is your child doing in school?" "Is your child having any problems getting along with other children?"
  - o For teenagers, "How is your child doing in school?" "How does your child treat you?" "Is your child having any problems with getting into fights, or with alcohol or drugs?"

Assess for readiness to change:

- "Have you ever felt like you wanted to change the way you treat your partner?"
- If so, "Tell me about those thoughts of wanting to change"
- "How do you feel your behavior affects your health and the health of your partner/children?"
- "Are there other ways in which the way you treat your partner affects your life or that of your partner/children?"
- "Have you ever tried to solve problems without using physical force or threats toward your partner and children?"
- "How do you think the way you interact with your partner affects your children?"
- "How do you think your drug/alcohol use affects your behavior/temper?"
- "Have you ever discussed your behavior toward your partner with anyone else?" (friend, pastor, family member, counselor?)
- "Could you discuss your behavior and feelings toward your partner with someone else?" ("Who would that be?")

Assess for history of past abuse

- "Have you ever been in another relationship in which you hit, hurt, or threatened your partner?"
- "Are you in contact with your ex-partner?"
- "Do you share custody of children with your ex-partner?"
- "Are you involved in any lawsuits/legal problems related to domestic violence?"

2. If patient is victim of IPV:

Assess for Immediate Safety of Patient and Partner/children
(See Jacqueline Campbell's website on lethality assessments at http://www.dangerassessment.com/WebApplication1/default.aspx)

- "Where is your partner now?"
- "Do you think you are in immediate danger of being hurt or killed?"
- "Has your partner threatened you with a weapon?"
- "Has the violence gotten worse or is it getting scarier? Is it happening more often?"
- "Has your partner ever held you or your children against your will?"
- "Does your partner watch you closely, follow you or stalk you?"
- "Has your partner ever tried to choke you?"
- "Have there been threats or direct abuse of the children?"
- "Does your partner use alcohol or drugs?"

Assess the impact of the IPV (past or present) on the patient's health:

There are common health problems associated with current or past IPV victimization. Disclosure should prompt providers to consider these health care risks and assess:

- How the current or past IPV victimization affects the presenting health issue
- "Does your partner control your access to health care or how you care for yourself?"
- How the current or past IPV victimization relates to other associated health issues
- Specifically address mental health and substance use affects of abuse:
  - "Sometimes people who are being hurt by their partner use alcohol or drugs to cope. Are you using alcohol or drugs at all?"
  - "Do you ever feel that you are so depressed that you want to hurt or kill yourself?" (See ***Appendix B on Duty to Warn***)
  - Do you ever feel so desperate that you want to kill your partner?

Assess for Pattern and History of IPV:

- "When was the first time your partner hit, hurt, or threatened you?"
- "Have you ever been injured by your partner's use of physical force?"
- "Describe your worst injury to me"
- "Have you ever been hospitalized as a result of the abuse?"
- "Has your partner ever been arrested or incarcerated for domestic violence or other violence?"

Assess for Effects of IPV on children:

- "Where are your children when your partner is hurting you or yelling at you?"
- "Sometimes children can get caught in between you and your partner when you are fighting. Have your children ever been hurt by your partner or you?"
- Ask about developmentally appropriate behaviors in children that might be affected by abuse. A victim of IPV may also be motivated to make changes in a relationship when he realizes that his children are being affected by witnessing IPV. So, ask the following types of questions.
  - For infants, "How is your baby feeding and growing and sleeping?"
  - For toddlers, "How is your child doing learning to walk and talk?" "Describe your toddler's play to me"

- For school age children, “Do your children have nightmares, headaches, stomachaches? How is your child doing in school?” “Is your child having any problems getting along with other children?”
- For teenagers, “How is your child doing in school?” “How does your child treat you?” “Is your child having any problems with getting into fights, or with alcohol or drugs?”

Assess for readiness to change and level of autonomy and support

- “How do you feel the abuse is affecting your health? Your life?”
- “Do you want your relationship to change? How do you want your relationship to change? Do you think it will change in this way?”
- “Have you ever tried to break up with/divorce/separate from your partner?”
- “Do you want to (or feel you have to) go home with your partner?”
- “Have you ever told anyone about what is going on in your relationship?”
- If so, “Whom did you tell? What was her/his response?”
- “Have you ever used any community DV programs?”
- “How do you feel the abuse is affecting your children’s health and behavior?”

