

COALITION REPORTER

December 1999

Legislative Update

The 2-year 208th Legislature was rapidly coming to an end at the time this newsletter was being produced. The following are the domestic violence and related bills that passed into law during this legislature to date.

P.L. 1998, Chapter 98. Effective December 3, 1998. This law prohibits commercial individual and group health insurers, hospital service corporations, medical service corporations, health service corporations and health maintenance organizations (HMOs) from denying benefits, otherwise available under the terms of a person's health insurance coverage, to a covered person for expenses incurred in the treatment of an injury or injuries sustained as the result of DV.

P.L. 1998, Chapter 17. Effective May 6, 1998. This law prohibits a person who is serving a term of imprisonment or who is on parole or probation as the result of a conviction an indictable offense from using the provisions of the "Right-to Know Law", NJSA 47:1A-1 et seq., to obtain public records containing personal identifying information about the victim or the victims' family. However, an inmate or representative of the inmate may make a motion to obtain the information if it is necessary to assist in the inmate's own defense. Should an incarcerated person unlawfully obtain or seek to obtain such information, he or she shall be subject to forfeiture of accumulated time credits or remissions.

This law also upgrades the offense of stalking to a crime of the third degree if a person commits stalking while serving a term of imprisonment or while on parole or probation as a result of a conviction of an indictable offense. It upgrades the offense of harassment to a crime of the 4th degree if a person commits harassment under the same circumstances.

P.L. 1999, Chapter 73. Effective April 30, 1999. This law amends the "duty to retreat doctrine" by eliminating a person's duty to retreat from his or her own home if assailed in the home by another person from the same household. Under NJ law, the use of deadly force is justifiable if the actor reasonably believes that such force is necessary to protect him or herself against death or serious bodily harm, except that the actor knows he or she can avoid the necessity of using such force with complete safety by retreating or by surrendering possession of a thing. A person is not required to "retreat" before using deadly force if attacked in his or her own home. Prior to passage of this law, however, a person was required to retreat in their home if attacked by another person from the same home. Therefore, a battered woman was required to retreat if she could do so safely if attacked by her husband in their mutual home, but was not required to retreat if attacked in her home by a person not belonging to her household. Until this exception was eliminated, a battered woman on trial for killing the batterer had the additional problem of showing that she could not safely retreat from the batterer's attacks prior to defending herself.

In *State v. Gartland*, a NJ Supreme Court case where the Court reversed the conviction of a woman who had killed her abusive husband (and who had subsequently died), the Court found that the woman did have the statutory duty to retreat. However, the Court commended to the Legislature consideration of the application of the retreat doctrine in the case of a spouse battered in her own home. This law is a result of that commendation.

P.L. 1999, Chapter 199. Effective June 9, 1999. The purpose of this new law is to improve the collection and reporting of civil and criminal domestic violence statistics. The law amends the Prevention of Domestic Violence Act to require the creation and use of uniform forms to record sentencing, bail conditions and dismissals. It also requires the collection and reporting of information regarding domestic violence civil and criminal complaints and dispositions over and beyond what is currently reported by the Administrative Office of the Courts, and regarding domestic violence calls to which the police respond over and beyond what is currently being reported by the State Police.

P.L. 1999, Chapter 209. Effective Sept. 17, 1999. This new law was opposed by the NJ Coalition for Battered Women. It adds a violation of a domestic violence restraining order to the list of “aggravating factors” to be considered by a jury or court when deciding on whether a defendant should be sentenced to death. If a person violated a restraining order while committing murder, the jury or court now needs to weigh that factor along with other aggravating factors against any mitigating factors when making a death sentence determination.

P.L. 1999, Chapter 236, Effective October 13, 1999. This law amends the Prevention of Domestic Violence Act to require defendants ordered to attend professional counseling by a family or criminal court to provide documentation of attendance to the court. The law also amends the Act to specify that if professional counseling has been ordered by either a family or criminal court, no request by the defendant to dissolve restraints shall be granted unless, in addition to any other provisions required by law or conditions ordered by the court, the defendant has completed all required attendance at such counseling.

P.L. 1999, Chapter 288. Effective December 20, 1999. This law requires the fingerprinting and photographing of any person: 1) arrested for domestic violence under the mandatory arrest provision of the Prevention of Domestic Violence Act; 2) convicted of assault or harassment constituting domestic violence; or 3) against whom a final order has been entered under the provisions of the Prevention of Domestic Violence Act. Since persons charged with indictable offenses are already required to be fingerprinted, the purpose of the law is to include a record and identification of those arrested or convicted of the most common, usually non-indictable domestic violence offenses of assault and harassment. Fingerprinting of those against whom a final domestic violence order is entered will enable a cross-reference between criminal and civil domestic violence histories in NJ’s central registry and greater compatibility with national registries. This bill represents a compromise between the sponsors and the NJCBW and other groups that

were concerned about the numbers of battered women who would be subjected to fingerprinting under this law.

