NEW YORK STATE OF OPPORTUNITY. Department of Health

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August 11, 2021

DHDTC DAL 21-07

Dear Chief Executive Officer:

The purpose of this letter is to inform hospitals that the New York State Public Health Law was amended to include a new Section §2805-z, regarding Hospital Domestic Violence Policies and Procedures, effective December 23, 2020. Domestic violence is a public health issue that affects the health and well-being of many individuals regardless of gender, race, ethnicity, age, socio-economic status, religion, or sexual orientation. With the proper training and tools, hospital staff can play a significant role in recognizing and responding to domestic violence, and in turn, improve patients' physical and emotional health and safety, and reduce domestic violence incidents.

Pursuant to this new law, every general hospital shall:

(a) develop, maintain, and disseminate written policies and procedures for the identification, assessment, treatment and referral of confirmed or suspected cases of domestic violence;

(b) establish and implement a training program for all nursing, medical, social work and other clinical personnel, and security personnel working in hospital service units on these policies and procedures;

(c) designate a staff member to contact the domestic violence or victim assistance organization providing victim assistance to the geographic area served by the hospital to establish the coordination of services provided to domestic violence victims; and

(d) upon admittance or commencement of treatment of a confirmed or suspected domestic violence victim, advise the victim of the availability of the services of a domestic violence or victim assistance organization, and contact the appropriate organization and request that a victim assistance advocate be provided if the domestic violence victim requests one.

To assist hospitals in complying with the requirements of §2805-z, a model policy is attached. In addition to the model policy, the attached flow chart has been developed to assist providers on determining what steps should be taken when they assess a patient for domestic violence. A list of domestic violence or victim assistance organizations operating in each county can be found at https://ocfs.ny.gov/programs/domestic-violence/providers.php.

Thank you for your prompt attention to this very important issue and your continued commitment to the safety and well-being of your patients. If you have any questions, please contact hospitaldvinfo@health.ny.gov .

Sincerely,

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Stephanie Shulman, DrPH, MS
Director
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New York State Department of Health
Guidance for Developing a Model Domestic Violence Policy

This guidance document is an outline of a model domestic violence policy for hospitals in New York State. The policy is meant to serve as a guide for hospitals to adapt to their own format, with more specific institutional procedures. This guidance document provides an example policy that is in compliance with Public Health Law section 2805-z. However, the language and specific protocols provided are not meant to replace existing hospital policies that comply with all New York State laws and regulations.

Policy Name:	**Domestic Violence Policy**
Policy Number:	
Approved By:	

I. Purpose

- To aid staff in identifying and responding to patients who are the victims of domestic violence.
- To comply with Public Health Law section 2805-z.

II. Background

Domestic violence is defined as a pattern of behavior used by an individual to establish and maintain power and control over their intimate partner. The behavior includes abusive tactics, threats, and actions that may or may not rise to the level of criminal behavior. The victim may experience acts or threats of physical or sexual violence, as well as intimidation, humiliation, isolation, verbal abuse, and economic control. While some victims who are experiencing domestic violence present to the hospital with symptoms related to abuse, such as traumatic injury, others may show no signs of victimization. All victims of domestic violence may be at great risk of serious emotional, psychological, or physical harm, including homicide.

Domestic violence affects people of any gender, sexual orientation, race, ethnicity, socio-economic status, age, or religion. It is important to remember that men, adolescents, and elders are also at risk of domestic violence. It is critical that health care providers screen for abuse with all patients regardless of gender, race, age, sexual orientation, or any other identity. All health care providers should also be able to recognize indicators of abuse exhibited by their patients, address the health consequences of abuse, and offer support.

Hospital staff can play a significant role in recognizing and responding to domestic violence, and in turn increase patient safety and improve patients' physical and emotional health. Talking

with patients about their intimate relationships in a trauma-informed manner increases the likelihood that patients will seek help and access resources. Even when a patient is not ready to acknowledge or disclose abuse, staff can inform patients that abuse is never their fault, that they are not alone, and that resources for help are available.

The hospital has partnered with local domestic violence services to provide support to staff and patients when domestic violence is suspected or identified. Hospital staff are not required to be experts on domestic violence; they are required to:

- Screen for domestic violence in a supportive, non-judgmental manner.
- Address health and safety concerns.
- Make appropriate referrals.

Every hospital in New York State is required to have a designated domestic violence coordinator. The hospital designee is available to all staff to assist with any questions or concerns. Their primary function is to assist staff with referrals to the domestic violence organization.

III. Policy

Health care providers will be required to routinely screen patients for domestic violence. If domestic violence is suspected or confirmed, the health care provider will complete an assessment and provide treatment, as needed. Finally, they must contact the designated domestic violence coordinator.

The designated domestic violence coordinator must advise the patient of the availability of services from the local domestic violence organization. If the patient requests the presence of a domestic violence advocate, the designee will contact the organization and request an advocate respond to the hospital.

IV. Procedure for Screening

A. Screening Frequency

Routine screening is a key component to identifying domestic violence. All health care providers should be familiar with the indicators of abuse (complete list below). However, screenings should not be limited to patients who present with a complaint of domestic violence, or those with obvious or visual signs of abuse. The majority of patients who are experiencing domestic violence do not present with obvious signs and may not disclose abuse. Patients are more likely to disclose abuse and seek assistance when they are asked directly about their circumstances by a health care provider that they perceive as caring and supportive.

Domestic violence screening must occur when a patient is admitted to the hospital, in all emergency department visits, and at predetermined intervals in ambulatory and specialty services. In primary care practices, screening is required for all new patients and at annual visits. In OB/GYN practices, screening is required at annual visits, during at least one prenatal

visit, and at antepartum admissions. In any setting, a screening must occur every time a patient presents with indicators of abuse.