Assess for history of past abuse

- “Have you ever been in another relationship in which a partner hit you, hurt you, or threatened you?”
- “Do you feel you are still at risk for being hurt or threatened?”
- “Are you in contact with your ex-partner?”
- “Do you share custody of children with your ex-partner?”
- “How do you think the abuse in this relationship has affected you emotionally and physically?”

3. If it is unclear whether patient is perpetrator or victim

Assess for Safety and History of IPV

- “Have you or your partner ever been injured during a fight?”
- “Where are your partner and children now?”
- “When you leave here do you think you or your partner or children will be hurt in a family fight?”
- “Do you or your partner have access to a weapon?”
- “Have you ever threatened your partner with a weapon/ or has your partner ever threatened you with a weapon?”
- “Have you threatened to kill your partner/children or has your partner ever threatened to kill you or your children?”
- “Where are your children when you and your partner fight?”
- “Sometimes children can get caught in the middle of a fight. Have your children ever been hurt during a fight?”
- “Sometimes when people are experiencing this much stress in a relationship they can feel desperate or depressed. Have you or your partner ever felt so upset that either of you felt suicidal?”
- Assess for concurrent mental health and substance use disorders using standard questions and tools.

INTERVENTION

Goals of intervention:

- Assist in improving the safety of patient, partner, and any involved children
- Base the specifics of the intervention on the severity of the abuse, the patient's level of autonomy, and the patient's readiness for change
- Recognize that because the process of change is often very slow, change should be facilitated by setting small, achievable goals
- Assist in motivating perpetrators to change while holding them accountable for their actions
- Assist in empowering victims to have more autonomy and safety
- Assist indeterminate patients in recognizing that IPV is unhealthy

Intervention Process:

The intervention should occur in the same manner as the assessment. It should occur in private, with a highly trained provider, social worker, or IPV advocate under the same circumstances as the assessment. The complete intervention will occur over many visits and may be shared by the health care team and outside agencies that specialize in IPV treatment.

1. Intervention with a patient who discloses perpetration of IPV:

If your patient discloses perpetration of IPV or you suspect he is a perpetrator of IPV:

1. Provide Helpful Messages (verbally and through educational materials):

    - "I know it can be hard to discuss what is going on in your relationship, but I'm glad that you were able to tell me about this so we can get you help"
    - "I'd like to talk with you about this/have you talk to someone because I am concerned about your health and safety and the health and safety of your partner/children."
    - "You can change the way you treat your partner. There are programs that can help you do this."
    - "Trying to control your partner can make her/him feel trapped rather than loved"
    - "Your behavior toward your partner makes it difficult for you to be as good a parent as you want to be"
    - "I am concerned that your anger and violent behavior are some of your most important health problems"

2. Provide Information (verbally and through educational materials):
    - "Being hurtful towards your partner and in front of your children affects your health and well-being and that of your partner and children"
    - "Your violent behavior can worsen your illnesses, cause injuries and depression, and worsen your substance use".
    - "Your violence causes injuries to your partner and children"
    - "Your hurtful behavior towards your partner teaches your children that violence in relationships is acceptable and puts them at risk for being in violent relationships as teenagers and adults"
    - "Your violence can cause both you and your partner to miss work and your children to miss school"

- "What you are doing is against the law. You are risking your freedom because you could be arrested and convicted for hurting your partner"
- "People who have problems with anger and who try to hurt and control their partners can change their behavior by enrolling in a treatment program for IPV".

3. Do Safety planning ("safety" refers to safety of all persons involved in the violent relationship including those who are not the patient of the provider)—see ***Appendix B on Duty to Warn***

- Call police immediately for any threatened danger at clinical site or for suspicion of imminent danger to patient's partner or children.
- Contact victim(s) immediately for suspicion of imminent danger to patient's partner or children.
- Commit patient for urgent psychiatric hold if patient is acutely suicidal or homicidal
- Determine whether patient's partner accesses same clinical site. If so, activate planned steps for safety in the clinical site and take extra safeguards to protect victim and clinical staff
- In situations in which the patient discloses perpetration and the provider feels that the "duty to warn" threshold has not been reached, request that the patient voluntarily release his confidentiality about the abuse so that provider can meet with the victim. ("I would like to meet privately with your partner and share what you have told me about your behavior so I can make sure your partner has appropriate safety information")[17]
- Determine whether patient is ready to take any steps to improve safety.