P.L. 1999, Chapter 289, Effective June 17, 2000. This law requires that judges receive annual, rather than biannual, training on domestic violence issues. Because at the time of writing there remains one voting session of both the Senate and the Assembly, it is possible that a couple of additional domestic violence bills could pass into law during this legislature. Of particular note is A-2366/S-869 that would allow victims of DV to apply for unemployment insurance benefits if they need to leave their job due to DV (and are otherwise eligible to apply).

Addressing the Needs of DV Victims in the Emergency Room

By Ellen W. Ninger

Every day in emergency rooms all over this country thousands of physicians see the effects of domestic violence on their patients. According to Stark and Flitcraft, each year more than one million women seek medical treatment for injuries deliberately inflicted upon them by their husbands or boyfriends, injuries that are identified as resulting from battering in only 4 percent of the cases. In the US, domestic violence accounts for nearly 100,000 days of hospitalizations, 30,000 emergency room visits and 40,000 visits to doctors each year. The yearly medical costs related to domestic violence in the US are close to 150 million dollars. With numbers this staggering, it is astonishing that physicians do not routinely screen for DV. A recent study by the Journal of American Medical Assn. found that less than 10% of primary care physicians screen during checkups. Even more surprising is that most ER personnel, even faced with obvious injury, don't always ask the appropriate questions. Recently a client of mine presented at the ER with a broken arm, a blackened eye, a split lip, and contusions on her neck, back, and abdomen. When questioned she stated that she fell down the attic stairs while getting Christmas decorations. No one ever questioned her story or asked if anyone had hurt her. With proper training most physicians would be aware that one usually incurs distal injury (injury to limbs) by falls, but proximal injuries (neck, back and abdomen) are usually inflicted by other means. Recent surveys state that over 90% of women who were physically abused by their partners did not discuss this with a health care practitioner.

Many hospitals are attempting to comply with Joint Commission on Accreditation of Healthcare Organization Standards which require that accredited emergency departments have policies and procedures to address domestic violence, and a plan for educating staff on the treatment of battered adults. Although this is mandated, my experience is that there is resistance on the part of physicians for several reasons. Physicians often feel that they do not have either the necessary time or the knowledge about DV to advocate on behalf on their patients. This is not an uncommon issue.

Police departments have recognized that working with a victim of intimate violence, when done properly, takes time and appropriate training. Due to the nature of police work, their primary focus is typically on the perpetrator, rather than the victim. For this reason Crisis Intervention Teams were formed. When a victim is brought to the police station after a domestic assault she is seen by a trained domestic violence advocate who can take the time and has the expertise to assist her. This model has been extremely

beneficial to both survivors of domestic violence and police departments throughout NJ. The same model may be advantageous in a hospital setting. With a large number of hospital employees to draw from, a hospital based Crisis Intervention Team could easily reflect its patient's culturally diverse community. Team members could include not only medical personnel, but security, housekeeping, administrative, and technical staff as well. The advantages of an on-site domestic violence advocate are many.

Victims would have immediate access to emotional support, thereby lessening the effects of the emotional trauma. Advocacy and access to community resources would be instantaneous. Victims would then be better equipped to make decisions regarding their options.

As an extension of on-site training, hospital personnel would become increasingly sensitized to the specialized needs of DV victims. Physicians may be more likely to screen for DV knowing that assistance is close at hand. Giving women potentially lifesaving information and referrals (quickly and effectively) is essential to their very survival.

Domestic violence is an epidemic in this country and it is essential for all health care professionals and institutions to develop effective protocols to combat it. Those in the medical community are often the first line of defense for millions of women against a debilitating and life threatening existence. DV is a preventable health care issue if we work together.

Ellen W. Ninger, MA, LPC, DVS is the Intake Coordinator at The Women's Center of Monmouth County.

**Time and trouble will tame an
advanced, young woman, but an
advanced old woman is
uncontrollable by any force. - - -
*Dorothy Sayers***

Responding to the Health Care Needs of Children in Shelter By Marna Borrás

Many children of DV victims have not been able to establish a medical history. Obstacles facing battered women such as the abuser's control, lack of money or insurance, lack of transportation, constant moving and lack of awareness of or access to available resources, have made consistency impossible. Some may feel uncomfortable communicating with medical professionals. The battered women's focus on survival for herself and her family may not have afforded her the luxury of establishing a medical history for her children. The ER may be the only sources of medical service available to her.

