



# **FOCUS ON DOMESTIC VIOLENCE**

## **Self-Study Guide**

## Objectives

Upon completion of this self-study, employees will be able to:

1. Define domestic violence.
2. Identify the types of domestic violence.
3. Identify the common characteristics of abusers and victims in domestic violence situations.
4. Describe why domestic violence is a serious problem in rural America.
5. Identify the steps involved to screen, document, and report domestic violence.
6. Understand what is mandated to be reported.

## Introduction

Domestic violence is probably one the most difficult topics to discuss because it is an issue that is incredibly personal. Most of us probably know someone who was in an abusive situation. Some of us know people who were able to get out of these situations. We also know of individuals who stayed in abusive situations for a variety of reasons that will be discussed later. Domestic violence is also a topic that makes many healthcare workers nervous—we wonder what do we do in these cases, what is our legal responsibility, how I approach the subject with a patient, what about my own safety as a caregiver, what do I report, what do I not report, etc. Many healthcare workers<sup>1</sup> become professionally crippled when we are treating a potential victim of domestic violence. We try to ignore the signs because “if I don’t see it, I don’t have to address it.” It is not intentional, but human. Domestic violence makes even the most seasoned professional uneasy. To address such concerns, this self study will explore the issue of domestic violence and provide staff with knowledge to help address potential domestic violence situations in a more professional, competent manner. To begin this discussion, providers need to understand how common domestic violence is.

The numbers surrounding domestic violence are staggering both in terms of people impacted and the financial costs involved. Below are some facts regarding domestic violence in the United States.

- One in every four women will experience domestic violence in her lifetime.<sup>2</sup>
- Nearly 7.8 million women have been raped by an intimate partner (spouse, significant other, member of the household) at some point in their lives.<sup>3</sup>
- One in 33 men has experienced an attempted or completed rape.<sup>4</sup>
- An estimated 1.3 million women are victims of physical assault by an intimate partner each year.<sup>5</sup>
- The costs of domestic violence exceed \$4.1 billion dollars per year in direct medical and mental health care services. An estimated \$150 million annually is spent on medical expenses resulting from domestic violence injuries.<sup>6</sup>

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<sup>1</sup> Healthcare workers and providers are used interchangeably throughout this self study. A healthcare provider for the purpose of this self study is an employee of Pike Community Hospital.

<sup>2</sup> *Domestic Violence Facts: Ohio*. National Coalition of Domestic Violence, Updated Fall, 2007.

<sup>3</sup> *Domestic Violence Facts*. National Coalition of Domestic Violence, Updated August 2007.

<sup>4</sup> *Domestic Violence Facts*. National Coalition of Domestic Violence, Updated August 2007.

<sup>5</sup> *Domestic Violence Facts: Ohio*. National Coalition of Domestic Violence, Updated Fall, 2007.

<sup>6</sup> *Healthcare and Domestic Violence*. National Coalition of Domestic Violence, Updated July 2007.

- Victims of domestic violence account for 22-35% of all women seeking emergency medical care.<sup>7</sup>
- More than one third of the women treated for violent injuries in emergency rooms were hurt by an intimate partner.<sup>8</sup>
- Less than one fifth of victims reporting an injury from intimate partner violence sought medical treatment following the injury.<sup>9</sup>

Knowing how many people are impacted by domestic violence is only one piece of the puzzle. Throughout this study providers will gain a better understanding of what is domestic violence and what their role is in addressing this growing problem.

## **Defining Domestic Violence**

When defining domestic violence most people think of physical abuse where a male assaults a female. This is a common myth as domestic violence involves more than physical assault and domestic violence victims are not limited only to women. Domestic violence is when a family or household member uses physical violence, threats, intimidation and/or emotional, sexual, and economic abuse to maintain power and control over the other person, usually within an intimate relationship.<sup>10</sup> More often than not, domestic violence is a combination of abuses. For example, someone may present having been physically assaulted, verbally abused and raped. Physical abuse is the aspect of domestic violence that is discussed the most in domestic violence literature and the media as it is the most visible. Please refer to Appendix 2 at the end of this self-study for examples of each type of abuse.

All aspects of domestic violence are potentially harmful and even life-threatening. There are 16,800 homicides each year due to intimate partner violence.<sup>11</sup> It should also be noted that 25 percent of women who attempt suicide are victims of at least one type of domestic violence.<sup>12</sup>

In Ohio, domestic violence involves one of the following: knowingly causing or attempting to cause physical harm; recklessly causing serious physical harm; or by threat of force knowingly causing another to believe the defender will cause imminent physical harm.<sup>13</sup> Domestic violence refers only to family or household members, which according to Ohio law fit into one of the following categories:

- A relative by blood or marriage who the victim lives with now or has lived with in the past;
- A partner who the victim lives with now or has lived with within the past five years (this includes same-sex couples);
- Any person the victim was married to; or

<sup>7</sup> *Healthcare and Domestic Violence*. National Coalition of Domestic Violence, Updated July 2007.

<sup>8</sup> *Healthcare and Domestic Violence*. National Coalition of Domestic Violence, Updated July 2007.

<sup>9</sup> *Domestic Violence Facts*. National Coalition of Domestic Violence, Updated August 2007.

<sup>10</sup> *Adult Victim Information Pamphlet*. Pike County Partnership Against Domestic Violence, 2007.

<sup>11</sup> *Domestic Violence Facts*. National Coalition Against Domestic Violence. Updated August 2007.

<sup>12</sup> *Health Care and Domestic Violence*. National Coalition Against Domestic Violence. Updated July 2007.

<sup>13</sup> *Domestic Violence: Know what you can do – Criminal Law and Domestic Violence*. Ohio Domestic Violence Network. No publication date.

- Any individual with whom the victim has had a child with.<sup>14</sup>

Ohio law has determined that some forms of abuse are criminal behavior and are reportable. Examples include physical abuse, economic abuse, or verbal harassment.<sup>15</sup> There is more on mandated reporting in another section of this self study. If you have a patient who is a victim of abuse and the domestic violence laws do not apply, this individual may have some protection from Ohio's stalking laws.<sup>16</sup> Refer the individual to law enforcement or the Pike County Partnership Against Domestic Violence in such cases.