    - "Are there any steps you could take to improve the safety of your partner, yourself, and your children? "
    - Suggest specific actions by asking whether the perpetrator thinks he could:
        - Utilize "time-outs"
        - Refrain from the use of physical force
        - Refrain from the use of threats
        - Discuss the violence further with an experienced counselor or other trusted person
        - Be accountable for the violence and abuse to provider and other persons in his life
        - Attend a treatment program for IPV perpetration
        - Leave the home and stay elsewhere for now
        - Get rid of a weapon
        - Avoid the use of physical force, yelling, and making threats in front of children
        - Get treatment for concomitant substance use or mental health problems

4. Make Referrals

- Describe and refer to any treatment programs available through the health care setting if patient is willing to go
- Describe and refer to a community batterer's treatment program if patient is willing to go
- Refer patients to organizations that address their unique needs such as organizations with multiple language capacities or those that specialize in working with specific populations (.ie. teen, elderly, disabled, deaf or hard of hearing, particular ethnic or cultural communities or gay, transgender or bisexual clients)
- If communicating with victim(s) of this perpetrator through "duty to warn" or through release of confidentiality by perpetrator provide victim's services referrals to partner of patient
- Make referrals to appropriate mental health and substance use treatment programs

5. Report

- Learn and follow state laws about requirements to report child abuse, elder abuse, mandatory reporting of victimization, mandatory reporting of perpetration and/or imminent danger to police, social service agencies, victim or contacts of victim.
- If communicating with victim(s) of perpetrator through "duty to warn" or through release of confidentiality by perpetrator, inform victim(s) of any imminent mandatory reports to police, CPS, or APS. Assist victim(s) in planning for safety in regards to these reports and inform all agencies receiving reports of the concerns and safety needs of victim(s).
- When making CPS reports for known or suspected abuse or neglect discuss the dynamics of the IPV with the CPS staff and advocate for the safety of the victim along with the children. (Be aware of the possibility that the perpetrator may either retaliate against the victim during a CPS investigation or try to use CPS to harm the victim by fabricating information or details about abuse in order to have children taken away from the victim)

6. Arrange for follow up care

- Arrange for ongoing follow up healthcare to continue to assess effects of violent and/or controlling behavior on health of patient
- Follow up on referrals made to enhance adherence to treatment plan. (Provider can request that patient sign release of information allowing healthcare team to check with IPV treatment program(s) on patient's attendance and progress.)
- Continue to monitor and re-evaluate level of danger of perpetrator

2. Intervention with a patient who discloses IPV victimization or whom the provider determines that IPV victimization is most likely:

For more comprehensive guidelines on intervening with victims of IPV please see the Family Violence Prevention Fund's, National Consensus Guidelines for Responding to Intimate Partner Violence Victimization in the Health Care Setting
http://endabuse.org/programs/healthcare/files/Consensus.pdf

1. Provide Validating Messages:
(verbally and in written materials if patient wants to take)

- "I am so glad you told me about what is happening to you. That was very brave of you"
- "I am concerned for your safety (and the safety of your children)"
- "You are not alone and help is available"
- "You don't deserve the abuse and it is not your fault"
- "Stopping the abuse is the responsibility of your partner, not you"

2. Provide information
(verbally and in written materials if patient wants to take)

- "Intimate partner violence is common and happens in all kinds of relationships"
- "Violence tends to continue and often becomes more frequent and severe"
- "The abuse can impact your health in many ways"
- "You are not to blame, but exposure to violence in the home can emotionally and physically hurt your children and other dependent loved ones"

3. Safety Planning
(See ***Appendix H in http://endabuse.org/programs/healthcare/files/Consensus.pdf for sample safety plan***)

- Review ideas about keeping information private and safe from the abuser
- Offer the patient immediate and private access to an advocate in person or via phone
- Offer to have a provider or advocate discuss safety then and/or at a later appointment
- If patient is willing, carry out safety planning
- If the patient wants immediate police assistance, offer to place the call and have patient wait safely in health care setting for police
- Reinforce the patient's autonomy in making decisions regarding her/his safety
- If there is significant risk of suicide the patient should be kept safe in the health setting until emergency psychiatric evaluation can be obtained
- Establish a safe, confidential way to reach patient in the future in the case of an emergency or need for private communication