With this in mind, the Women's Center of Monmouth County, Inc. in collaboration with Monmouth Medical Center have provided a unique service for the families affected by DV. Bi-weekly, a team of health professionals consisting of a

pediatrician, a child psychologist and a medical resident in training from Monmouth Medical Center, facilitate an educational group for the mothers in shelter. This informal setting provides a safe, comfortable environment in which mothers can talk about their concerns and fears with regard to their children; as well as to educate themselves on the stages of child development. The Child Advocate is present at these meetings to act as a liaison and to encourage empowerment through active dialogue between the mothers and the medical professionals. Time is set aside for the doctors to answer questions on an individual case basis for the mothers and to provide resources and referrals for the medical and emotional needs of the children. Reviewing the general health care needs of the children insures the smooth coordination of services provided by other community based health professionals such as The Visiting Nurse Association. This information is invaluable to the mothers in raising healthy children.

The medical team joins the shelter staff in cases conference on alternating weeks to become familiar with issues specific to child observers of domestic violence. This information also educates the pediatricians in recognizing the signs and symptoms in women and children who are in or escaping an abusive home. The result is a more alert, sensitive intervention by medical professionals. The contact with the child's pediatrician may be the only safe contact that the battered woman has in order to receive help.

This collaboration provides the shelter staff with a direct link with which to advocate for the client in the event the client has been misinformed or underserved. The Monmouth Medical Center team also provides the staff with in-service training with regard to childhood diseases, immunizations, stages of child development and any other related topics of interest to assist the staff in meeting the current needs of the families in shelter. They have made themselves available by phone for emergency questions by shelter staff which can be reassuring.

In the past 4 years, the collaboration between medical personnel and shelter staff has been a very rewarding experience for all involved. The initial thought was to attempt to create a medical history for the children and give medical professionals some insight into DV in a non-clinical setting. It has been so much more, in ways no one could have imagined at the time of inception. The benefits are as numerous and diverse as the individual stories themselves. The initial medical contact has opened the door to services for adults as well as children. When a pregnant mother who speaks very little English is able to find counseling for herself and her children, as well as medical attention for herself, her children and her unborn baby all in her own language, in a culturally sensitive atmosphere, our collaborative effort has achieved more than we could have ever hoped for.

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Medical Community Responds to DV

- The University of Minnesota's School of Dentistry and the Program Against Sexual Violence have developed comprehensive training to enhance clinical skills and techniques related to family violence. The program will offer several trainings in Minnesota and at least 5 national trainings for dental professionals. More information is available by calling Jamie Tiedemann at 612-626-9988

In collaboration with the following medical organizations, the National Coalition Against Domestic Violence offers the following free services to survivors of DV:

- The American Academy of Cosmetic Dentistry, “Give Back A Smile” program. Call 1-800-773-4227 for more information.
- The American Academy of Facial Plastic and Reconstructive Surgery program, for face, neck & head injuries, “Face to Face,” can be reached at 1-800-842-4546.
- The American Society for Dermatologic Surgery, S.C.O.R.E.S. (Skin Care Outreach Empowers Survivors), can be reached at 1-888-892-6702.

Screening for Domestic Violence Changed My Practice

An Interview with Leigh Kimberg, MD

Internist Leigh Kimberg, MD is the Attending Physician at Maxine Hall Health Center, a San Francisco public health clinic. She has served as the Coordinator of DV services at the SF Department of Public Health Community Public Health Service. In 1994, she was appointed Clinical Assistant Professor of Medicine at the University of California at San Francisco, Dr. Kimberg is a graduate of Harvard Medical School.

This Summer, the Health Resource Center sat down with Dr. Kimberg to ask about her screening practices.

When did you start identifying domestic violence as a health care issue?

In medical school. I remember the 1st patient I realized was a victim of DV. She had a number of injuries in which the mechanism of injury made no sense. I went to that patient and talked to her. Without training, it was very hard, but I felt like she was dealing with issues that were getting in the way of her health improving.

What is your practice on screening for DV?

When I became more formally educated on DV, I realized that I had probably dramatically underestimated the problem. So, I decided that in order to gain experience, I needed to start asking every single woman or girl who came into my practice whether they had ever been a victim of violence. I began that way. I decided to use questions from the Abuse Assessment Screening Form and questions that I developed, that I felt comfortable with. I asked direct and more open-ended questions.

Do patients feel somehow insulted when you ask them these personal questions?

I find that people are extraordinarily receptive to my screening questions. The main response I have – and this is one of the things that encourages me to continue asking – is a real sense of relief and appreciation that most people express.

How you ask the questions must be important.

Of course, the way you ask the questions makes a big difference – using body language that says I’m ready to hear this answer, not shuffling through papers, not writing while someone’s speaking, not looking like I’m about to rush out the door. There are plenty of ways you can enhance someone’s comfort level.

Many providers tell us that they are afraid patients will feel singled out or be offended.

There are occasional patients who are, not necessarily offended but slightly paranoid about why I am asking them in particular, thinking it is something I noticed or something unusual to ask this question. I promptly explain that I ask this of all my patients, and that this isn't an unusual question to ask, and it is nothing in particular about them that is triggering me to ask.