A flow chart has been developed to assist providers on determining what steps should be taken when a patient presents at their location and a domestic violence assessment is conducted (see flow chart "New York State Department of Health Model Domestic Violence Policy Flowchart").

B. Screening Provider

The screening should not be completed at intake or triage. The primary assigned health care provider is responsible for completing the screening. The primary health care provider may not delegate screening to ancillary service providers.

Clinical services areas may choose to include domestic violence screening questions in written patient self-assessment questionnaires. This method does not replace the requirement for direct provider screening of patients. Providers should review both the written patient self-assessment and verbally screen patients for domestic violence.

C. Screening Steps

Complete the '*Screening and Assessment Tool*' (attachment 1). Some tips for completing the screening tool include:

- Interview the patient alone. Some strategies for interviewing the patient alone include:
    - Ask the accompanying person to stay in the waiting area before the patient is seen. Cite hospital policy if necessary.
    - Ask the patient to follow you to another area for a diagnostic test.
    - Ask the accompanying person to step out of the room for assistance with a task, such as paperwork, food or drink for the patient, etc.
- The patient may choose to have a support person stay with them during the exam. A support person is someone that the patient has identified as an emotional or reassuring advocate, friend, or family member. Not all friends or family members who present with the patient are support persons, especially young children.
- Use interpreters as needed or at the patient's request. Never use a friend or family member as an interpreter.
- Use gender-neutral language. For example, use the term "partner" or the person's name.
- Maintain eye contact and avoid checking notes or the computer.
- Use an introductory statement before screening. It is useful to introduce screening as universal practice. For example, state: "Because domestic violence is a common problem and affects the health and well- being of our patients, I ask all patients about their safety at home."
- Ask questions that are specific to the patient and keep the screening conversational.
- Ask questions about current and past domestic violence.
- Ask questions that screen for an array of domestic violence tactics. For example,
    - Have you ever felt unsafe or been afraid of your partner?

  - Is your partner trying to control who you see and talk to, where you go, what you wear, or how you spend money?
  - Has your partner ever hit, kicked, slapped, choked or punched you?
  - Has your partner ever forced you to perform sexual acts against your will?
  - Has your partner ever threatened to hurt you or someone else that you care about?
- When a patient presents with any indicators of abuse, ask the patient directly whether the injuries or complaints are a result of an assault or abuse by a partner or someone that the patient knows.
- Assess for feelings of shame, worthlessness, denial, or hopelessness.
- Communicate back to the patient that domestic violence is never their fault and that the patient has value and worth.
- Always respect the patient's readiness to discuss domestic violence or accept help.

D. Screening Follow-up

If the patient has a negative screen with no indicators of abuse, acknowledge that you are invested in supporting the safety and well-being of all patients. Should abuse issues arise in the future, reinforce that you are able to help.

If the patient has a negative screen with indicators of abuse, acknowledge that you respect that the patient is giving a negative response to the screen. Maintain a non-judgmental approach. The patient may be fearful or mistrustful. State your concerns directly to the patient. Note the pattern of injuries or indicators that could signal abuse. Emphasize your desire to help the patient and address symptoms or medical conditions. Respect the patient's wishes for next steps.

- Note: while it is critical to respect the wishes of the patient, you may provide education, resources, and referrals to the patient. The provider should give the patient materials on the local domestic violence organization and how to reach them if/when needed. Continue to collaborate with the domestic violence coordinator and social work department on next steps.

If the patient has a positive screen, respond to the disclosure. Offer a compassionate, supportive response. Recognize that a victim is often at greater risk in disclosing abuse because abusive partners may retaliate and threaten to harm a victim if they tell anyone. Use direct statements to reassure and offer support. For example, state: "Thank you for telling me. I'm concerned for you. There are so many people in similar situations - it's not your fault. You deserve to be safe. I can connect you with advocates that can help."

- For next steps, refer to procedures for assessment, treatment, and referrals.

E. Screening Documentation

The completed *'Screening and Assessment Tool'* (attachment 1) must be added to the patients' medical record. Add clinical notes to indicate that a screening was completed.

- If negative screen, document "Patient negative response to domestic violence screen". Avoid subjective description. For example, do not write: "patient denies abuse."
- If positive screen, document "Positive screen for domestic violence." Where relevant to the current care of the patient, describe abuse and health effects or injuries per clinical documentation standards. Note the assessment, treatment, and referral provided.
- If patient presents with indicators of abuse but does not disclose domestic violence (negative response to screening questions), note the question of abuse, assessment of health effects of abuse or injuries, and follow-up plan.

V. Procedure for Assessment and Treatment

A. Indicators of Abuse

The following table outlines indicators that signal the possibility of domestic violence or abuse. If any indicators are present, further screening and assessment is warranted to determine if abuse is a current or underlying issue impacting the patient's health or well-being.

History	• Chronic abdominal, pelvic or chest pain • Chronic, unexplained pain • Irritable bowel syndrome • Chronic gynecologic conditions • Sexually transmitted diseases • Exposure to HIV • Exacerbation of systems of a chronic disease such as diabetes or asthma • Headaches, migraines • Chest pain/palpitations • Chronic joint or back pain, headaches, numbness and tingling from injuries • Chronic fatigue • Non-compliance with medical treatment
Psychological	• Insomnia, sleep disturbances • Depression and suicidal ideation • Suicidal ideation or attempts • Anxiety symptoms and panic disorder • Eating disorders • Substance abuse • Post-traumatic stress disorder • Use of psychiatric services • Self-Harm • Somatic Disorder • Impaired Concentration • Physical Exhaustion • Feeling dissociative/emotionally numb
Physical	• Dental trauma • Burns • Sexual assault or injuries to the genitalia or breasts