4. Referrals

- Always offer patient a hotline number that is available 24 hours per day; local and national numbers can be offered (National DV Hotline 800-799-SAFE (7233), TTY 800-787-3224). The hotline numbers can be written on provider card, small piece of paper, or brochure according to patient preference
- Describe and facilitate referrals to any advocacy and support systems available through the health care setting
- Describe and facilitate referrals to community DV agencies. (Offer patient access to a phone to make calls to agencies confidentially.)
- Refer patients to organizations that address their unique needs such as organizations with multiple language capacities or those that specialize in working with specific populations (.i.e. teen, elderly, disabled, deaf or hard of hearing, particular ethnic or cultural communities or gay, transgender or bisexual clients)
- Make referrals to appropriate mental health and substance use treatment programs

5. Reporting

- Learn and follow state laws about requirements to report child abuse, elder abuse, mandatory reporting of victimization, mandatory reporting of perpetration and/or imminent danger to police and social service agencies
- Whenever possible and appropriate warn victim(s) of any imminent reports to police or social service agencies so that a victim may protect her/himself during the course of an investigation.

6. Follow up care
    - Arrange for follow up healthcare to continue assess for health effects of IPV, level of danger to victim and any children exposed to IPV

3. Patient discloses relationship violence but it is unclear to provider whether patient is experiencing primarily perpetration or victimization of IPV:

- Continue to re-assess over time in supportive and non-judgmental terms
- Emphasize the harmful effects of IPV on the health and safety of victims, exposed children, and perpetrators
- Seek expert assistance and consultation from a IPV agency or specialist
- Encourage the patient to meet with an IPV advocate or specialist for further discussion and assessment ("I am concerned for your safety and that of your partner and children. I would like you to meet with a consultant so I can understand how best to help you")
- Offer the patient educational materials, preferably those that address both IPV perpetration and victimization
- Treat concomitant substance use and mental health problems (and see if this treatment clarifies or affects relationship dynamics)

4. Patient denies IPV but provider suspects IPV perpetration or victimization is present:

- Respect his response and offer intervention in the event of future IPV— "Fighting and violence in a relationship can be extremely stressful and dangerous. If this ever happens to you in the future, you can speak with a provider here or call this toll free hotline"
- Reiterate any limits of confidentiality—"Sometimes patients are afraid to discuss violence with their provider because they are worried that this conversation will not be private. Let me re-explain the limits of your confidentiality"
- Provide messages and information appropriate to whether IPV victimization or perpetration is suspected by the provider as discussed above in "Intervention with Perpetrators and Intervention with Victims". As discussed above, provide information and resources verbally and in written form.
- Inform patient that it is your routine practice to screen for IPV regularly in the future --- "Because IPV is so common and can be so damaging to one's health, I will ask you about this again in the future"
- Re-screen for IPV at regular intervals

DOCUMENTATION

Goals of documentation:

- Label IPV as a health problem in the medical record
- Communicate to others providing care to a particular patient that the patient is affected by IPV (while following HIPPA guidelines)
- Provide clinical impression of patient's role in IPV (victim, perpetrator, indeterminate) to guide treatment plan
- Provide clear and legible evidence of IPV in case a patient or authorities need to use the medical record in legal proceedings

Who should document IPV?

- Documentation should be conducted by a health care provider who is authorized to record in the patients medical record, is directly caring for the patient, and has been trained in IPV care.

What to document?

Document relevant history:

- Chief complaint and history of present illness
- Record details of the abuse and its relationship to the presenting problem
- Document any concurrent medical problems that may be related to the abuse

Document a summary of past and current abuse including:

- Social history, including relationship to abuser/victim and abuser's/victim's name if possible
- Patient's statement about what happened in her/his own words rather than what led to abuse (e.g. "My boyfriend, John Smith, hit me in the face" rather than "patient and partner arguing over money" OR "I hit her in the face" rather than "She took my money without asking")
- The date, time, and location of incidents where possible
- Description of any objects or weapons used in an assault (e.g. knife, iron, closed or open fist)
- Patient's accounts of any threats made or other psychological abuse
- Names or descriptions of any witnesses to the abuse
- Legal systems involved in lives of victims, perpetrators, and children

