Evaluation of the WomanKind Program: Support Systems for Battered Women

Executive Summary Report

on behalf of the

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

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MACRO INTERNATIONAL INC.

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The Macro International Study Team is pleased to have played a part in assessing strategies for improving the responsiveness of health care providers to individuals victimized by intimate partner violence. It is our sincere hope that this report provides valuable insight and guidance to hospitals and other health care settings seeking to provide better services to such patients or clients.

The core project team brought an extraordinary level of commitment and dedication to the study. Nicole Lezin, as original project manager, contributed the vision to create the basic evaluation framework and an unerring commitment to conducting research in a manner that is sensitive to the needs and concerns of the study population. Erika Reed has done a masterful job of managing a very complex database and went far beyond this to contribute conceptual and practical insight that strengthened the project overall and particularly this final report. Eric Zook played a critical role in designing the study, developing the evaluation instruments, and providing guidance for the data analysis. Qinghong Liao joined the project mid-way and immediately proved invaluable for her expertise and competence in data analysis and interpretation.

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Evaluation of the WomanKind Program

Executive Summary

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Executive Summary

I. Background

Each year, the prevalence of all types of violence in our society continues to climb past already unacceptable levels. For millions of women, this escalation of violence strikes not only close to but literally within their homes. The terms "domestic violence", "domestic abuse", and "intimatepartner violence" are generally used interchangeably to refer to physical, sexual or psychological abuse by partners (boyfriends, husbands, estranged husbands, ex-husbands, and ex-boyfriends). Numerous studies have documented the prevalence of such violence as a public health problem and the statistics are startling:

- A woman is beaten every 12 seconds in the United States. More than 2 million women a year are severely beaten in their homes.'
- One in every eight women has, by the age of eighteen, been physically abused by a boyfriend. Half of all couples have had at least one violent incident.[2]
- Women age 12 or older annually sustained almost 5 million violent victimizations in 1992 and 1993. About three-quarters of all lone-offender violence against women and 45 percent of violence involving multiple-offenders was perpetrated by offenders whom the victim knew.[2]
- In 29 percent of all violence against women by a lone perpetrator, the perpetrator was an intimate (husband, ex-husband, boyfriend or ex-boyfriend).[3]
- Women were about six times more likely than men to experience violence committed by an intimate partner.[3]
- Female victims of violence by an intimate partner were more often injured by the violence than females victimized by a stranger. If the attacker was an intimate partner rather than a stranger, injured women were also more likely to receive medical care and require hospitalization.[3]

To address this very serious public health issue, a variety of medical organizations and individuals have called for health care providers to take an active, vigorous role in identifying this recurrent problem. Nevertheless, domestic abuse remains largely under-detected in the health care

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[1] U.S. Department of Justice Report to the Nation on Crime and Justice: The Data, Washington, D.C., October 1983.

[2] Bachman R and Saltzman L. Violence Against Women: Estimates from the Redesigned Survey. U.S. Department of Justice Programs, Bureau of Justice Statistics, Washington, D.C., August 1995.

settings.[3,4,5,6] More than one million women seek medical assistance for injuries caused by battering each year and approximately 35 percent of women visiting hospital emergency rooms are there because of injuries sustained as a result of domestic violence.[7] Despite the fact that they seek health care frequently, as few as one in 20 abused women are correctly identified by the health care professionals with whom they interact.[4]

Taken together, these facts make a compelling argument for early intervention by medical professionals. Through intervention in healthcare settings, victims can receive needed support in protecting themselves and reducing or eliminating the violence in their lives. An objective of the Public Health Service's *Healthy People 2000* is for at least 90 percent of hospital emergency departments to have protocols for routinely identifying, treating, and referring victims of sexual assault and spouse abuse. The Joint Commission on Accreditation on Healthcare Organizations (JCAHO) has also required that accredited emergency departments have policies, procedures, and education in place to guide staff in the treatment of battered adults.[8] In addition, currently seven states require physicians to report criminal activity such as family and intimate partner violence to law enforcement authorities. Clearly there is a great need for and interest in improving the response of health care providers to victims of abuse.

Regardless of the growing recognition of intimate partner violence as a significant health problem, hospital and clinic staff operate under stringent time demands, and by necessity and training focus on the physical care and treatment of their patients. Further complicating this scenario is the social awkwardness of broaching such an emotionally turbulent subject with patients. Health care providers aren't sure what questions are appropriate to ask, aren't clear about what clues to look for, and are reluctant to ask about abuse when they have nothing to offer a woman who acknowledges that this is happening to her. This observation is important not for purposes of castigating hospital staff, but rather to acknowledge the complicated psychosocial components of intimate violence, which require differential expertise and greater commitments of time than standard medical treatment.

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3 Novello AC, Rosenberg M, Saltzrnan L, Shosky J. A Medical Response to Domestic Violence. JAMA 1992; 267:3132.

4 Stark E, Flitcraft A, Zuckerman D, et al. Wife Abuse in the Medical Setting: an Introduction for Health Personnel. Washington (DC): Office of Domestic Violence, 198 1. Monograph No.7.

5 McLeer SV, Anwar RAH. A Study of Battered Women Presenting in an Emergency Department. Am J Public Health 1989; 79:65-6.

6 Warshaw C. Limitations of the Medical Model in the Care of Battered Women. Gender Soc 1989; 3:506.

7 American Bar Association. Report from the Commission on Domestic Violence. 1995.

8 Scott C. and Matricciani R. Joint Commission on Accreditation of Healthcare Organizations Standards, to Improve Care for Victims of Abuse. Maryland Medical Journal, October 1994.

In recognition of this complexity, recent efforts to address intimate partner violence have focused on developing an integrated system of health care and social service providers that offers the full complement of requisite responses-early detection, referral and treatment on a more holistic level. In such systems, female victims of violence need no longer settle for being patched up and sent home. Rather, they can find, at least in theory and by design, the psychological care and support that allows them to embark on a process that stops the violence or at least removes them from its path.

II. Purpose of This Evaluation

The purpose of this research was to conduct an assessment of one such integrated program, *WomanKind: Support Systems for Battered Women,* in Minneapolis, Minnesota. Through education and training, WomanKind creates a hospital-based network of physicians, nurses, social workers, and volunteers who work together to identify cases of intimate partner violence and channel them appropriately to existing community services. The WomanKind program strives to increase health care providers' capacity and motivation to identify abuse and initiate a course of action through referral to Woman&d's in-house services.* Woman&d's paid program staff and volunteer advocates then work with these women to evaluate their situations, develop plans for change, facilitate decision making, and mutually identify and access community services as needed.

WomanKind has a focus on providing case management and advocacy services and hospital staff education with the overarching goal of creating system change. Case management/advocacy services are provided by trained volunteer advocates and paid staff. These services include crisis intervention and ongoing assistance. The program emphasized accepting the woman as she is, supporting her choices, and helping her explore her feeling, her options, and the possible consequences of her decisions. WomanKind also offers a weekly self-help support group and serves as a bridge to the community by connecting women to a wide array of services. The hospital staff education component is a flexible professional education program that can be adapted to the needs and demands of various hospital departments and other medical settings. Training can be delivered in l-, 2- or 3-hour sessions, with follow-up sessions as needed and requested. The training covers the basic topics of. scope and prevalence of domestic violence; dynamics, myths and realities, cycle of violence; assessment, identification, and intervention; documentation; WomanKind program and community connections; victim's process of change. From its inception, WomanKind has had a focus and commitment to influencing system change by creating integrated health care systems that can address the issue of domestic abuse in all health care settings. In addition to providing services and education, WomanKind staffhave worked with hospital colleagues to influence policies and protocols throughout the Fairview Health Services system to make assessment and intervention for domestic violence a routine part of every patient's care. The number of referrals to the program has grown from 141 in the first six months of operation at one hospital (June through December, 1986) to over 15,000 in three hospitals by March of 1997.

III. Evaluation Design and Methodology

The overall intent of this evaluation was to determine: 1) the extent to which the WomanKind program increases health care providers' capacity and motivation to identify cases of intimate partner violence and initiate a course of positive change through referral to WomanKind in-house services; and 2) the extent to which the WomanKind program provides assistance to the women referred. In addition to identifying the outcomes associated with the program, we assessed and documented the components of the program and how they are implemented, for purposes of replication and adaptation in other settings. The research questions were developed to examine three aspects of the program: training for volunteers and staff; outcomes for staff and program clients; and process – how the program is implemented and implications for replication.

A longitudinal, quasi-experimental research design was used to collect and compare information from a total of 5 hospitals, all of which are located in the greater Minneapolis, Minnesota area. The experimental sites were the three hospitals in the Fair-view Healthcare Services System where the WomanKind program is in place. Two additional hospitals were selected to participate in the study as comparison sites, based on their similarity to the experimental sites in size and population served. These two hospitals, Ridgeview Medical Center and Abbott Northwestern Hospital, had no formal domestic violence program in place during the study period. To comprehensively assess the WomanKind program, we employed a variety of quantitative and qualitative research methods. The primary source of data was through the collection and analysis of statistical and survey data to measure the knowledge, attitudes, beliefs, and behaviors (KABB) related to domestic violence among hospital staff, volunteer advocates and WomanKind clients. The survey instruments included:

- A 51-item survey for hospital staff which formed seven conceptual domains or scales, including: self-efficacy for identification and interaction; self-efficacy for referral and services; understanding of abusive relationships; sense of responsibility to address domestic violence; self-reported behaviors; preparation; and victim autonomy. These surveys were administered at three different points during the study.

- A 42-item pre- and post-training survey for volunteer advocates which formed six conceptual domains or scales, including: self-efficacy for identification and interaction; self-efficacy for referral and services; hospital staffresponsibility to address domestic violence; hospital staff preparation; victim autonomy; and understanding of abusive relationships.

- A 34-item client survey instrument administered at intake, two weeks following intake, and at 14-week intervals thereafter.

Survey data was augmented by additional information and data collection, including:

- Review of WomanKind program materials;
- Observation of WomanKind program activities i.e., training for hospital staff and volunteer advocates, monthly meetings with volunteer advocates;
- Review and abstraction of medical charts from emergency departments ; and
- Interviews and group discussions with hospital staff, WomanKind volunteer advocates, and WomanKind program staff.

Using a variety of research methods allowed the research team to develop a more in-depth picture of the WomanKind program than would have been achieved otherwise. For example, anchored surveys that measured hospital staff knowledge, attitudes, beliefs and behaviors (KABB) provided aggregate outcome information on the effects of the program, while individual interviews with hospital staff allowed us to further explore, on a more individual level, staff perceptions of their role in addressing domestic violence and their opinions about the value of the program. Taken together, the methods used in this study provide rich insight into an innovative and multi-faceted program.

Data collection activities took place over the course of two years, beginning in January 1995 with the development and pre-testing of instruments and an initial site visit to interview WomanKind program staff and volunteer advocates and hospital staff at all participating hospitals. Data were collected over the next two years through surveys and additional site visits, concluding in March 1997.

Exhibit II-1 presents the core research questions and the research methods for each component of the evaluation.

Exhibit II-1
Components of the Evaluation

Evaluation Component	Research Questions	Research Methods
Training Evaluation	**WomanKind Volunteer Advocates**	**WomanKind Volunteer Advocates**
	What is addressed in the WomanKind training for advocates? How is the training conducted? What contributes to the effectiveness of the training?	Observations of training sessions. Review of training curriculum.
	what are the advocates' perceptions of the value of the training?	Interviews with volunteer advocates.
	How does WomanKind training affect the knowledge, attitudes, beliefs and behaviors of volunteer advocates?	Pre- and post-training KABB surveys.
	Hospital Staff	**Hospital Staff**
	What is addressed in the WomanKind training for staff? How is the training conducted? What contributes to the effectiveness of the training?	Observations of training sessions. Review of training curriculum.
	What are the staff perceptions of the value of the training?	Interviews with hospital staff.
	How does WomanKind training affect the knowledge, attitudes, beliefs and behaviors of hospital staff!	Pre- and post-training KABB surveys.

Exhibit II-I (cont.)
Components of the Evaluation

Evaluation Component	Research Questions	Research Methods
Outcome Evaluation	**Hospital Staff**	**Hospital Staff**
	Are there significant differences in the knowledge, attitudes, beliefs and behaviors of hospitals staff!	KABB surveys, administered 3 times during the course of the evaluation.
	Is there significant change over the time of the study in the knowledge, attitudes, beliefs and behaviors of staff in the experimental hospitals and the comparison hospitals?	KABB surveys, administered 3 times during the course of the evaluation.
	Are there significant differences in the knowledge, attitudes, beliefs and behaviors of staff of the initial WomanKind site and the other two Fairview hospitals?	KABB surveys, administered 3 times during the course of the evaluation.
	What are the perceived effects of the WomanKind program on the hospital system and the hospital staff?	Interviews with medical staff, social workers in the experimental hospitals.
	Is there significant difference in the rate of documentation of definite and suspected cases of abuse in the emergency departments of the experimental and comparison hospitals?	Review of emergency department medical charts.

Exhibit II-I (cont.)
Components of the Evaluation

Evaluation Component	Research Questions	Research Methods
Outcome Evaluation (cont.)	**WomanKind Clients**	**WomanKind Clients**
	How many clients are referred to WomanKind?	WomanKind program statistics.
	How are these clients supported and served by WomanKind?	WomanKind program statistics.
	Are there significant differences in the knowledge, attitudes, beliefs and behaviors of WomanKind clients over time?	KABB survey of clients referred from hospital emergency departments. Administered at intake into WomanKind and again in follow-up telephone interviews.
Process Evaluation	What are the goals and components of the program?	Interviews with WomanKind staff. Review of WomanKind statistics and descriptive materials.
	How are the components of the WomanKind program implemented? What factors need to be considered for replication/adaptation of the program?	Interviews with WomanKind staff. Interviews and focus group discussions with WomanKind staff, volunteer advocates and hospital staff.

IV. Evaluation Findings and Recommendations

A. Volunteer Advocate Trainina

Women who apply to become WomanKind volunteer advocates are required to complete a 30-hour training program before they are accepted. Training is conducted as ten 3-hour sessions held over a two week period. The stated training objectives reflect the expectations and responsibilities of volunteer advocates as presented in the job description and hospital policies. These objectives are clearly linked to the specific topics covered in the training.

This training immerses the potential volunteer in the issue of domestic abuse and provides them with a rich and compelling picture of how pervasive the problem is and how it affects the lives of those who experience it. It is an intense, comprehensive educational program that demands a strong commitment from the volunteer. It is expected that the volunteer advocates will discover things that they didn't know, take a new look at things they thought they knew, begin to deal with their own attitudes and emotions around some very difficult issues, and begin to understand what they will be able to do when working with clients. Findings from the curriculum review, volunteer advocate interviews, and pre- and post-training surveys indicate that:

The training program is well conceived and organized. Care is taken in selecting and preparing speakers to address different topics and WomanKind staff play a significant role in helping the volunteer advocates understand the program and the value of the volunteers. A reference manual that is distributed during the training is very comprehensive and provides volunteer advocates with articles and other materials that will support their work as advocates. Together, the topics presented in the training and the reference manual present a full and comprehensive picture of domestic abuse and reflect the most current practice and research in the field. WomanKind staff continually reviews both the training and the reference manual to determine where changes or updates are needed.

After the training, volunteer advocates demonstrated increased confidence in their abilities to identify and support victims of abuse, their knowledge of services to assist victims, confidence in being able to make appropriate referrals to these services, and understanding of the dynamics of abusive relationships. Scores increased for three out of six conceptual scales: *Self-efficacy for Identification and Interaction; Self-efficacy for Referral and Services; Understanding of Abusive Relationships.*

Volunteer advocates who participated in interviews conducted by the evaluation team were positive about the training experience and believed that it was helpful to them in understanding the issue of domestic abuse and how they could work with clients.

Specifically, they mentioned that it helped them understand why women stay in abusive relationships, made them aware that they had accepted some of the myths about domestic abuse, and increased their sensitivity to the woman's overall process.

Perhaps the best endorsement for the advocate training program is the perception of the hospital staff in the Fair-view hospitals. In interviews with the evaluation team, hospital staff repeatedly described the volunteer advocates of the WomanKind program as professional and *well-trained*. Obviously this contributes to the overall effectiveness of the program as the hospital staff have the confidence to refer patients to the program.

B. Hospital Staff Training

Formal training provided to hospital staff is a fundamental component of the WomanKind program and is linked to the goal of improving the health care providers' responses to victims of domestic violence. Our assessment of the training suggest that even brief (1 to 2 hour) training sessions have an impact on staffs' level of awareness of domestic abuse and their belief that they can do something about it, Key findings are summarized below.

The curriculum is instructionally sound and responds to the identified needs of the targeted audience, i.e., health care providers' need to understand the prevalence and dynamics of domestic abuse and the role they can play in preventing and reducing abuse. It is practical and straightforward in addressing the issue of domestic violence, and learning objectives are clearly linked to the topics addressed in the curriculum. Concrete information is provided that can be used by health care providers as soon as they leave the training. The material presented is firmly grounded in real-life experience and reflects the most up-to-date information and research on domestic violence.

Medical, nursing, and social work staff participants described the training as valuable and enlightening. Several made a point of saying that they were surprised or even shocked by things they learned, such as the prevalence of domestic abuse or that women are often abused during pregnancy. Individuals stated that the training made them more comfortable with the topic, taught them that there were things they could do for patients who are victims or abuse, and helped them understand what the woman is going through.

Many hospital staff have adopted the language of WomanKind, i.e. "understanding the woman's process", "my role is to identify, assess and refer". Many stated that the training had raised their awareness of the problem, they look for it more often since the training.

Comparison of mean KABB scores at baseline and for the third follow up indicated increases on all seven scales, five of which were statistically significant, suggesting that the training is effective in 1) helping staff develop confidence in their ability to recognize and

communicate effectively with victims of domestic abuse and their ability to make appropriate referrals for these individuals, 2) increasing the belief that hospital staff in general have a responsibility to address domestic violence and that they themselves are more likely to ask questions about abuse of their patients and document such information in their charts, 3) increasing the belief that hospital staff have the knowledge, time and training to assist victims of domestic violence.

Staff who had previous exposure to domestic violence issues (through other educational opportunities or personal experience) or who had also participated in WomanKind training prior to this evaluation period, had higher mean scale scores over time than those with no previous exposure. This is consistent with an expectation that someone who has been exposed to information about domestic violence from a number of sources over time, or has personally been affected by it, would have a greater understanding of the problem and stronger beliefs about intervening.

C. Hospital Staff Outcomes

Results indicate that the WomanKind program has a positive effect on the knowledge, attitudes, beliefs, and behaviors ofhospital staff, both in terms oftheir awareness of domestic abuse and their understanding of the role of the health care provider in addressing it. The presence of an in-house referral source, as well as the formal and informal educational opportunities that WomanKind offers to hospital staff, appears to make a difference in how confident staff feel about identifying and interacting and referring patients. Hospital staff at the Fair-view sites where WomanKind operates are enthusiastic about the program, and more importantly, have developed a trust and confidence in the program.

Highlights from the KABB survey and staff interviews include:

Hospital staff in all five hospitals experienced some positive change in their knowledge, attitudes, beliefs and behaviors related to domestic abuse. Total scores on the KABB significantly increased over time and mean scores for each of the scales also increased over time, indicating a level of change in all seven dimensions.

Staff in the hospitals where WomanKind operates are more confident in their ability to identify and communicate with victims of abuse and are more likely to ask questions about abuse or relationships and to record relevant information in patients' charts. Total scores on the KABB surveys were significantly higher for the experimental hospitals than for the comparison hospitals, at all time intervals during the study. In addition, significant between-group effects, showing higher mean scores for the experimental hospitals, were found on four scales: self-efficacy for identification and interaction; self-reported behaviors; staff preparation; and victim autonomy.

The degree of institutionalization of the WomanKind program (i.e., the length of time in operation) has a positive effect on staff KABB. Staff at Fair-view Southdale, where the WomanKind program was originated, were more knowledgeable and positive about the role they play in addressing domestic violence than staff in the other hospitals.

Staff who had previous exposure to issues of domestic violence (prior to their exposure to WomanKind) were made aware of the dynamics of abuse and the role that health care providers can play in addressing it. Staff who had attended training seminars, worked as volunteers in a domestic violence program, or had personal experience with domestic violence had higher KABB scores than other staff on all seven scales.

Staff at the Fairview hospitals have an overwhelmingly positive perception of **the WomanKind program. In** conversations with over 70 staff across these three hospitals, all stated that they were comfortable referring patients to the program, and were confident that if they called WomanKind for help they would receive a dependable, quick, and competent response. Most staff indicated that their interactions with patients have improved, and that they and their colleagues are more sensitive, empathetic, and willing to listen. They stated that they were more aware of domestic violence and more comfortable asking questions about it. A number of staff commented on the fact that the WomanKind program appeared to be everywhere, that it was "entrenched" in their departments and that everyone was aware of the program. Some comments underscored a central theme of the program as hospital staff described that they were more likely to ask a question about abuse since they had somewhere to refer the patient if needed.

D. Client Outcomes

Program statistics and records clearly indicate that WomanKind is recognized and used throughout the Fair-view Hospitals -- client referrals come from all departments, particularly chemical health and emergency. Statistics also show that WomanKind does in fact provide more than crisis intervention services to clients, as evidenced by a large number of both client initiated and WomanKind initiated follow-up calls. Finally, program records also show that WomanKind consistently uses a range of community services as referral sources for clients, reinforcing a basic tenet of the program which is to link with the community and not to create duplicate services.

WomanKind's impact on a client starts as soon as contact is made. The client is made to feel that someone is there for her, to listen to her and assist her as needed. As WomanKind staff and volunteer advocates work with a woman to evaluate her situation and begin to make decisions, an important step is the development of a safety or protection plan. Data collected from clients that participated in the study indicate that this works even in a crisis situation.

Executive Summary

In reviewing program records for the entire year of 1996, we discovered the following:

- Almost 20% of the total referrals to the WomanKind program came from the chemical dependency units in the hospitals, followed by the emergency departments (15%), and mental health units (12%).

- The WomanKind program made a total of 2832 contacts with clients in 1996. This includes initial contacts (46%), client initiated repeat calls (20%), and WomanKind initiated follow-up calls (35%). This is a clear illustration that WomanKind services extend beyond crisis intervention into on-going case management and advocacy.

- WomanKind made a total of 2062 referrals to community services in 1996. The referrals made most often were to support groups (WomanKind support groups and others in the community), mental/chemical health services, and shelters. Other referrals included: legal services/law enforcement; county social services; and other services including Al-Anon, food banks, Alcoholics Anonymous.