It sounds like you spend an incredible amount of time going through this. With today's health care time constraints, how do you take the time to screen, talk through these issues and make referrals?

Screening for DV has actually made my practice more efficient and more effective. Screening very early on in the patient-provider relationship deepens the relationship, makes it more trusting, and therefore makes it more efficient in the sense that I'm able to understand how the psychological and physical stress of domestic violence is playing a role in this person's health and I'm able to see risk factors for illness that I might not have seen. This, in turn, has made my practice more effective. Certain visits may take longer, but the depth that I achieve is worth it.

Really, screening does not take very long. If there's a negative answer, the screening is over immediately and you've let the patient know that if that ever happens, you're open to hearing the answer. If someone comes in the midst of an incredibly violent relationship, that visit will not be brief, and I view that the same way as I would crushing chest pain. I must stop what I'm doing and deal with that situation because it's an urgency. There are timesaving techniques as well.

What kind of techniques?

One that I've used very frequently is when I am treating someone who is in an abusive relationship. I ask the person if they'd be willing to talk to a DV counselor on the phone while they're in the clinic.

Keeping a hotline number in exam rooms is not very difficult. In areas where there's no local number, the national number can be utilized. Someone in your office just needs to call a local DV shelter and ask what's the best hotline number to refer patients to.

You do it right there with the patients?

I do it right there. I finish most of the visit, put the patient on the phone with an advocate, and ask one of the nurses or health workers to come find me when the patient's done. Then I continue on with seeing my other patients. It's a major timesaver for me and it probably increases the likelihood that the person would feel comfortable dialing that number again.

It also takes the burden off you to become the counselor.

Definitely. When I call for a patient, I say, "I'm a physician working in a very busy clinic. I've just talked to a patient of mine here about DV and she's in a violent relationship, and I was hoping that you could talk to her." Of course, I make sure the patient is comfortable talking to an advocate first.

When you have a patient that discloses that they're not comfortable calling the hotline, what do you do?

The main thing is trying to establish a few basic facts, trying to figure out whether the perpetrator is in the clinic, what kind of immediate danger a person might be in, whether there are weapons in the home, if they've ever been threatened with a weapon, and how children are involved. I explain the limits of confidentiality and reporting requirements. I see what that person wants to do and ask whether they've ever told anybody else. This is a very important question because it gets at the level of isolation. Then I try to figure out whether they would like to talk to someone more, all the while giving supportive messages, explaining that they don't deserve this and that there is help, and that the violence isn't their fault.

What do you do when the perpetrator is right there during the interview?

This definitely happens. I'm thinking of one woman who I suspected might have been a victim of DV. Her partner was hovering very closely in the clinic, he was reluctant to allow us to have a private interview.

How did you handle that/

I basically tell all partners this is just our policy, we always have some time alone, if your partner wants to come back in later, they can come back in later, but this is just what we do. He was uncomfortable with me having private time with her, but gave in when he believed it was some kind of official exam policy.

Did she disclose once he was out of the picture?

She said no, that wasn't happening. I told her that we ask all women here about the violence in their lives and that there is a lot of help available, and if that ever happens to her, or a friend of hers, she should feel free to come back because we consider it a very important health problem, and would be happy to help. There are people that are not ready to say what's happening. We have to remember that what she had in clinic was probably far more support than she ever had, and that, in and of itself, was a successful visit. She knows we're available to her if she needs help.

That certainly speaks to the way you define a successful intervention. Can you talk about how you view that as a success?

I trained in a program in which most of my patients were facing almost insurmountable obstacles to a healthy life. Poverty, drug use, mental illness, violence, lack of housing. It was quite obvious that I could not rescue my patients. But asking about violence has enabled me to be truly supportive and empowering to my patients.

I've integrated my screening with my intervention in a more profound way, whereby as I'm asking questions about violence in someone's life, I'm pointing out how strong they must be to be coping with the things they're coping with, how resourceful they must be just to get through a single day, or a single hour of a single day, and how intelligent they must be to have figured out how to survive in that situation. Since I can't rescue patients, I realize all I need to do is be empathic and supportive, and this simple intervention can really help empower someone.

How has all this affected you?

Ironically, by backing off from a rescuing role and instead respectfully appreciating someone's strengths and giving messages of support, my relationship with my patients becomes more important in their lives. That paradigm shift from rescuer to supporter and empowerer has been a very important one.

Before I started doing this work, I felt somewhat overwhelmed and powerless in dealing with the violence that exists in this world. Now I know I'm helping to relieve some of the suffering.

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Call the National Health Resource Center on Domestic Violence at 1-888-Rx-ABUSE to receive your free "Screening to Prevent Abuse" packet.