	• Central distribution of injuries • Injuries of the head, neck, mouth • Defensive injuries of the forearms • Injuries to multiple areas • Bruises in various stages of healing • Fractures • Fresh scars or minor cuts • Gastrointestinal disorders • Unexplained stroke in a young woman • Localized hair loss and scalp injury • Strangulation and related injuries
Behavioral	• Harmful alcohol or drug use • Delay in seeking treatment • Unexplained Injuries or injuries inconsistent with explanation • Repeated use of Emergency Services for trauma or primary care needs • Evasiveness of patient • Isolation • Refers to partner's temper/anger • Silent or reluctant to speak in partner's presence • Partner answers all questions for patient or insists on being present when asked to leave exam room • Overly attentive or verbally abusive partner • Any suspected or documented concern of abuse or neglect of children or elderly adult in the home • Abuse of pets • Recent separation or divorce • Need to be home by a certain time
Pregnancy and childbirth	• Unwanted pregnancy • Terminated pregnancy • Complications such as miscarriage, low birth weight of infant, premature labor, and antepartum hemorrhage • Late or no prenatal care

B. Assessment and Treatment

Provide emergent care and address immediate threats to safety right away. Follow hospital safety protocols for any concerns about immediate on-site threats to safety. If necessary, call Security with immediate concerns. If recent sexual assault or rape is part of the domestic violence, refer the patient immediately for a full medical and forensic exam, in accordance with the hospital's policies and procedures for the treatment of sexual assault patients.

In general, adhere to standards of practice for all treatment. Address the patient's current health needs and the potential long-term health consequences of abuse. Assess how the abuse has affected the patient's health and well-being and develop an appropriate treatment plan. It

is important to remember that well-coordinated care is essential in addressing complex domestic abuse issues. Recognize that a history of abuse may affect a patient's health and impair their ability to cope with an illness. Incorporate safety planning and sensitivity to victims' trauma in routine care.

C. Photography

Photographic documentation is intended to complement written documentation and provides additional evidence of abuse that may be used in court proceedings. Photographs should be offered to every patient who screens positive for domestic violence and presents with any injuries.

The provider must obtain informed, written consent from the patient regarding the taking and storing of forensic photographs relating to the signs of domestic violence. The consent form must be maintained in the patient's medical record, and provide detail on what photographs will be taken and how they will be confidentially stored by the hospital, as well as a reminder that a patient may withdraw consent for the photographs to be maintained by the hospital at any time. Refer to the hospital policies and procedures relating to the storage of forensic photography for more information on storage and a consent form.

A camera is available and may be borrowed for use in on-site clinical areas. Take photographs only if a patient consents verbally and signs a written consent form specifically authorizing photography (which may be a separate consent form or expressly listed in the hospital's general consent for treatment form, provided that the use and purpose of photography is expressly indicated). Place photographs in a sealed envelope within a medical record and label as "Confidential – to be used only for litigation purposes."

The photographer must adhere to the following guidelines:

- Take an initial photo of the person, including the person's face and any visible injuries. It is helpful to include an identifying document (e.g., person's license or ID) in the set of photos.
- Take a medium range photo showing the location of the injury on the person's body.
- Take close-up photos of the injury or injuries, using a ruler or other item for scale. Be sure to include a photo that enables the viewer to identify the body part where the injury was sustained.
- Label each photo with the date (including year) and time the photo is taken, the name of the hospital, the name of the patient, the signature of the patient if able, the photographer and a witness.
- Indicate in the medical record that photographs were taken with the photographer's name, date, and time.
- Offer the patient a follow-up appointment for photos in 2 to 4 days to document the duration and progress of injuries.

D. Strangulation

Strangulation is a very serious event. The patient may not recognize injuries from the strangulation for days, weeks, or even years after the event. In fact, most cases do not result in any visible injuries. Strangulation is a sign of increased violence in a relationship. Non-fatal strangulation in a domestic violence case puts someone at higher risk for being killed or severely injured by the abuser. It only takes 8 pounds of pressure for 30 seconds to render someone unconscious and 4-5 minutes for brain death to occur. Educate the patient on the risks and life-threatening consequences that are associated with strangulation.

If you suspect any potential recent strangulation or if strangulation is disclosed, conduct a strangulation assessment using the *'Assessment and Documentation sheet'* (attachment 2). Also, refer to *'Recommendations for the Medical/Radiographic Evaluation of Acute Adult, Non-Fatal Strangulation'* by the Training Institute on Strangulation Prevention (attachment 3).

E. Documentation

Complete documentation of domestic violence in an accurate and timely manner. Documentation provides a record of the pattern of abuse over time, facilitates coordinated care, and may serve as evidence in court proceedings. Be clear, concise, and objective. Providers who document detailed, objective, and legible accounts of patient encounters may be less likely to be subpoenaed to appear in court than those who write vague notes. Include what is said by the patient and observed, including:

- Date and time of incident.
- Patient's account of what happened, including the name of the person who abused them.
- Any observable physical injuries or bruises.
- Patient's coping and responses to the abuse.
- Relevant history reported.
- Type of injuries sustained, if relevant and any weapons used.
- Location of injuries.
- Type and nature of threat to patient's safety.
- The provider's intervention – physical findings, assessment, information provided, safety planning, and referrals provided. Do not list the names of specific services or agencies if it could jeopardize the person's safety.

Avoid using judgmental or legalistic language. For example, do not write "patient alleges", "patient denies", or "patient claims." These phrases may be misinterpreted as disbelief by the provider and used to discredit a victim of abuse in court.

Report what you saw and heard and avoid phrases that leave room for misinterpretation. For instance, instead of "Patient was hysterical" write "Patient was shaking and crying while describing abuse history."