- Ninety-seven percent of WomanKind clients in 1996 were women. Eighty-four percent were Caucasian, and sixty percent were between the ages of 20 and 39. These statistics were relatively similar across hospitals with one notable exception: clients at the Fair-view University Hospital -- Riverside Campus were more ethnically diverse, with fourteen percent being African American, and seven percent Native American, reflecting the communities served by these hospitals.

A total of 52 clients agreed to participate in the study by completing KABB surveys, beginning with an initial "intake survey" that was administered during the first contact with WomanKind. A follow up survey was administered (typically by phone) approximately one week after the intake survey and subsequent surveys were administered at 14-week intervals thereafter. Unfortunately, many clients could not be contacted or were not in a position to respond to a survey during the follow-up and subsequent surveys so we effectively lost the ability to track a clients process over time. However, we did gain a better understanding of how the women perceived their situations at the time of the initial contact. In general, these findings included:

- Clients generally believed in their ability to leave their abusive relationships
- Clients believed that their children were aware of the violence in their relationship
- Clients believed that they had somewhere to turn for help
- Clients did not believe that it was their fault when their partner acts violently toward them
- Clients did not believe that they could change their partner for the better
- Clients characterized themselves as often feeling lonely, isolated, and hopeless
- Clients believed that their partners would hurt them again

In addition to asking about the items above, clients were asked to describe a protection plan for themselves. This is a cornerstone of the WomanKind program -- advocates work with each client to develop (and revise over time) a plan for her safety. The fact that 43 out of 52 clients were able to articulate at least one item for a protection plan at the time of the intake survey seems to indicate that advocates are having some success in assisting clients to evaluate her situation and make decisions about how to protect herself. The most often cited items on a protection plan were "obtain an order of protection" and "move away".

E. Documentation in Medical Records

At four points during the evaluation, we reviewed the medical charts of women who presented to the emergency departments of the study hospitals with symptoms or injuries that could be related to domestic violence. Our intent waste determine if there was a difference between the experimental and comparison hospitals in how these cases were documented.

Our findings show evidence that there is a difference in documentation as follows:

- The rate of documentation of definite cases of domestic was consistently higher at the experimental hospitals, suggesting that emergency department are more likely to record information about definite abuse.

- Documentation in the records suggest that emergency department staff in the experimental hospitals ask about domestic violence about twice as often, though this difference was not evaluated to be statistically significantly overall.

F. Process Evaluation Findings and Implications for Replication

Perhaps the strongest aspect of the WomanKind program is that it offers both education and consultation to hospital staff and case management and advocacy services to victims of abuse. Educating medical, nursing and social work staff about the prevalence and dynamics of domestic abuse, and about the role they can play in identifying, intervening, and preventing such abuse would likely not have the same impact without an in-house, convenient and trusted referral service available. Similarly, focusing only on providing services to clients misses the opportunity to enhance health care providers abilities to recognize women who need such services. Critical to the WomanKind is its strong theoretical and professional base, grounded in the current literature and research on domestic violence and standard social work practice. Every aspect of the program is well thought out and reflective of a deep understanding of the dynamics of intimate partner violence, the barriers facing medical staff in addressing violence and abuse, and the intricacies of the managed care environment. The program is practical and driven by the belief that individual

change produces policy change which results in system change. The most essential elements of the WomanKind program structure include:

- In-service training and on-going education and consultation for hospital staff
- Case management and advocacy services that extend beyond crisis intervention, and into assisting a client over time to evaluate her situation and to make decisions that will be best for her.
- Case management and advocacy services that are based on a strong theoretical and practical base, drawing from the fields counseling psychology and social work, and from the growing body of literature and research in domestic abuse and the health care response to it.
- A strong, professional program staff..
- A structured and well developed program for recruiting, screening, training, supporting and supervising, and evaluating volunteers.
- Comprehensive program marketing -- including formal and informal marketing activities.
- An understanding that improving the health care response to victims of domestic abuse means changing the health care system through policies, procedures, routine screening, and a multi-disciplinary team approach.

Tho WomanKind program as described in this report is the result of 11 years of growth and evolution. Findings from this evaluation provide strong support for the success of this program model. Although the program model may at first seem too ambitious to a hospital or other health care setting that is just getting started in improving its responsiveness to domestic abuse, many of the program components can be phased in and many of the lessons learned from the WomanKind program can be extracted and adapted for other settings.

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Final Report

on behalf of the

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

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Chapter I

Introduction

Chapter I. Introduction

I. Overview

Health professionals are in a pivotal position to identify injuries or symptoms caused by domestic abuse, in many cases years before the violence has become so extreme that it may drive a victim to a shelter or result in death. The critical timing of this early identification and intervention may not only prevent or reduce further suffering and violence in victims' lives, but may also reduce the devastating physical and emotional consequences on women, children, and families.

Health care providers may be the first and only professionals in a position to recognize violence in their patients' lives.[1] As an innovative model of health care response, WomanKind has pursued the goal of comprehensive health system integration to address the issue of domestic violence. The WomanKind model is based on the assumption that victims of domestic violence will interact with the health care system for both routine and abuse-related health care. Therefore health care providers should be prepared to identify victims of domestic violence, provide appropriate support, and provide referrals to needed services.

Based on this understanding of the important role of the medical community, the National Center for Injury Prevention and Control (NCIPC) of the Centers for Disease Control and Prevention (CDC) has sought to identify effective programs for enhancing health professionals' abilities to identify and attend to the needs of victims of intimate partner violence. WomanKind was selected for evaluation because of its innovative approach to training health professionals in a hospital setting and creating an ongoing, supportive connection between the victim of intimate partner violence in the health care setting and the resources available in the community. The CDC contracted with Macro International Inc. to conduct a comprehensive evaluation of this program. This report presents the results of the evaluation.

II. Background

We are continually confronted with news and images of violence in our society. For millions of women, violence strikes not only close to but literally within their own homes. Consider the following statistics:

- A woman is beaten every 12 seconds in the United States. More than 2 million women a year are severely beaten in their homes.[2]

---

1 Randall T. Hospital-Wide Program Identifies Battered Women; Offers Assistance, *JAMA* 1991; 266: 1177-80.

2 U.S. Department of Justice Report to the Nation on Crime and Justice: The Data, Washington, D.C., October 1983.

- One in every eight women has, by the age of eighteen, been physically abused by a boyfriend. Half of all couples have had at least one violent incident.[2]

- Women age 12 or older annually sustained almost 5 million violent victimizations in 1992 and 1993. About three-quarters of all lone-offender violence against women and 45 percent of violence involving multiple-offenders was perpetrated by offenders whom the victim knew.'

- In 29 percent of all violence against women by a lone perpetrator, the perpetrator was an intimate (husband, ex-husband, boyfriend or ex-boyfriend).[3]

- Women were about six times more likely than men to experience violence committed by an intimate.[3]

- Female victims of violence by an intimate were more often injured by the violence than females victimized by a stranger. If the attacker was an intimate rather than a stranger, injured women were also more likely to receive medical care and require hospitalization.[3]

Numerous studies have documented the prevalence ofdomestic violence* as a public health problem and, in response, a variety of medical organizations and individuals have called for health care providers to take an active, vigorous role in identifying this serious recurrent problem. Nevertheless, domestic abuse remains largely under detected in health care settings.[4,5,6,7] More than one million women seek medical assistance for injuries caused by battering each year and approximately 35 percent of women visiting hospital emergency rooms are there because of injuries sustained as a result of domestic violence.[8] Despite the fact that they seek health care frequently, as few as one in 20 abused women are correctly identified by the health care professionals with whom they interact.[4]

* The terms "domestic violence", "domestic abuse", and "intimate partner violence" will be used interchangeably in this report to refer to physical, sexual or psychological abuse by partners (boyfriends, husbands, estranged husbands, ex-husbands and ex-boyfriends).

3 Bachman R and Saltzman L. Violence Against Women: Estimates from the Redesigned Survey. U.S. Department of Justice Programs, Bureau of Justice Statistics, Washington D.C., August 1995.

4 Novello AC, Rosenberg M, Saltzman L, Shosky J. A Medical Response to Domestic Violence. JAMA 1992; 267:3 132.

5 Stark E, Flitcraft A, Zuckerman D, et al. Wife Abuse in the Medical Setting: an Introduction for Health Personnel. Washington (DC): Office of Domestic Violence, 198 1. Monograph No.7.

6 McLeer SV, Anwar RAH. A Study of Battered Women Presenting in an Emergency Department. Am J Public Health 1989; 79:65-6.

7 Warshaw C. Limitations of the Medical Model in the Care of Battered Women. Gender Soc 1989; 3:506.

8 American Bar Association. Report from the Commission on Domestic Violence. 1995.

Taken together, these facts make a compelling argument for early intervention by medical professionals. Through intervention in healthcare settings, victims can receive needed support in protecting themselves and reducing or eliminating the violence in their lives. An objective of the Public Health Service's *Healthy People 2000* is for at least 90 percent of hospital emergency departments to have protocols for routinely identifying, treating, and referring victims of sexual assault and spouse abuse. The Joint Commission on Accreditation on Healthcare Organizations (JCAHO) has also required that accredited emergency departments have policies, procedures, and education in place to guide staff in the treatment of battered adults.[9] In addition, currently seven states require physicians to report criminal activity such as family and intimate partner violence to law enforcement authorities. Clearly there is a great need for and interest in improving the response of health care providers to victims of abuse.

Regardless of the growing recognition of intimate partner violence as a significant health problem, hospital and clinic staff operate under stringent time demands, and by necessity and training focus on the physical care and treatment of their patients. Further complicating this scenario is the social awkwardness of broaching such an emotionally turbulent subject with patients. Health care providers aren't sure what questions are appropriate to ask, aren't clear about what clues to look for, and are reluctant to ask about abuse when they have nothing to offer a woman who acknowledges that this is happening to her. This observation is important not for purposes of castigating hospital staff, but rather to acknowledge the complicated psychosocial components of intimate violence, which require differential expertise and greater commitments of time than standard medical treatment.

In recognition of this complexity, recent efforts to address intimate partner violence have focused on developing an integrated system of health care and social service providers that offers the full complement of requisite responses-early detection, referral and treatment on a more holistic level. In such systems, female victims of violence need no longer settle for being patched up and sent home. Rather, they can find, at least in theory and by design, the psychological care and support that allows them to embark on a process that stops the violence or at least removes them from its path.

III. Purpose of This Evaluation

The purpose of this research was to conduct an assessment of one such integrated program, *WomanKind: Support Systems for Battered Women,* in Minneapolis, Minnesota. Through education and training, WomanKind creates a hospital-based network of physicians, nurses, social workers, and volunteers who work together to identify cases of intimate partner violence and channel them appropriately to existing community services.

---

[9] Scott C. and Matricciani R. Joint Commission on Accreditation of Healthcare Organizations Standards to Improve Care for Victims of Abuse. Maryland Medical Journal, October 1994.

Chapter I. Introduction

The WomanKind program strives to increase health care providers' capacity and motivation to identify abuse and initiate a course of action through referral to WomanKind's in-house services.* WomanKind's paid program staff and volunteer advocates then work with these women to evaluate her situation, develop a plan for change, facilitate her decision making, and mutually identify and access community services as needed.

The evaluation sought to determine the extent to which these program goals are achieved and to document the design and implementation of the program for purposes of strengthening the existing program and, more importantly, to develop recommendations for replication or adaptation in other medical settings.

This report presents the results of the evaluation. Chapter I provides background information about the evaluation and the WomanKind program, as well as an introduction to the issue of health care response to domestic violence. The evaluation design is presented in Chapter II. Chapter III through VII present the research methods and the findings of each component of the study. Chapter VIII summarizes the findings from the evaluation and the final chapter provides recommendations for strengthening the WomanKind program and for replicating/adapting the program for other health care settings.

IV. The WomanKind Proaram

WomanKind: Support Systems for Battered Women, of Fairview Health Services in Minneapolis, Minnesota, was developed in response to a compelling need to provide crisis intervention, case management/advocacy and ongoing support for victims of abuse who interact with the health system. The program was founded in June 1986 by Susan M. Hadley, MPH, as a private non-profit corporation providing services at Fairview Southdale Hospital. Services were expanded to Fairview Ridges Hospital in November of 1989. Both initial locations are suburban hospitals. In March of 1994, the program was expanded again to Fairview Riverside Medical Center in urban Minneapolis. In July, 1992, WomanKind formally joined Fairview Health Services as a hospital department.

Nationally recognized as an innovative, model program, WomanKind has been profiled in numerous publications including the *Journal of the American Medical Association* (*JAMA*), the *Journal of Emergency Nursing,* and *Women's Health Issues.* Appendix A provides copies of these articles for more in-depth descriptions of the program. The first program of its kind in the United States, WomanKind has been featured on the health care reports of the NBC TODAY Show, Physicians' Journal Update on the Lifetime Channel, and "Today's Breakthroughs, Tomorrow's Cures", a television news documentary featuring current medical problems and innovative solutions.

* Men as well as women are victimized by intimate partner violence. WomanKind accepts referrals of men into the program, then helps them locate appropriate community services. However, cases of intimate partner violence overwhelmingly involve an abused woman; 95 percent of the referrals to WomanKind are women. Therefore, this report will refer to women victimized by abuse and violence.

Chapter I. introduction

Preliminary research by WomanKind found that many victims of abuse are simply never asked about the cause of their injuries or related symptoms when they show up at the hospital or doctor's office. They are most often treated for their medical problems and discharged. The program started with the assumption that health professionals don't intervene because:

> *"I was terrified tha t someone would ask me how I got my injuries. I was just as terrified that no one would ask and I would have to return home without talking to anyone about what was happening to me."*
>
> -WomanKind Client

- they have little or no training to help them recognize the signs of domestic abuse
- they are uncomfortable intervening with a victim of abuse
- they don't see such intervention as their responsibility
- they don't have the time or the resources that would be needed to assist the victim of abuse.

The program addresses these barriers through training for hospital staff, the implementation of universal screening procedures, and an in-house system of paid program staff and volunteer advocates available 24 hours per day, seven days per week to provide immediate and on-going services to victims of abuse.

> *"Domestic abuse offers a perfect situationfir health **care** providers to rediscover the relationship between intervention andprevention. Grounded in the preventive tenets of public health, WomanKind, working through the health care system, is based on the belief that healthcare providers and health care settings are ideally positioned for **early** intervention-potentially preventing years or decades of abuse, injuries, medical and mental health symptoms and the suffering and costs associated with them."*
>
> -Susan M. Hadley, MPH
> Founder of WomanKind

The following pages provide a snapshot of the WomanKind program, beginning with Exhibits I-l and I-2 to illustrate the WomanKind program model. A more comprehensive description to the program appears in chapter VII of this report.

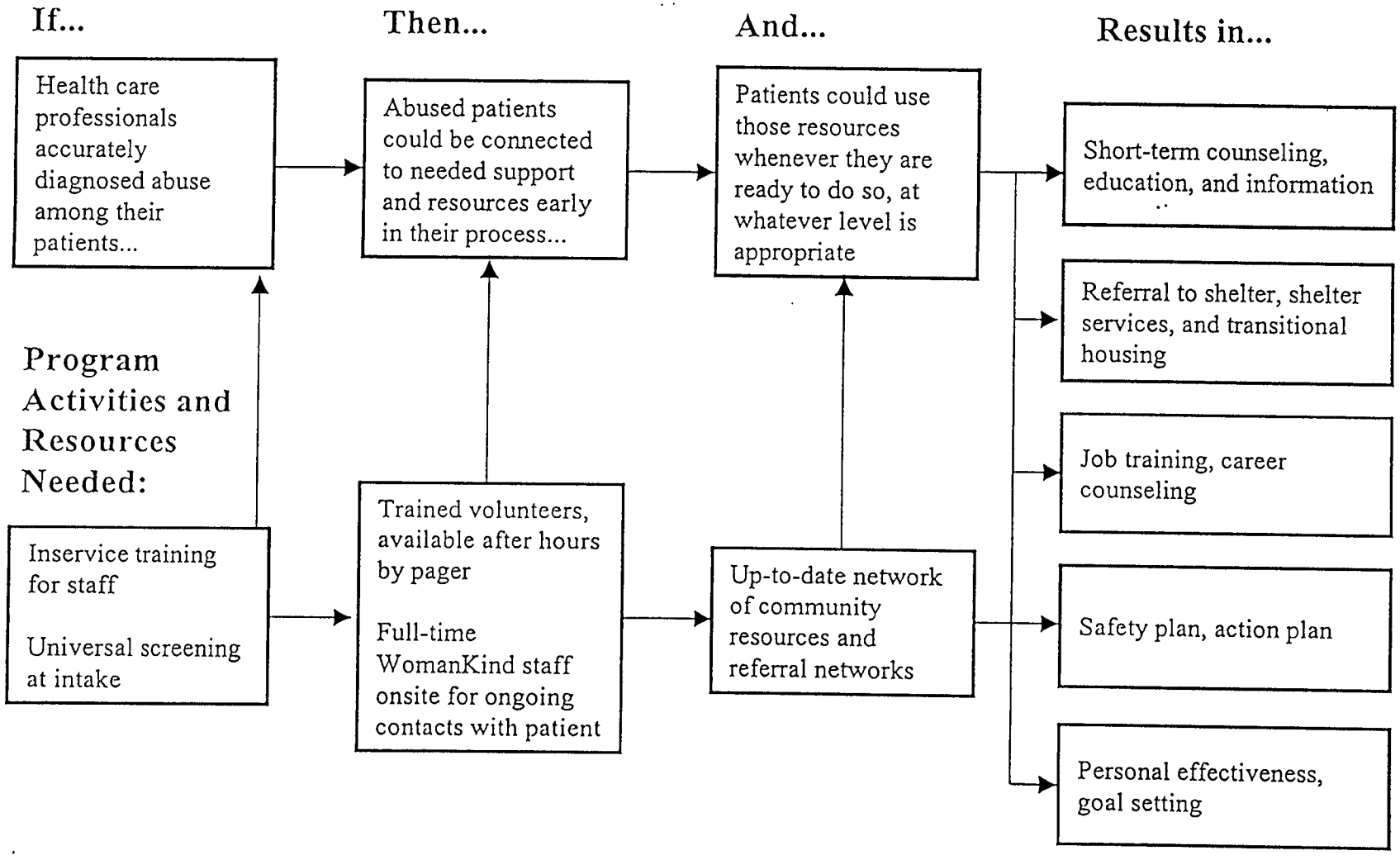
Exhibit l-l
The WomanKind Model

	Health Care Staff	WomanKind Staff	WomanKind Volunteers	Patients
Goals	To increase their awareness and skills to better identify and treat victims of domestic abuse. To improve the health care response to domestic abuse resulting in overall system change.	To coordinate and manage an in-house referral source for victims of domestic abuse, available 24 hours a day, 7 days a week. To provide case management/ advocacy services to victims of domestic violence. To provide on-going education and consultation to health care staff. To provide supervision, management and education to volunteer advocates.	To provide advocacy services to victims of domestic abuse through emergency department and client crisis line after hours, with back-up and support from WomanKind staff.	To assist the abuse victim through her process of change, and refer her to appropriate resources when she is ready.
Philosophy	Routine assessment and identification combined with early intervention may result in prevention of injuries, mental health symptoms and victimization of children.	Partnership with medical staff, providing services in a caring professional manner that inspires trust and respect.	To provide a challenging and rewarding experience for "women helping other women."	Respect for the patient's process, timetable, and decisions in a supportive environment.

Exhibit I-l (cont.)
The WomanKind Model

	Health Care Staff	WomanKind Staff	WomanKind Volunteers	Patients
Principles	Health professionals intervene where: • Domestic abuse can be identified • Support and information can be given • Options and resources can be provided	To implement personal and professional values through program coordination, client services, volunteer program management and health care education.	Implementing personal and professional values through direct service: "Making a difference one person at a time".	Process of change - redefining success: • Rediscovering a sense of self • Building **hope and** reducing isolation • Developing strength and direction • Acknowledging small steps "Hold fast to dreams for if dreams die, life is a broken bird that cannot fly." -From WomanKind brochure, by L. Hughes
Results	Early identification combined with early intervention results in prevention of domestic abuse.			

Exhibit I-2
WomanKind Logic Model



WomanKind Program Goals

- *Understanding early intervention is prevention*

Women who are abused experience a lengthy process of losing a sense of self-worth and then regaining a sense of power and control in their relationships—a process that may take years or even a lifetime. Health care intervention has the potential to occur early in the woman's process and may accelerate her process toward change. This early intervention may ultimately lead to prevention of more serious injuries and medical symptoms, prevention of mental health and psychiatric symptoms, prevention of abuse during pregnancy, and prevention of abuse of children of these women.

> ***"WomanKind's effect on this hospital? National recognition and high quality of care to our patients."***
>
> —Nurse,
> Fairview Southdale Hospital

- *Modifying the traditional medical approach*

Medical providers are trained and expected to solve problems relatively quickly and may be reluctant to address the psychologically complex and protracted problems presented by victims of domestic abuse. They often experience frustration in dealing with a woman who doesn't seem willing to take any immediate overt steps toward safety or change, or who may actually deny the problem. WomanKind helps hospital staff scale back their expectations of what can be accomplished to goals that are more in keeping with a woman's own timetable and individual situation and to recognize that the most valuable assistance they may be able to provide is to let the woman know that the health care setting is a safe place to return when she is ready.

- *Redefining success*

This goal reflects the recognition that the victim of domestic abuse is in a process, and that it is essential to respect this process, her timetable, and her decisions. WomanKind's goals for the victim may include strategies to help her rediscover a sense of self, build hope, reduce isolation, develop strength and direction, and acknowledge small steps toward change and safety. It is important for the victim to feel support and safety and, when she is ready, to talk about the violence, evaluate her situation, consider possible options and make necessary decisions. Health care professionals can help most by providing assessment for domestic abuse in a respectful, nonjudgmental manner.

- *Influencing hospital policies and protocols*

  Since the inception of the program, WomanKind staff have worked with hospital colleagues to influence hospital policies and protocols in order to make domestic violence assessment and intervention a routine aspect of patient care. There are now policies in place to ensure that every patient who comes to the Fairview Health Services system is assessed for domestic abuse, child abuse and elder abuse. Acknowledgment of domestic abuse results in an automatic referral to WomanKind. Having policies in place facilitates an improved system response to domestic violence and leads to better, more integrated health care for patients. It also takes the onus off of hospital staff. Instead of singling out particular patients, staff can explain that they ask these questions of all patients.