**FROM SENSITIVITY TO COMPETENCY:
Clinical and Departmental Guidelines to Achieving Cultural
Competency**

*Prepared by Sujata Warriar, PhD in Collaboration with JoEllen Brainin-Rodriguez, MD.
Excerpt from Family Violence Prevention Fund – Improving the Healthcare Response to DV, Resource Manual for Health Care Providers, 1998.*

Since 1960, the US has not only opened its borders to people from all over the world but has also begun the process of opening doors to issues of cultural diversity. Specifically, within the past decade, the cultural demographics of health care professionals and consumers have changed noticeably. In response to this shift, health care providers have started to recognize the need to deliver culturally appropriate services in order to reach a large percentage of their clients effectively. This recognition has led to an increased understanding across institutions and systems, and of the notion of multiculturalism.

Only recently has DV come to be recognized as a public health concern. For decades, women presenting with clinical indicators of DV were treated only for their symptoms. Professionals did not ask questions regarding the origins of their injuries. In the past decade, however, much has changed in how victims of DV are treated in the health care setting. The Joint Commission for the Accreditation of Health Care Organizations (JCAHO) regulations were established, requiring hospitals to develop and implement protocols for the identification and treatment of victims of domestic violence. Additionally, the American Medical Association (AMA) recommended universal screening of all female victims in the health care setting.

Domestic violence cuts across race, class, sexual identity, and disability. These complex issues intersect in various ways for different individuals. To intervene effectively in cases of DV, providers need to recognize that victims experience violence in different ways and often have to deal with multiple issues simultaneously.

For a successful health care interaction with a diverse client population, the provider has to be able to elicit social and cultural information regarding a victim's hopes and fears, and norms about privacy and dignity. All of these are defined by the victim's cultural frame of reference. By being aware of one's own assumptions, the provider can elicit specific information provided by the victim, and combine it with general knowledge about DV. This is a culturally competent approach for treating DV victims from diverse backgrounds. The more open and respectful the interaction, the more successful is the health care intervention.

Culture: Culture is a complex term, having different meanings to different individuals. Traditionally, culture has been often thought of as a pattern of beliefs, attitudes and behaviors that are transmitted from generation to generation for the purpose of successfully adapting to society. The traditional definition was applied most frequently to racial and ethnic communities. More recently, the term culture has come to be recognized as fluid and heterogeneous, bound by time and geography.

For the purposes of these guidelines, "culture" refers to the shared experiences or other commonalities that groups of individuals based on race, ethnicity, sexuality, class, disability status, religion, age, immigration, and other axes of identification have developed in relation to changing social and political contexts. These guidelines use the contemporary concept of culture, recognizing that is multifaceted, often changing and contains contradictory elements.

Often, some providers assume that they know the victim's beliefs or experiences based on previous interactions with the victim's communit(ies). This knowledge may be useful at times. However, in a clinical encounter it may also create difficulties leading to incorrect assumptions about the victim. This is why it is important that the provider be fully aware of bias and the source of knowledge about any community. It is easy to use the incorrect assumptions to impose the provider's values on others.

Exploring any option has to be done with victim safety at the forefront. Victims are constantly balancing safety and risk. If an option is unsafe at a particular point in time, it may not be later. The viability of an option depends largely on sources of support both within the victim's communit(ies) and that which is made available by providers. A health care intervention is likely to work only if the provider gently negotiates without infringing upon the victim's right to dignity and privacy, letting the victim know her/his options that are available at the time. Keep in mind that options have to make sense from the victim's frame of reference.

RECOMMENDED PRACTICE IN SCREENING

Screen all female victims universally and routinely for domestic violence, regardless of cultural background. Screen male victims when they present with clinical indicators.

Research indicates that women are the majority of victims in DV, but men can be victims too. Screening should include men when they present with clinical indicators, in order to capture men who are in same-sex, bi-sexual and heterosexual relationships. Men may be reluctant to disclose abuse for fear of not conforming to traditional male stereotypes or of potential consequences involved by “coming out.”

In General

- Ask about concerns regarding loss of confidentiality. In some small, closely-knit communities, disclosure can escalate lethality.
- Use language that is comfortable for the victim. Use simple terms by describing actual behaviors with reference to physical abuse: “have you been hit, slapped, bitten?” More general questions include: “Have you been hurt or threatened by anyone in your family?” Avoid words with a stigmatizing effect such as “abuse,” “battering,” and “domestic violence.”
- Include discussions of a partner’s drug or alcohol use, or concerns for the safety of children. “Have you ever been hurt or threatened when (s)he was using?”, “Have you ever been hurt when you were trying to protect your child?”
- Provide the victim with an opportunity to talk with someone else from their community if they are uncomfortable with you: “If you are not comfortable with me, let us figure out whom you can talk to about this situation.”