### *Cycle of Violence*

When discussing domestic violence, it is important to understand the *Cycle of Violence*<sup>17</sup> that can be seen in many abusive situations. This cycle has three components:

- The Tension Building Stage – No matter what the victim does, s/he is unable to please the abuser. In this stage the abuser may shout, blame, criticize, threaten, resort to name calling behavior, or give the victim the “silent treatment”.
- The Explosion Stage – The explosion is the act of violence. It can be verbal, physical and/or sexual (rape). The batterer may scream, yell, shove, slap, hit, punch, kick, break things, or even use weapons.
- The “I’m Sorry” Stage - This stage is when the abuser apologizes for the explosion. The abuser may bring the victim candy, flowers or other gifts. This stage is also one with empty promises, “I promise it won’t happen again.” Some abusers threaten suicide in this stage if the victim threatens to leave the situation.

Providers need to understand that every abusive relationship is different. Not all abusive relationships will have each stage. For example, many victims never describe an “I’m sorry” stage when telling their story. What often happens in the *Cycle of Violence* is that the “I’m sorry” stage becomes a shorter period of time and may become non-existent. The “Tension-Building Stage” takes less time, but the “Explosion” becomes more violent. Victims look for the calm following the “I’m Sorry” Stage that does not come as an abusive situation progresses over time. Understanding the *Cycle of Violence* may assist providers in establishing rapport with a patient who has experienced domestic violence. Knowledge of the *Cycle of Violence* will also assist providers in putting an abusive relationship in a context to understand the situation better.<sup>18</sup>

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<sup>14</sup> *Domestic Violence: Know what you can do – Criminal Law and Domestic Violence*. Ohio Domestic Violence Network. No publication date.

<sup>15</sup> *Adult Victim Information Pamphlet*. Pike County Partnership Against Domestic Violence, 2007.

<sup>16</sup> *Domestic Violence: Know what you can do – Criminal Law and Domestic Violence*. Ohio Domestic Violence Network. No publication date.

<sup>17</sup> *Cycle of Violence*. Brochure. ETR Associates. 2000.

<sup>18</sup> *Cycle of Violence*. Brochure. ETR Associates. 2000. *Cycle of Violence*. [www.domesticviolence.org](http://www.domesticviolence.org) Creative Communications. 2007.

## **Characteristics of People<sup>19</sup> in Domestic Violence Situations**

To better understand and assess for domestic violence, it is important to be familiar with the characteristics of both the perpetrators of domestic violence and the victims of domestic violence.<sup>20</sup> Please keep in mind that these are generalities. Each characteristic is not applicable to every abuser and every victim. Later in this self study there will be discussion about domestic violence in rural areas such as Pike County and the implication this has on healthcare providers.

### *The Perpetrators*

Researchers have identified some common characteristics among perpetrators of domestic violence. Below is a summary of some of these characteristics.

- Dual personalities – When speaking with victims of domestic violence, the abusers are often described as having two personalities. The abuser may be pleasant and social one moment and then in attack mode the next moment. Abusers are typically not known in the community as “violent”. Acts of physical aggression are usually committed in private settings such as at home. Some describe an abuser’s emotions as being “on a switch”. Once the abuser believes s/he is in a “safe” environment, then the abuse is likely to occur. If the abuser thinks someone may be watching, s/he is on “good behavior”. Abusers may be loving, kind and remorseful at times, but this is all part of maintaining power and control.
- Extreme jealousy – An abuser may be jealous about the relationships a victim has in his or her life. Jealousy emerges in all types of relationships that the victim may have with individuals other than the abuser including parents, in-laws, children, siblings, friends, coworkers and even pets.
- Controlling and possessive behavior – Some abusers control all aspects of their victim’s life. An abuser may control access to money, social relationships, employment, etc. Some victims report having to account for time spent away from the abuser or the money s/he spent. An abuser may also treat the victim as a “possession” and may engage in seemingly “playful” but unwelcome use of force during sex. Please note that you can be raped by a spouse.
- Emotional dependency – An abuser may be emotionally dependent on his or her victim making constant demands for reassurance and gratification. An abuser may be hypersensitive to anything interpreted as criticism and may be critical of others or difficult to please.
- Poor self-esteem – An abuser may feel inadequate about a variety of things, including (but not limited to) masculinity, sexuality, providing for the family, and parenting. These

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<sup>19</sup> Please note that the characteristics described in this section are generalities. Every characteristic will not be seen in every abuser or every victim. This is meant only as a guide to assist providers in their assessments.

<sup>20</sup> *Adult Victim Information Pamphlet*. Pike County Partnership Against Domestic Violence, 2007. Pages 4-10.

feelings may be masked through other emotional characteristics such as an extremely tough or “macho” image.

- Roles – Abusers tend to enforce rigid gender roles. For example a male abuser may feel that he is the “head of the household”.
- Blame – Abusers may blame other people or circumstances for their behavior and feelings. They have difficulty taking responsibility for their mistakes or problems.
- Abusive history – A high proportion of abusers experienced abuse as children or witnessed abuse as children.
- Unpredictable – Victims often describe an abuser’s actions as being unpredictable. Victims state that they never knew what the abuser was going to do or say next. Some abusers hold others, especially the victim, to unrealistically high expectations.
- Social isolation – Abusers typically have few friends outside the family and may have poor social skills. However, abusers may also be “social charmers” and have a lot of friends, none of who would think they would be abusive.
- Cruelty – Abusers may not only be cruel to their intimate adult peer (spouse, partner), but also to children and animals. The abuser may be preoccupied with guns, violence, knives, etc.
- Inappropriate use and display of anger – Abusers may use anger if they do not get what they want. They may display anger as verbal abuse, physical touching of any kind, threats of violence, and breaking/destroying objects of value to the victim.

### *The Victims*

Victims of domestic violence also seem to have characteristics<sup>21</sup> that are common to them as a group. Such characteristics are:

- Over-functioning or over-achieving – The victim may take on more than a reasonable share of responsibilities. The victim may have a high need to succeed and please others. The abuser’s failure to accept responsibility may force the victim to compensate for his/her behavior.
- Feeling powerless – One feeling victims describe is a sense of having no control over their lives. Victims may be immobilized by fear and feel as though they “have to take it (the abuse)”.
- Feelings of guilt or shame – Victims may feel guilty over the failure of a marriage or relationship. This is often reinforced by the abuser who blames the victim for all that

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<sup>21</sup> *Adult Victim Information Pamphlet*. Pike County Partnership Against Domestic Violence, 2007. Pages 4-10.

goes wrong. Guilt over failure may be accomplished by shame for “putting up” with the abuse.