- *Developing a community connection*

  WomanKind functions as a bridge to help connect clients with community services. In this way the program is able to address the unique needs of individual clients and to enhance the visibility and involvement of the Fairview system in the larger community.

WomanKind Services

Education of Hospital Staff

The WomanKind program provides ongoing education and consultation for hospital staff to help them identify and initiate effective intervention for victims of domestic violence. This education focuses on understanding the dynamics of intimate partner violence and developing the skill and motivation to effectively assess a patient for signs of abuse.

For medical professionals who are trained to "cure" medical problems, working with a woman who may not be ready to get out of an abusive relationship or who is reluctant to acknowledge that it is occurring can be very frustrating. Part of WomanKind's training is geared toward sensitizing hospital staff to the "process" that battered women go through, and recognizing the need to respect the patient's own timeline for taking small steps toward making decisions in her life.

Although WomanKind services were initially offered only in the original hospital's emergency department, the program now has hospital and system wide impact, with referrals coming from the perinatal department, medical/surgical and intensive care units, the chemical dependency and mental health units, and employee health service at all three sites. This is the result of WomanKind's total educational effort directed at hospital staff, which includes:

- In-service training sessions directed to physicians, nurses, social workers, and pastoral counselors;

- Brochures and flyers available and posted in the hospital;
- The visibility of WomanKind program staff and volunteer advocates and their willingness to consult with medical staff;
- The participation of WomanKind program staff on interdisciplinary case review teams within the hospital.

System Change

WomanKind has a focus on creating system change as well as providing service and education. From its inception, WomanKind has been committed to the concept of an integrated, comprehensive health system that can address the issue of domestic abuse in all health care settings. Over the past decade, WomanKind staff have worked with hospital colleagues to influence policies and protocols throughout the Fairview Health Services, to make assessment and intervention for domestic violence a routine part of every patient's care. This focus was expressed by the following question, often asked of medical staff and administrators by the founder of WomanKind: "If our mission is assessing and treating the total health care needs of our patients, how can we NOT address domestic violence?"

Every patient who comes to one of the hospitals in the Fair-view system is now automatically screened for domestic violence and abuse. Beginning in March of 1995, the following question was added to the standard admission form that nurses use to assess a patient's health history: "Are you now or have you ever been in a relationship where you have been abused physically, emotionally, or sexually?" Patients answering yes are referred to the WomanKind program. This protocol allows health professionals to identify not only those victims of abuse who come to the emergency room but also those who come to the hospital for non-abuse related care such as illness, surgery, or child birth.

The WomanKind program reflects the Fairview Health Services' commitment to community health and to the prevention of domestic violence through early intervention and prevention. Through its support of the program, Fair-view not only institutionalizes direct services for victims of abuse but also the education of physicians, nurses, and other health professionals to help them make the connection between a patient's health problems and the violence that may be the underlying root cause of those problems.

The success of the WomanKind program over the last decade is reflected by the steadily increasing number of referrals to the program each year. Initially, approximately 15-20 women at the first site were referred to the program monthly. That number has increased to an average of 150 per month currently across three sites, with a cumulative total of more than 15,000 women being served since the program's inception,

Case Management/Advocacy

WomanKind provides case management/advocacy services, crisis intervention and ongoing assistance to women who suffer from physical, emotional or sexual abuse by a current/former husband or partner. These services are available 24 hours a day, 7 days a week upon referral from hospital staff. The services are confidential and free of charge.

This component of the program emphasizes accepting the woman as she is, supporting her choices, and helping her explore her feelings, her options, and the possible consequences of her decisions. Trained volunteer advocates provide much of the advocacy services, helping clients assess their situations and to understand the various medical, law-enforcement, legal, and social service options available to them. The volunteer advocates can support WomanKind clients in many ways: by staying with them during medical procedures; offering them a safe place to talk; discussing options; and assisting them in developing a safety plan for their unique situations.

> *"This program doesn't maintain victim mentality—focuses on women's choices, positive aspects of the woman, provides support within her time frame."*
>
> —WomanKind Staff Member

In addition to immediate case management and advocacy services, WomanKind also offers a weekly, confidential self-help support group for women in abusive relationships. The support groups are facilitated by volunteer advocates who receive specialized training and are open to hospital patients and community members.

WomanKind serves as a bridge to the community by connecting women with a wide array of services: emergency shelter; food; clothing; transportation; transitional and/or permanent relocation assistance; civil and criminal court advocacy; mental health services; chemical dependency treatment programs; emergency financial aid programs; job/career counseling programs; and public health agencies to coordinate services. Rather than creating a parallel service system that duplicates efforts, WomanKind helps women to identify and access services in the community that will be most helpful to them, when they are ready.

Chapter II

Evaluation Design

Chapter II. Evaluation Design

I. Overall Study Design

The overall intent of this evaluation was to determine: 1) the extent to which the WomanKind program increases health care providers' capacity and motivation to identify cases of intimate partner violence and initiate a course of positive change through referral to WomanKind in-house services; and 2) the extent to which the WomanKind program provides assistance to the women referred. In addition to identifying the outcomes associated with the program, we assessed and documented the components of the program and how they are implemented, for purposes of replication and adaptation in other settings.

A longitudinal, quasi-experimental research design was used to collect and compare information from the three hospitals where the WomanKind program operates and from two comparison hospitals where there was no formal program to address intimate partner violence. To comprehensively assess the WomanKind program, we employed a variety of quantitative and qualitative research methods, including:

- Collection and analysis of statistical and survey data from medical staff of all participating hospitals, WomanKind volunteer advocates and WomanKind clients;
- Review of WomanKind program materials;
- Observation of WomanKind program activities i.e., training for hospital staff and volunteer advocates, monthly meetings with volunteer advocates;
- Review and abstraction of medical charts from emergency departments of all five hospitals; and
- Conduct of interviews and group discussions with staff of all participating hospitals, WomanKind volunteer advocates, and WomanKind program staff.

Using a variety of research methods allowed the research team to develop a more in-depth picture of the WomanKind program than would have been achieved otherwise. For example, anchored surveys that measured hospital staff knowledge, attitudes, beliefs and behaviors (KABB) provided aggregate outcome information on the effects of the program, while individual interviews with hospital staff allowed us to further explore, on a more individual level, staff perceptions of their role in addressing domestic violence and their opinions about the value of the program. Taken together, the methods used in this study provide rich insight into an innovative and multi-faceted program.

Data collection activities took place over the course of two years, beginning in January 1995 with the development and pre-testing of instruments and an initial site visit to interview WomanKind program staff and volunteer advocates and hospital staff at all participating hospitals. Data were collected over the next two years through surveys and additional site visits, concluding in March 1997.

II. Research Questions

There were three components of the evaluation:

Training Evaluation - to determine the effects of the WomanKind training on hospital staff and volunteer advocates. This component also included a curriculum review.

Outcome Evaluation - to determine how the program affects knowledge, attitudes, beliefs, and behavior of hospital staff and clients referred to the program.

Process Evaluation - to document the components or "processes" of the WomanKind program.

Exhibit II-1 presents the core research questions and the research methods for each component of the evaluation.

Exhibit II-I
Components of the Evaluation

Evaluation Component	Research Questions	Research Methods
Training Evaluation	**WomanKind Volunteer Advocates**	**WomanKind Volunteer Advocates**
	What is addressed in the WomanKind training for advocates? How is the training conducted? What contributes to the effectiveness of the training?	Observations of training sessions. Review of training curriculum.
	What are the advocates' perceptions of the value of the training?	Interviews with volunteer advocates.
	How does WomanKind training affect the knowledge, attitudes, beliefs and behaviors of volunteer advocates?	Pre- and post-training KABB surveys.
	Hospital Staff	Hospital Staff
	What is addressed in the WomanKind training for staff? How is the training conducted? What contributes to the effectiveness of the training?	Observations of training sessions. Review of training curriculum.
	What are the staff perceptions of the value of the training?	Interviews with hospital staff.
	How does WomanKind training affect the knowledge, attitudes, beliefs and behaviors of hospital staff?	Pre- and post-training KABB surveys.

Exhibit II-1 (cont.)
Components of the Evaluation

Evaluation Component	Research Questions	Research Methods
Outcome Evaluation	Hospital Staff	Hospital Staff
	Are there significant differences in the knowledge, attitudes, beliefs and behaviors of hospitals staff?	KABB surveys, administered 3 times during the course of the evaluation.
	Is there significant change over the time of the study in the knowledge, attitudes, beliefs and behaviors of staff in the experimental hospitals and the comparison hospitals?	KABB surveys, administered 3 times during the course of the evaluation.
	Are there significant differences in the knowledge, attitudes, beliefs and behaviors of staff of the initial WomanKind site and the other two Fair-view hospitals?	KABB surveys, administered 3 times during the course of the evaluation.
	What are the perceived effects of the WomanKind program on the hospital system and the hospital staff?	Interviews with medical staff, social workers in the experimental hospitals.
	Is there significant difference in the rate of documentation of definite and suspected cases of abuse in the emergency departments of the experimental and comparison hospitals?	Review of emergency department medical charts.

Exhibit II-1 (cont.)
Components of the Evaluation

Evaluation Component	Research Questions	Research Methods
Outcome Evaluation (cont.)	WomanKind Clients	WomanKind Clients
	How many clients are referred to WomanKind?	WomanKind program statistics.
	How are these clients supported and served by WomanKind?	WomanKind program statistics.'
	Are there significant differences in the knowledge, attitudes, beliefs and behaviors of WomanKind clients over time?	KABB survey of clients referred from hospital emergency departments. Administered at intake into WomanKind and again in follow-up telephone interviews.
Process Evaluation	What are the goals and components of the program?	Interviews with WomanKind staff. Review of WomanKind statistics and descriptive materials.
	How are the components of the WomanKind program implemented? What factors need to be considered for replication/adaptation of the program?	Interviews with WomanKind staff Interviews and focus group discussions with WomanKind staff, volunteer advocates and hospital staff.

III. Study Population

Three populations were under study for this evaluation effort:

- WomanKind volunteer advocates
- Hospital staff
- Female victims of intimate partner violence (clients)

The hospital and client populations were drawn from a total of 5 hospitals, all of which are located in the greater Minneapolis, Minnesota area. The experimental sites were the three hospitals in Fairview Healthcare Services where the WomanKind program is in place. Two additional hospitals were selected to participate in the study as comparison sites, based on their similarity to the experimental sites in size and population served. These two hospitals, Ridgeview Medical Center and Abbott Northwestern Hospital, had no formal domestic violence program in place during the study period. In this section of the report, we introduce each study population. Further information is provided in later sections as we describe data collection with each population and study findings.

A. Volunteer Advocates

An essential component of the WomanKind program is the use of volunteer advocates to provide referral and support services to victims of intimate partner violence through the emergency department and client crisis line. Each of the Fairview Hospitals has access to a cadre of specially trained volunteer advocates. Sixty-seven volunteer advocates were active during the study period, and all of them were recruited to participate in the study. Exhibit II-2 presents information on the volunteer advocates who participated in the study through surveys and/or interviews.

Exhibit II-2
Volunteer Advocates Participating In Study

Active Volunteer Advocates	Advocates Who Completed Pre-Post Training Surveys?.	Advocates Who Completed Follow-up Surveys**,,	Advocates Who Participated in Interviews
67	25 (38%)	45 (67%)	21 (31%)

* The 27 advocates who were trained in January 1996 were given pre- post surveys.
** Follow-up surveys were distributed to all active advocates in February 1997.

B. Hospital Staff

1) Staff targeted for overall study

Within each hospital, medical staff affiliated with the following three departments were eligible to participate in the study: emergency department (ED), intensive/special care unit (ICU), and the obstetric/gynecology or perinatal unit (Ob/Gyn). The one exception was that the Ob/Gyn staff members in Abbott Northwestern were excluded from the study because of their participation in a similar study examining staff opinions regarding workplace violence. Forty-eight percent of eligible staff participated in surveys; fifteen percent participated in interviews.' Exhibit II-3 presents specific information about staff who participated in surveys and/or interviews.

Exhibit II-3
Hospital Staff Participating In Study

	Fairview Southdale	Fairview Ridges	Fairview Riverside	Waconia Ridgeview*	Abbott Northwestern	TOTALS
Emergency Room						
Eligible	47	52	37	34	52	222
Surveys	43	36	31	18	41	169 (76%)
Interviews	12	9	28	9	6	64 (29%)
Intensive Care						
Eligible	38	13	30	47	55	183
Surveys	13	5	1	12	33	64 (35%)
Interviews	6	4	0	3	3	16 (97%)
Perinatal/Ob/Gyn						
Eligible	60	62	70	71	N/A**	263
Surveys	26	20	18	23	N/A	87 (33%)
Interviews	6	3	2	3	N/A	14 (5%)
Totals						
Eligible	145	127	137	152	107	668
Surveys	82 (57%)	61 (48%)	50 (36%)	53 (35%)	74 (70%)	320 (48%)
Interviews	27*** (19%)	16 (13%)	30 (22%)	15 (9%)	9 (8%)	97 (15%)

*** This number includes three "float nurses" who serve all three departments

** Ob/Gyn staff at Abbott Northwestern hospital were not included in the study.

* Ridgeview Medical Center is a small suburban hospital which employs a larger number of part-time staff than the other hospitals participating in the study, thus total number of staff eligible to participate was slightly higher than the other hospitals.

2) Hospital staff who received WomanKind training

As part of our evaluation of WomanKind training, we specifically targeted those individuals who participated in the training during the study period. WomanKind training was offered on an ongoing basis within the Fairview hospitals. Approximately 400 hospital staff participated in the 70 training sessions conducted between February 1996 and February 1997. This training was also provided to staff of the two comparison hospitals near the end of the study—upon the request of these hospitals. Thirty staff at Waconia Ridgeview participated in training, twenty participated at Abbott. Exhibit II-4 presents the number of staff who participated in the study through surveys and/or interviews and also participated in WomanKind training. A total of 115 survey respondents attended WomanKind training, 28% of our total survey respondents.

Exhibit II-4
Hospital Staff Participants in the Study Who Also Participated in WomanKind Training

	Fairview Southdale	Fairview Ridges	Fairview Riverside	Waconia Ridgeview	Abbott Northwestern*	TOTALS
Surveys	29	29	44	8	10	115
Interviews	14	6	12	6	2	40

* Ob/Gyn staff at Abbott Northwestern hospital were not included in the study.

C. WomanKind Clients

Within the three experimental sites, all identified female victims of intimate partner violence (over the age of 12) who accepted a referral to speak with a WomanKind advocate were asked to participate in the study. Similarly, in the emergency departments of the two comparison sites, all identified female victims of intimate partner violence who were referred to a social worker were asked to participate in the study. Patients have the right to decline a referral to either a WomanKind advocate or a social worker and certainly the right to refuse to participate in a research study. Therefore, respondents are those clients who accepted referrals to a WomanKind advocate or a social worker *and* agreed to participate in the study. Twenty-three percent of the women who were asked to participate in the study agreed to do so. Exhibit II-5 presents the number of abused patients from each hospital who participated in the study.

Exhibit II-5
Clients Participating in Study*

	Women referred to WomanKind or social worker by emergency department	Women who agreed to participate in the study
Fairview Southdale	87	12 (14%)
Fairview Ridges	55	23 (42%)
Fairview Riverside	50	4 (8%)
Waconia Ridgeview	0	0
Abbott Northwestern	32	13 (4%)
TOTALS	224	52 (23%)

* Clients were recruited into the program from January through December, 1996.

Chapter III

Evaluation of Training of WomanKind Volunteer Advocates

Chapter III. Evaluation of Training of WomanKind Volunteer Advocates

Introduction

Volunteer advocates provide crisis advocacy, in the emergency department, to victims of domestic abuse who have consented to talk with them. They are on-call and can be reached by emergency room staff after regular business hours, making the WomanKind program available 24 hours per day, seven days per week. Volunteer advocates also provide crisis advocacy to victims ofdomestic abuse who contact the WomanKind program by telephone. Advocates are supported and supervised by the full-time, paid WomanKind program coordinators. Because of the critical role advocates play in the program, and the sensitive nature of their work with clients, individuals who apply to be advocates are carefully screened and participate in a intensive training program before being accepted into the program and assigned to work with clients. For this component of the program evaluation, we took a close look at this training program to answer the following questions:

Research Questions

- What is addressed in the training? How is it conducted? What contributes to the effectiveness of the training?
- What are the volunteer advocates' perceptions of the training?
- How does WomanKind training affect the knowledge, attitudes, beliefs, and behaviors of volunteer advocates?

I. Curriculum Review

Nature of the Review

Our first step in evaluating the training provided to volunteer advocates was to assess the training curriculum and its implementation. The purpose was to determine the extent to which the curriculum materials address the training objectives and how the content and process of the training could be strengthened.

A number of factors were used to assess the curriculum materials in an effort to identify what contributes to the effectiveness of the training and identify any areas where the training could be strengthened. The specific factors included:

- The existence of clear and measurable learning goals and objectives

- Appropriateness of training methods, given the learning objectives and intended audience
- Opportunity for discussion, questions, debate, practice
- Comprehensiveness of the content presented
- Relationship between the content and learning objectives
- Clarity of intent for each training activity
- Clarity of the mechanics for each training activity, including set-up, facilitation, and processing
- Clarity of transitions and connections between training activities
- Realistic timing for content presentations and other activities
- Logical sequence and building of activities
- Options or trainer considerations if circumstances necessitate changes in the curriculum
- Inclusion of cultural issues
- Preparation needed prior to training—for trainers and participants
- Role and relevance of any additional readings

Methods

We conducted the curriculum assessment by: reviewing all written curriculum materials; interviewing the founder and manager of WomanKind who together have developed and refined the training; and observing the training twice during the study period. This activity provided us with an opportunity to interact informally with advocates during the training and to debrief with WomanKind program staff.

The following sections present the findings from this curriculum assessment, including:

- What is addressed in the training;
- How the training is conducted; and
- What contributes to the effectiveness of the training.

This last section presents the assessed strengths of the training and suggestions for strengthening the training.

A. What is Addressed in the Training?

The overall goal of the training is to enable the volunteer advocate to provide advocacy services within the volunteer job description and policies and procedures of the WomanKind program. These materials were developed by WomanKind management staff and are a part of the Fairview Health Services system policies. Copies can be found in Appendix B of this report.

Chapter III. Evaluation of Training of WomanKind Volunteer Advocates

The training is a comprehensive and intense educational experience for volunteers, encompassing a range of topics related to domestic abuse and taking 30 hours over a two week-period. Exhibit III-1 provides an overview of the training.

Exhibit III-1
WomanKind Volunteer Advocate Training

Training Objectives

By the completion of the training, volunteer advocates will be able to:

- Describe the WomanKind program history, development and implementation since 1986.
- Discuss the myths, realities and dynamics of domestic abuse and violence.
- Recognize and describe signs of abuse using the "Checklist" and the "Power and Control Wheel."
- Discuss the barriers to leaving an abusive relationship.
- Describe the attitudes and behaviors of, and treatment provided for, men who are abusive.
- Discuss the impact or effects of violence on children.
- Discuss statistics that demonstrate the importance of health care intervention for domestic abuse.
- Recognize the signs and symptoms of domestic abuse in the medical office, clinic, home health or hospital setting.
- Describe intervention techniques and appropriate questions/responses with victims of domestic abuse.
- Discuss the personal bias and frustration health professionals may feel in working with victims of family violence.
- Discuss the relationship between chemical use and abuse and domestic abuse.
- Identify and discuss the unique factors important in same sex battering.
- List the myths, facts and effects concerning homophobia and racism in our culture in relation to domestic abuse.
- Discuss the effects of abuse on the victim's sense of responsibility, spiritual being and issues of grief and loss.
- Identify a victim who may be exhibiting suicidal gestures or behavior.
- List the levels of assault and legal options available for victims of domestic abuse.
- Discuss the effects of violence on women and the support and therapy available.
- Discuss patient autonomy, informed consent and confidentiality.
- Discuss the importance of respect for the victim's process and timetable.

Exhibit III-1 (cont.)
WomanKind Volunteer Advocate Training

Training Outline*

Session 1

I. Welcome and Introduction
II. Role of Volunteer Advocate
III. WomanKind Program
IV. Training Schedule
V. Power and Control Wheel, Equality Wheel
VI. Checklist and Signs of Abuse
VII. Cycle of Violence
VIII. Abuse is Learned Behavior
IX. Questions and Answers

Session 2

I. Video - "One Hit Leads to Another"
II. Myths and Realities
III. Responsibility for Abusive Behavior
IV. Barriers to Leaving Abusive Relationships
V. Video - "Just to Have a Peaceful Life"
VI. Questions and Answers
VII. Health Care Assessment, Identification and Intervention

Session 3

I. Video - "It's Not Always Happy at My House"
II. Discussion of Video
III. Video - "Heart on a Chain"
IV. Discussion of Video
V. Effects of Violence on Children and Adolescents

Session 4

I. Chemical Health
II. Questions and Answers
III. Working with Men who are Abusive

Session 5

I. Legal Advocacy
II. Questions and Answers
III. Law Enforcement

* A more detailed schedule for the Volunteer Advocate Training conducted in January 1996 appears in Appendix C.

Exhibit III-1 (cont.)
WomanKind Volunteer Advocate Training

Training Outline (cont.)

Session 6

I. Same Sex Battering/Homophobia, Racism, and Systems of Oppression
II. Questions and Answers
III. Video - "Broken Vows: Religious Perspective on Domestic Violence"
IV. Religion

Session 7

I. Active Listening
II. Questions and Answers
III. Working with Potentially Suicidal Clients

Session 8

I. Volunteer Advocate's Role
II. Security/Safety Policy and Procedure
III. Working with Women who are Victims and Survivors of Abuse
IV. Questions and Answers

Session 9

I. On-Call Procedures
II. Role Play - "Case Study Analysis"

Session 10 (Held at respective hospital sites)

I. Volunteer Services Director
II. Emergency Department Tour
III. Individual Interviews

Resource Materials Used in Training

Volunteer advocates receive a reference manual during the training. Some of the materials are reviewed during the sessions, while others are provided as additional reading materials. It is expected that volunteers will maintain the manual, reading materials on their own and using the materials, as appropriate, in their work with battered women.**

** An outline of the Reference Manual appears in Appendix D.

B. How is the Training Conducted?

The formal training program for volunteer advocates is mandatory and conducted in January of each year. At that time all new volunteer applicants, for all three Fairview metropolitan hospitals, participate in the 10 sessions over a two week period, for 3 hours per evening. Training gives potential advocates the opportunity to connect with each other and with all of the WomanKind staff members before they are accepted into the program and begin their volunteer work in one particular hospital under the supervision of the coordinator for that site. In this way they learn about the program as a whole, receiving consistent information about the program and its philosophy and practice. This also gives program staff the opportunity to get to know them.