Document results of the physical examination:

- Patient's appearance and demeanor (e.g. "tearful, shirt ripped" rather than "distraught" OR "pounding fist on exam room table, swearing at provider, raising voice loud enough to be heard outside exam room" rather than patient "angry")
- Findings related to IPV including neurological, gynecological or urologic, and mental status exam if indicated
- If there are injuries (past or present) describe type, color, texture, size, and location
- Use a body map and/or photographs to supplement written description
- Obtain written consent from patient prior to photographing patient. Include a label and date on photograph (see appendix for photography tips)
- Results of any lab tests, x-rays, or other diagnostic procedures and their relationship to the current or past abuse

Document results of assessment and intervention:

- Record information pertaining to the patient's health and safety assessment including your assessment of health impact of IPV, potential for serious harm, suicide, or homicide.
- Record information pertaining to the health and safety of any children exposed to IPV including your assessment of safety, recommendations made, and any reports filed
- Describe your evaluation of the patient's potential to cause serious harm to other(s) and your rationale for the actions you have taken to protect other(s)
- Document referrals made and options discussed
- Document follow-up arrangements
- Document time, date, and details of any official police, legal, or mandatory reports filed.

If patient does not disclose IPV victimization or perpetration

- Document that the screening was conducted and that the patient did not disclose victimization or perpetration
- If you suspect abuse, document your reasons for concerns (e.g. physical findings are not congruent with history OR patient referred to you for health care by IPV perpetrator treatment program but patient denies ever being involved in a violent relationship)

Document your clinical impression:

As discussed earlier, it will not always be clear to the provider whether a patient is being primarily victimized or is primarily perpetrating violence. Yet, these problems are treated quite differently. Victims are supported and empowered to assume more independence and safety and to cease self-blaming. Perpetrators are respectfully held accountable for their actions and are supported in increasing their empathy for those they are harming and for how they may have been harmed in childhood. Thus, it is important that the provider document her/his clinical impressions in the medical record to guide an appropriate treatment plan. Document the clinical evidence and factors supporting the clinical impression.

Documentation may be needed in court proceedings in the future as well. Documentation of the clinical impression and the evidence supporting this impression is essential to avoid confusion.

Evidence Preservation:

- Obtain written patient consent to preserve evidence
- Document where evidence will be stored (e.g. evidence to be stored with police—include case # and badge number of officer taking evidence)
- Always store clothing, weapons, or other evidence related to IPV in a paper bag. (An airtight bag such as plastic will degrade and destroy evidence).

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Appendix A: Lethality and Homicide

Intimate partner homicide is a devastating problem in the United States[1, 2] representing 40-50% of the cases of femicide of women and 5.9% of the cases of homicide of men.[3]Of the intimate partner homicides in the United States between 1991-1998, 6.2% of the homicides of men are by same-sex partners and .5% of the femicides of women are by a same-sex partner.[1]

To date, there is no method of predicting lethality that has been evaluated prospectively. There is strong evidence, though, that intimate partner violence is highly associated with homicide and that physical abuse of the female victim by a male partner precedes homicides in the vast majority of cases[3] A recent 11-city, case-control study of femicides examined various models to determine whether there are risk factors that predict homicide. Multiple multi-variate analyses were done beginning with risk factors most distal to the femicide (demographics) and progressing to models including risk factors most proximate to the femicide (use of weapon to kill partner).[3]

Overall, the risk factors that were found to remain significant through most of the models were perpetrator's unemployment if not seeking employment, perpetrator's access to a gun, perpetrator's previous threats with a weapon, having a stepchild living in home with victim and perpetrator, and separation after living together (especially with a highly controlling partner). In bivariate analysis, stalking, forced sex and abuse during pregnancy were associated with femicide. These became non-significant in multivariate analysis. Previous arrest for domestic violence was protective against femicide. [3]

There are no studies that we are aware of that examine whether when interviewing a male perpetrator a provider can reliably determine enough information to assess the lethality risk factors found in this study. We are also unaware of any studies of homicide specifically done in gay men. There is ample experience and evidence demonstrating male perpetrators' denial and minimization of their violent acts[4, 5]. When interviewing men suspected of perpetration, though, an attempt to determine 1) the level of control the male patient tries to maintain over his partner, 2) the perpetrator's interpretation of the relationship status (is he suspicious that his partner is leaving the relationship imminently?), 3) the perpetrator's access to a weapon and previous threats with a weapon, and 4) the perpetrator's employment status and employment prospects and 5) whether a stepchild is living with the perpetrator and victim. Also, providers should be aware that there is federal law banning the possession of a gun for individuals previously convicted of domestic violence or subject to a restraining order barring the possession of a gun.