For Culturally Competent Screening

- Avoid making assumptions based on the person’s appearance. Do not assume a victim’s economic, educational and immigration status, his/her sexuality, or the community(ies) he/she belongs to based on name, clothes, or accent.
- Ask about support systems available in each of the victim’s communities for victims who identify with multiple communities.
- Be aware of your assumptions about family. Victims belong to and are part of families, extended families and communities. As a result, the victim’s definition of family might be different from that of the provider.
- Use the term “partner” or “any other family member” or “anyone close to you” when you interview the victim regarding DV.
- Be aware that for lesbian or gay victims, disclosing abuse may be their first experience coming out.

INS, Law Enforcement, & Child Protective Services

- Be aware that undocumented victims may be reluctant to disclose due to fear of deportation or coming to the attention of the INS. Although there have been changes in immigration laws, it is important to let victims know that some legal remedies may be available regarding their immigration status.
- Be aware that victims from communities of color may also be reluctant to disclose due to previous negative experiences with law enforcement and legitimate fears about police detainment brutality.

- Become familiar with police procedures in your area with respect to mandatory reporting and DV arrests, in order to respond appropriately to any victim concerns. Mandatory reporting can be a barrier to disclosure, as immigrant victims and others may have past negative experience with the police or military authorities.
- Note that women with histories of substance use may have legitimate fears about Child Protective Services taking away their children.

Immigrants

- Ask whether the victim would prefer to use an interpreter if English is not the victim's first language. Do not use a partner, children, or any other accompanying person to interpret.
- Be mindful of translation style and dialect differences when using interpreters. The use of specific words to describe violence, for example, hitting, fighting, slapping or pushing may be more effectively translated than general questions about "experiencing violence and domestic violence."

RECOMMENDED PRACTICE IN ASSESSMENT

Allow the victim to define her/his culture and community; ask the victim about the community's response to marriage, divorce, domestic violence, health and healing; and find out how the victim responds to cultural expectations.

For Culturally Competent Assessments

- Let the victim tell her/his story, rather than you leading the narrative: "What is your life like? Who are the important people in your life, and what are your relationships with them like?"
- Assess the victim's support system: "How is your relationship affecting your ability to meet your responsibilities, participate in work and school, etc.?" "Who can you trust to help you in this situation?"; "What is it like in your community when someone talks about these issues to an outsider?"
- Listen to a victim's assessment of danger. For example, women in some communities may minimize the violence for survival reasons or as a defense mechanism.
- In same-sex relationships, assess who is the batterer (primary aggressor) and who is the victim. Ask very specific follow-up questions.
- Support the victim's desire to bring someone else along during the health care visit, but also create some time alone with the victim. Be sure to ask about the victim's relationship to the accompanying person, and don't make assumptions about the relationship. For example, two women who may appear to be mother and daughter, or friends, may in fact be intimate partners.
- Don't assume people have resources, such as a home or access to transportation. Ask: "How long did your trip take? "How did you get here?" Rephrase questions about going back home: "Where will you be going after we are done?" "Is it safe to go back there?"

- Modify danger assessment tools to meet the culturally specific needs of your patient population. But remember that these tools can never adequately predict lethality.

RECOMMENDED PRACTICE INTERVENTION

Culturally competent intervention respects a victim's right to dictate the course of her/his actions. This means acknowledging that a victim may have multiple pressures, including community expectations that prevent the acceptance of safety options. Though the provider's goal is to ensure victim safety, it is important to keep in mind that the victim will accept an option only when it makes sense from her/his frame of reference. Remember to validate the victim's experiences, and provide unconditional support.

Victims of DV often experience a loss of control over their lives. As a result many victims may feel that they are placing themselves in greater jeopardy by disclosing the abuse. This may have particular significance for communities impacted by xenophobia, racism, poverty, sexism, and homophobia.

To help restore a sense of control in the victims' lives, remember to:

- Explain all medical procedures in a simple, easy-to-understand manner for victims whose primary language is not English, and for victims with low-literacy levels.
- Inform the victim about her/his rights, and resources and referrals that serve the community.
- Gather information and knowledge about community resources, including DV advocates and culturally specific agencies who might work with you and the victim.
- Develop a safety plan with the victim that applies to all areas of their lives, and that takes into account culturally specific needs, even if the victim is reluctant to disclose specific information or press charges. This may require coordination with community-based agencies or DV advocates.
- Save questions regarding sexual identity and immigration status for later in the interview. Asking too soon can create fear amongst victims who do not want to be reported, or who have concerns that they will receive less care because of their status.

Finally, as in all other DV interventions, provide unconditional support for the choices that the victim makes, even if you disagree. Remember that an adult victim has the right to self-determination.

RECOMMENDED PRACTICE IN DOCUMENTATION

A culturally competent documentation should include the identification of culturally specific issues in addition to regular medical documentation. It is important to be aware of how culturally specific issues are phrased. The report should also include referrals to specific community-based agencies or advocates.