WomanKind program staff attend all sessions of the training and connect with the volunteer advocates in an on-going informal manner throughout. Particular staff members conduct the segments of the training that address the history of the WomanKind program, the role, and responsibilities of advocates, and the basics of domestic violence. Guest speakers from agencies and organizations in the community are used to address specific topic areas in the training. In the last session of the training, WomanKind program coordinators meet with the volunteer advocates that will work in their hospital to conduct a tour of the emergency department in the hospital and to conduct individual interviews with the advocates. These interviews are critical. It is the point where the coordinator and the advocate make a mutual decision on whether the advocate will join the program.

Because WomanKind accepts applications for volunteer advocate positions throughout the year, a few advocates were provided with more personalized training since they entered the program after the formal training program was conducted. Five individuals were trained in this way during the study period.

C. What Contributes to the Effectiveness of the Training?

Strengths of the Training

In essence this training immerses the volunteer advocates in the issue of domestic abuse and provides them with a rich and compelling picture of how pervasive the problem is and how it affects the lives of those who experience it. The training affects volunteers on every level: cognitive, attitudinal, emotional, and behavioral. Specific strengths of the training program include:

- *Intensity*

The WomanKind training for volunteer advocates is an intense, comprehensive educational program that demands a strong commitment from the volunteer. The emphasis is on developing a sensitivity to and awareness of the complex issue of domestic abuse, creating a solid knowledge base and helping volunteers understand their role and responsibility within the program. It is not expected that volunteers will remember all of the detailed information they receive in the training. It is expected that they will discover things that they didn't know, take a new look at things they thought they knew, begin to deal with their own attitudes and emotions around some very difficult issues, and begin to understand what they will be able to do when working with clients. It is expected that the volunteers will learn how to use the WomanKind program staff and each other as resources and will learn where to turn for additional information and support.

- *Objectives and Training Activities*

The curriculum and the reference materials directly reflect the training objectives, which are stated in behavioral and measurable terms. Further, the training objectives reflect the expectations and responsibilities of volunteer advocates as presented in the job description and hospital policies. Training activities include: presentations by WomanKind program staff and guest speakers from various community agencies and organizations; videos; group discussions and question and answer periods; role playing; a tour of the emergency room; and individual consultations with the staff coordinators. The use of this variety of methods makes the training interesting and addresses different learning styles. A tremendous amount of information is covered in each session, and in total the training covers a wide range of topics.

- *Design*

The design of the training reflects a deliberate decision to give volunteers a small amount of information about their role and the WomanKind program, followed by an extensive journey through a range of issues such as the effects of abuse on children, the dynamics of abuse, abuse within teen dating relationships, and the influence of religion, and then provide them with more in-depth information about how they will work with clients.

To make this approach work, the WomanKind staff are careful to present and reinforce several messages throughout the training:

- The value of the volunteer advocates to the success of the WomanKind program.

- This training course is just the beginning of their education; there are other educational activities built into the program.

- The importance of taking care of themselves and debriefing with staff.

- The role of the volunteer advocate is well accepted and well regarded by the medical staff of the Fairview hospitals.

• *The Role of WomanKind Staff*

WomanKind program staff try to help advocates feel comfortable with the hospital and the emergency room, to help them understand that they are welcome and will be able to do their job without interfering with the physicians and nurses. Program staff are calm, warm, and accepting of the advocates. They model how advocates are expected to be with clients.

WomanKind program staff encourage the advocates to think about their own feelings, their own experiences. They encourage advocates to discuss these feelings with staff, particularly if they find they have difficulty dealing with any particular issue—"You can come to us; no one is going to judge you here." This is especially important for a program like this; many women who volunteer have been victims of abuse themselves and will need to deal effectively with their own feelings before they can be of assistance to others.

• *Preparation of Guest Speakers*

The use of guest speakers is a large part of the training design and therefore is critical to the effectiveness of the training. WomanKind management staff spend a great deal of effort preparing the speakers, taking steps which include:

- Explaining the purpose and objectives of the training and how the volunteer advocates fit into the overall WomanKind program.

- Providing speakers with written information on the program and the goals and objectives of the training.

- Being specific in what they want speakers to cover and how they want them to do it, including parameters and whether to lead a question/answer period following their presentation.

- Asking them to submit a written outline of their presentation. This outline is reviewed and discussed with the speakers ahead of time.

- Preparing for what they will do if a speaker does not stick to his/her outline or goes over the time limit.

- Continually updating the training, by adding new information or addressing new topics. For example, working with women of different ethnic backgrounds is becoming more of an issue. Updating may mean seeking new guest speakers or asking those who have been a part of the program in the past to address new issues.

- Debriefing with guest speakers to provide feedback on their presentation and to solicit any observations they may have.

Suggestions for strengthening the training:

- In the beginning of the training, review the objectives and the overall agenda, presenting a "roadmap" of the training. Refer to this roadmap periodically to help volunteer advocates see how all of the sessions build upon one another, culminating in a thorough review of the role they will play within the program. This should alleviate some of the anxiety that advocates start to feel as they begin to question if they will be able to help clients. Reinforce where they are in the training and where they are going.
- Quickly assess the expectations of advocates at the beginning of the training and describe to participants how they will or will not be addressed.
- Build in time for group and individual processing, since the information is so intense and emotional. Following videos or speakers, lead brief discussions which would allow them to talk about their reactions, opinions, and concerns. This will help participants start to deal with what they are learning and how it affects them.
- Build in more time for skill practice and feedback so advocates get a better feel for what to expect in working with clients and to increase their comfort level with the counseling skills.
- Consider using a journal for volunteer advocates to record their own thoughts and reflections at the end of each session as a way to begin processing their reactions to the training information. Encourage them to look inside themselves: How does this affect me? What can I do with this information? This will give them structured reflection time. It could also serve as a place to record their questions. Periodically, give participants the opportunity to discuss the items they record in their journal, but respect their privacy and reassure them that the journal is for their use.
- Encourage the participants to summarize/make connections between the various topics. This will help them put the pieces together and will help staff to see how advocates are assimilating the information.
- Incorporate a more definite closure in each session, giving participants a summary of key points (or eliciting a summary from them) and setting the session in the broader context of the overall training.

Chapter III. Evaluation of Training of WomanKind Volunteer Advocates

Ii. Volunteer Advocates' Perceptions of Training

Interviews with Volunteer Advocates

In February 1997, we invited all active volunteer advocates to participate in interviews or discussion groups to give us their perceptions of the WomanKind program in general and the training program specifically. The protocol for the interviews/discussions appears in Appendix E. Approximately ⅓ of the active volunteer advocates (21 out of 67) participated in the interviews/discussions.

Findings -We specifically asked the volunteer advocates to comment on the training program and their perceptions of how it impacted them. All of the advocates stated that they found the training helpful, and they were glad to go through it before they began their volunteer work. A few of the advocates suggested that the training was overwhelming and made them even more anxious about the role they were stepping into.

Volunteer advocates cited the energy, commitment and enthusiasm of the WomanKind program staff as one of the major strengths of the training. They felt that the WomanKind program staff was welcoming and drew the advocates in, made them want to be a part of the program, and made them feel important. They also commented that the staff was supportive and accepting, "They didn't think any question was dumb or inappropriate."

Other strengths 'of the training noted by the advocates included the high caliber of the speakers, the comprehensiveness of the overall training, and the opportunity to role-play and practice skills such as active listening, Almost all of the advocates referred to the Reference Manual during the interview, though there seems to be variation in how it is used. Several said that they found it extremely valuable, and they used it quite a bit for their own education and in working with clients. Others believed that the manual was overwhelming, and they had not read all of the materials.

All of the volunteers indicated that the training raised their level of awareness and understanding of the complexity of domestic abuse. Specifically, they mentioned that it helped them understand why women stay in abusive relationships, made them aware that they had accepted some of the myths, and increased their sensitivity to the woman's overall process. Training helped them understand their role and the value of listening rather than "fixing."

When asked if they had suggestions for how the training could be improved, the advocates said they would have welcomed more opportunity to practice skills such as active listening and conducting an initial session with a client. They wanted more feedback from WomanKind staff on these skills and perhaps more time to explore the emergency room to feel more comfortable with the environment.

Volunteer advocates were mixed in their opinions about the schedule for the training. Several said it was quite a commitment, but it was okay the way it was designed. A few thought it would be better to spread out the training; a few others thought it would better to conduct the training in a more concentrated time frame such as a weekend.

Training Surveys

From the volunteer advocates who participated in the 1996 training program, we collected more in-depth information about their perceptions of the training. The 27 volunteer advocates in this program were asked to complete a brief training assessment survey at the end of each of the 10 sessions to determine their views on the following issues.

- Usefulness and value of the training for improving advocates' understanding of domestic violence
- Usefulness and value of the training for improving advocates' understanding of the WomanKind program and their role and responsibility as advocates
- Effectiveness of the trainer(s)
- Suggested changes and recommendations

The assessment surreys asked respondents to rate the value of each component of the session, using a five-point Likert scale training from 'Not at all" to "To a Great Extent." Copies of the ten surveys used to assess 1996 training are included in Appendix F.

Findinss - Overall, respondents rated the training sessions as very valuable. The mean scores for the perceived value of each training session show that session 7, which covered active listening and working with potentially suicidal clients, was the most highly rated session (mean of 4.87). No session had a mean of less than 4.18, which was the rating for session 5, legal advocacy and law enforcement. Exhibit III-2 presents the mean rating for each session in the training program.

Exhibit III-2
Ratings of the Value of Each Training Session*

Session	Mean
7. Active listening and working with potentially suicidal patients	4.87
3. Videos - "It's Not Always Happy at My House" and "Heart on A Chain" and effects of violence on children and adolescents	4.83
9. On-call procedures and case study analysis	4.69
2. Myths and realities, barriers to leaving, and health care assessment, identification and intervention	4.67
8. Volunteer advocate's role, safety policy, and working with women who are victims and survivors of abuse	4.66
10. Emergency department tour and individual interviews	4.5
6. Same sex battering, religious perspective on domestic violence	4.46
1. Role of volunteer advocate, WomanKind program	4.30
4. Chemical health and working with men who are abusive	4.26
5. Legal advocacy and law enforcement	4.18

* Rating scale: 1 = "Not at all valuable"
5 = "Valuable to a great extent"

The assessment survey also gave respondents the opportunity to indicate if they thought more time should be spent on specific topics or training activities. Out of a total of 40 topics/activities covered in the sessions, seven were identified by 5 or more respondents as needing more time. These were:

Topics/Activities	# of Respondents
Legal advocacy (session 5)	9
Law enforcement (session 5)	7
Signs of abuse (session 1)	5
Abuse as a learned behavior (session 1)	5
Health care assessment, identification and intervention (session 2)	5
Role play (session 9)	5
Tour of emergency department (session 10)	5

The fact that only few of a total of 27 respondents indicated that topics needed more time suggests a well organized and planned training agenda. It is helpful to note, however, where participants felt they needed additional time to address issues they felt were important to understand.

III. Impact of Training on Volunteer Advocates' Knowledge, Attitudes, Beliefs, and Behaviors (KABB)

A. Evaluation Design/Methodology

To determine the impact of training on volunteer advocates' knowledge, attitudes, beliefs, and behaviors, we developed a 42-item KABB survey and administered it to the volunteer advocates who participated in the January 1996 training. Out of the 27 advocates who participated in the training, 25 completed both a pre- and post-training KABB, giving us the opportunity to look at changes in the KABB for this particular subset ofvolunteers. We also administered the KABB survey to all active volunteers near the end of the study, in February 1997. (Forty-five out of 67 volunteer advocates completed this survey.) While this did not provide information about any changes in KABB that advocates may have experienced as a result of training or as a result of their involvement in the WomanKind program, it did provide us with some helpful profile information on volunteer advocates.

Instrumentation - The volunteer advocate KABB survey (which appears in Appendix G) was based upon a survey used to collect similar information from hospital staff. Survey items from the staff survey were slightly altered to fit the volunteer advocate population and their roles and responsibilities within the WomanKind program. The resulting survey contains 42 items and consists of 6 scales that address the following areas:

- Self-Efficacy for Identification and Interaction
- Self-Efficacy for Referral and Services
- Staff Responsibility to Address Domestic Violence
- Staff Preparation
- Victim Autonomy
- Understanding of Abusive Relationships

The volunteer advocate KABB survey uses an anchored 7 point Likert scale, ranging from "Strongly Disagree" to "Strongly Agree." Scales rather than individual survey questions or items are used here because ofimproved reliability and validity obtained from using multiple items to measure a given conceptual domain. High inter-item reliability increases the likelihood that the face-valid items are, in fact, measuring related facets of a single concept. The use of multiple items reduces error variance associated with the measurement of any given item."

Some survey items were worded in the negative to provide some variety in the phrasing and thus, reduce potential response bias. When combining these items with the others in their scales, it was necessary to reverse the scoring so that all survey items would be measuring the scale construct in the same direction. For example, the score on the item *"I do nor have the necessary skills to effectively support a victim of abuse"* is reversed so that it corresponds with other items that tap the positive aspects of Self-efficacy for Identification and Interaction with victims of intimate partner violence.

Psychometric Analysis of the KABB Instrument - Giventheextremely small sample size of volunteer advocates (N=45), and the fact that the survey scales were based on those derived from the hospital staff survey, a factor analysis was not conducted. However, an assessment of internal consistency was conducted. Three of the six scales evidenced Cronbach Alphas between .61 and .76. The remaining scales evidenced an alpha of .50 or above. Although an alpha of .60 is the traditional cut-off for scales in the preliminary stages of development, the decision was made to include these scales for comparison purposes and because of the importance of the items. Exhibit III-3 presents the factor structure and reliability statistics, based on the 45 surveys returned by active volunteers.

[10] Anastasi A. Psychological Testing, Seventh Edition. New York: McMillan Publishing, 1993.

Exhibit III-3
Volunteer Advocate KABB Factor Structure and Reliability Statistics (N=45)

Item	Reverse Scoring	Item Statement (Cronbach Alpha)
		Self-Efficacy for Identification and Interaction (α=.6699)
26.		I am capable of identifying victims of abuse,
27.		I can create an environment that builds trust, so that a patient can discuss domestic violence with me.
28.	R	I have difficulty knowing how to respond when a patient minimizes or denies the abuse.
31.		I can put victims of abuse at ease.
32.	R	I do not have the necessary skills to effectively support a victim of abuse.
34.		I can provide support to victims of abuse.
41.		I feel comfortable discussing domestic violence with patients.
42.		There are specific things I can do to help a victim of domestic violence.
		Self-Efficacy for Referral and Services (α=.5073)
33.		I am aware of legal requirements in Minnesota that I report suspected cases of abuse.
35.		I can make appropriate referrals for victims of abuse.
37.		If I detected an abusive relationship with a patient, I would report it to the police.
38.		There are services within our hospital for victims of domestic abuse.
39.		There are services within the community for victims of domestic abuse.
40.	R	The support services for domestic abuse victims in the community are fairly poor.
		Responsibility to Address Domestic Violence (α=.6127)
1.	R	Domestic Violence is not as important as other health problems.
3.		The high physical, emotional, and economic costs of domestic violence justify a stronger prevention effort.
4.		Hospital staff who interact with patients are in a prime position to identify victims of domestic violence.
5.		Hospital staff play an important role in addressing situations of domestic violence.
6.	R	It is not appropriate for hospital staff to ask female patients about domestic violence.
8.	R	If a patient repeatedly refuses to discuss the real cause of presenting injuries, there is little hospital staff can do except treat the injuries.
9.		Hospital staff have a responsibility to talk to patients who are being abused about their situation so that they can assess their situation, support them, and make a referral if appropriate.
10.		Hospital staff need to be more persistent in helping patients address an abusive relationship.

Exhibit III-3 (cont.)
Volunteer Advocate KABB Factor Structure and Reliability Statistics (N=45)

Item	Reverse Scoring	Item Statement (Cronbach Alpha)
		Responsibility to Address Domestic Violence (α=.6127)
11.	R	Hospital staff's responsibility for domestic violence intervention stops with identification.
19.	R	If a victim of abuse refuses to acknowledge her problem, there is very little that volunteer advocates can do to help.
		Staff Preparation (α=.7682)
12	R	Hospital staff do not have the training required to assist individuals in resolving situations of domestic violence.
13.	R	Hospital staff do not have the time necessary to be of real assistance in resolving domestic violence.
14.	R	Hospital staff do not have the time necessary to be of real assistance in addressing domestic violence.
		Victim Autonomy (α=.5374)
7.		Hospital staff should not pressure patients to acknowledge that they are living in an abusive relationship.
18.		Victims of abuse have the right to make their own decisions about whether hospital staff can intervene.
20.		However frustrating it may be personally, volunteer advocates must allow abuse victims to make their own decisions about how to handle the situation.
		Understanding of Abusive Relationships (α=.5210)
15.	R	If a victim of abuse remains in the relationship after repeated episodes of violence, she must accept some responsibility for that violence.
16.		The victim of abuse is not responsible for the abuse she receives.
17.	R	Abusers can be provoked into becoming violent.
21.		Victims of abuse may have valid reasons for remaining in the abusive relationship.
22.	R	I cannot understand why any victim of abuse would choose to remain in the relationship.
23.	R	Sometimes there are justifiable reasons for a woman being hit by her partner.
24.		It is not anger that is the problem with abusers, but the fact that they express their anger with violence.
25.	R	In some situations, victims of domestic violence may provoke the abuse.
36.	R	Pregnant women are less likely than non-pregnant women to be hit by their partners.

B. Findings

Pre and post-training **KABB survey** results - Pre-and post-training surveys were distributed at the January 1996 training. Twenty-seven volunteer advocates participated in this training program, and pre- and post-training surveys were received from 25 advocates. A multi-variate analysis of variance (MANOVA) was performed to determine if there were any significant differences between their survey responses prior to the advocacy training and after the training. As depicted in Exhibit III-4 below, there were significant increases in advocates' responses on scales 1, 2 and 6.

Exhibit III-4
WomanKind Advocates Pre-training and Post-training Mean Scale Scores

Scales	Pre-training (sd)	Post-training (sd)	F-value
1. Self-Efficacy for Identification and Interaction	4.92 (.82)	5.85 (.62)	19.925 p=.000
2. Self-Efficacy for Referral and Services	5.27 (.83)	6.00 (.69)	11.160 p=.002
3. Staff Responsibility to Address Domestic Violence	5.65 (.59)	5.86 (.64)	1.316 p=.257
4. Staff Preparation	3.64 (1.22)	3.6 (1.63)	.009 p=.925
5. Victim Autonomy	5.33 (.85)	5.25 (1.07)	.084 p=.774
6. Understanding of Abusive Relationships	5.52(.67)	6.22 (.66)	13.556 p=.001

These findings would indicate that training does increase volunteer advocates' confidence in their abilities to identify and support victims of abuse, their knowledge of services to assist victims, and their confidence in being able to make appropriate referrals to these services. Additionally, the findings point out an increase in the volunteer advocates' understanding of the dynamics of abusive relationships. All of these are intended outcomes of the training.

It is interesting to note that on one scale where there was not significant change over time, the mean score before the training was the highest of all the scales. The items under the scale *Staff Responsibility to Address Domestic Violence* relate to the responsibility of medical or hospital staff to address domestic violence. We would expect volunteer advocates to believe that medical personnel do have an important responsibility and role to play since they are seeking the opportunity to work in the hospital setting with medical staff.

Participant Demographics - Demographic information was collected from volunteer advocates during a final data collection effort in February 1997. Sixty-seven percent of all volunteers who were active at that time (regardless of when they had entered the program) returned this final survey. Given that all WomanKind advocates are female, we collected data on their age, professional background, years of experience working with the WomanKind program, and previous background, experience, or training in domestic violence. Exhibit III-5 presents the findings.

Exhibit III-5
Demographics of Volunteer Advocates (N=45)

Age	(N)	Percent of Sample'
20-24	3	6.7
25-29	8	17.8
30-34	6	13.3
35-39	4	8.9
40-44	4	8.9
45-49	18	40.0
60-64	1	2.2
Missing	1	2.2
'rofessional Background		**Percent of Sample**
student		15.6
career in health		28.9
other		33.3
none		22.2
lumber of years as a WomanKind volunteer advocate		**Percent of Sample**
3 or more years		28.9
2 years		24.4
1 year		35.6
less than 1 year		11.1
'revious Experience or Training in Domestic Violence		**Percent of Sample**
WomanKind Training		57.8
Other training (e.g. hospital in-service)		31.1
Lecture or Seminar		28.9
Volunteer		33.3
Personal Experience		46.7
• Other experience		13.3
specific Role within the WomanKind Program		**Percent of Sample***
on-call volunteer		100.0
support group facilitator		31.1
office assistant		6.7
Number of times (over past 12 months) called in to work with a victim of abuse		**Percent of Sample**
0		13.3
1-5		46.7
6-10		20.0
II-15		15.5
16-20		2.2
>21		2.2

* Total exceeds 100% because advocates can serve more than 1 role in the WomanKind program.

Final KABB Survey Results - As noted in the Instrumentation section, all six of the scales that were conceptualized for the volunteer advocate KABB had adequate internal consistency (Cronbach Alphas >.50) to consider them for further statistical analysis. Thus, these 6 scales, along with the total score, were used as the dependent variables in analysis of advocates' survey responses and are further discussed below.

Each respondents' score for a given scale was derived by 1) summing their responses to each item (survey question) within the scale and 2) computing the mean scale score for that respondent by dividing the sum by the total number of items within the scale. A mean score for each scale (for all respondents) was derived by summing their individual mean scale scores and dividing this new sum by the total number of respondents to obtain an overall mean for the scale. This overall mean thus corresponds to the Likert scale of 1 to 7 used on the volunteer KABB. As depicted in Exhibit 111-6, their mean scale scores were high on five of the six scales. Responses on each of the scales is further discussed below.

Exhibit ill-6
Advocates' Responses on the Final KABB (N=45)

Scale	Mean Scale Score (sd)
1. Self-Efficacy for Identification and Interaction	5.84 (.64)
2. Self-Efficacy for Referral and Services	6.07 (.69)
3. Staff Responsibility to Address Domestic Violence	5.90 (.62)
4. Staff Preparation	3.99 (1.36)
5. Victim Autonomy	5.40 (1.12)
6. Understanding of Abusive Relationships	5.97 (.69)
Total Score	221.31 (18.36)

Self-efficacy for Identification and Interaction. Items in this scale examined advocates' self-efficacy to identify cases of domestic violence and to interact with victims of abuse. Advocates' mean response was 5.84, with 91.1% of advocates expressing confidence (scale score ≥5.0) in their abilities to identify cases of abuse and interact with victims of abuse. In fact, over 40% of advocates *strongly* believed (mean scale score ≥ 6.0) in their abilities to identify cases of abuse and interact with victims.