VI. Procedure for Telehealth

Addressing domestic violence during a telehealth visit presents unique challenges regarding building rapport and protecting patient confidentiality and safety. Additional steps must be implemented during telehealth visits to decrease the risk of danger or harm to the patient. When screening for domestic violence virtually it is critical to ensure to the best of the provider's ability that the patient has privacy and can talk openly during the visit.

Build rapport and trust by taking some extra time to put the patient at ease, explain the process and the technology and let the patient know their health and safety is your priority during the telehealth visit. Inform the patient that:

- Technology can be compromised.
- Though the platform is encrypted, there is no guarantee that the patient's information will be completely protected.
- They have the right to change the way they want to be contacted, or even to be contacted at all, at any time.
- They have the right to make informed choices about the technology they are using.
- They can decline telehealth appointments for any reason including concerns about someone else having access to their phone, computer, or accounts.
- They should inform the healthcare provider of the safest, most private times for telehealth appointments.
- They should inform the healthcare provider of any safety or privacy concerns they have related to telehealth appointments.
- They may want to delete, hide, or eliminate the history or evidence that may remain on their devices.
- If there is anything that they don't want to speak about while on the computer/phone they can let the provider know and the provider will move on.
- They should be mindful of who else has or may gain access to the electronics that they are using and what the potential consequences of that could be.
- Recording telehealth appointments is not allowed.

Assess safety prior to screening for domestic violence and throughout the screening process. It is important to check in with the patient periodically throughout the visit to assure that they still have privacy.

Establish to the best of your ability that the patient feels safe and comfortable to proceed with the telehealth visit by asking any or all the following questions:

- Is this a good time to talk?
- Who's home with you now?
- Is it safe for us to speak right now?
- If your partner or someone else came home or entered the room, how would that affect you?

- If you become upset, who can comfort you? Is there anyone who would have a negative reaction to your emotions?
- If you need assistance, how will you get it?
- Are you in any danger currently?
- If the location is not optimally secure, explore other options for how they can proceed safely and privately with the visit. They may be able to speak privately in the car, a different room or outside.

If the patient is unable to speak privately or you suspect they are not alone, provide them with information on how to contact you at another time and end the visit. If the patient expresses concern about anyone hearing the visit, ask them to let you know how they can notify you if they want to end the appointment. Inform the patient if a child or someone else interrupts that you will be silent until the other person leaves. Ask the patient to inform you when it is safe to resume the visit.

Ask the patient how they would like you to respond if they become concerned for their safety during the visit. Let them know you can call 911 at any time if they request you to do so and that you may be required to call 911 in certain circumstances.

Once the patient has indicated they can talk privately, begin the screening process as outlined in this policy. Provide assessment, treatment, and referrals as indicated in this policy.

VII. Procedure for Referrals

A. Notify the Domestic Violence Coordinator

As soon as the provider identifies a patient as a suspected or confirmed victim of domestic violence, the provider must notify the designated domestic violence coordinator (referred to here as the 'designee'). Communicate the situation to the nurse manager or supervisor in charge. The supervisor in charge will have access to a schedule with the current designee's name and contact information.

This should not interfere with any emergent care. Continue to provide an assessment and treatment once the designee has been notified.

The designee will meet with the patient to offer the services from **[insert DV organization name here]**. Verbal consent is required to notify the organization. If the patient consents, the designee will notify the organization to request that an advocate be provided. The provider and designee must work together to make sure that this referral is made as soon as possible. If the designee cannot meet with the patient in a timely manner, the provider may obtain verbal consent from the patient.

If the patient declines services from the local domestic violence organization, the provider or designee must provide the patient with information on the organization and encourage the patient to reach out to them for help when they are ready. The provider or designee may also

request consent from the patient for the organization to contact the patient directly the next day.

- It is important to understand why the patient is declining services. Work with the patient to understand their current situation and needs. Meet the patient where they are and provide education, resources, and other referrals that meet the needs that they are prioritizing.

If an advocate from the organization is not available, they may meet with the patient by phone. The provider and designee must assist the patient with connecting to the advocate. The provider or coordinator may also request consent from the patient for the organization to contact the patient directly the next day.

B. Role of the Domestic Violence Coordinator

Domestic Violence Coordinator: **[insert name here]**
Contact Information: **[insert contact information here]**

The domestic violence coordinator is a member of the hospital social work department. The primary assigned staff member may designate other staff from the social work department to assist with referrals when they are not available. The domestic violence coordinator and all designees must receive an annual training on domestic violence. This training must be provided by the local domestic violence organization or the New York State Office for Prevention of Domestic Violence.

The role of the domestic violence coordinator is to:

- Develop a schedule with the name and contact information for the designated staff member to assist providers with referrals 24/7.
- Disseminate the schedule to all necessary parts of the hospital.
- Assist in the development of an MOU with **[insert DV organization name here].** Maintain an ongoing relationship with the organization.
- Connect domestic violence patients with an advocate from **[insert DV organization name here].**
- Assist the provider with any mandatory reporting requirements.
- Assist the provider with any other referrals or safety planning that must be done in the hospital.
- Develop and disseminate a training for all clinical, social work, and security personnel on domestic violence and this policy. Maintain documentation on training requirements.

C. Mandated Reporting

Filing a report to a state agency or the police may have the unintended effect of escalating risks to the victim of domestic violence. It is essential to notify the victim of domestic violence of mandatory reports.

There is no law requiring hospital employees to report domestic violence unless it overlaps with other reportable conditions. However, the patient must be offered the option of reporting the incident to law enforcement.