If the provider suspects that a patient poses a potentially lethal risk of harm to victim(s), the provider should contact and counsel the intended victim(s) about this risk and urge the intended victim(s) to access safety assistance in accordance with specific state law and professional ethical guidelines. (see Appendix B on Duty to Warn).

The following references may be useful in the area of assessing lethality. Criminal justice methods used to assess lethality are beyond the scope of these pilot guidelines and are not included.

Expert opinion on lethality risk can be found in Ganley, A. "Health Care Responses to Perpetrators of DV" and "Appendix K: Perpetrators" in Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers, The Family Violence Prevention Fund, Authors: Warshaw, C and Ganley, A.

Information on Danger Assessment tools (used in the abovementioned study and others) and information about their predictive ability and validation can be found at: http://www.dangerassessment.com/WebApplication1/default.aspx

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Appendix B: Duty to warn

"Duty to warn" refers to a legal precedent first established in California in the 1970's. The case, Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976), established the duty of a therapist to breach patient confidentiality and warn not only the police authorities but also the intended victim(s) and those close to the victim(s) whenever the therapist suspected or could be reasonably expected to predict that her/his patient was likely cause imminent harm to other(s).

Since the establishment of this legal precedent in California, multiple other states have either adopted regulations that codify a similar "duty to warn" or have established case law that similarly requires that therapists or other providers breach confidentiality to warn victim(s) of potential impending harm. Regulations and legal precedents vary from state to state and there is no national legislation establishing a "duty to warn." Not all states have laws, regulations, or case law establishing a "duty to warn" and, thus, protection for the therapist from breach of confidentiality.

Therefore, it is very important that providers and health care institutions obtain legal counsel to understand the specifics of regulations and case law in their states. Providers and health care institutions should also debate the ethics and practical issues that arise in protecting confidentiality of individual patients and protecting intended victim(s) of patients. Ideally, health care institutions would have specific advisory and consultative processes to assist individual health care practitioners with the processes of assessing potential lethality, breaching confidentiality to protect potential intended victim(s), and taking appropriate precautions to protect potential intended victim(s).

Helpful references:

The text of the final Tarasoff appeal can be found online at:
http://biotech.law.lsu.edu/cases/privacy/tarasoff.htm

The American Psychological Association publishes a series of books on mental health and the law which discuss the "duty to warn" in great detail. There are books for each state in the United States. Their titles and ordering information can be found at:
http://www.apa.org/books/mental.html.

Multiple references by Alan Felthaus and Claudia Kachigian describe the "duty to warn" in detail:

Felthous, A. J. (1999). "The Clinician's Duty to Protect Third Parties." Forensic Psychiatry **22**(1): 49-60.

Felthous, A. J. and C. Kachigian (2001). "To Warn and Control: Two Distinct Legal Obligations or Variations of a Single Duty to Protect?" Behavioral Sciences and the Law **19**: 355-373.

Felthous, A. R. and C. Kachigian (2001). "The Fin de Millenaire Duty to Warn or Protect." Journal of Forensic Sciences **46**(5): 1103-1112.

Felthous, A. R. and C. Kachigian (second edition). The Duty to Protect. Principles and Practice of Forensic Pyschiatry. R. Rosner. London, Arnold.

A review of the dilemmas of the "duty to warn" can be found in the consensus statement of Ontario's Medical Expert Panel on Duty to Inform in the article:

Ferris LE, Barkun H, Carlisle J, Hoffman B, Katz C, Silverman M. "Defining the physician's duty to warn: consensus statement of Ontario's Medical Expert Panel on Duty to Inform", CMAJ. 1998 Jun 2: 158(11): 1473-9.