Self-Efficacy for Referral and Services. Items in this scale examined advocates' belief in their ability to provide support for victims of abuse and make appropriate referrals. With a mean scale score of 6.07, over 90% of advocates were quite confident (scale score ≥5.0) in their ability to refer victims of abuse and provide support services, with over two-thirds of advocates expressing ***strong*** belief (mean scale score ≥ 6.0) in their skills and abilities in this particular area.

Staff Responsibility to Address Domestic Violence. Items in this scale examined advocates' perceptions of hospital staffs responsibility to address domestic violence as well as their own. Mean responses were normally distributed ($\bar{x}$=5.90), and 93% of advocates expressed agreement (scale score 25.0) with items stating that it is the responsibility ofhospitals staff and advocates to address domestic violence. Close to half (46.7%) of advocates expressed ***strong*** sentiments (mean scale score ≥ 6.0) on this scale.

Staff Preparation. Advocates' perceptions of hospital staffs training and preparation to address domestic violence were assessed by the three items in this scale. In comparison to other mean scale scores, advocates' responses to items in this scale were low (x=3.99). Less than one-third of advocates expressed confidence (mean scale score ≥ 5.0) in hospital staffs preparedness to address domestic violence. Another one-third expressed a definitive lack of confidence (mean scale score ≤ 3.0) in the training and preparation of hospital staff to address domestic violence.

Victim Autonomy. Items in this scale explored advocates' opinions regarding the extent to which victims of abuse should be allowed the freedom to make their own decisions about seeking assistance with domestic violence. With a mean scale score of 5.40, 73% of advocates believed that victims of abuse have the right to make their own decisions regarding their personal relationships (mean scale score ≥ 5.0). More than one-third of advocates felt very ***strongly*** (mean scale score ≥ 6.0) about victims' right to autonomy.

Understanding of Abusive Relationships. This particular scale examined advocates' understanding ofthe various dynamics ofabusiverelationships as well as their attitudes towards abusers and victims. Responses were normally distributed ($\bar{x}$=5.97), with 93% of advocates demonstrating a good understanding of abusive relationships (mean scale score ≥ 5.0) and close to 60% demonstrating a very ***strong*** understanding of abusive relationships (mean scale score ≥ 6.0).

IV. Summary of Findings

In this component of the evaluation, we assessed the training that is provided to volunteer advocates in the WomanKind program. We conducted a review of the training curriculum and materials, interviewed volunteer advocates who had completed the training and had been working in the program, and used surveys to gain information about the knowledge, skills, attitudes and behaviors of the advocates.'

Women who apply to become WomanKind volunteer advocates are required to complete a 30-hour training program before they are accepted. Training is conducted as ten 3-hour sessions held over a two week period. The stated training objectives reflect the expectations and responsibilities of volunteer advocates as presented in the job description and hospital policies. These objectives are clearly linked to the specific topics covered in the training.

Strengths of the Training Program

The training immerses the potential volunteer in the issue of domestic abuse and provides them with a rich and compelling picture of how pervasive the problem is and how it affects the lives of those who experience it. It is an intense, comprehensive educational program that demands a strong commitment from the volunteer, It is expected that the volunteer advocates will discover things that they didn't know, take a new look at things they thought they knew, begin to deal with their own attitudes and emotions around some very difficult issues, and begin to understand what they will be able to do when working with clients.

Indeed, volunteer advocates that participated in interviews conducted by the evaluation team were positive about the training experience and believed that it was helpful to them in understanding the issue of domestic abuse and how they could work with clients. Specifically, they mentioned that it helped them understand why women stay in abusive relationships, made them aware that they had accepted some of the myths about domestic abuse, and increased their sensitivity to the woman's overall process.

Volunteer advocates who participated in the January 1996 training program completed pre- and post-training KABB surveys. Results from the comparison of these surveys indicated that scores increased for three out of six conceptual scales: *Self-efficacy for Identification and Interaction; Self-efficacy for Referral and Services; Understanding of Abusive Relationships.* These findings would indicate that training does increase volunteer advocates' confidence in their abilities to identify and support victims of abuse, their knowledge of services to assist victims, and their confidence in being able to make appropriate referrals to these services. Additionally, these findings point out an increase in the volunteer advocates' understanding of the dynamics of abusive relationships. All of these are intended outcomes of the training.

The training program is well conceived and organized. Care is taken in selecting and preparing speakers to address different topics and WomanKind staff play a significant role in helping the volunteer advocates understand the program and the value of the volunteers. A reference manual that is distributed during the training is very comprehensive and provides volunteer advocates with articles and other materials that will support their work as advocates. Together, the topics presented in the training and the reference manual present a full and comprehensive picture of domestic abuse and reflect the most current practice and research in the field. WomanKind staff continually reviews both the training and the reference'manual to determine where changes or updates are needed.

Suggestions for Strengthening the Training Program

Based on the curriculum assessment, observations of the evaluation team, and the comments from the volunteer advocates, a few things could be done to strengthen the training. These include:

- In the beginning of the training, review the objectives and the overall agenda, presenting a "roadmap" of the training. Periodically come back to this to through summaries of sessions to illustrate how sessions are building on one another and to help point out the connections between sessions.

- Build in time for group and individual processing, since the information is so intense and emotional. Training participants need the chance to discuss their reactions to videos or presentations, to ask questions or express concerns. Without this opportunity, they may not be able to continue to absorb new information or be able to put the information together in a way that will be useful to them.

- Build in more time for skill practice and feedback so advocates get a better sense of what to expect in working with clients and to increase their comfort level with their counseling skills.

- Integrate the reference manual into the training a bit more. Refer participants to specific materials that will reinforce or expand on information presented by a speaker. Look for ways to use the reference manual with volunteer advocates outside of the training, perhaps in monthly volunteer meetings.

Conclusion

The training program for the volunteer advocates is well designed and appears to meet its objectives in raising volunteers' awareness and understanding of the dynamics of domestic violence and preparing them to work with clients. Volunteer advocates receive on-going support in their work, through supervision from the WomanKind coordinators and monthly volunteer advocate meetings, but the training program provides the foundation of their experience and is an important element in their preparation to assume the role of advocate.

Chapter III. Evaluation of Training of WomanKind Volunteer Advocates

Perhaps the best endorsement for the advocate training program is the perception of the hospital staff in the Fairview hospitals. In interviews with the evaluation team, hospital staffrepeatedly described the volunteer advocates of the WomanKind program as professional and well-trained. Obviously this contributes to the overall effectiveness of the program as the hospital staff have the confidence to refer patients to the program.

Chapter IV

Evaluation of Training of Hospital Staff

Chapter IV. Evaluation of Training of Hospital Staff

introduction

An underlying assumption of the WomanKind program is that health professionals do not assess for domestic abuse among their patients and do not intervene on this issue because they lack knowledge about domestic abuse and how to intervene appropriately. WomanKind addresses this through in-service training provided to health care providers within each hospital.

As we discuss further in the outcome evaluation component of this study, the overall presence of the WomanKind program appears to affect the knowledge, attitudes, beliefs and behaviors of medical providers within the Fair-view Health Services by increasing their knowledge and understanding of domestic abuse and giving them an in-house resource for referral. However, the training for these providers is such an important component of the WomanKind program that we believed it would be valuable to assess the training on its own. In this assessment we sought to answer the following questions.

Research Questions

- What is addressed in the WomanKind training for hospital staff? How is the training conducted? What contributes to the effectiveness of the training?
- What are the staff perceptions of the value of the training?
- How does WomanKind training affect the knowledge, attitudes, beliefs and behaviors of hospital staff?

In the following sections, we describe how this assessment was conducted and what was discovered with regard to each of these questions.

Chapter IV. Evaluation of Training of Hospital Staff

I. Curriculum Review

Nature of the Review

The curriculum for WomanKind's in-service training for health care providers was reviewed to determine the extent to which the curriculum materials address the training objectives, how the content and process of the training may be strengthened, and the potential for replication and/or adaptation. In addition to reviewing all curriculum materials, evaluation staff also observed two training sessions for hospital staff which allowed us to see how the training is conducted and the training activities used.

A number of factors were used to assess the curriculum materials for the professional education program for health care providers, in an effort to identify what contributes to the effectiveness of the training and identify any areas where the training could be strengthened. The specific factors included:

- The existence of clear and measurable learning goals and objectives
- Appropriateness of training methods, given the learning objectives 'and intended audience
- Opportunity for discussion, questions, concerns, debate, practice
- Comprehensiveness of the content presented
- Relationship between the content and learning objectives
- Clarity of intent for each training activity
- Clarity of the mechanics for each training activity, including set-up, facilitation, and processing
- Clarity of transitions and connections behveen training activities
- Realistic timing for content presentations and other activities
- Logical sequence and building of activities
- Options or trainer considerations if circumstances necessitate changes in the curriculum
- Inclusion of cultural issues
- Preparation needed prior to training-for trainers and participants
- Role and relevance of any additional readings

A. What is Addressed in the Trainina?

The overall goal of the training for health care providers is to increase their knowledge, ability, and motivation to assess for domestic violence and refer patients to the WomanKind program. Exhibit IV-l provides an overview of the training objectives and the information that is covered within the training.

Exhibit IV-1

Professional Education Program for Health Care Providers
Health Care and Domestic Abuse

Training Objectives

By the completion of the program, participants will be able to:

- Describe the myths, realities and dynamics of domestic abuse and violence
- Describe the criteria for identifying domestic abuse in the medical office, clinic, home health or hospital setting
- Describe identification and intervention techniques with victims of family violence in the medical office, clinic, hospital or home health setting
- Describe the victim's process of change including the importance of respecting that process, timetable and decisions
- Discuss statistics that demonstrate the importance of health care intervention

Training Outline

I. *Scope and Prevalence of Domestic Violence*

Discuss statistics that demonstrate the importance of health care intervention for domestic abuse.

II. ***Dynamics, Myfhs and** Realities, Cycle **of Violence***

Describe the myths, realities and dynamics of domestic abuse and violence.

III. ***Assessment, Identification and** Intervention*

Review the signs and symptoms of domestic abuse in the medical office, clinic, home health or hospital setting.

Continued

Exhibit IV-I (cont.)

Professional Education Program for Health Care Providers
Health Care and Domestic Abuse

Professional Education Program for Health Care Providers
Health Care and Domestic Abuse

Training Outline (cont.)

IV. Intervention and Documentation

Describe intervention techniques along with case study analysis, including appropriate questions/responses with victims of domestic abuse.
Describe appropriate documentation of domestic abuse and violence in the medical chart.

V. WomanKind Program and Community Connection

Describe the working relationship between WomanKind, a hospital-based domestic abuse program, and appropriate resources available in the community

VI. Victim's Process of Change

Describe the victim's process of change including the importance of respecting that process, timetable and decisions

Describe the personal bias and frustration health care professionals may feel in working with victims of family violence

Key Handout Materials Used in Training*

1. Statistics on the Prevalence of Abuse
2. Domestic Abuse and Health Care
3. Myths and Realities of Domestic Abuse
4. Power and Control Wheel
5. Equality Wheel
6. Cycle of Violence
7. Identification of Victim of Domestic Abuse
8. Asking the Question
9. Description of WomanKind
10. Case Studies: The Role and Response of the Health Care System to Domestic Violence

**Copies of these materials appear in Appendix H.*

B How is the Training Conducted?

WomanKind has designed the professional educational program described above as a flexible program that can be adapted to meet the needs and demands of the staff of various hospital departments and other medical settings. In some situations, a department may decide to sponsor a three-hour in-service training opportunity for their staff and the entire program can be delivered during that time. More often, WomanKind is asked to deliver the training to staff of a particular unit in 1- to 2- hour blocks of time, possibly with a follow-up session at a later date. In this situation, the training covers prevalence of domestic violence, myths and realties, and identification. Information about the woman's process is incorporated into these topics and the session ends with a briefpresentation on the WomanKind program. A follow-up session would provide more information on assessment, identification and documentation, as well as more discussion on the woman's process of change.

The training is conducted largely as a knowledge building opportunity with presentations on each topic, supported by slides or overhead transparencies and handout materials. Participants are encouraged to ask questions of the presenters before moving into a new topic, and presenters often engage participants by posing a question to them about their own experience or perceptions, though restrictions on time limit the opportunity for this kind of discussion. Presenters also attempt to engage participants through the use of case studies, presenting a case and asking participants how they perceive the situation and how they would/could respond in the situation. Training is presented by Susan M. Hadley, MPH, founder of WomanKind and/or Sherrie Eisele, program manager for WomanKind, which provides for a high degree of consistency in the training.

At the request of nurses and nurse managers, a self-learning packet has been developed containing materials from the training and information about the WomanKind program. It is being distributed through the nursing education department to the appropriate hospital units and used for:

1. those unable to attend the didactic training
2. those who need education (directive from supervisor or nurse manager) on specific JCAHO Standards
3. those who would like refresher updates
4. those who need CEU's

Since this self-learning packet was developed recently and not yet widely distributed, it was not included in the training evaluation component of the study.

C. What Contributes to the Effectiveness of the Training?

Strengths of the Training

This is an instructionally sound curriculum that responds to the identified needs of the targeted audience, i.e., health care providers' need to understand the prevalence and dynamics of domestic abuse and the role they can play in preventing and reducing abuse. There is clear, direct connection between the learning objectives, which are stated in behavioral, measurable terms, and the topics covered through presentation. The handout materials correspond to the topics and are used to reinforce and provide more detail to the presentations.

> *"I didn't think of the hospital as a place to work with domestic violence victims, but now I see this as a critical moment for change."*
> -Social Worker
> Fairview Ridges Hospital

Perhaps the greatest strength of the curriculum is that it is straightforward and practical in addressing the issue of domestic abuse. It provides concrete information (statistics on prevalence, suggestions on how to ask about domestic abuse, cues to look for in assessing for violence) that health care providers can use as soon as they leave the training. It is obvious that the material presented is firmly grounded in real-life experience. The presenter(s) use many examples from their own work with abused women to illustrate the points and to underscore the urgency of health care providers playing a role in assisting these women. The material also reflects the most up-to-date information and research on domestic violence.

The curriculum design allows for modifications based on the time available, the specific characteristics of the audience and their knowledge and experience with the subject. Since the training priorities are clearly identified within the objectives, the training can be delivered in total or broken into segments and delivered over two or three sessions. If a particular group of trainees is more knowledgeable about one topic, the topic can be covered more briefly allowing more time for another topic. The design ensures that all topics will be addressed to some extent. Presenters have identified the most important messages or points that they want to convey in each topic and are prepared to go deeper into a topic if necessary. This allows for a high level of consistency in the training as well as a flexibility to address differing needs and conditions as they are identified.

The primary method of delivery for the training is presentation with visual aids, which seems appropriate given the short time frame of the training and the fact that this is likely an introduction to the issue of domestic violence. Giving participants the opportunity to raise questions is extremely important for their learning and as a way for presenters to see if they are being clear. Some time is built in for this. In the last year, the presenters began using

case studies to engage participants a bit more in the training and this seems to work well, particularly in small groups where discussion can take place.

Suggestions for Strengthening the Training

While skill-building is not an imrnediate objective, ultimately the training is intended to encourage medical providers to interact differently with patients to more effectively assess for and intervene in abusive situations. The training provides information of how to ask about abuse and the rationale for asking, but little or no opportunity to practice asking. The review ofcase studies does offerparticipants the chance to think through a situation and what they might do, but more practice would be beneficial. This is a consideration for future training, particularly second or third sessions with a particular group of participants.

A related consideration is the likely need to develop more "advanced" training for staff who have been exposed to the training, While the basic curriculum will remain appropriate for new staff members, more experienced staff will be ready to move into other topics related to intimate partner violence and to process their own experiences in more depth.

Implementation Issues

In implementing the educational program, WomanKind has had to confront a number of structural and logistical issues, likely to be issues that will affect any hospital's effort to train their staff in this area. These are on-going issues that present dilemmas for how to conduct the training. They include:

- Regular staff meetings or departmental meetings don't offer much time for training, often have a lengthy agenda and may not be well attended. How do you make the most of an opportunity to address staff, even if for a short time?

- Rotating shifts. How do you schedule training so the greatest number of staff have the opportunity to attend?

- Incentives for training. At a minimum, continuing education units should be offered to all participants. Food is also a good incentive. Since training is not likely to be mandatory and staff have opportunities for training in many topics, how do you motivate them to attend? (An example of a brochure used to advertise WomanKind training appears in Appendix I).

- In most hospitals there are substantial numbers ofpart-time employees who may not be as inclined to participate in training. How can you reach them?

- Downsizing is a fact of life within many hospitals, often accompanied by a drop in morale among staff. How can you reach staff who may already feel overburdened?

II. Hospital Staff Perceptions of Training

In February 1997, the evaluation team conducted a site visit to Minneapolis to interview staff at all hospitals participating in the study. The overall purpose of these interviews was to collect staff perceptions about the WomanKind program in general, but it was also an opportunity to ask specifically about the WomanKind training. The facilitator guide for the interviews appears in Appendix J. A total of 40 staff members who had attended WomanKind training participated in the interviews.

Findings - Hospital staff in all of the Fairview sites were asked in interviews if they had participated in WomanKind training and to give their perceptions of the training. Even staff who had not participated in the training were aware of it. A few said that they could not attend for some reason and wanted to attend a later session. A few said that they did not feel that they needed to attend the training because they had similar training in medical or nursing school or because they already knew the information that was to be covered.

Those individuals who had participated in the training described it as valuable and enlightening. Several made a point of saying that they were surprised or even shocked by things they learned, such as how prevalent domestic abuse is or that women are often abused during pregnancy. Some staff found that the training reinforced what they already knew but they found this valuable and worth their time. A number of staff also made comments about how dynamic the training was and that material was presented in such a way that it jolted staff to action.

Many staff members described what they got out of the training and how they have been able to use it. Examples include:

- Made me more aware of what to look for, reinforced the need to be patient
- Taught me that there are things I can do
- Helped me understand what the woman is going through, even if I have a hard time with it
- Helped me understand that we can't fix everything
- Made me feel more comfortable with the topic, I know how to ask about it now
- Opened my mind to the possibility that more problems are violence related

Staff also had suggestions for improving or advancing the training, including:

- Include role playing

- Let us bring patient scenarios and discuss them or act them out
- Give us more help in handling difficult cases, especially when children are also being abused
- Give us more specific how-to's, such as how to get the partner out of the room
- Help us deal better with the frustration of seeing them come in again and again

Since WomanKind training was also offered in the two comparison hospitals during the last months of the study, we also asked staff in those hospitals to comment on the training. Their remarks were extremely similar to the comments cited above in terms of the value of the training and the things that they learned. In addition, many staff in these two hospitals commented that the training has made them more aware that their hospital needs to do more to address this issue and has provided them with a forum for discussing the issue among themselves.

> *'From WomanKind training, I gained new insight. It broadened our definifion of abuse. We should be infervening with more pafien ts".*
>
> -Social Worker
> Ridgeview Medical Center

> *"I saw a case of possible domestic violence the day before the training, it helped me put the pieces togefher. Next time I'll ask, I'll express more concern to her, refer her to the social worker".*
>
> -Nurse
> Emergency Department

III. Impact of the Training on Staff, Knowledge, Attitudes, Beliefs and Behaviors (KABB)

The WomanKind training program is designed to increase hospital staff members' awareness of the extent of domestic violence among their patients, and the role they can play in addressing it. The training is also intended to increase their willingness and ability to identify patients who are victims of abuse, and then offer them the resources of trained WomanKind program staff and volunteer advocates who can work directly with the victim. Thus, another aspect of the evaluation of the WomanKind training program for hospital staff involved measuring the impact of this training on these core set of attitudes and beliefs as well as determining the impact of the training on staff KABB over time.

Chapter IV. Evaluation of Training of the Hospital Staff

A. Evaluation Design/Methodology

A repeated measures, quasi-experimental, non-equivalent comparison group design was used to determine the impact of the WomanKind training program on staff knowledge, attitudes, beliefs, and self-reported behaviors.

The study population for this component of the study was the sub-set of hospital staff who participated in the evaluation of the overall WomanKind program *and* received WomanKind training over the course of the study. Between baseline and TIME2 administrations of the overall staff survey, WomanKind training was offered (in various departments) to staff from the three experimental sites. Between TIME and TIME3, WomanKind training was offered in both the experimental and comparison sites.

The survey responses of all staff who received WomanKind training over the course of the study were tracked so that they could be segregated from the larger population of staff and analyzed. Consequently, the staff baseline survey from the outcome evaluation serves as the ***pre-training*** measure. Subsequent surveys at TIME2 and TIME3 serve as ***post-training*** measures. The figure below graphically depicts the evaluation design (O=observation or survey, X=intervention, i.e. WomanKind training):

Experimental:	$O_{(baseline)}$	X	$O_{(TIME2\ survey)}$	X	$O_{(TIME3\ survey)}$
Comparison Sites:	$O_{(baseline)}$		$O_{(TIME2\ survey)}$	X	$O_{(TIME3\ survey)}$

Instrumentation. As discussed above, the same survey used to examine the impact of the overall WomanKind program on staff KABB was also used to measure the impact of the WomanKind staff training program on trainees' KABB. The instrument uses an anchored 7 point Likert scale ("Strongly Disagree to "Strongly Agree") and contains 5 1 items and 7 scales which address the following issues:

- Self-efficacy for Identification and Interaction: belief in their ability to identify victims of abuse and interact appropriately with them.
- Self-efficacy for Referral and Services: belief in their ability to make appropriate referrals for victims of abuse and their intent to do so.
- Staff Understanding of Abusive Relationships: their understanding of the myths and realities and the dynamics of domestic abuse.

- Staff Responsibility to Address Domestic Violence: belief in the role of medical staff to identify and address domestic violence.
- Self-Reported Behaviors: behaviors related to asking patients about abuse and documenting in patient charts how, injuries occurred.
- Staff Preparation: beliefs around the extent to which medical staff have the training, time, and knowledge to address domestic violence,
- Victim Autonomy: attitudes and beliefs concerning victim's needs and rights to make their own decisions about their situations.

In addition to their usefulness in assessing the impact of the WomanKind ***program,*** these conceptual domains, or scales, were also developed to correspond with the goals and objectives of the WomanKind staff training. The KABB instrument appears in Appendix K.