- If children (under 18 years of age) are at risk or injured in the context of domestic abuse, refer to Administrative Policy.
- If elders (60 or over) are at risk or injured in the context of domestic abuse, refer to Administrative Policy and New York State Social Services Law 491 regarding mandatory reporting of incidents involving certain vulnerable persons.
- If certain vulnerable persons (e.g., elderly, persons with disabilities) are at risk or injured in the context of domestic abuse, refer to Administrative Policy and New York State Social Services Law 491 regarding mandatory reporting of incidents involving certain vulnerable persons.
- If domestic violence involves gunshot wounds, serious stab wounds, or burns affecting 5% or more of surface area of the body; refer to Administrative Policy.

VIII. Procedure for Training

The domestic violence coordinator is responsible for ensuring that all nursing, medical, social work and other clinical personnel, and security personnel, receive a domestic violence training upon hire and annually. Completed training must be documented for all staff.

Topics must include:

- Domestic violence and intimate partner violence basics
- Recognizing the 'indicators of abuse'
- NYS laws and regulations on the treatment of domestic violence patients in hospitals
- Utilizing interview techniques to screen patients for domestic violence
- Domestic violence assessment and treatment, including strangulation and photography
- Hospital domestic violence policy and tools
- Community resources and common referrals to support domestic violence victims

IX. Resources

[insert DV organization name here] is a domestic violence program that provides specialized advocacy services and support to domestic violence victims. The program offers crisis intervention, safety planning, individual counseling, support groups, outreach, medical advocacy, criminal justice advocacy, information and referrals. Services are free, confidential and voluntary. A person does not need to leave an abusive partner nor end a relationship to use the services. The goals are to increase a person's safety, break the isolation/stigma of domestic violence and support a person's choices and rights.

Hours of operation:

Contact name:

Contact number:

Hotline number:

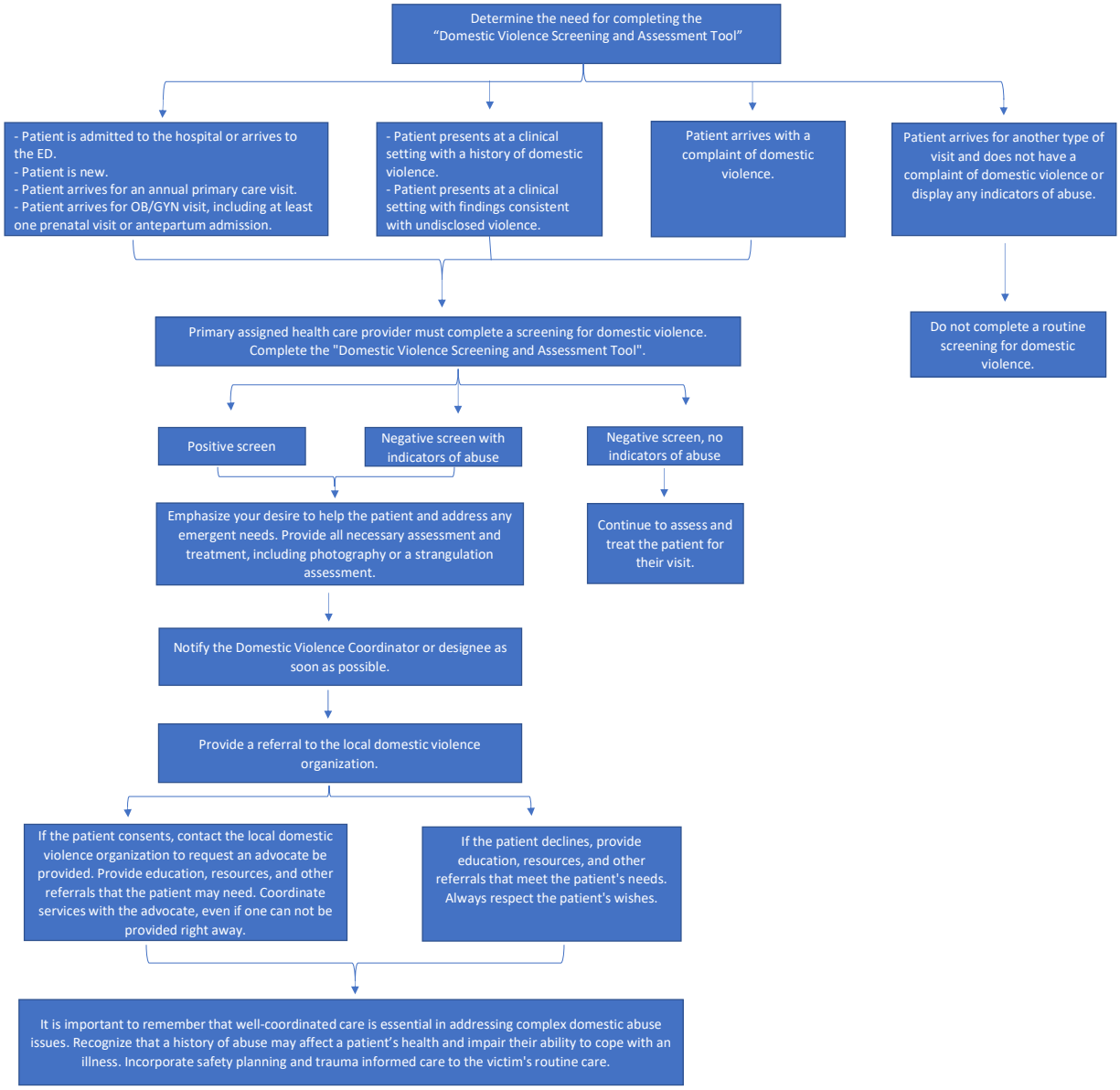
Additional resource: Anyone can contact the New York State Domestic and Sexual Violence Hotline at any time.