As in all cases, documentation should include descriptions of injuries and old healed ones; the provider's objective assessment of the impact on health and a description of the victim's affect; victim history of abuse as it is disclosed, as well as any denial of abuse; safety plans that were made; information, referrals and resources that were provided; and the name(s) of the perpetrator(s). Language of documentation should include statements such as: "patient states," "patient says."

Culturally competent documentation in particular should include the following:

- A subjective assessment that includes a social and cultural history.
- Non-pejorative documentation. Avoid statements such as: "Patient refuses to talk or disclose." Instead, replace with "Patient finds it difficult to communicate about the abuse at this time." "Patient does not want to talk to community advocates" could be replaced with "Patient feels that she cannot meet with any members of her community at this time."
- Any community linkages that were made as part of the referral.

DEPARTMENT GUIDELINES

One of the first steps toward developing culturally competent health care services is to examine the assumptions and biases of the institution and the clinical staff.

Health care institutions play a vital role in the development of the cultural competency of their staff. Developing policies and procedures, and monitoring clinical activities and internal in-service trainings can facilitate the attainment of cultural competency.

Staff Diversity

To provide culturally competent health care to a diverse population, the provider staff should also reflect patient diversity.

The health care site can provide opportunities for expertise to develop among staff. This will ensure that there is continual reinforcement of intercultural understanding and expertise from within the institution. The public perception of the institution as sensitive to the needs of the community is also enhanced by the visibility of diverse personnel in positions of leadership. This may include hiring and promoting more people of color, bilingual persons, gays and lesbians or others representing the patient population served. However, this does not mean that one resident "cultural expert" is sufficient; each staff person needs to make the investment of time and resources to become culturally competent.

Environmental Change

The health care setting should provide a culturally appropriate environment for all the populations served.

Reassure victims that the health care site is there to serve them. Visual images posted in public areas and examination rooms of people of color, gays and lesbians, and other individuals reflecting patient diversity, along with posters saying “there is never an excuse for domestic violence” impart the institution’s commitment to reaching out to victims from all communities. The institution should also:

- Collect and/or develop handout materials available in all the languages spoken by the patient population. These include brochures, palm cards, safety planning instructions, and resource and referral lists. The materials should be distributed in a wide range of safe places: private exam rooms, rest rooms, as well as public spaces like waiting rooms.

Take into account the literacy level of the patient population when developing these materials or selecting from available materials.

Community Outreach

To achieve cultural competence within the health care setting institutions and clinicians need to have links to, and collaborate with, community based agencies. It is the responsibility of the health care provider to initiate collaboration.

An important clinical exercise for the institution can be the identification of community agencies and experts providing culturally specific advocacy for victims of DV. Regular administration activities should include meetings with these agency representatives, who can share valuable insights into barriers encountered by victims.

Training

Health care institutions should establish regular and mandatory training on DV and cultural competency for all staff.

Training is an essential component for achieving cultural competency in working with victims of DV. It is important to:

- Ensure that training is ongoing and established as standard practice.
- Use videotaped interviews of interactions with routine patients. This can illustrate the impact of body language, which may appear forbidding or judgmental. Where video is not available, supervision sessions on a weekly basis with more experienced personnel can provide useful feedback.
- Pre and post training surveys are essential. These can inform the administration about barriers encountered by victims from diverse communities.

Monitoring Departmental Progress

Health care institutions should establish a multidisciplinary team to evaluate and monitor current practices, allowing staff release time to carry out the tasks.

Development of New Tools

As the specific needs of each health care setting are identified and implemented, new educational materials for victims and providers alike should be developed.

Administration can fund the production of articles and other educational materials developed with the collaboration of community agencies and health care institutions. Sponsoring conferences where culturally competent materials and teaching methods are shared is another way of adding to the collective resources on DV training for health care providers.

This paper was edited by Josephine Yeh and Debbie Lee of the Family Violence Prevention Fund (FUND). It was developed with the generosity of the Cultural Competency Committee, who contributed extensively to the discussion of key issues and the drafting of this paper. The Family Violence Prevention Fund and the authors thank the following committee members: Francis L. Brisbane, PhD; Vickii Coffey; John Fazio, RN, MS; Anne Ganley, PhD; Deana Jang; JD, Beckie Masaki; Illena Norton, PhD; Rachel Rodriguez, RN, PhD, Beverly Wilkins; and Rose Quinones, PA. Contributions were also made by the following FUND staff: Suzie Jacinthe, Lisa James, MA, Kelly Mitchell-Clark, Sylvanna Falcon, and Sharlene Hill.

For a complete copy of this article please contact the Family Violence Prevention Fund: 415-252-8900.