Psychometric Analysis of the Instrument. The psychometric properties of this instrument were fully explored in the outcome component of the evaluation (Chapter V). The instrument was found to be internally consistent with each scale evidencing Cronbach Alphas between .56 and .87. The correlation coefficient for the total score was .8723.

Data Collection Procedures. The surveys of those staff who received WomanKind training over the course of the study were segregated from the larger population of staff who participated in the overall evaluation. At each WomanKind training session, trainees were asked to complete a survey and sign a log sheet which asked for their name, address, and the 4 digit code used on their survey. This was done approximately 15 minutes before training commenced.

These log sheets and completed surveys were then compared to the database of all participants in the study. Trainees' names and 4 digit codes which were found in this database were then uniquely coded as having received WomanKind training. The names and codes of those trainees ***not*** found in this database were added, also coded, and their surveys included in the outcome evaluation component of the study.

While this tracking method was found to be extremely effective, we felt that additional methods should be employed to further insure that all staff who received training over the course of the study would be identified. Also, we wanted to separate those staff who received training ***during*** the study from those who may have received training ***prior*** to the study. Thus, on the survey administered at TIME3 respondents were asked to indicate whether or not they had received WomanKind training and the approximate date (month and year). A total of 115 staff, approximately one-third of the study population at baseline (N=327);

received WomanKind training over the course of the study, either between baseline and TIME2 or between TIME2 and TIME3.

Response Rate. We experienced similar levels of attrition with staff who participated in WomanKind training sessions as with all study participants. While we have baseline surveys on 115 staff who received training, less than half of these participants completed a survey at TIME2 (N=51). However, because of incentives used at TIME3 (movie tickets), we regained a substantial segment of our initial study population (N=85). Thus, baseline and TIME3 surveys are available for 85 trained staff.

WomanKind training records indicate that 70 training sessions were conducted between February 1996 and February 1997. Approximately 400* staff from the Fairview hospitals participated in the training, thus we have survey information from approximately ¼ of these individuals.

Demographic Information. A total of 115 hospital staff who completed baseline surveys received WomanKind training over the course of the study-93 were trained between baseline and TIME2 and the remaining 22 were trained between TIME2 and TIME3. Demographic data (see Exhibit IV-2) indicate that the majority of staff who received training are women (66 percent), are under the age of 40 (60 percent), employed full time (60 percent), and have been employed at their respective hospital sites for less than 6 years. Additional data collected at TIME3 indicate that emergency medicine is the most frequent staff specialty and that close to 40 percent of staff have been working in health care for less than 6 years. Unfortunately, due to logistical constraints, staff from the Waconia Ridgeview site (a comparison site) received and completed their final surveys in January 1997, prior to when these additional questions were added to the survey at TIME3. Hence, this information is not available for staff from this site. Exhibit IV-3 presents the additional data collected at TIME3.

* Numbers were drawn from sign-in logs from the training and may not reflect individuals who arrived at the training after it began.

Exhibit IV-2 Demographics of Trained Staff (N=115)

Hospital	(N)	% of Sample
Fairview Southdale	24	20.9
Fairview Ridges	29	25.2
Fairview Riverside	44	38.3
Abbott Northwestern	10	8.7
Waconia Ridgeview	8	7.0
Department	**(N)**	**% of Sample**
Emergency Department	78	67.8
ICU	7	6.1
Ob/Gyn	23	20.0
Other	7	6.1
Age	**(N)**	**% of Sample**
20-24	4	3.5
25-29	24	20.9
30-34	14	12.2
35-39	27	23.5
40-44	21	18.3
45-59	22	19.1
60-64	3	2.6
Sex	**(N)**	**% of Sample**
Male	39	33.9
Female	76	66.1
FTE (Full-time Equivalent Status)	**(N)**	**% of Sample**
full time	60	52.1
part time (.50-.90)	31	26.9
less than part time (<.50)	8	6.9
Missing	I6	13.9
Position	**(N)**	**% of Sample**
Nursing Staff (RN, LPN, NP)	43	37.4
Physician Staff	30	26.1
Paramedic/Emergency Medical Technician	23	20.0
Physician's Assistant	6	5.2
Other	12	IO.4
Missing	1	.9
Hiredate (Number of years working at hospital)	**(N)**	**% of Sample**
less than 1 year	15	13.0
1 to 5 years	43	37.4
6 to 10 years	22	19.1
11-20 years	21	18.3
21-30 years	2	1.7
31-40 years	1	.9
over 40 years	0	0.0
Missing	II	9.6
Previous exposure or training in domestic violence	**(N)**	**% of Sample**
yes	33	28.7
no	78	67.8
Missing	4	3.5

Exhibit IV-3
Staff Demographic Data Collected at TIME3 (N=77)*

Specialty	(N)	% of Sample
Pediatrics	2	1.7
Emergency Medicine	20	17.4
Ob/Gyn	13	11.3
Surgery	1	.9
Internal Medicine	17	14.8
Other	37	32.2
Missing	25	21.7
Number of Years Working In Health-	**(N)**	**% of Sample**
1 to 5 years	12	10.4
6 to 10 years	17	14.8
11 to 20 years	28	24.3
20 years or more	16	13.9
Missing	42	36.5
How have you learned about domestic violence issue?**	**(N)**	**% of Sample**
WomanKind	72	62.6
Other training (e.g. hospital in-service)	40	34.8
Lecture or seminar in professional school	32	27.8
Volunteer	8	6.9
Personal Experience	24	20.9
Other	11	9.6
Have you identified a victim of intimate partner violence within the last 12 months?	**(N)**	**% of Sample**
yes	49	42.6
no	28	24.3
Missing	38	33.0

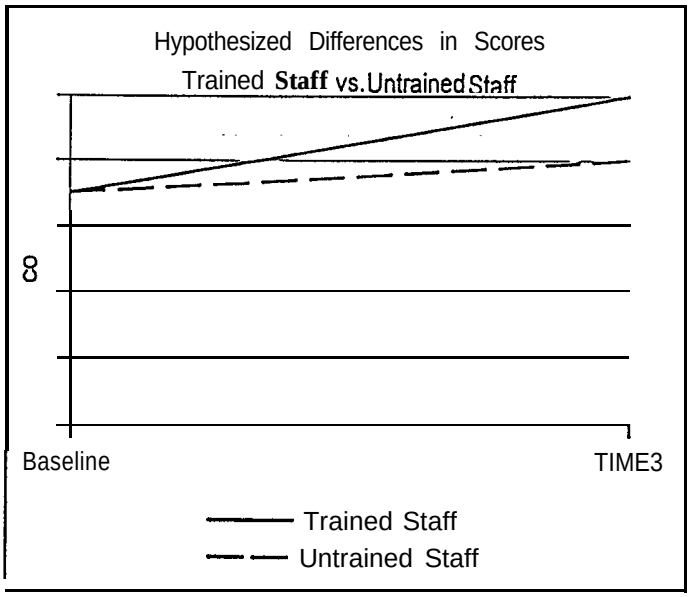
* 85 of the 115 trained staff completed TIME 3 surveys. Of these 8 were from Waconia Ridgeview, a site for which these data are not available, leaving a N of 77.

** Numbers exceed total because respondents could chose more than one response.

B. Findings

Overview of Hypothesis. We hypothesized that staff who received WomanKind training over the course of the study would demonstrate significantly higher KABB scores at TIME3. This hypothesis is graphically depicted below (Exhibit IV-4):

Exhibit IV-4



Tests for Potential Confounding Effects. Because participation in WomanKind training is voluntary, the issue of selection bias warranted analysis. In an effort to explore this issue, baseline survey responses of staff who participated in WomanKind training and staff who did not participate in this training were compared using a General Linear Model Multivariate Analysis. This test indicated that there were no significant differences between baseline scores of trained and untrained staff on any of the seven scales or on the total score. ($p>.05$). Mean scale scores for each group are presented in Exhibit IV-5.

Exhibit IV-5
: Staff Mean Scale Scores at Baseline
Trained vs. Untrained Staff

Scale	Trained Staff (N=1 1 5)	Untrained Staff. (N=212)
1. Self-Efficacy for Identification and interaction	4.25	4.27
2. Self-Efficacy for Referral and Services	5.57	5.65
3. Staff Understanding of Abusive Relationships	5.54	5.58
4. Staff Responsibility to Address Domestic Violence	5.65	5.63
5. Self-Reported Behaviors	4.12	4.23
6. Staff Preparation	4.05	3.93
7. Victim Autonomy	4.40	4.32
Total Score	189.23	191.56

Because staff received training at varying intervals during the study (between baseline and TIME2 or TIME2 and TIME3) and because they completed their baseline (or pre-training) surveys at varying times (Spring, Summer or Fall) differences in survey responses over time were assessed on these factors. There were no significant differences in mean scale scores over time based upon when staff received training or when they completed their surveys ($p>.05$). Hospital affiliation, departmental affiliation, age, position, and fte were also found to have no significant effect on staff mean scale scores over time.

Since 33 of the trained staff stated that they have had some type of previous exposure to domestic violence issues, differences between these staff and those with no previous exposure were explored so that the true effect of training could be ascertained. The analysis indicated that those trained staff who also had previous exposure to domestic violence issues had significantly higher mean scale scores over time than those with no previous exposure (all 7 scales, $p<.01$). Data collected at TIME3 also indicated that of the 115 trained staff, 15 had also participated in a WomanKind training session prior to this evaluation. Analyses indicated that these staff had significantly higher mean scale scores than those who have only participated in a WomanKind training session during the course of the study (all 7 scales, $p<.01$).

Given that we were interested in exploring the specific effects of the WomanKind training on staff KABB, those trained staff with previous exposure to domestic violence issues and/or who participated in a WomanKind training session prior to this study were separated from the sample. Thus, the sample size was reduced from 115 to 53. The following analyses are based upon the survey responses of these 53 trained staff.

Analysis: Assessing the impact of the WomanKind training on staff KABB over time involved using a General Linear Model (GLM), repeated measures multivariate analysis of variance.

Results

When comparing trained staff scores at baseline and TIME3, significant within group effects were found on scales 1, 2, 4, 5, 6. Also, the overall mean scale scores of trained staff significantly increased from baseline to TIME3. These results are graphically depicted in exhibit IV-6.

Exhibit IV-6
Changes in KABB Scores Over Time (N=53)
Mean (Standard Deviation)

Scale	Baseline	Time3	F, p values within group effect
1. Self-Efficacy for Identification and Interaction	4.06 (.8744)	4.76 (.657)	F=33.65, p<.000
2. Self-Efficacy for Referral and Services	5.37 (.8564)	5.92 (.8189)	F=11.79, p<.001
3. Staff Understanding of Abusive Relationships	5.45 (.7175)	5.59 (.6169)	F=2.13, p<.150
4. Staff Responsibility to Address Domestic Violence	5.48 (.7156)	5.81 (.6923)	F=8.92, p<.004
5. Self-Reported Behaviors	3.95 (.7820)	4.46 (1.0987)	F=10.60, p<.004
6. Staff Preparation",	3.77 (1.0252)	4.48 (.9171)	F=22.19, p<.002
7. Victim Autonomy	4.34 (.8644)	4.49 (.9270)	F=.945, p<.37
Total Mean Score	4.72	5.13	F=29.58. p<.000

IV. Summary of Findings

A goal of the WomanKind program is to provide education to health care staff to increase their knowledge and skills in identifying and treating victims of domestic violence. In this chapter we focused on the formal education program that has been developed for health care staff. The methods used to assess the education or training program included: a curriculum review; interviews with health care staff who participated in the training; and pre- and post-test measures of knowledge, attitudes, beliefs and behaviors.

WomanKind has designed the professional educational program as a flexible program that can be adapted to the needs and demands of various hospital departments and other medical settings, Training can be delivered in l-, 2- or 3-hour sessions, with follow-up sessions as needed and requested. The training covers the basic topics of:

- Scope and prevalence of domestic violence
- Dynamics, myths and realities, cycle of violence
- Assessment, identification, and intervention
- Intervention and documentation
- WomanKind program and community connection
- Victim's process of change

The training is conducted largely as a knowledge building opportunity with presentations on each topic, supported by visual aids and handout materials. Presenters encourage questions and often use case studies to engage participants in discussion, though time restrictions often limit this type of interaction.

Hospital Staff Perceptions of Training

Hospital staff (medical, nursing, social work staff) who participated in training described it as valuable and enlightening. Several made a point of saying that they were surprised or even shocked by things they learned, such as the prevalence of domestic abuse or that women are often abused during pregnancy. Individuals stated that the training made them more comfortable with the topic, taught them that there were things they could do for patients who are victims or abuse, and helped them understand what the woman is going through.

It was interesting to note in the interviews that many hospital staff used the language of WomanKind, i.e. "understanding the woman's process", "my role is to identify, assess and refer". Many stated that the training had raised their awareness of the problem, they look for it more often since the training.

Chapter IV. Evaluation of Training of the Hospital Staff

Changes in Staff KABB Over Time

A 5 l-item KABB survey was used to measure the hospital staffs' knowledge, attitudes, beliefs, and behaviors related to domestic violence, administered at three different points during the study. To assess the impact of the training, we analyzed the surveys for those who had participated in the training, using the baseline survey as a training pre-test, and TIME3 survey as a post-training measure. The 5 1 items form seven conceptual domains or scales, which were used for the analysis.

When mean scores for baseline and TIME3 KABB surveys were compared for trained staff, the scores increased on all seven scales. Five of these were statistically significant increases:

- Self-efficacy for identification and interaction
- Self-efficacy for referral and services
- Staff responsibility to address domestic violence
- Self-reported behaviors
- Staff preparation

These findings suggest that the training is effective in helping staff develop confidence in their ability to recognize and communicate effectively with victims of domestic abuse and their ability to make appropriate referrals for these individuals. The findings indicate that the training positively affected their beliefs that hospital staff have a responsibility to address domestic violence and that they themselves are more likely to ask questions about abuse of their patients and document such information in their charts. Finally, an increase in the mean score for the last scale suggest that the training made staff more likely to believe that hospital staff do have the knowledge, time, and training to assist victims of domestic violence.

These items very clearly reflect the primary focus of the training, which is to help hospital staff understand their role in identifying and intervening with patients who are in abusive situations and to show them that with an in-house referral service available to them, their intervention does not have to extend to counseling or other activities for which they feel they do not have the time nor expertise.

The analysis of KABB surveys also indicated that trained staff who had previous exposure to domestic violence issues (through other educational opportunities or personal experience) or who had also participated in WomanKind training prior to this evaluation period, had higher mean scale scores over time than those with no previous exposure. This is consistent with an expectation that someone who has been exposed to information about domestic violence from a number of sources over time, or has personally been affected by it, would have a greater understanding of the problem and stronger beliefs about intervening.

Strengths of the Training Program

This is an instructionally sound curriculum that responds to the identified needs of the targeted audience, i.e., health care providers' need to understand the prevalence and dynamics of domestic abuse and the role they can play in preventing and reducing abuse. There is a clear, direct connection between the learning objectives and the topics that are covered in the training. Consistency in the messages conveyed in the training is strong because so much of the curriculum exist in writing, including handout's that training participants take with them.

The curriculum is practical and straightforward in addressing the issue of domestic violence. It provides concrete information that health care providers can use as soon as they leave the training. It is obvious that the material presented is firmly grounded in real-life experience and reflects the most up-to-date information and research on domestic violence.

The curriculum design allows for modifications based on the time available, the specific characteristics of the audience, and their knowledge and experience with the subject. Since the training priorities are clearly identified within the objectives, the training can be delivered in total or broken into segments and delivered over two or three sessions,

Suggestions for Strengthening the Training Program

The training provides information on why and how to ask about abuse, but little or no opportunity to practice asking. The review of case studies does offer participants the chance to think through a situation and what they might do, but more practice would be beneficial. This is a consideration for future training, particularly second or third sessions with a particular group of participants.

A related consideration is the need to develop more "advanced" training for staff who have been exposed to the training. While the basic curriculum will remain appropriate for new staff members, more experienced staff will be ready to move into other topics related to intimate partner violence and to process their own experiences in more depth.

When staff who had participated in training were asked for suggestions for how the training might be improved, they offered the following ideas:

- Include role playing
- Let us bring patient scenarios and discuss them or act them out
- Give us more help in handling difficult cases, especially when children are also being abused
- Give us more specific how-to's, such as how to get the partner out of the room
- Help us deal better with the frustration of seeing them come in again and again

Conclusion

Formal training provided to hospital staff is a fundamental component of the WomanKind program and is linked to the goal of improving the health care providers' responses to victims of domestic violence. Our assessment of the training suggest that even brief (1 to 2 hour) training sessions have an impact on staffs' level of awareness of domestic abuse and their belief that they can do something about it.

Chapter V

Outcome Evaluation of the Hospital Staff

. Chapter V. Outcome Evaluation of the Hospjtal Staff

Introduction

The objective of this component of the evaluation was to determine how the WomanKind program affected hospital staff. The central research questions were:

Research Questions:
Outcome Evaluation-Hospital Staff

- Is there significant change over the time of the study in the knowledge, attitudes, beliefs and behaviors of hospital staff?
- Are there significant differences in the knowledge, attitudes, beliefs and behaviors of staff of the initial WomanKind site (Fairview Southdale Hospital) and the other two Fairview hospitals?
- Are there significant differences in the knowledge, attitudes, beliefs and behaviors of staff of the experimental hospitals and the comparison. hospitals?

As the primary method of collecting data for this evaluation, hospital staff in the WomanKind sites were asked to complete questionnaires specifically designed to measure their knowledge, attitudes, beliefs, and behavioral intentions (KABB) regarding intimate partner violence. Hospital staff in the comparison sites (with no comparable program in place) were asked to complete the same survey. This component of the study sought to determine the impact of the program over time, therefore, surveys were administered to staff at approximately 4-month intervals over the course of 13 months.

Additionally, interviews were conducted with staff in the hospitals where WomanKind operated to gain insight into their perception of the prog-ram's impact. Staff in the comparison hospitals were interviewed to determine their perspectives on intimate partner violence and how it is addressed in their hospitals.

I. Impact of the WomanKind Program on Knowledge, Attitudes, Beliefs, and Behavioral Intentions (KABB)

A. Methodology

Design

A repeated measures, quasi-experimental, comparison group design was used to determine the impact of the WomanKind program on staff knowledge, attitudes, beliefs, and self-reported behaviors. The study design entailed baseline, follow-up, and final administrations of the survey to hospital staff from both the experimental and comparison sites.

Instrumentation

Survev Development. Thestaffsurveywasdeveloped toassessrespondents'knowledge, attitudes, beliefs, and self-reported behaviors regarding domestic violence as well as collect demographic information on each respondent. The survey appears in Appendix K, and is also discussed in chapter IV of this report. This instrument contained 51 items and 7 scales which addressed the following areas:

- Self-efficacy for Identification and Interaction: belief in their ability to identify victims of abuse and interact appropriately with them.
- Self-efficacy for Referral and Services: belief in their ability to make appropriate referrals for victims of abuse and their intent to do so.
- Staff Understanding of Abusive Relationships: their understanding of the myths and realities and the dynamics of domestic abuse.
- Staff Responsibility to Address Domestic Violence: belief in the role of medical staff to identify and address domestic violence.
- Self-Reported Behaviors: behaviors related to asking patients about abuse and documenting in patient charts how injuries occurred.
- Staff Preparation: beliefs around the extent to which medical staff have the training, time, and knowledge to address domestic violence.
- Victim Autonomy: attitudes and beliefs concerning victim's needs and rights to make their own decisions about their situations.

The conceptual domains (or scales) used for this survey were based upon a review of relevant issues derived from the professional literature on domestic violence, the explicit objectives of the WomanKind program, and discussions with the WomanKind founder and staff. According to our extensive review of the literature, this instrument represents a pioneering effort in the development of a tool to measure the knowledge, attitudes, beliefs and behaviors of professional health care providers in relation to domestic violence.

We were able to draw from the findings of a previous study conducted by CDC/Macro to enhance our development of this instrument. This earlier study examined the KABBs of second year UCLA medical students regarding intimate partner violence and contained almost identical survey items as the WomanKind staff survey. Analysis of this earlier survey instrument yielded 6 out of 10 scales that showed robust psychometric properties.

Because participants from the UCLA study were *medical students* and therefore less experienced in working with patients than the medical staff who participated in the WomanKind study, we re-examined the factor structure suggested by the UCLA findings. To empirically test the conceptualized factor structure of the KABB, a principal components factor analysis of the scores for the that scales was conducted. The factor analysis confirmed the conceptualized factor pattern. Analyses of the baseline staff surveys from the WomanKind study supported much of the same factor structure as the UCLA study. However, there were some differences that we believed were significant enough to warrant modification of the instrument for use with this population. For example, factor analysis of the baseiine staff surveys suggested the separation of items that measure self-efficacy for identification and interaction from those that measure self-efficacy for referral and services. The factor analysis also suggested the merging of items that addressed the motivations of abusers and victims into one scale *(Understanding of Abusive Relationships*). Thus, seven scales (39 items) were developed for the staff survey. Items belonging to scales that were not found to be psychometrically sound were not used in the analysis of survey responses.

The WomanKind staff survey uses an anchored seven-point Likert scale, ranging from "Strongly Disagree" to "Strongly Agree." Scales rather than individual survey questions or items were used here because of improved reliability and validity obtained from using multiple items to tap a given conceptual domain. High inter-item reliability increases the likelihood that the face-valid items are, in fact, tapping related facets of a single concept. The use of multiple items to tap these facets reduces error variance associated with the measurement of any given item."

[11] Anastasi, A. Psychological Testing, Seventh Edition. New York: McMillan Publishing, 1993.

Some survey items were worded in the negative to provide some variety in the phrasing and to reduce potential response bias. When combining these items with the others in their scales, it was necessary to reverse the scoring so that all survey items would be measuring the scale construct in the same direction. For example, the score on the item *"I don't have the necessary skills to discuss abuse with a victim"* was reversed so that it corresponded with other items that measured the positive aspects of Self-efficacy for Identification and Interaction with victims of intimate partner violence.

Although the instrument was based upon a previously tested and analyzed survey, it was reviewed by CDC and WomanKind program staff and pilot tested among eight staff at Fair-view Southdale Hospital. This additional review and pilot testing of the survey ensured 1) clear wording of questions; 2) language that reflected hospital settings and medical practice; 3) the fit between items and the constructs they were supposed to represent; and 4) an overall length that minimized the burden on survey respondents.