- Call: 1-800-942-6906
- Text: 844-997-2121
- Chat: opdv.ny.gov

X. Acknowledgements

This policy was adapted from Brigham and Women's hospital Domestic Violence and Strangulation Policy (2013).

New York State Department of Health
Model Domestic Violence Policy Flowchart



* July 2021

New York State Department of Health
Sample Domestic Violence Policy
Attachment 1: Domestic Violence Screening and Assessment Tool

The purpose of this tool is to provide additional information on screening patients for domestic violence. There are many domestic violence screening tools that have been developed and researched for use in a health care setting. Hospitals are encouraged to use their existing screening tools, implement alternative screening tools, or modify this screening tool as an attachment to the domestic violence policies and procedures.

Patient Name:		Date:	
MRN:		Time:	

Positive Screen for Domestic Violence: ☐

Negative Screen for Domestic Violence: ☐

Negative screen for Domestic Violence with Indicators of Abuse: ☐

Provider Name/Title: _____

Provider Signature _____

1. Ask about domestic violence
   - Begin with an opening statement
     - "Since personal safety plays such an important role in a person's overall health, I always ask about safety at home."
   - Screen for past domestic violence
     - "Since violence in relationships can happen at any time in a person's life, I'd like to get a sense of your history. So let's go back a little bit first. Has anyone ever been physically or emotionally violent towards you?"
   - Screen for current domestic violence
     - "And how about more recently..."
     - "Is there anyone in your life now who is threatening or hurting you?"
     - "What about hitting, kicking, choking, or physically hurting you?"
     - "Has anybody forced you to do something sexual that you didn't want to do?"
     - "Do you feel safe at home?"
     - "Is there anything else you'd like to add or ask while we're on this topic?"

Notes:

Adapted from Schrier, M., Rougas, S., Schrier, E., Elisseou, S., and Warier, S. (2017). Intimate Partner Violence Screening and Counseling: An Introductory Session for Health Care Professionals. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6338198/#s002

2. If the patient answers "yes" to any of the current domestic violence screening questions, continue with follow-up questions.
   - I'd like to hear a little bit more about that. How often does [partner's name]
     - Physically hurt you?
     - Insult or talk down to you?
     - Threaten you with physical harm or otherwise?
     - Scream or curse at you?
   - Express empathy and concern
     - "I'm so sorry to hear that this has happened to you."
     - "It's really important for you to understand that everyone has the right to be safe and treated respectfully, including you."
     - "The violence that you've described should not have happened and is not your fault, even if you think you may have triggered it in some way."

Notes:

3. Assess readiness to make a change
   - Ask about previous response to domestic violence
     - Have you tried to, or considered, seeking help in the past?"
   - Assess readiness to seek help now
     - "Okay, so just to get a sense of where you are, on a scale of 1-10, where 1 means 'not important' and 10 means 'very important,' how important would you say it is to try to seek help right now?"
     - "And on a scale of 1-10, if 1 is 'not confident' and 10 is 'very confident,' how confident are you that you could seek help right now?"

Notes:

4. Advise on next steps
   - Provide affirmation and state your concern
     - "Thank you for your honesty and for sharing this with me. I know this can be really difficult to talk about."
     - "To tell you the truth, I'm concerned about your safety at home with [partner's name]."
   - Explore desired changes
     - "What is your number one concern at this time?"

Adapted from Schrier, M., Rougas, S., Schrier, E., Elisseou, S., and Warier, S. (2017). Intimate Partner Violence Screening and Counseling: An Introductory Session for Health Care Professionals. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6338198/#s002

    - "How would you like things to be different at home?"
- Make a recommendation
    - "I have a couple of ideas that might help."
    - "Let's explore some options for dealing with this."
- Manage resistance and avoid confrontation
    - "Okay, but before we move on, I just want to make sure you understand that I am concerned about your situation and am available to help you figure out some options, if and when you're ready. In the meantime, I have some resource materials that I'd like to share with you."
    - Maybe we need to try a different way of approaching this. What makes sense to you at this point?"

Notes:

5. Assist and provide resources
    - Connect the patient with the Domestic Violence Coordinator
        - "We have a domestic violence coordinator at the hospital who can help. We can get your connected with an advocate from **[insert name of DV organization here]** today."
    - Connect the patient's goals with specific referrals if an advocate is not available
        - Provide patient with up-to-date pamphlets, handouts, or phone numbers of the local DV organization, or other community resources
        - "I can make a personal referral for you today, if you want."
    - Make a safety plan if an advocate is not available
        - "We've talked about some of the conflicts that you've had with [partner's name] and I'd like to discuss some ways to help you stay safe at home. Is that OK?"
        - "What ideas do you have about how to keep yourself safe in your relationship?"
        - "Do you feel safe going home today?"

Notes:

6. Arrange for follow-up
    - Arrange for a follow-up visit and establish clear contact information

Adapted from Schrier, M., Rougas, S., Schrier, E., Elisseou, S., and Warier, S. (2017). Intimate Partner Violence Screening and Counseling: An Introductory Session for Health Care Professionals. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6338198/#s002

    - "I'd like to follow-up with you in a few days to see how you're doing with the goals we discussed. Can we plan a way for me to reach you when you'll be alone and able to talk?"
- Discuss a safe way to identify yourself on the phone
    - "How would you like me to identify myself when I call so I won't cause a problem for you?"
- Identify a code word/phrase for calling the police or ending the conversation
    - "If you feel unsafe and want me to call the police for you, what word can you use to let me know?"
- Arrange for follow-up with the advocate if they are not currently available
    - "**[insert name of DV organization here]** is a domestic violence program that provides specialized advocacy services and support to domestic violence victims. The program offers crisis intervention, safety planning, individual counseling, support groups, outreach, medical advocacy, criminal justice advocacy, information and referrals. Services are free, confidential and voluntary. Their goals are to increase a person's safety, break the isolation/stigma of domestic violence and support a person's choices and rights. May I give them your contact information to call you tomorrow?