COMMUNITY HEALTH CLINICS JOIN THE FRONTLINES IN THE FIGHT AGAINST DOMESTIC VIOLENCE

By Esta Soler

For as long as women have been beaten and injured by their partners, doctors have set their broken bones, sutured lacerations, and sent them home, usually without any exploration of the underlying problem. For more than 12 years, the Family Violence Prevention Fund has provided training, model programs and protocols to help improve the health care system's response to DV, with the critical support of the Conrad N. Hilton Foundation and the U.S. Department of Health and Human Services. Now, the Fund is launching an exciting, new pilot project to explore ways that community-based health clinics can work to prevent DV, called *The California Clinic Collaborative on DV*. The project is working with community health clinics throughout the state, helping them to implement comprehensive DV prevention strategies for the populations they serve. The California Collaborative project was generously funded by the California Endowment.

“Community clinics are an ideal place for prevention to occur,” according to Associate Director Debbie Lee, who directs the Fund's National Health Care Initiative on DV. “Community clinics take a holistic view of an individual's health and try to involve the entire community in delivering health care.”

Twenty community health care clinics were selected to participate, representing a broad spectrum of service providers. “The Watts Foundation in Los Angeles is huge, in a very urban setting,” says Lee, “and the Hill Country Clinic in Shasta County is small and very rural. We wanted to learn from that diversity.”

The project aims to institutionalize a comprehensive health care system approach to DV identification, treatment and referral, and create the understanding among patient populations that the health care system is a safe place to come for help. The Clinic Collaborative project is also building support for DV prevention among policy makers and health care leaders through statewide advocacy efforts.

Project components include the development and distribution of DV prevention materials to health care clinics, as well as intensive training and technical support to the 20 selected facilities. “Each site is on 2 of our 3 decision-making committees to help shape the programs: clinical intervention and evaluation, public education and prevention, or policy and advocacy,” says Lee.

“It’s very exciting to form relationships with the other participants and have the opportunity to gain from their experiences,” says Dr. Moira Shannon, Associate Director of the Watts Health Foundation and a program participant. “We’re trying to address DV, just like we have other health issues such as substance abuse, by putting programs in place. This really is a huge public health issue.”

“Community health centers really do care about people,” Lee adds. “They know the characteristics of their community, and are in a great position to provide prevention. The materials and strategies they create here can be a model for the rest of the country.”

Esta Soler, Founder/Executive Director, Family Violence Prevention Fund. Under her guidance, the FUND has created innovative domestic violence training, policy, advocacy, prevention and education programs that have been replicated in all 50 states and 7 foreign countries. She is co-author of the book Ending Domestic Violence: Changing Public Perceptions/Halting the Epidemic. Ms. Soler has received numerous awards for her work on domestic violence and women’s rights, including a Kellogg Foundation National Leadership Fellowship in 1990, the Koret Israel Prize in 1995, and the University of California, Public Health Heroes Award in 1998.

Article reprinted from the California Alliance Against Domestic Violence newsletter Alliance News, August 1999.

NEW IMMIGRATION NATURALIZATION SERVICES GUIDANCE ON PUBLIC CHARGE

When is it safe to use public benefits?

The U.S. Government has important news about “public charge” – when receiving public benefits may affect your immigration status or your ability to travel outside of the US. The government’s new guidance, which took effect May 25, 1999, gives clear rules about when it is and is not safe to use public benefits.

Highlights of the New Public Charge Guidance

- Use of Medicaid, CHIP or other health services by you or your family members will **not** affect your immigration status unless you use Medicaid or other government funds to pay for long-term care (nursing home or other institutionalized care)
- Use of food stamps, WIC, public housing, or other non-cash programs by you or your family members will **not** affect your immigration status.
- Use of cash welfare by your children or other family members will **not** affect your immigration status unless these benefits are your family's only income.
- Your own use of cash welfare, like SSI, TANF, or General Assistance, **might** affect your immigration status, depending on your situation. This is because the INS or State Department can count these benefits in deciding whether you are likely to become a "public charge."

Overview of Public Charge

What is "Public Charge"?

"Public charge" is a term used in immigration law. The term describes persons who cannot support themselves and who depend on benefits that provide cash, like Temporary Assistance for Need Families (TANF) or Supplemental Security Income (SSI) for their income. Depending on your immigration status, the Immigration and Naturalization Service (INS) and State Department consular officers abroad can refuse to let you enter the U.S., or become a permanent resident, if they think you will not be able to support yourself without these benefits in the future. Under very rare circumstances the INS can also deport you if you become a public charge within 5 years of entering the US. Public charge is not an issue for immigrants who are applying to become a citizen. Public charge is not an issue for refugees or persons granted asylum.

What kinds of benefits might cause a public charge problem?

In deciding whether you are likely to become a public charge, the INS can look at whether you have used cash welfare, such as SSI, TANF, or General Assistance, or if you need long-term institutional care. But even if you used cash welfare in the past, you can still show that you will not need it in the future (for example, because you have a job now). The INS is supposed to look at your whole situation when it decides if you might become a public charge in the future.

*Excerpted with permission from the Community Education page of the **National Immigration Law Center Web Page**. For more information, go to www.nilc.org*