- Continuous hope – Victims maintain hope for the positive change in the abuser’s conduct. Others often try to tell victims that they do not deserve to be treated this way, but victims continue to hope that the situation will improve.
- Previous abuse – Significant portions of abuse victims were abused earlier in their lives by others either inside or outside of the family.
- Decreased self-esteem – Victims may underestimate their abilities and level of achievements. Self-esteem is likely to be eroded over time by constant criticism from the abuser such as name-calling, put-downs, and belittling the victim’s achievements.
- Identity concerns – Victims may lack a firm sense of individualization and autonomy. Victims may feel incomplete without a partner. For some victims, their identity may be or becomes strongly dependent upon their roles as a partner or spouse.
- Passive/dependent behavior – Victims may accept the traditional feminine role, often to an exaggerated degree. Their behavior may be reinforced by economic dependency and increasing feelings of helplessness and fear as the abuse continues.
- Self-blame – The abuser blames the victim and the victim believes it is his or her fault over time. Victims may accept responsibility for the abuser’s actions. Anger turned inward often produces guilt.
- Fear and denial – Victims may fear the abuser’s anger, but victims often try to deny and minimize this fear. Denial and minimization are common coping strategies to survive abusive situations.
- Stress – Victims may have severe stress reactions (headaches, stomachaches, sleeplessness, anxiety, etc.). Victims may spend an increasing amount of time trying not to make the abuser angry.
- Social Isolation – Victims may be isolated from family, friends, neighbors, and other sources of support, usually not by choice. The abuser may criticize and blame family and friends.

Knowing the characteristics of both victims and abusers in domestic violence situations is not enough to be effective as a healthcare provider in these situations. Many of us have heard our peers say statements regarding people in abusive situations that are not supportive or understanding of the situation. Such statements include “someone hit me like that, I’d be gone” or “if it is so bad, why don’t you just leave?”. After reading the characteristics of both the abusers and victims, you have probably come to the conclusion that escaping an abusive situation is not as easy as you might think. Victims remain in abusive situations for a number of reasons. The reasons vary from person to person. Some victims feel that they deserve what they are getting. Others find it is too expensive financially to leave the situation and start a new life. Some victims are afraid for their lives or the

lives of their children if they leave. And for some, they simply feel that they deserve nothing better.<sup>22</sup> Healthcare providers need to be empathetic to our patients in these abusive situations because escaping is often not as simple as opening the door and walking away from the abuse.

## **Domestic Violence in Rural America**

Most studies on domestic violence portray the problem as occurring primarily in urban areas. Various media outlets describe the services available to victims in cities. Victims in urban America have access to outreach programs designed to help individuals leave abusive situations. In rural areas such as Southern Ohio resources are limited if they exist at all. Living in a rural county such as Pike makes it difficult for victims to access services, report the abuse or even find a way to leave the abusive situation.<sup>23</sup>

Place yourself in the shoes of an individual wanting to escape an abusive situation in Pike County. To leave the situation the individual must find a place to live, which can be more complicated if children and/or pets are involved. Next, the individual must secure some financial resources to support him/herself and other family that might be involved. The individual may have to find employment, which is challenging if the person has never worked or been allowed to work. The individual is often put in a position of always thinking of safety issues – can I go here safely, what is my plan to leave if needed, etc.<sup>24</sup> This individual may also have to learn how to do things on his or her own. Oftentimes in abusive situations, the victim has never learned how or had the opportunity to do many of the things we may take for granted including opening a checking account and writing a check, driving a car, establishing credit, scheduling an appointment, or arranging for services such as electric, telephone, or cable.<sup>25</sup>

Mandated reporters of child and elder abuse<sup>26</sup> also have a challenging dilemma when it comes to assessing and reporting abuse and neglect in rural America. Often the mandated reporters have other relationships with both the victim and the abuser. This makes it more difficult to identify the situation as abusive because the mandated reporter has such personal connections with everyone involved. Mandated reporters sometimes dismiss the situation in their minds or are not sure how to report the abuse to the appropriate authorities. For example, the mandated reporter may justify what is happening to the victim by trying to put the situation in context instead of seeing the abusive situation for what it is. The authorities in rural America are also in the same situation or knowing both the perpetrator and the family making it difficult to end the personal ties and do a professional duty.<sup>27</sup> More regarding mandated reporting will be discussed in another section.

## **Domestic Violence and Healthcare**

The Ohio Domestic Violence Network (ODVN) established best practices standards in 2003 to assist healthcare providers in situations where domestic violence was involved. This protocol was a collaborative effort of providers from a variety of healthcare disciplines. Some of the agencies

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<sup>22</sup> *Domestic Violence*. National Center for Victims of Crime. 2008.

<sup>23</sup> *Rural Victims of Domestic Violence*. National Coalition Against Domestic Violence. Updated August 2007.

<sup>24</sup> *Adult Victim Information Pamphlet*. Pike County Partnership Against Domestic Violence, 2007.

<sup>25</sup> *Rural Victims of Domestic Violence*. National Coalition Against Domestic Violence. Updated August 2007.

<sup>26</sup> Ohio Revised Code has defined who mandated reporters are.

<sup>27</sup> *Rural Victims of Domestic Violence*. National Coalition Against Domestic Violence. Updated August 2007.

endorsing the protocol were the Ohio Department of Health, Ohio Hospital Association, and the Ohio Emergency Nurses Association. This section is a review of these practices. The entire protocol is available at [www.odvn.org](http://www.odvn.org), where an electronic form can be obtained and printed.

## **Screening for Domestic Violence**

As discussed earlier, domestic violence is more common than many providers think. Knowing this, what should a provider do to address the situation? The answer is screening patients for domestic violence and acting accordingly.

So, who should be screened? The National Consensus Guidelines developed by the Family Violence Prevention Fund (FVPPF) include the following statement: “Patients should be screened for current and lifetime exposure to Intimate Partner Violence (IPV) and victimization including direct questions about physical, emotional, and sexual abuse. Because of the long-term impact of abuse on a patient’s health, we recommend integrating screening for current and lifetime exposure into routine care. However, we acknowledge there will be times (particularly in emergency/urgent care) when screening for lifetime exposure to abuse will not always be possible due to time constraints.”<sup>28</sup> To put it simply, all patients, regardless of cultural background or language barriers, should be screened for domestic violence.