Appendix C: Lifetime screening approach

While these pilot guidelines describe the prevailing approach of screening only for adulthood IPV, some experts and the American Psychological Association recommend screening for lifetime exposure to abuse. An expanded focus on lifetime exposure to abuse is validated by data that show the persistence of negative effects of childhood abuse into adulthood. Abuse of boys (and girls) in childhood is extremely common. In the ACE study, out of 3,777 men who were of a relatively high SES and had access to HMO health care, 42.4 % experienced some type of childhood abuse.[1] This same large study found that children who have experienced one type of abuse are highly likely to have experienced multiple types of abuse (physical, sexual, emotional, witnessing of parental IPV).[2] For men, exposure to childhood abuse led to persistent mental health effects in adulthood especially when the intensity of emotional abuse was high.[2]

Cumulative abuse, or having experienced abuse as both a child and adult, may also be associated with poor health outcomes. In studies of women, victimization as *both* a child and an adult was associated with poorer health status than those patients who had experienced *either* childhood abuse alone *or* adulthood abuse alone.[3] The cumulative effects of both childhood and adulthood victimization on men have not to our knowledge been studied. Yet, because data supports the association of poor health status with both exposure to childhood abuse [1]and adulthood abuse [4]it is reasonable to hypothesize that men will be similarly found to be more severely affected by higher cumulative abuse experiences. Expert experience suggests that adult patients who have experienced a high burden of lifetime abuse starting in childhood and continuing through most adult relationships may have complex psychosocial needs that patients who have had supportive, non-abusive childhoods do not.

Exposure of men to childhood abuse also increases their risk of future involvement in violent intimate relationships. In a longitudinal study, Widom found that the abuse of boys in childhood does lead to an increased risk of perpetration of IPV as an adult.[5] Yet, only a small percentage of boys who are abused go on to perpetrate violence against an intimate partner later in life. When men were screened in a health care setting for IPV perpetration, a personal history of abuse was one of three predictor variables found for perpetration of IPV.[6] In the NVAWS , the strongest risk factor for IPV victimization was having been physically assaulted as a child for both men and women (aRR for men was 2.5).[7]

Screening men for lifetime abuse also allows the provider to establish rapport with the patient and assist the patient in gaining insight into the nature of his behavior, self-care, and relationships with intimate partners.

There are standardized research tools that can be used for assessing adults for childhood physical, sexual, emotional abuse and the witnessing of abuse [2, 8-10]Below follow more brief screening questions recommended by this committee that could be used in a lifetime screening approach:

Opening Comments to Screening Questions:

Because how you were treated as a child can affect both your health and behavior throughout your life, I want to ask you some questions about your childhood.

Because family experiences, particularly exposure to family violence have a long-term health impact, I will start with some questions about your childhood.

Screening questions for lifetime exposure to abuse during childhood:

- How were you treated by your family/guardians/caregivers as a child?
- During your childhood or adolescence, were you ever hit, kicked or threatened by your parents, guardians, or others?
- During your childhood or adolescence, were you ever forced to do something sexually that you did not want to do by your parents, guardians, or others?
- During your childhood, did you ever see or hear one of your parents, stepparents, or guardians being physically hurt or threatened by their spouse or partner?

Assessment when patient discloses childhood abuse or IPV witnessed as a child:

Indirect (open-ended) questions:

- How do you feel your experience of _____(type of abuse) affected you?
- Do you feel your experience of _____ continues to affect your health or behavior?
- How do you feel it affects your adult relationships?
- How do you feel that watching your _____(eg father hurt your mother) affected you?
- How do you feel that being exposed to this as a child affects your adult relationships?

Direct (yes/no) questions:

- Have you ever discussed this with anyone before?
- Do you have ongoing nightmares or flashbacks of this experience?
- Do you want any assistance with coping with what happened to you as a child?

Assess for Depression, Suicidality, Substance Use, and Risky Sexual Practices:

Because the prevalence of mental health disorders, substance use, and risky sexual practices are higher in adults who experienced or witnessed abuse as children, use standard tools and methods to assess for these conditions.