Notes:

Adapted from Schrier, M., Rougas, S., Schrier, E., Elisseou, S., and Warier, S. (2017). Intimate Partner Violence Screening and Counseling: An Introductory Session for Health Care Professionals. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6338198/#s002

New York State Department of Health
Sample Domestic Violence Policy
Attachment 2: Strangulation Assessment and Documentation

Strangulation is a serious, life-threatening event that often occurs in the context of domestic violence. Many times, there are no visible injuries from the strangulation. It is important to ask about strangulation in all positive screens for domestic violence or if signs and symptoms are present. For example, 'has your partner choked you or put hands/ objects against your neck?" The term 'choked' may be used when screening or talking to patients, strangulation should be used in professional context/documentation.

- Complete a physical exam checking for all possible signs of strangulation. Use this form as a guide.
- Fill out this form completely and file it in the patient's medical record. Make sure to note not only physical symptoms and injuries, but also the details of the incident as reported by patient.
- Take photographs of any visible injuries following the procedure for photography.
- Make plans for follow up with the patient.

Patient Name:		Date:	
MRN:		Time:	

How long did the strangulation occur?_____seconds_____minutes

- Victim unable to estimate/remember length of time ☐

Was the patient also smothered? ☐ YES ☐ NO

Was the patient shaken during the incident? ☐ YES ☐ NO

Was the patient's head pounded against any object during the incident? ☐ YES ☐ NO

Provider Name/Title: _____

Provider Signature _____

Date: _____

Adapted from Taliaferro, Hawley, McClane and Strack, *Strangulation in IPV, Intimate Partner Violence, a Health-Based Perspective (*eds Mitchell,et al) 224 (2009). Adapted from SA-116 Strangulation Documentation Form, SA-110 Strangulation Assessment, Strangulation Form

Symptoms of Strangulation

The following symptoms should be documented, both in writing and photographed (if visible) for evidence collection.

Look for and ask about the following SYMPTOMS of injury, and check ALL that apply:

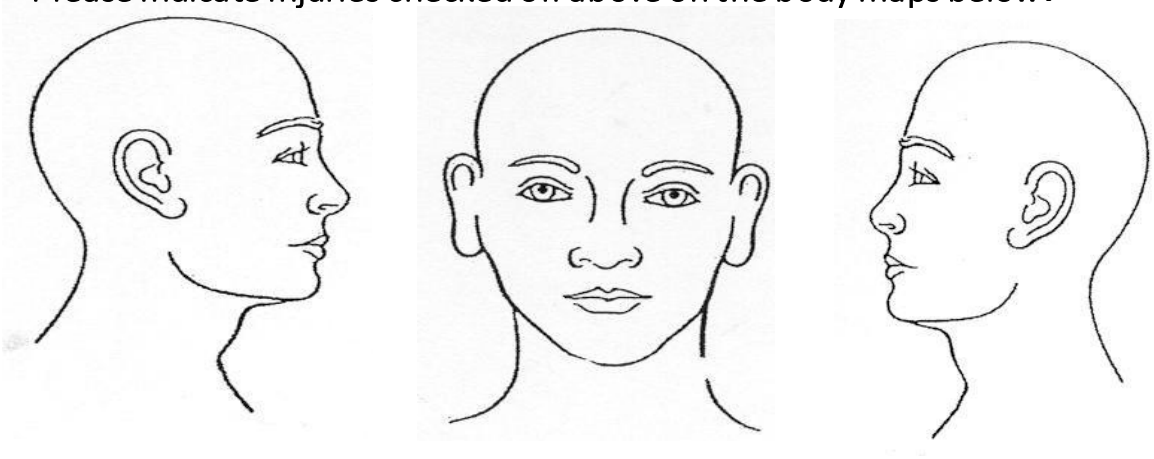
RESPIRATORY	VOICE	THROAT/NECK	BEHAVIOR	OTHER
⎦ Stridor	⎦ Raspy	⎦ Trouble swallowing	⎦ Mental status change	⎦ Dizzy
⎦ Hoarseness	⎦ Hoarse	⎦ Painful swallowing	⎦ Anxiety	⎦ Headaches
⎦ Subcutaneous emphysema	⎦ Coughing	⎦ Neck pain	⎦ Memory problems	⎦ Fainting
⎦ Respiratory distress	⎦ Aphasia	⎦ Nauseous		⎦ Urination
⎦ Hemoptysis	⎦ Unable to speak	⎦ Vomiting		⎦ Defecation
⎦ Inability to tolerate the supine position				⎦ Tinnitus
⎦ Dysphonia or aphonia				⎦ Vaginal bleeding