While the ODVN supports the National Consensus Guidelines for screening, the purpose of this protocol is to address the needs of women and men over the age of 18. Additional protocols and screening tools are necessary to address specific needs and concerns of minors, those with guardians, and the elderly population.<sup>29</sup>

The Ohio Domestic Violence Network developed a protocol to assist healthcare providers in screening for domestic violence. Their process involves awareness of the violence indicators and questioning techniques that the provider can use with the patient.

### ***Violence indicators***<sup>30</sup>

Any person seen in a health care setting may be a victim of abuse and should be screened. Patients present to healthcare workers with a variety of complaints and ailments. The following is a list of some of the common complaints patients who are victims of domestic violence report when seeking medical attention. This list suggests some, but not all, of the indicators of abuse. Also, keep in mind that just because a patient presents with these complaints does not mean that a patient is an abuse victim.

#### **Common Complaints**

- Indication of having been hurt physically, sexually, and/or emotionally

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<sup>28</sup> *The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care*. Ohio Domestic Violence Network. 2003.

<sup>29</sup> *The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care*. Ohio Domestic Violence Network. 2003.

<sup>30</sup> *The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care*. Ohio Domestic Violence Network. 2003.

- Unexplained injuries or injuries inconsistent with the history given
- Assaulted by alleged stranger
- Chronic pain syndrome, headaches
- Overdose/suicide attempts
- Anxiety, depression, insomnia
- Miscarriage, sexually transmitted diseases, and non-specific gynecologic complaints (e.g. pelvic pain, painful intercourse), as well as rapid repeat pregnancies and (unwanted) abortions
- Multiple motor vehicle and single vehicle accidents

### **Red Flags in Medical History**

Review patient's past medical history for:

- Any old unexplained injuries
- Delay in seeking care
- "Accident prone" patient
- Documented history of family violence
- High stress in family
- Pregnancy
- Frequent Emergency Department, urgent care, or office visits
- Drug/alcohol addiction (partner and/or patient)
- Request for medication for anxiety, sleep, or "nerves"

### **Red Flags of Patient Presentation**

Patient's presenting any of the following should be further assessed for domestic violence:

- Patient is evasive/guarded
- Patient appears embarrassed and/or exhibits poor eye contact
- Patient presents with injuries and appears depressed
- Patient has financial concerns
- Patient experienced a recent separation with partner
- Patient has a recent loss of job, close family member or intimate relationship
- Patient seems upset by recent unemployment
- Patient denies abuse too strongly
- Patient minimizes injury or demonstrates unexpected responses (e.g. cries, laughs)
- Patient has intense and/or fearful behavior with partner
- Patient appears angry and defensive "Last straw phenomena"
- Patient defers to partner
- Partner answers questions and/or refuses to leave patient alone

### **Physical Findings**

The following are often suggestive of domestic violence:

1. Injuries to areas not prone to injury by falls
2. Injuries to multiple sites
3. Symmetrical injuries
4. Wounds in varying stages of healing
5. Mid-arm injuries (defensive)
6. Strangulation marks: petechiae, ligature marks, and subconjunctival hemorrhage

7. Weapon injuries or marks
8. Bites/burns (scald and cigarette)
9. Black eyes
10. Dental injuries
11. Mid-face injuries
12. Breast/abdomen injuries (particularly during pregnancy)
13. Neck injury
14. Injuries to hidden sites (covered by clothes)
15. Internal injuries

Screening must be done in a private area with no one other than the patient and healthcare provider present. Ask any visitors to wait for a few minutes in the lobby or waiting area before starting the abuse assessment. Let visitors know that this is standard practice. Check to ensure that the visitor/s are not standing outside the door. Suggestions for private interviewing of patient include:

- a. Interview patient in private area, bathroom, X-ray or treatment room.
- b. Excuse visitor/s while you do a physical exam.
- c. Ask social worker, patient liaison, registration, reception etc. to ask family to step out for several minutes in order to attain privacy (eg. have second party request to speak with visitor outside of exam room).

Listed below are some suggested screening questions and strategies developed by the Family Violence Prevention Fund. By using appropriate screening questions, providers are able to get the information needed to accurately assess for the abuse, document the findings, and assist patient (if necessary) in development of a safety plan.

### **Framing questions**

Framing questions are those that allow a provider to lead into his or her assessment of the potential abuse with the patient. These questions help “set the stage” and inform the patient that you are not singling him or her out or just being “nosey”. Some examples of framing questions are:

- “Because family violence is so common in people’s lives, I’ve begun to ask all my patients about it”
- “I am concerned that your symptoms may have been caused by someone hurting you”
- “I don’t know if this is (or ever has been) a problem for you, but many of the patients I see are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I routinely ask about it.”

Once the provider has introduced the topic of the abuse assessment, the provider can ask more direct questions.

### **Direct verbal questions**

Direct verbal questions are questions intended to get specific information from the patient. Answers to these questions let the provider know if the patient is at-risk of being abused or is a victim.

Examples of direct questions are:

- “Are you in a relationship with a person who physically hurts or threatens you?”
- “Did someone cause these injuries? Was it your partner/husband?”
- “Has your partner or ex-partner ever hit you or physically hurt you?”
- “Do you (or did you ever) feel controlled or isolated by your partner?”
- “Do you ever feel afraid of your partner? Do you feel you are in danger?”
- “Has your partner ever forced you to have sex when you didn’t want to?”

- “Has your partner ever refused to practice safe sex?”
- “Has any of this happened to you in previous relationships?”
- “Is it safe for you to go home?”

### **Cross Cultural Screening Strategies**

It is important to adapt your screening questions and approach in order to be culturally relevant to individual patients. Listen to patients, pay attention to words that are used in different cultural settings and integrate those into screening questions. For example: for coastal Inuit groups, “acting funny” describes domestic violence, while in some Latino communities, “disrespects you” indicates domestic violence. Focusing on actions and behaviors as opposed to culturally specific terminology can also help. Be aware of verbal and non-verbal cultural cues (eye contact or not, patterns of silence, distance between people, and active listening during the interview). Some examples are:

- Use your patient’s language: “Does your boyfriend disrespect you?”
- Be culturally specific: “Abuse is widespread and can happen even in same-sex relationships. Does your partner ever try to hurt you?”
- Focus on behaviors: “Has your partner ever hit, shoved, or threatened to kill you?”
- Begin by being indirect: “If a family member or friend was being hurt or threatened by a partner, do you know of resources that could help them?”

Now that providers have screened for domestic violence, it is important to go to the next step of assessment and intervention.