Intervention for Adults Exposed to Childhood Abuse:

1. Provide Validating Messages and Information

- Domestic violence is common and happens in all kinds of families
- No one deserves to be treated the way you were treated
- What happened to you was not your fault
- Witnessing abuse and being abused can impact your health in many ways
- What happened to you as a child may be related to your health problems and health habits now

2. Other intervention

- Assist patient in accessing any desired counseling
- Treat associated health problems (mental health disorders, substance use, risky health practices) with attention as to how childhood experience affected patient's health behaviors, coping mechanisms, and health

- Intervene in any adulthood involvement in IPV as victim or perpetrator as described in the main body of these pilot guidelines

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Identifying and Responding to Male Intimate Partner Violence (IPV) in the Health Care Setting—Pilot Guidelines

Screening	Assessment	Intervention	Documentation	Reporting
1. Establish privacy (screen patient alone) * 2. Use staff or professional translation for translation (not family or friends) 3. Ask direct questions: • Has your partner ever hit you, hurt you, or threatened you? • Have you ever hit, hurt, or threatened your partner? • Have you and your partner ever had physical fights? • Has your partner ever forced you to have sex when you didn't want to? • Have you ever forced your partner to have sex when she/he didn't want to? 4. Ask indirect questions: • How does your partner treat you? • How do you treat your partner?? 5. Also ask about past history of IPV: • Have you ever had a partner who hit you, hurt you, or threatened you? • Have you ever hit, hurt, or threatened your partner? • Did you ever have a relationship in which you had physical fights?	Assessment of current IPV Assess for role in IPV: Ask questions to determine who holds the power and control in the relationship (or refer patient to a provider/advocate who can assess for patient's role in IPV). Assess current safety immediately: 1. Assess for safety in clinic • Are partner and children in clinic with patient? 2. Assess for current safety • Threats of homicide by patient or partner • Weapons involved in threats or fights • History of strangulation or stalking 3. Assess for suicidality and homicidality in patient 4. Assess for safety of children Assess current IPV over time: 5. Assess for pattern of abuse 6. Assess history of effects of abuse • ??injuries/hospitalization • ?? physical and psychological health effects.?? economic, social, or other effects 7. Assess for readiness for change 8. Assess for capacity to change (victim—level of support, autonomy, and coping strategies. Perpetrator—level of denial, motivating factors, and societal sanctions against his violence) Assessment of past IPV 1. Assess for current safety ("Are you (and any children involved) safe from this person now?") 2. Assess history of effects of past IPV on health, economics, and social situation.	1. Give repeated messages: Victim: Messages of support (violence is not his fault) Perpetrator: Messages of accountability (violence is his responsibility, is harmful, and he needs to stop it) Indeterminate Role: Messages that IPV is harmful and dangerous to couple and children 2. Offer crisis phone numbers 3. Do safety planning (or connect patient with a person who can) Victim: Assist in making a safety plan for patient and children Perpetrator: Develop plan to stop violence. If imminent danger of homicide or severe injury to victim(s), commit patient to psychiatric hold and notify police and victim(s) Indeterminate: Develop plan to avoid violence and enhance safety of patient, partner, and children 4. Offer advocacy and counseling—batterer's treatment for perpetrator 5. Offer police and legal assistance 6. Arrange for follow-up visits and a safe way to contact patient	1. History: • Write legibly • Use patient's own words in quotes • Document as much info as patient will provide regarding specific events (who, what, where, when) 2. Physical Findings: • Describe injuries in detail • Draw diagrams of injuries • If patient consents, take photographs of injuries • Take serial photographs of injuries over time 3. Clinical Impression: • Provide a clinical impression of the patient's role in the IPV (victim, perpetrator, or indeterminate) to guide the treatment plan • Document the treatment plan • Document any reports made to law enforcement in a manner consistent with state law 4. Physical Evidence: • If patient consents, preserve physical evidence in paper bag • Describe physical evidence in detail	1. IPV Reporting: Follow the laws of your state in reporting IPV or IPV injuries to the appropriate law enforcement and/or social service agencies. 2. Duty to Warn: Follow the laws of your state and the ethics guidelines of your profession in warning victim(s) of impending severe harm, committing perpetrator to psychiatric hold, and notifying law enforcement of impending severe harm to a victim. 3. Child abuse reporting: If you suspect children are being neglected or harmed, file a CPS report. (Advocate on behalf of adult victim/survivor's safety with CPS) 4. Elder Abuse Reporting: If patient is ≥ 65 or a dependent adult, follow the laws in your state in reporting elder abuse.

*If caring for a couple and the victimized partner tells you that screening her/his partner for IPV would increase danger of victim and/or children, do NOT proceed with screening.

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