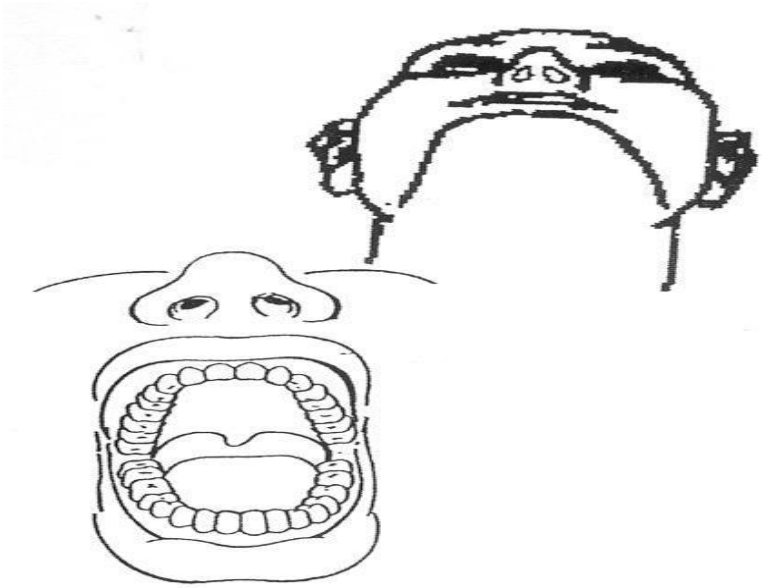
FACE	EYES/EYELIDS	NOSE	EARS	MOUTH
⎦ Red, flushed	⎦ Petechiae (eyeball) *R or L or Both*	⎦ Bloody	⎦ Petechiae *R or L or Both*	⎦ Bruises
⎦ Petechiae	⎦ Petechiae (eyelids) *R or L or Both*	⎦ Broken	⎦ Bleeding from the ear canal *R or L or Both*	⎦ Swollen tongue
⎦ Scratch marks	⎦ Subconjunctival hemorrhage *R or L or Both*	⎦ Petechiae		⎦ Swollen lips
	⎦ Ptosis *R or L or Both*			⎦ Cut/abrasion

UNDER CHIN	CHEST	SHOULDERS	NECK	HEAD
⎦ Redness	⎦ Redness	⎦ Redness	⎦ Redness	⎦ Petechiae on scalp
⎦ Scratch marks	⎦ Scratch marks	⎦ Scratch marks	⎦ Scratch marks	⎦ Pulled hair
⎦ Bruises	⎦ Bruises	⎦ Bruises	⎦ Bruises	⎦ Bump
⎦ Abrasions	⎦ Abrasions	⎦ Abrasions	⎦ Abrasions	⎦ Skull fracture
			⎦ Swelling	
			⎦ Ligature marks	

Adapted from Taliaferro, Hawley, McClane and Strack, *Strangulation in IPV, Intimate Partner Violence, a Health-Based Perspective* (eds Mitchell,et al) 224 (2009). Adapted from SA-116 Strangulation Documentation Form, SA-110 Strangulation Assessment, Strangulation Form

Please indicate injuries checked off above on the body maps below:





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Adapted from Taliaferro, Hawley, McClane and Strack, *Strangulation in IPV, Intimate Partner Violence, a Health-Based Perspective* (eds Mitchell,et al) 224 (2009). Adapted from SA-116 Strangulation Documentation Form, SA-110 Strangulation Assessment, Strangulation Form

RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION

Prepared by **Bill Smock, MD** and **Sally Sturgeon, DNP, SANE-A**
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Endorsed by the **National Medical Advisory Committee**: Bill Smock, MD, Chair; Cathy Baldwin, MD; William Green, MD; Dean Hawley, MD; Ralph Riviello, MD; Heather Rozzi, MD; Steve Stapczynski, MD; Ellen Tailiaferro, MD; Michael Weaver, MD

GOALS:

1. **Evaluate carotid and vertebral arteries for injuries**
2. **Evaluate bony/cartilaginous and soft tissue neck structures**
3. **Evaluate brain for anoxic injury**

Strangulation patient presents to the Emergency Department

History of and/or physical exam with ANY of the following:

- **Loss of Consciousness** (anoxic brain injury)
- **Visual changes**: "spots", "flashing light", "tunnel vision"
- **Facial, intraoral or conjunctival petechial hemorrhage**
- **Ligature mark or** neck **contusions**
- **Soft tissue neck injury/swelling of the neck/cartoid tenderness**
- **Incontinence** (bladder and/or bowel from anoxic injury)
- **Neurological signs or symptoms** (LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorders, stroke-like symtoms.)
- **Dysphonia/Aphonia** (hematoma, laryngeal fracture, soft tissue swelling, recurrent laryngeal nerve injury)
- **Dyspnea** (hematoma, laryngeal fractures, soft tissue swelling, phrenic nerve injury)
- **Subcutaneous emphysema** (tracheal/laryngeal rupture)

Recommended Radiographic Studies to Rule Out Life-Threatening Injuries*
(including delayed presentations of up to 6 months)

- **CT Angio of carotid/vertebral arteries** (***GOLD STANDARD*** for evaluation of vessels and bony/cartilaginous structures, less sensitive for soft tissue trauma) ***or***
- **CT neck with contrast** (less sensitive than CT Angio for vessels, good for bony/cartilaginous structures) ***or***
- **MRA of neck** (less sensitive than CT Angio for vessels, best for soft tissue trauma) ***or***
- **MRI of neck** (less sensitive than CT Angio for vessels and bony/cartilaginous structures, best study for soft tissue trauma) ***or***
- **MRI/MRA of brain** (most sensitive for anoxic brain injury, stroke symptoms and intercerebral petechial hemorrhage)
- **Carotid Doppler Ultrasound** (***NOT RECOMMENDED:*** least sensitive study, unable to adequately evaluate vertebral arteries or proximal internal carotid)

*References on page 2

(-)

Continued ED/Hospital Observation (based on severity of symptoms and reliable home monitoring)

History of and/or physical exam with:

- **No LOC** (anoxic brain injury)
- **No visual changes**: "spots", "flashing light", "tunnel vision"
- **No petechial hemorrhage**
- **No soft tissue trauma to the neck**
- **No dyspnea, dysphonia or odynophagia**
- **No neurological signs or symptoms** (i.e. LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorder, stroke-like symtoms)
- And **reliable home monitoring**

Discharge home with detailed instructions to return to ED if:
neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens

(+)

- Consult NeurologyNeurosurgery/Trauma Surgery for admission
- Consider ENT consult for laryngeal trauma with dysphonia

Brochure Design by Yesenia Aceves

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RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION

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