## **Assessment and Intervention**<sup>31</sup>

Once providers have screened patients for domestic violence, the provider needs to take the next steps. This section will assist providers in understanding what to do with the information learned in the screening process.

### **If Abuse is Denied**

If abuse is denied and no indicators of abuse are present, document the findings in the medical record. Referral information can be offered for future reference for the patient. This process can be done verbally with the patient.

### **Patient CONTINUES TO DENY ABUSE but provider still suspects abuse:**

This scenario is difficult for providers. When this happens providers need to consider taking the following actions:

1. “Even though you have said that you have not experienced any type of violence, you seem (describe patient’s affect that increases the index of suspicion). Is there anything else that you can tell me that might explain your being uncomfortable with these questions?”
2. Contact individuals designated by Pike Community Hospital’s Domestic Violence Policy and Procedure to further assess the patient. This is located in your department’s policy and procedure manual.
3. “If you are ever abused, please come back to the hospital or contact the Pike County Partnership Against Domestic Violence at (740) 947-1611.”

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<sup>31</sup> *The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care*. Ohio Domestic Violence Network. 2003.

4. Let patient know that experts and help are available.
5. Discuss possible repercussions if his or her partner finds the card.
6. Do not write any domestic violence referral on discharge papers that will be taken home with the patient.
7. If patient has obvious or suspected abuse but cannot communicate to acknowledge abuse (i.e. unconscious or impaired), schedule a follow-up appointment or initiate appropriate social work consult to ensure follow up.

**If Abuse Is Acknowledged But Patient Refuses Further Intervention:**

Sometimes a patient will acknowledge that s/he is being abused, but feel that this is not the time to take action.<sup>32</sup> In such cases staff should:

1. Encourage follow-up with the Pike County Partnership Against Domestic Violence.
2. If in potential need of shelter, encourage patient to contact local domestic violence shelter. Access to the shelter is obtained through the Pike County Partnership Against Domestic Violence. The agency has crisis workers available in an emergency.
3. Offer the use of the phone for the patient to contact the local domestic violence program. Try to direct patient to a phone in a private location.
4. Advise patient to return to the hospital, physician's office, or make contact if further abuse occurs.
5. Do not write referral numbers on discharge form.
6. Confer with social worker and offer additional appropriate referral information and materials.

*If Abuse is Identified and Patient is cooperative*

1. Validate patient's feelings. Let them know they are not responsible and that abuse occurs in many relationships. Tell them they are not alone and that help is available.
2. Express concern for their safety. Providers want to assist victims in identifying the danger present in their life so that they can make informed decisions about their safety.
3. Prior to discharge, providers need to ask the victim if it is safe to go home today. If the victim indicates that it is not safe offer to make a referral, such as a hospital social worker, domestic violence shelter or other community resource per the hospital protocol (such as Scioto Paint Valley Mental Health Center), upon completing your examination. If patient says s/he do not need to leave home today, emphasize that there are ways to increase his or her safety in all situations, whether patient leaves the situation or not. This information is available through Social Services if needed.

## **Expanded Assessment**<sup>33</sup>

Assessment time will vary with the severity of the abuse, the readiness of the patient to discuss it and time available with the provider. Unless the patient is in crisis, the assessment can be conducted

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<sup>32</sup> Some cases staff are mandated to report. For more information on this, please refer to the mandatory reporting section of this self study.

<sup>33</sup> *The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care.* Ohio Domestic Violence Network. 2003.

over time. Expanded health assessments can include assessment of associated health problems and/or expanded assessment of the abuse. If the patient is uncomfortable speaking with the provider about the abuse, the provider should offer or suggest that the victim talk with someone else from the community who is a trained advocate. Expanded assessments can occur in primary care, obstetric/gynecology, mental health settings or in any setting where a trained health care provider, social worker, or advocate can conduct the assessment in private. Often in Pike County these assessments are completed with the assistance of the Domestic Violence Partnership.

### **Expanded Assessment of Related Health Problems**

- Health issues related to domestic violence injuries, chronic pain (neck, back, pelvic, migraines) peptic ulcers, irritable bowel syndrome, sexually transmitted infections (including HIV/AIDS), insomnia, vaginal and urinary tract infections, multiple pregnancies, miscarriages, and abortions
- Substance abuse by the patient, such as tobacco, alcohol, or others
- If attempted strangulation (choking) or head injury occurred and the patient was unconscious, conduct a neurological exam
- Ability to manage other illnesses (such as hypertension, diabetes, asthma, HIV/AIDS)
- Mental health problems such as depression, Post-Traumatic Stress Disorder, anxiety, stress and suicide risk
- If pregnant, pregnancy complications such as miscarriages, low weight gain, anemia, infections, first and second trimester bleeding, and low-birth weight babies
- If forced sex occurred, assess for gynecological problems including Sexually Transmitted Infections (STI), anal/vaginal tearing, sexual dysfunction, and ask about safe sex practices and family planning
- Assess for exposure to dating and sexual violence or forced use of drugs such as MDMA (Ecstasy), GHB (Gamma Hydroxybutyric acid) etc.
- Encourage and help facilitate preventive health behaviors, such as regular mammography, pap smears, early pre-natal care, etc.

### **Questions About the Batterer**

- Does the batterer use illicit drugs and/or alcohol? How much? How often?
- Does the batterer increase his/her violent behavior when under the influence?
- Does the batterer have any mental health problems?
- Does the batterer's violent behavior extend outside of the home?

### **Suicide and Homicide Assessment Questions**

In addition to the initial danger assessment the following questions assess the risk for victim's homicidal and suicidal ideation:

#### *Risk of Suicide by Victim*

- Have you ever felt so bad that you didn't want to go on living?
- Have you ever attempted or thought about suicide in the past?
- Are you thinking about killing yourself? Do you have a plan?
- Do you feel this way now?

*Risk of Homicidal Thought by the Victim*

- How do you perceive your options for safety?
- Have you ever attempted or thought about seriously harming your partner?
- Have you thought about how you would do it? Do you have a plan?
- Do you have access to a weapon?
- Assess if the patient is expressing anger or a genuine intent to kill.

If there is significant risk of suicide or homicidal ideation the patient should be kept safe until an emergency psychiatric evaluation can be obtained. Immediate, explicit threats of homicide must be reported to local law enforcement.