Psychometric Analysis of the instrument. We conducted several additional analyses to more fully evaluate the psychometric properties of the survey with the WomanKind study population. Internal consistency was assessed using baseline survey responses from all five hospital sites. The 7 scales evidenced Cronbach Alphas between .56 and .87. With the exception of only one scale (victim autonomy), all scales have alpha values of .60 or above, the traditional cut-off for comparison purposes. The consistency coefficient for the total score was .8723. Exhibit V-l shows the reliability statistics for the instrument.

Exhibit V-l
Factor Structure and Internal Consistency Statistics N=327

Item	Reverse Scoring	Item Statement (Cronbach alpha)
Self-Efficacy for Identification-and Ink-action (α=.8754)		
5.		I can put victims of abuse at ease.
25.		I am capable of identifying victims of domestic abuse.
26.		I can create an environment that builds trust, so that a patient can discuss domestic abuse with me.
27.		I am able to gather the necessary information to identify domestic abuse as the underlying cause of patient injuries.
28.		I am able to gather the necessary information to identify domestic abuse as the underlying cause of patient illnesses.
29.	R	I have difficulty knowing how to respond when a patient insists that suspicious injuries are not the result of abuse.
37.	R	I don't have the necessary skills to discuss abuse with a victim.
39.		I can provide support to victims of abuse.
50.		I feel comfortable discussing domestic abuse with my patients.
Self-Efficacy for Referral and Services (α=.7655)		
30.		I can make appropriate referrals within the hospital for victims of domestic abuse.
3 1 .		I can make appropriate referrals to services within the community for victims of domestic abuse.
46.		I intend to provide support and appropriate referrals to any victims of domestic abuse that I encounter in my professional practice.
47.		There are services within our own hospital for victims of domestic abuse.
48.		There are services within the community for victims of domestic abuse.

Exhibit V-l (cont.)
Factor Structure and Internal Consistency Statistics N=327

Staff Understanding of Abusive Relationships (α=.6377)		
item	Reverse Scoring	Item Statement (Cronbach alpha)
2.	R	I cannot understand why any victim of abuse would choose to remain in the relationship.
9.	R	Sometimes there are justifiable reasons for victims being hit by their partners.
12.	R	Abusers would not be violent if they weren't provoked.
17.	R	If victims of abuse remain in the relationship after repeated episodes of violence, they must accept some responsibility for that violence.
22.		Victims of abuse may have valid reasons for remaining in the abusive relationship.
23.	R	Sometimes there are justifiable reasons for a woman being hit by her partner.
24.	R	Abusers are not always responsible for their violent behavior.
33.	R	Victims of abuse could leave the relationship if they wanted to.
42.		Victims of abuse are not responsible for the abuse they **receive.**
Staff Responsibility to Address Domestic Violence (α=.6654)		
3.	R	Medical and hospital staff should not be responsible for identifying cases of domestic abuse.
8.		Medical and hospital staff who see patients are in a position to identify victims of domestic abuse.
13.		Medical and hospital staff have a responsibility to ask all patients about domestic abuse.
18.		Medical and hospital staff have an important role in addressing situations of domestic abuse.
21.	R	It is not appropriate for medical and hospital staff to ask patients about domestic abuse.
35.		The physical, emotional and economic costs of domestic abuse justify a stronger prevention effort.
Self-Reported Behaviors (α=.6136)		
38.		I review patients' charts to determine possible evidence of prior abuse.
40.		I ask all female patients about problems in their relationships.
44.		I document in patients' charts their statements about how the injury occurred.
45.		I comply with the AMA recommendations and Joint Commission standards that require inquiries about domestic abuse of all female patients.

Exhibit **V-I (cont.)**
Factor Structure and Internal Consistency Statistics N=327

Staff Preparation (α=.7661)		
item	Reverse Scoring	Item Statement (Cronbach alpha)
14.	R	Medical and'hospital staff do not have the training to assist individuals in addressing situations of domestic abuse.
15.	R	Medical and hospital staff do not have the time to assist patients in addressing domestic abuse.
16.	R	Medical and hospital staff do not have the knowledge to assist patients in addressing domestic abuse.
Victim Autonomy (α=.5632)		
6.		Abuse victims need to make their own decisions about how to handle the situation.
II.		Medical and hospital staff should not pressure patients to acknowledge that they are living in an abusive relationship.
20.		Victims of abuse have the right to make their own decisions about whether hospital staff can intervene.

Data Collection Procedures

At the start of the study, administrators of each department in each hospital announced support for the research during staff meetings and encouraged participation. Beginning in February 1996, baseline surveys were distributed across the study sites by a designated hospital staffperson serving as study ***coordinator*** for each department, within each hospital.

Staffreceived consent forms with the surveys that explained the research effort and the level of confidentiality that would be maintained throughout the study. A copy of this consent form appears in Appendix K. Participants were asked to select a four digit code as an identifier for their surveys and to use it when completing the follow-up surveys as well, so all of their responses could be matched for the study.

In general, surveys were distributed at staff meetings, conferences, and any other venues at which staff convened. While great efforts were made to collect all baseline surveys from staff during the month of February, logistical difficulties prevented this from occurring. Initial low participation rates led us to distribute baseline surveys through the end of April. Also, we distributed baseline surveys to those staff attending WomanKind training sessions who had not completed a baseline survey earlier in the year. Thus, baseline surveys were

collected through the month of October. However, nearly 80 percent of baseline surveys were collected in the Spring (February through May 1996.)

At the time that baseline surveys were administered, study participants were also asked to provide their mailing addressed for receipt of the follow-up and final surveys. Approximately 16 weeks following completion of the baseline survey, participants received a follow-up survey (along with a letter and fact sheet describing the survey) in the mail. Participants were asked to complete the enclosed survey and return it (in a pre-addressed, pre-stamped envelope) to an off-site data analysis site (Macro International in Atlanta, Georgia). This procedure was used to protect participants' confidentiality as well as to reduce the burden on hospital staff to distribute, collect, and return staff surveys. A third and final survey was administered via mail to hospital staff in late February 1997, approximately 1 year after baseline surveys were administered.*

Response Rate. A total of 327 hospital staff (48 percent of those eligible to participate) completed baseline surveys. Inherent within any repeated measures study design, including this one, is the problem of attrition. Although reminder letters and additional surveys were sent to participants and study coordinators urged staff to complete their surveys, approximately 50 percent of these study participants did not complete the first follow-up survey. Given this attrition rate, study participants were offered an incentive to complete the final survey. One movie pass and an official letter of thanks from CDC were mailed to each study participant with the final survey. Excluding those study participants who could not be located (N=35), 73 percent (2111292) of the study participants completed final surveys. The following table summarizes the response rate for each measure.

Response Rate for Hospital Staff/Surveys

Scale	Baseline	Time2	Time3
1. Surveys Retufned	327	154 (47%)	211 (65%)
2. Study Participants Who Could Not Be Located			35 (1%)
3. Study Participants Who Completed All 3 Surveys			135 (41%)

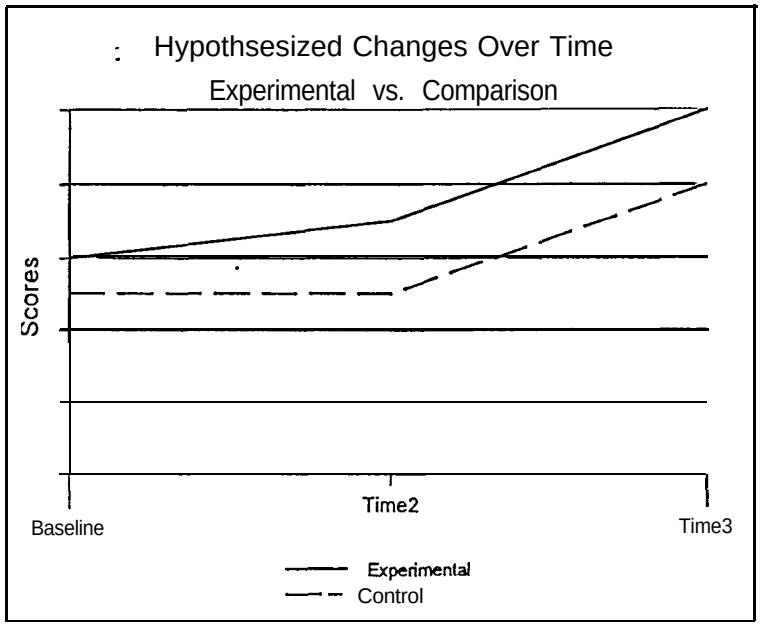
* Logistical considerations at one of the comparison sites, Waconia Ridgeview, called for the administration of the final survey in late January 1997.

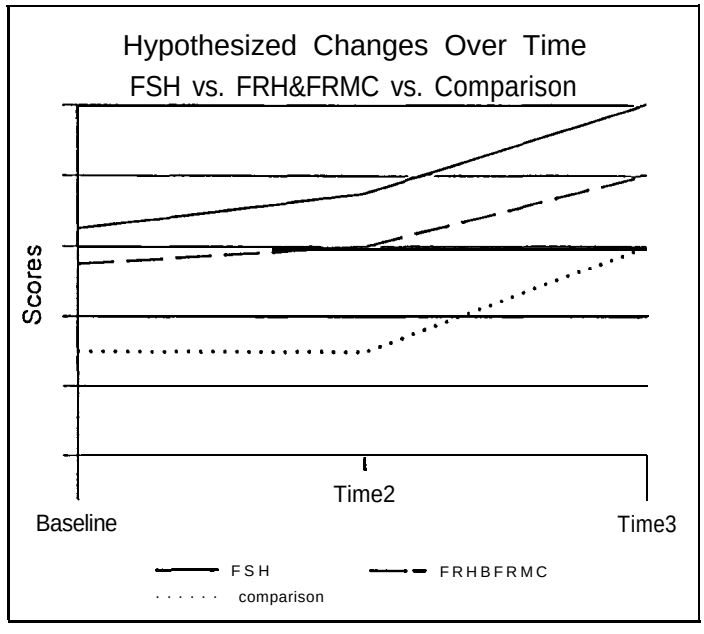
B. Findings

The most discrete element of WomanKind's intervention with hospital staff is standardized training courses. However, the multi-faceted aspect of the WomanKind program means that the intervention extends beyond the training. For example, WomanKind staff attend staff meetings and speak about the program, routinely visit the emergency departments and other units of the hospitals to review charts and communicate with staff, assist physicians and nurses in developing patient discharge plans, and are available for patient consults. In addition, WomanKind posters and brochures can be found throughout the three experimental sites including the cafeteria, staff break rooms, individual departments, and even in staff and patient restrooms. As one hospital staff person explained, "the WomanKind program has permeated the hospital, it's everywhere."

Hypotheses

We therefore, hypothesized that at baseline, the experimental sites would have higher KABB scores than the comparison sites, and that the Fairview Southdale site would have higher KABB scores than the other two experimental sites. Each of these hypotheses is graphically depicted on the following page. As indicated in both of these graphs, we also hypothesized that the effects of the institutionalization of the WomanKind program would continue to significantly contribute to higher staff KABB scores in the experimental sites than in the comparison sites. Although we expected that staff KABB scores from the comparison sites would increase between TIME2 and TIME3 as a result of having received WomanKind training, the absence of an overall domestic violence program would keep staff KABB scores lower than those from the experimental sites. The institutionalization of the WomanKind program was also believed to produce higher staff KABB scores in the Fair-view Southdale site (FSH) than in the other two experimental sites (FRH and FRMC), due to the fact that the program was founded at Fairview Southdale and had been in place there for a longer period of time.


Hypothsesized Changes Over Time
Experimental vs. Comparison
Scores
Baseline
Time2
Time3
Experimental
Control


Hypothesized Changes Over Time
FSH vs. FRH&FRMC vs. Comparison
Scores
Baseline
Time2
Time3
FSH
FRHBFRMC
comparison

Additional Hypotheses, Demographic Variables

In addition to the effects of hospital site on staff KABB scores, we hypothesized that certain characteristics such as sex, age, departmental affiliation, and staff position might affect survey responses. We believed that female staff might have higher KABB scores than male staff (indicating a greater level of awareness and understanding of domestic abuse) and that, similarly, nursing staff (most of whom are female) would have higher scores than the predominantly male physidian staff. We also believed that emergency department staff might have an increased exposure or experience working with victims of abuse and may, therefore, have higher KABB scores than their colleagues in the ICU or Ob/Gyn departments. In addition, we believed that age might affect staff KABB scores but were unsure of how. On one hand, older staff may have higher KABB scores as a result of their increased work experience. Conversely, because many medical and nursing schools are now addressing intimate partner violence in their curricula, younger staff may exhibit higher KABB scores than their older colleagues who most likely had not had the benefit of such training.

Research hypotheses also focused on the potential effects of such factors as previous training (non-WomanKind), exposure to domestic violence issues, and employment status (full time vs. part-time). Staff with previous exposure to domestic violence issues through personal experience, training in professional school, or through volunteer activities were expected to have higher KABB scores. Also, staff who were full-time and therefore had a possibly increased level of exposure to patients who were victims of abuse were assumed to have higher KABB scores.

Demographic Data

Demographic data were collected at baseline so that the effects of various social and demographic factors could be assessed and these hypothesis tested. Exhibit V-2 summarizes these data, while Exhibit V-3 illustrates the distributions of staff sex and position by hospital and department. Seventy-three percent of the study participants were female, over half were nursing professionals, and over 40 percent work part-time. Staff between the ages of 45 and 59 comprised the largest age group (26 percent), while staff ages 35 through 39 comprised the next largest age group (22.9 percent).

Exhibit V-2
Hospital Staff Demographics and Characteristics
(Baseline Data, Total N=327)

Age	(N)	% of Sample
20-24	9	28.0
25-29	36	11.0
30-34	47	14.4
35-39	75	22.9
40-44	69	21.1
45-59	85	26.0
60-64	4	1.2
Missing	2	.6
Sex	**(N)**	**% of Sample**
Male	84	25.7
Female	239	73.1
Missing	4	1.2
FTE (Full-time Equivalent Status)	**(N)**	**% of Sample**
full time	130	39.8
part time (.50 - .90)	142	43.4
less than part time (<.50)	25	7.6
Missing	30	9.2
Position	**(N)**	**% of Sample**
Nursing Staff (RN, LPN, NP)	186	56.9
Physician Staff	81	24.8
Paramedic/Emergency Medical Technician	27	8.3
Physician's Assistant	6	1.8
Other	17	5.2
Missing	10	3.1
Hiredate (Number of years working at hospital)	**(N)**	**% of Sample**
less than 1 year	21	6.4
1 to 5 years	104	31.8
6 to 10 years	93	28.4
1 I-20 years	64'	19.6
21-30 years	16	4.9
31-40 years	1	.3
over 40 years	0	0
Missing	28	8.6
previous exposure or training in domestic violence	**(N)**	**% of Sample**
yes	91	27.8
no	226	69.1
Missing	IO	3.1

Exhibit V-3
Distribution of Staff by Hospital, Department, and Position
(Baseline Data, Total N=327)

		FSH*	FRH	FRMC	AN	WR	
ED	RN	21	8	7	26	11	
	MD	10	5	22	6	6	
	Paramedic	2	21	0	4	0	
	Other	9	1	2	3	0	
	Missing	1	1	0	2	1	
	Total	43** (30F, 12M)	36 (11F, 25M)	31 (17F,14M)	41 (36F, 5 M)	18 (14F, 4M)	169 (108F, 60M)
ICU	RN	12	4	1	13	10	
	MD	1	0	0	17	2	
	Missing	0	1	0	3	0	
	Total	13 (11F, 2M)	5 (4F, 1M)	1 (1F, 0M)	33 (22F, 11M)	12 (8F, 2M)	64 (46F, 16M)
Ob/Gyn	RN	26	18	17	N/A***	11	
	MD	0	0	0	N/A	11	
	Other	0	2	1	N/A	0	
	Missing	0	0	0	N/A	1	
	Total	26 (26F, 0M)	20 (20F, 0M)	18 (18F, 0M	N/A	23 (16F, 6M)	87 (80F, 6M)
Other	RN	0	0	1	0	0	
	MD	0	0	1	0	0	
	Other	0	0	5	0	0	
	Total	0	0	7	0	0	7 (5F, 2M)
Totals by Position	RN	59	30	26	39	32	186
	MD	11	5	23	23	19	81
	Paramedic	2	21	0	4	0	27
	Other	9	3	8	3	0	23
	Missing	1	2	0	5	2	10
	All Sites	82	61	57	74	53	N=327

*FSH - Fairview Southdale; FRH= Fairview Ridges; FRMC=Fairview Riverside; AN-Abbott Northwestern (comparison site); WR=Waconia Ridgeview (comparison site)
**F - Female, M=Male--numbers for sex do not equal total due to missing data
***Ob/Gyn staff at Abbott Northwestern Hospital were not included in the study

Preliminary analyses of baseline data indicated that staffs previous exposure to domestic violence issues had a significant impact on their responses. However, we had no further details on what *type* of exposure staff had received (training, personal experience, etc.). Also, we needed to differentiate those staff who received WomanKind training prior to the study from those who were trained during the study. In addition, informal discussion groups conducted in early February 1997 suggested that additional staff characteristics such as specialty or number of yearsworking in health care may also have affected survey responses. Consequently, prior to administering the final survey, several new questions were added to the staff characteristics portion of the survey, each aimed at collecting additional data on staff background and experience regarding domestic violence.

Staff were asked to provide the number of years they had been working in the health care profession, more specific information regarding how they had learned about domestic violence issues, their specialty, and whether or not they had identified a victim of abuse over the course of the study. Unfortunately, due to logistical constraints, staff from the Waconia Ridgeview site (a comparison site) had to receive and complete their final surveys in January 1997, prior to when these questions were added to the survey. Hence, this information is not available for staff from this site. Exhibit V-4 presents the additional demographic data collected at TIME 3.

Exhibit V-4
Staff Characteristics (N=185)

Specialty	(N)	% of Sample
Pediatrics	3	1.6
Emergency Medicine	56	30.2
Ob/Gyn	44	23.8
Surgery	8	4.3
Internal Medicine	30	16.2
Missing	44	23.8
#years in health	(N)	% of Sample
less than 1 year	1	.5
1 to 5 years	20	10.8
6 to 10 years	28	15.1
11 to 20 years	68	36.8
20 years or more	62	33.5
Missing	6	3.2
How have you learned about domestic violence issue?* (N)		% of Sample
WomanKind	137	74
Other training (e.g. hospital in-service)	78	42.2
Lecture or seminar in professional school	59	31.9
Volunteer	16	8.6
Personal Experience	49	26.5
Other	33	17.8
Have you identified a victim of intimate partner violence within the last 12 months?		% of Sample
Yes	112	60.5
No	73	39.5

* Numbers exceed total because respondents could chose more than one response

Analyses of Baseline Survey Responses. Three key steps were involved in the analysis of baseline surveys: 1) computing staff mean scores on each of the seven scales, 2) performing statistical analyses to determine the effects of social and demographic factors on staff responses, and 3) performing statistical analyses to determine the differences between hospitals and between the experimental sites and the comparison sites over time.

Tests for Potential Confounding Effects. In order to speak to the impact of the WomanKind program on staffs responses to the KABB survey, it is important to first examine whether other factors such as demographic characteristics also have an effect on how staff respond to the survey. If any of these demographic effects are significant, they would confound the effects of the program and need to be controlled in the analysis. A GLM Multivariate Analysis was conducted on the baseline data of 327 cases to test the hypothesis of whether staffs demographic characteristics have significant impacts on their responses:

When determining the effects of social and/or demographic factors, all the scales and the potential factors were examined together, because of the interrelationship between the 7 scales, and the possible correlation between the independent variables such as sex and position.

Neither employment status (fte) nor number of years employed at hospital (hiretime) was found to be significant on any scale (p>.05). However, previous training or experience in domestic violence (exposure) was found to be significant on all 7 scales (p<.01). Other variables such as age*, sex, hospital, department, and position were found to have significant effects on certain scales, as demonstrated in Exhibit V-5.

Exhibit V-5
Effects of Staff Characteristics at Baseline

Scale	Age	Sex	Hosp.	Dept.	Position
1. Self-Efficacy for Identification and Interaction	F=.028 p=.868	F=.905 p=.342	F=.805 p=.523	F=1.67 p=.173	F=.571 p=.684
2. Self-Efficacy for Referral and Services	F=4.45 p=.036	F=.020 p=.888	F=2.45 p=.046	F=2.26 p=.082	F=4.00 p=.004
3. Staff Understanding of Abusive Relationships	F=5.22 p=.023	F=5.18 p=.024	F=.742 p=.564	F=.221 p=.882	F=2.48 p=.044
4. Staff Responsibility to Address Domestic Violence	F=.000 p=.998	F=1.23 p=.268	F=.960 p=.430	F=1.33 p=.336	F=2.01 p=.093
5. Self-Repot-ted Behaviors	F=.938 p=.334	F=.369 p=.544	F=3.84 p=.005	F=3.28 p=.021	F=2.37 p=.052
6. Staff Preparation	F=8.52 p=.004	F=1.29 p=.257	F=1.36 p=.246	F=1.55 p=.202	F=1.11 p=.350
7. Victim Autonomy	F=.001 p=.972	F=2.76 p=.098	F=.689 p=.600	F=1.07 p=.361	F=.160 p=.958

On those scales for which age was found to have a significant effect on staff mean scores, in general, younger staff (those below the age of 40), had significantly higher mean scale scores than older staff. Significant differences in survey responses between male and female staff were only found on scale 3 (staff understanding of abusive relationships),with female staff scoring significantly higher than male staff. When departmental affiliation was examined, significant effects on staff responses were only found on scale 5 (self-reported behaviors), with ED and ICU staff scoring significantly lower than their colleagues in the OB/GYN department or from other departments in the hospital (e.g. social work).

* Age was categorized on a continuous scale from 1 to 9, with 1 being "less than 20 years old" and 9 being "65 years or older." The categories in between each have an interval of 4 years. For example, category 2 is "20-24 year old" and category 3 is "25-29 years old."

Another potential effect on staff survey responses was the time during which the baseline survey was completed. As previously discussed in the methodology section, baseline surveys were completed by staff from February through October of 1996. In addition, some staff completed baseline surveys at a WomanKind training session (approximately 15 minutes before training commenced) while other staff completed baseline surveys during staff meetings or on their personal time. Thus, we examined the effects of both of these factors on staff baseline survey responses and found that there were no significant effects at the .05 level of significance.