**Expanded Assessment of the History and Extent of the Abuse**

- Discussion of childhood history of abuse in family of origin
- Discussion about whether abuser is limiting access to friends, family, or coworkers
- Assessment of supports in place including friends, family, community, church, etc.
- Discussion of separation, divorce, or seeking shelter
- Assessment of how the victim's community responds to abuse, marriage, divorce, health and healing, and how the victim responds to cultural expectations
- Assessment of how the abuse has affected the children (physically, emotionally, etc.)
- Assessment of how abuse is affecting their life, work, school, and relationships

**Safety Planning**<sup>34</sup>

The next critical step in the process is the development of the safety plan. Safety plans can be developed by health care providers or support staff, social workers, and/or advocates depending on hospital protocol and resource availability. A very basic plan may be helpful depending upon the individual and their specific circumstances. The idea of a safety plan is to determine if it is safe to for the patient to return home or if an alternative location needs to be found. Options may be going to the home of a friend or family member or the domestic violence shelter. A patient should always be provided the opportunity to use a hospital/agency phone to contact the local domestic violence program for more intensive safety planning or shelter services.

**Documentation**<sup>35</sup>

When speaking with prosecutors, law enforcement, child protective services and adult protective services, their concern is that they want to proceed with the investigation of the abuse and press charges; however, there is no evidence of what happened. It is difficult for the investigation and trials to move forward when the only evidence is the victim's story against the abuser's story. Therefore it is crucial for healthcare providers to document their actions and findings accurately and adequately. The following are some guidelines to assist providers with their documentation of domestic violence.

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<sup>34</sup> *The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care*. Ohio Domestic Violence Network. 2003.

<sup>35</sup> *The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care*. Ohio Domestic Violence Network. 2003.

**Written Documentation**

When completing their documentation, providers need to remember to document their findings objectively. Attention should also be given to:

1. Document the results of initial screening.
2. If abuse is denied, but the health care provider suspects abuse, document the suspicions and validate with objective observations that the injuries are inconsistent with patient explanation.
3. Note patient's general demeanor.
4. Include with the narrative a body map documenting designated areas of injury.
5. Describe detailed positive and negative findings from physical assessment and interview.
6. Use as many patient quotes as possible. Use terms such as "stated" and "said."
7. Follow hospital protocol or practice guidelines for photographing injuries (see photo documentation section below).
8. Include documentation of safety plan, specific referrals and plans made.
9. Document contacts with social work, police, and other resources that were initiated during the patient care interaction.
10. Describe discharge plans (patient's plans for safety after leaving health care site).

**Photo documentation**

Photo documentation policies vary from facility to facility. If working in institutions other than Pike Community Hospital, providers should consult agency-specific procedures.

1. With the patient's permission, a physician, nurse, or other appropriate professional may take photos of any visible injury.
  - a. Consent for photos should be obtained according to hospital policy. At Pike Community Hospital, consent in the Emergency Room was obtained when a patient consented to treatment. If the patient is admitted, there is a photo consent form located in the applicable patient-care areas.
  - b. Instant photography (Polaroid) or digital photography can be used. However, some jurisdictions have a preference for criminal justice purposes. Area prosecutors should be consulted as to which type of photography they prefer, if possible. Ultimately, any photo taken is preferable to an absence of photographs.
2. Each health care system should develop a protocol for storage and retrieval of photos in accordance with the Ohio Revised Code and after consultation with local prosecutors and hospital risk management.
  - a. The primary purpose of photos is to visually document assault injury for use in criminal and civil proceedings. Copies of the photos should be available to patients in the same way that their medical records are available. All others seeking copies of the photos should present a subpoena to the hospital system for said photos.
  - b. A permanent log of photos should be maintained. When releasing photos to a patient or individual presenting a subpoena, that person must sign for the photos. The signature of the person releasing the photos should also be obtained, along with the date and time of the release.
  - c. Photos should be stored in the hospital system for a minimum of three years. Hospitals should discuss length of storage with area prosecutors. At Pike Community Hospital, photos are a part of the patient's medical record.

3. Photos should be taken noting the following on the back of the photo or attached document: date, location, patient name, patient record number, photographer's name, and part of body photographed.
4. Multiple photos should be taken of injuries to provide detail of the mechanism of injury and scope of the injury. A full facial photo must be taken for identification purposes.
  - a. If the patient requests copies of the photos, a second set can be taken. The patient should be advised to store the photos in a safe place (i.e. a relative's home). Otherwise, advise patients how they can obtain copies of their photos from the hospital system prior to discharge.

### **Discharge Checklist for Health Care Providers**<sup>36</sup>

Before a patient leaves Pike Community Hospital, providers should go through the following checklist to make sure the provider covered everything necessary with the patient. This is important as the provider may not get another opportunity to assist and advocate for the patient. As discussed earlier, assessing for domestic violence can potentially help save someone's life.

- Did you screen the patient for domestic violence?
- Did you screen the patient for sexual assault?
- Did the patient identify who assaulted them (husband, boyfriend, child, family member)?
- Did the patient describe in detail how they received their injuries?
- Did you document in detail, the patient's words about how the injuries occurred and who did it?
- Did you document on a body map where the injury was observed?
- Did you take multiple photographs, including a full head and body shot and the injury from different angles?
- Did you get the patient's consent to take the photographs?
- Did you offer the patient information about community resources, including the local domestic violence program?
- Did you ask the patient about safety concerns and plan accordingly?
- Did you document your suspicions about a patient's injuries whether or not they disclosed the abuse?
- Did you talk to the patient about follow-up procedures?

### **Mandated reporting**

When working in healthcare and encountering a domestic violence situation, most providers ask the same question: "Do I report this?" The answer is not always clear as it depends on the age of the victim and the circumstances involved. The section will help to clarify this.

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<sup>36</sup> *The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care.* Ohio Domestic Violence Network, 2003.

**What is reportable and what is not?<sup>37</sup>**

The Ohio Revised Code (ORC section 2921.22) requires that health care providers who suspect or identify that a patient is abused must document or write that assessment in the patient's medical record. Patients who identify that they have been abused can use the information recorded in the medical record at a later time for civil or criminal remedies.

Only the abused patient can assess the danger and relative risk of reporting versus nonreporting. Health care providers are not required to report abuse to police or other legal authorities *unless* the patient presents with injuries related to gunshot wounds, stabbings, second degree burns, serious injury and child or elder abuse (see ORC definitions in Appendix 3). Ohio does not have an explicit law requiring healthcare providers to report suspected instances of domestic violence beyond the definition of child and elder abuse. Child abuse is an act of violence (as outlined in Appendix 2) against a child under 18-years-old. Also reportable are individuals who have mental retardation or a developmental disability. In this case, a report must be made until the individual is 22-years-old. Elder abuse is an act of violence as also described in Appendix 2 against an individual 60-years-old or older. If the presenting injuries do not mandate reporting according to the ORC, health care providers only need to contact law enforcement at the patient's request. In other words, you are mandated to report suspected child and elder abuse to the appropriate authorities.

Reporting agencies in Pike County are:

*Pike County Children Services* – (740) 947-5080

*Pike County Job and Family Services (Adult Protective Services)* – (740) 947-2171

*Pike County Sheriff's Department* – (740) 947-2111

If you are a mandated reporter, it is **your** responsibility to make the report if the abuse or neglect was reported to you or you witnessed the abuse or neglect. Having someone else make the report for you does not provide you with the immunity afforded under Ohio Revised Code. Reporting is confidential, although you are encouraged to provide your name and credentials if making a report. Documentation of the report should be noted in the patient's medical record. The documentation should include staff member making the report, what was reported and to whom the report was given. Providers who are mandated reporters are:

- Physicians, including a hospital intern or resident;
- Dentist;
- Practitioner of a limited branch of medicine as specified in section 4731.15 of the Revised Code;
- Registered nurse;
- Licensed practical nurse; visiting nurse;
- Other health care professionals (such as Physical Therapist or Occupational Therapist);
- Licensed psychologist;
- Licensed school psychologist;
- Speech pathologist or audiologist;

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<sup>37</sup> *The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care*. Ohio Domestic Violence Network. 2003.

- Coroner;
- Person engaged in social work or the practice of professional counseling; or
- a person rendering spiritual treatment through prayer in accordance with the tenets of a well-recognized religion

If you are not a mandated reporter, but become aware of a domestic violence situation or suspect a domestic violence situation you are to inform your supervisor and someone from the above list caring for the patient. Often it is the housekeeper in the room, an aide bringing a patient water or the maintenance worker doing repairs that the patient may pick to confide his or her story. If a patient confides in you, advise patient that there are people who can assist and that you need to connect the patient to these individuals. Once domestic violence is suspected, documentation should appear in the patient's medical record.

### **Conclusion**

Women, men, and children who live with the terror of domestic violence deserve nothing less than our informed interventions to help them not only to survive, but to remain physically safe and spiritually free. Hopefully, this self study will assist you as a provider to be more informed of what our patients in a domestic violence live with day in and day out.

The appendices attached to this self study are meant as tools to further assist you in the assessment and treatment of our patients who face the daily difficulties with living in a domestic violence situation. Suggestions for way to improve our policies or additional content to be covered in this self study are appreciated.

Questions regarding this self study may be directed to the Social Services Department, ext. 389.

## **References**

Davis, D. (2000). Cycle of violence. ETR Associates. Brochure.

Davis, D. (2000). Domestic violence how to help. ETR Associates. Brochure.

National Coalition Against Domestic Violence (July 2007). Domestic violence facts.  
[www.ncadv.org](http://www.ncadv.org)

National Coalition Against Domestic Violence (July 2007). Health care and domestic violence.  
[www.ncadv.org](http://www.ncadv.org)

National Coalition Against Domestic Violence (2007). Domestic violence facts: Ohio.  
[www.ncadv.org](http://www.ncadv.org)

National Coalition Against Domestic Violence (August 2007). Rural victims of violence.  
[www.ncadv.org](http://www.ncadv.org)

Ohio Domestic Violence Network. Criminal Law and Domestic Violence. Brochure.

Ohio Domestic Violence Network (2003). The Ohio domestic violence protocol for health care providers: standards of care. Ohio Domestic Violence Network and the National Health Care Standards Committee, Ohio Chapter.

Ohio Revised Code 2151.421. Mandated Reporter Law. Taken from Warren County Ohio Children Services website.

## Appendix 1:

# Domestic Violence Protocol Summary

### Purpose

The purpose of the Ohio Domestic Violence Network's DV protocol is to provide standards of care for health care providers and agencies to address the needs of patient's seeking health care who are victims of domestic violence. The essential components of the protocol include:

### Prepare

- Understand the physical, emotional, and financial impact of domestic violence.
- Be familiar with documenting and reporting guidelines for abuse in the Ohio Revised Code 2321.22 (Appendix 3)
- Set the stage – Use environmental prompts that indicate your interest in domestic violence. Wear pins that say “You can talk to me about family violence.” Put posters in your office and in women's bathrooms about domestic violence and local resources. Leave safety cards with resource information and phone numbers in examination rooms and in women's bathrooms.

### Screen

- Patients frequently do not present with obvious signs of domestic violence, therefore universal screening should be implemented. Specific guidelines for screening are included in detail in the protocol. Patients should be screened at every emergency room visit, during initial visits and annual physicals, each hospital admission or screening and once each trimester during pregnancy.
- Ask privately – Do not ask when anyone else is in the room, including parents, partners, children over the age of 2, friends, or family members.
- Be honest – Describe why you are asking about domestic violence and what you will be doing with the information. Inform patients about state laws regarding reporting domestic violence and child abuse. Patients need to know what you will and will not report.
- Ask general non-threatening questions to introduce the screen: “Do you feel safe in your relationship? How does your partner treat you?”
- Ask about physical abuse “Have you been hit, slapped, kicked, or otherwise physically hurt by anyone?” “Who?” Remember to ask about additional perpetrators with teens – “Who else?” Ask about emotional abuse “Are you afraid of anyone?” or “Has anyone put you down or humiliated you? Ask about forced sex. “Has anyone forced you into having sex with them or becoming intimate with them against your will?” Remember that the perpetrator might be heterosexual or homosexual.

### Assess

- If you receive a positive response ask more questions about their domestic violence history and their health status.
- Ask how they cope or keep safe from violence. Listen for instances of use of substances, unsafe coping measures, and isolating strategies. Are there children in the household at risk for harm?
- Evaluate the victim's safety: fear of the abuser, use of alcohol /drugs, threats with weapons, increasing threats of severity of abuse, harm to children or pets, threats of suicide or homicide. If any of these are positive, then discuss your concern about patients' safety and encourage them to seek help.

**Intervene**

- Tell the patient that no one deserves to be hurt or put down.
- Affirm that it is hard to talk about abuse.
- Tell patients that they are not alone and that help is available.
- Reassure patients about confidentiality issues. Tell them that you will not reveal information about their violence experiences with their families or perpetrators. Keep the chart and abuse documentation in a secure area isolated from visitors. Tell patients that you will treat their perpetrators like any other family member so that you will not jeopardize their safety.
- Help patients to identify trusted individuals that they can approach for assistance.
- Discuss the importance of a safety plan. Help them to develop a plan or have them call the domestic violence crisis or hot line number from your agency to assist them with this.
- Provide information about community agencies.
- Ask them if they need additional help in any way to complete their safety plan
- Tell them that they can contact the hospital, clinic, or doctor's office for assistance between visits. Schedule a follow-up appointment.

**Document**

- Include information in the medical record with as many direct quotes as possible from the patient. Use a body map and photographs if there are bruises or scars present. Describe specific information about suggested resources and safety planning discussed during the interaction. Record the safety plan and referrals given to the woman.

**Evaluate**

- Ask about how things are going with the relationship at follow-up visits.
- Patients may choose to never leave or live with the abuse for awhile before choosing to leave the relationship. Continue to show the patient how the stress of the abusive relationship affects health.
- Celebrate each step taken as a step toward keeping safe.

Adapted from the ODVN Domestic Violence Protocol (2003) and Renker PR, (2003).

## Appendix 2:

# What is Abuse?

**DEFINITION**—Abuse is a pattern of physically and emotionally violent and coercive behaviors that one person uses to exercise power and control over another. Abusers may use verbal insults, emotional abuse, financial deprivation, threats, and/or sexual and physical violence as a way to dominate their partners and get their way. Here are some examples of abusive behaviors:

### VERBAL ABUSE

- yelling
- name calling
- threatening to hurt or kill
- degrading women in general
- criticizing appearance
- belittling accomplishments
- constant blaming

### EMOTIONAL MANIPULATION

- apologizing and making false promises to end the abuse; offering false hope
- isolating from others
- abusing pets
- ignoring, withholding affection
- neglecting physical or emotional needs
- ridiculing, criticizing, blaming
- accusing of affairs
- monitoring conversations
- making account for time
- criticizing friends, family
- constant phone calls/pages
- embarrassing in front of others
- undermining authority with children

### FINANCIAL/RESOURCE ABUSE

- taking or breaking phone
- controlling money/bank accounts
- withholding financial information
- making victim account for expenditures
- withholding child support
- destroying property
- taking or disabling car
- taking keys/purse
- running up debts

- sabotaging work or school
- quitting or losing jobs

### SEXUAL ABUSE

- constant sexual demands
- forcing unwanted sexual acts
- committing rape or incest
- forcing sadistic sexual acts
- treating others as sex objects
- calling fat, ugly, no good in bed
- wanting sex after abuse
- forcing to have sex with others
- forcing pregnancy or abortion
- making demeaning sexual remarks
- forcing family members to see
- pornographic materials
- insisting on unwanted and uncomfortable touching

### PHYSICAL ABUSE

- holding down
- hair pulling
- poking, grabbing
- pushing, shoving
- locking in or out of house
- subjecting to reckless driving
- burning
- throwing or hitting with objects
- using a knife or gun
- kicking
- biting
- hitting, slapping
- choking, strangling
- refusing to help when sick or injured

## Appendix 3:

# Ohio Domestic Violence Law

### **Failure to Report a Crime: ORC 2921.22**

A) No person, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authorities.

B) No physician, limited practitioner, nurse, or person giving aid to a sick or injured person, shall negligently fail to report to law enforcement authorities any gunshot or stab wound treated or observed by him, any serious harm to persons that he knows or has reasonable cause to believe resulted from an offense of violence, any second or third degree burn that was inflicted by an explosion or other incendiary device, or any burn that shows evidence of having been inflicted in a violent, malicious, or criminal manner.

E) (1) As used in this division, “burn injury” means any of the following:

- (a) Second or third degree burns;
- (b) Any burns to the upper respiratory tract or laryngeal edema due to the inhalation of superheated air;
- (c) Any burn injury or wound that may result in death;

(5) Anyone participating in the making of reports under division (E) of this section or anyone participating in a judicial proceeding resulting from the reports is immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of such actions. Notwithstanding, the physician-patient relationship is not a ground for excluding evidence regarding a section 4731.22 of the Revised Code person’s burn injury or the cause of the burn injury in any judicial proceeding resulting from a report submitted under division (E) of this section.

F) (1) Any doctor of medicine or osteopathic medicine, hospital intern or resident, registered or licensed practical nurse, psychologist, social worker, independent social worker, social work assistant, professional clinical counselor, or professional counselor who knows or has reasonable cause to believe that a patient or client has been the victim of domestic violence, as defined in section 3113.31 of the Revised Code, shall note that knowledge or belief and the basis for it in the patient’s or client’s records.

(2) Notwithstanding section 4731.22 of the Revised Code, the doctor-patient privilege shall not be a ground for excluding any information regarding the report containing the knowledge or belief noted under division (F)(1) of this section, and the information may be admitted as evidence in accordance with the Rules of Evidence.

### Appendix 3: Continued

#### Ohio Domestic Violence Law: ORC 2901.01

A) “Serious physical harm to persons” means any of the following:

- (1) Any mental illness or condition of such gravity as would normally require hospitalization or prolonged psychiatric treatment;
- (2) Any physical harm which carries a substantial risk of death;
- (3) Any physical harm which involves some permanent incapacity, whether partial or total, or which involves some temporary, substantial incapacity;
- (4) Any physical harm which involves some permanent disfigurement, or which involves some temporary, serious disfigurement;
- (5) Any physical harm which involves acute pain of such duration as to result in substantial suffering, or which involves any degree of prolonged or intractable pain.

#### Domestic Violence: 2919.25

A) No person shall knowingly cause or attempt to cause physical harm to a family or household member.

B) No person shall recklessly cause serious physical harm to a family or household member.

C) No person, by threat of force, shall knowingly cause a family or household member to believe that the offender will cause imminent physical harm to the family or household member.

#### Domestic Violence Training & Protocol Requirements: 3727.08

- Health care professionals who have reasonable grounds to believe a patient has been a victim of domestic violence shall note that in the patient’s record.
- Requires every hospital to adopt protocols for conducting interviews and creating a photographic record of injuries-when there is reasonable cause to believe domestic violence has occurred.
- Conforms Ohio definition of family members to include domestic violence committed by a person with whom the victim shares a child in common.