Month during which baseline survey completed (N)		% of Sample
Spring (February, April, May)	254	77.7
Summer (June, July, August)	49	14.9
Fall (September, October)	24	7.3
Time during which baseline survey completed (N)		**% of Sample**
Baseline completed at some other time	242	7
Baseline completed at a training session	85	26

Baseline Differences Among Sites

Once the effects of staff characteristics on survey responses were determined, the analyses proceeded to examining the differences between hospitals, in particular, the differences between the experimental sites and the comparison sites. When analyzing the differences between comparison sites and experimental sites, a General Linear Model of Multivariate Analysis was used, controlling the effect of exposure since it was found to be significantly related with the scales during analysis of baseline data. If it were not controlled, it would have a confounding effect on the differences in the scores between the two groups. Staff from the experimental sites had significantly higher mean scale scores than staff from the comparison sites on scales 2,5, and 7. Differences on other scales were not found to be significant. Staffmean scale scores by hospital and by group can be found in Exhibit V-6 and Exhibit V-7, respectively.

Exhibit V-6

Staff Mean Scale Scores by Hospital at Baseline (N=327)
(Standard Deviations)

	Scale	FSH	FRH	FRMC	A-W	WR	F p value
1.	Self-Efficacy for Identification and Interaction	4.38 (.91)	4.08 (.74)	4.27 (.82)	4.22 (1.03)	4.25 (.90)	F=.73 p=.570
2.	Self-Efficacy for Referral and Services	6.03 (.78)	5.65 (1.04)	5.89 (.75)	5.10 (.91)	5.35 (.77)	F=11.694 p=.000
3.	Staff Understanding of Abusive Relationships	5.55 (.82)	5.37 (.62)	5.63 (.69)	5.57 (.71)	5.65 (.40)	F=1.74 p=.739
4.	Staff Responsibility to Address Domestic Violence	5.75 (.74)	5.45 (.78)	5.82 (.73)	5.58 (.71)	5.60 (.71)	F=1.95 p=.10
5.	Self-Reported Behaviors	4.42 (1.10)	4.05 (.91)	4.66 (.78)	3.82 (1.00)	4.02 (.94)	F=6.32 p=.000
6.	Staff Preparation	4.11 (1.21)	3.96 (.99)	3.98 (1.17)	3.75 (1.14)	3.93 (1.36)	F=.36 p=.833
7.	Victim Autonomy	4.49 (1.01)	4.38 (.99)	4.52 (1.00)	4.17 (.94)	4.05 (1.05)	F=1.89 p=.111

3LM Multivariate Analysis - mean scores by hospital: A737, F=3.457, df=28, p=.000)

Exhibit V-7

Staff Mean Scale Scores at Baseline, by Group (N=327)

	Scale	Experimental	Comparison	F p values
1.	Self-Efficacy for Identification and Interaction	4.26 (.84)	4.23 (.98)	F=.560 p=.45
2.	Self-Efficacy for Referral and Services	5.87 (.87)	5.21 (.86)	F=37.92 p=.000
3.	Staff Understanding of Abusive Relationships	5.52 (.73)	5.60 (.60)	F=2.65 p=.104
4.	Staff Responsibility to Address Domestic Violence	5.67 (.76)	5.59 (.71)	F=.108 p=.74
5.	Self-Reported Behaviors	4.36 (.99)	3.90 (.97)	F=12.62 p=.000
6.	Staff Preparation	4.03 (1.13)	3.83 (1.23)	F=.612 p=.435
7.	Victim Autonomy	4.46 (1.00)	4.12 (.98)	F=6.66 =

3LM Multivariate Analysis - mean scores by group: A797, F=11.146, df=7, p=.000)

Changes Over Time

Time Intervals Between Surveys. As discussed in the methodology section, the staff survey was administered to staff from each of the hospitals at three 16-week time intervals: baseline, TIME2, and TIME3. While every effort was made to administer the survey to all staff at 16 week intervals, staff completed and returned their surveys at varying times. Thus, the number of weeks between surveys is distributed as follows:

# Weeks Between Baseline and TIME2	(N)	% of Sample
12 weeks	28	8.6
16 weeks	93	28.4
20 weeks	25	7.6
24 weeks	6	1.8
28 weeks	5	1.5
Missing (did not complete a TIME2 survey)	170	52.0
# Weeks Between TIME 2 and TIME3	**(N)**	**% of Sample**
8 weeks	1	.3
12 weeks	7	2.1
20 weeks	1	.3
24 weeks	9	2.8
28 weeks	42	12.8
32 weeks	27	8.3
36 weeks	47	14.4
Missing (didn't complete a TIME2 or TIME3 survey),	193	59.0
# Weeks Between Baseline and TIME3	**(N)**	**% of Sample**
20 weeks	15	4.6
24 weeks	2	.6
28 weeks	5	1.5
32 weeks	19	5.8
36 weeks	1	.3
40 weeks	18	5.5
44 weeks	70	21.4
48 weeks	2	.6
52 weeks	78	23.9
Missing (didn't complete a TIME3 survey)	117	35.8

As this table illustrates, the modal time intervals for each data collection were 16 weeks (4 months) between baseline and TIME2, 36 weeks between TIME2 and TIME3 and 52 weeks (13 months) between baseline and TIME3. However, a large number of staff completed the: final survey 28 weeks (7 months) after they completed the TIME2 survey and a large numbei

of staff completed the final survey44 weeks (11 months) after having completed the baseline survey.

Because the time intervals between completing surveys were so varied among staff, a General Linear Model Multivariate Analysis was performed to determine the effects of varying time intervals on staff survey responses. This analysis indicated that there were no significant differences in staff survey responses based upon *when* they completed their baseline, TIME2, or TIME3 surveys.

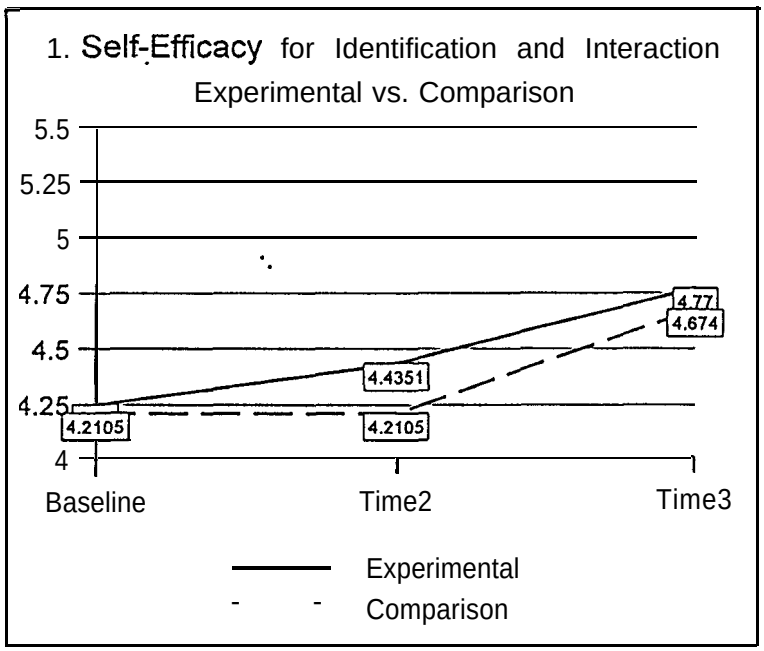
Results. A General Linear Model Repeated Measures multivariate analysis of variance was conducted to examine differences between the experimental and the comparison sites over time, on each of the seven scales using the sample of 135 participants who completed surveys at all three time intervals. Staff characteristics of AGE, SEX, POSITION, and EXPOSURE, which were found to have significant effects on mean scale scores at baseline, were first analyzed to determine their potential effects on staff survey responses over time.

While AGE was not found to have a significant effect on staff mean scale scores on any of the scales ($p>.05$), SEX, POSITION, and DEPARTMENT were found to have significant effects on staff responses on certain scales. Physicians demonstrated higher mean scale scores on Scale 1 (Self-efficacy for identifying and interacting with victims of abuse) and Scale 6 (Staff Preparation) than nurses ($p<.05$). Similarly, male staff (most of whom are physicians) also demonstrated higher mean scores on Scales 1 and 6 than female staff. However, female staff had higher mean scores on Scale 3 (Staff Understanding of Abusive Relationships) and Scale 4 (Staff Responsibility to Address Domestic Violence).

Staff departmental affiliation (DEPARTMENT) was found to have significant effects on staff responses on five of the seven scales (Scales 1, 2, 5, 6, 7) with staff from the ICU having consistently lower mean scale scores. And, as expected, previous training in domestic violence or exposure to domestic violence issues (EXPOSURE) was found to have a significant effect on all seven scales, over time ($p<.05$). Staff with previous exposure or training in domestic violence had higher mean scale scores than staff with no previous exposure or training.

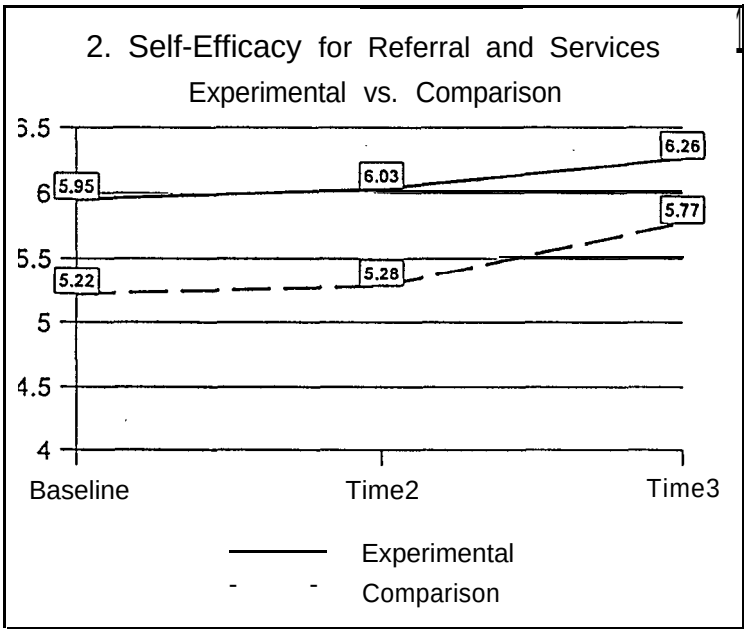
Given the significant effects of each of these staff characteristics on staff mean scale scores, these variables were used as covariates so that the effect of GROUP (experimental vs. comparison) could be rigorously examined on each scale. As Exhibits V-8 through V-14 illustrate, significant between-group effects ($p<.05$) were found on Scales 2 and 7. On these two scales, staff from the experimental sites demonstrated higher mean scale scores than their colleagues from the comparison sites. Staff from the experimental sites also had an overall higher total mean score than staff from the comparison sites.

Exhibit V-8



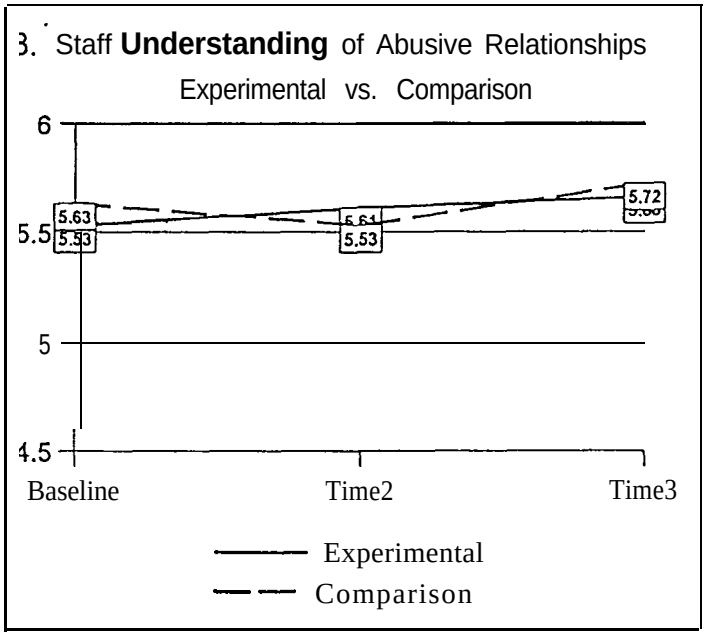
F=37.252, *df* =2/262, p=.OOO-within group effect
F=.145, *df*=1/131, *p*=.704—between group effect
F=.723, *df*=2/262, *p*=.607—interaction

Exhibit V-9



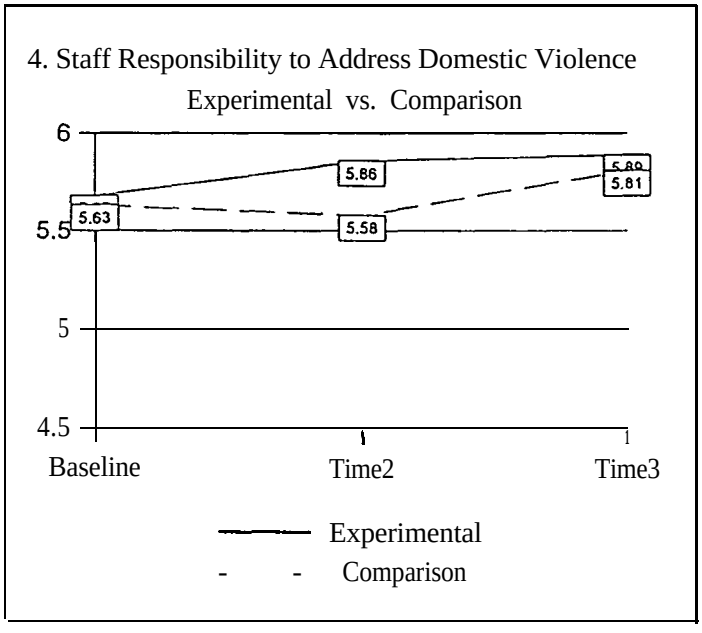
F=16.546, *df* =2/262, p=.OOO-within group effect
F=20.288, *df*=1/131, *p*=.000—between group effect
F=.766, *df*=2/262, *p*=.466—interaction

Exhibit V-I 0



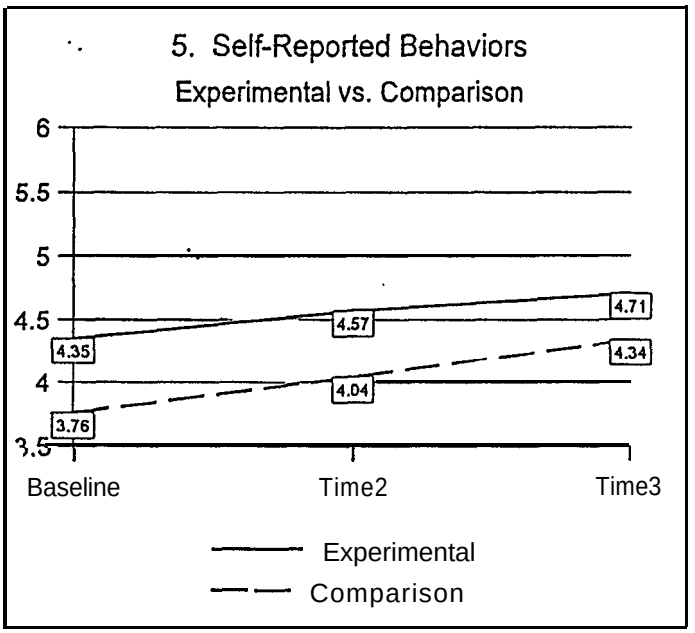
F=4.846, *df* =2/262, *p*=.009—within group effect
F=.038, *df*=1/131, *p*=.846—between group effect
F=.2.967, *df*=2/262, *p*=.053—interaction

Exhibit V-I 1



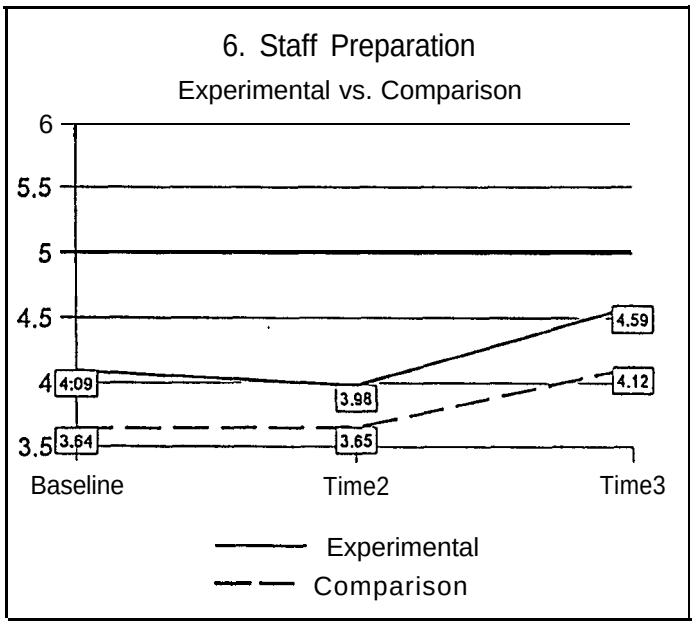
F=3.606, *df* =2/262, *p*=.029—within group effect
F=2.161, *df*=1/131, *p*=.144—between group effect
F=1.328, *df*=2/262, *p*=.267—interaction

Exhibit V-12



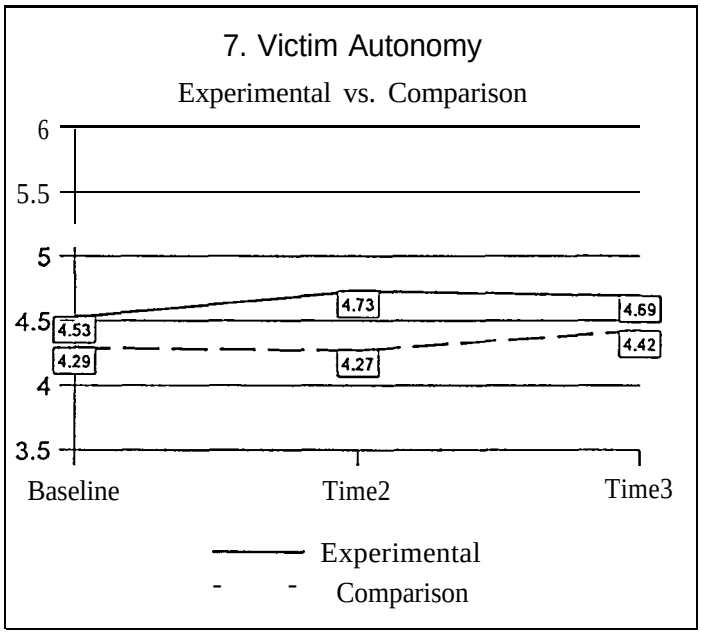
F=9.939, *df* =2/258, *p*=.000—within group effect
F=8.278, *df*=1/129, *p*=.005—between group effect
F=1.077, *df*=2/258, *p*=.342—interaction

Exhibit V-13



F=15.020, *df* =2/262, *p*=.000—within group effect
F=1.373, *df*=1/13 1, *p*=.243—between group effect
F=1.227, *df*=2/262, *p*=.295—interaction

Exhibit V-14



F=.85 1, *df* =2/262, *p*=.428—within group effect
F=2.144, *df*=1/131, *p*= .146—between group effect
F=1.007, *df*=2/262, *p*=.367—interaction

Significant within-group effects were also found on scales 1 through 6 (p<.05) indicating that staff mean scores on these particular scales significantly increased over time. Exhibit V-15 displays mean scale score8 and corresponding standard deviations foi both the experimental and comparison groups at each time interval.

Exhibit V-15
Changes Over Time in KABB Scores
Experimental vs. Comparison Hospitals (N=135)

Scale	Site	Baseline,	Time2	Time '3	F, p values
1. Self-Efficacy for Identification and Interaction	Experimental	4.25 (.86)	4.44 (.82)	4.78 (.8 1)	within group effect, F=37.252, p<.000
	Comparison	4.21 (1.0)	4.21 (.95)	4.67 (.93)	between group effect, F=. 145, p<.704
!. Self-Efficacy for Referral and Services	Experimental	5.95 (.83)	6.03 (.78)	6.26 (.71)	within group effect, F=16.546 p<.000
	Comparison	5.22 (.92)	5.28 (.97)	5.77 (.85)	between group effect, F=20.288 p<.000
3. Staff Understanding of Abusive Relationships	Experimental	5.53 (.74)	5.61 (.69)	5.66 (.54)	within group effect, F=4.846 p<.029
	Comparison	5.64 (.56)	5.53 (.72)	5.72 (.62)	between group effect, F=.038, p<.846
I. Staff Responsibility to Address Domestic Violence	Experimental	5.68 (.77)	5.86 (.72)	5.89 (.66)	within group effect, F=3.606 p<.029
	Comparison	5.63 (67)	5.58 (.78)	5.82 (.71)	between group effect, F=2.161 p<.144
5. Self-Reported Behaviors	Experimental	4.35 (.98)	4.57 (1.0)	4.71 (1.1)	within group effect, F-9.939, p<.000
	Comparison	3.76 (.92)	4.04 (.79)	4.34 (1.1)	between group effect, F=8.278, p<.005
5. Staff Preparation	Experimental	4.09 (1.15)	3.98 (1.37)	4.59 (1.20)	within group effect, F=15.02, p<.000
	Comparison	3.64 (1.06)	3.67 (1.07)	4.15 (1.09)	between group effect, F=1.373, p<.243
7. Victim Autonomy	Experimental	4.53 (1.08)	4.73 (1.08)	4.69 (1.06)	within group effect, F=.85 1, p<.428
	Comparison	4.29 (.97)	4.27 (1.05)	4.42 (1.13)	between group effect, F=2.144 p<.146

We also analyzed the scores of 211 respondents who completed both baseline and Time3 surveys. As illustrated in Exhibit V-16, there are significant within-group effects for scales 1, 2, and 5. And there are significant between-group effects for scales 2, 3, 5, and 6.

Exhibit V-l 6
Changes from Baseline to TIME3
Experimental vs Comparison Hospitals (N=211)

Scale	Site	Baseline	Time 3	F, p values
1. Self-Efficacy for Identification and Interaction	Experimental	4.28 (.84)	4.72 (.80)	within group effect, F=5.934, p<.016 behveen group effect, F=.009, p<.924
	Comparison	4.24 (1.03)	4.68 (1.0)	
2. Self-Efficacy for Referral and Services	Experimental	5.94 (.88)	6.20 (.80)	within group effect, F=19.293, p<.000 between group effect, F=28.698, p<.000
	Comparison	5.18 (.94)	5.70 (.89)	
3. Staff Understanding of Abusive Relationships	Experimental	5.52 (.77)	5.67 (.59)	within group effect, F=1.455, p<.229 behveen group effect, F=.709, p<.40 1
	Comparison	5.63 (.58)	5.69 (.66)	
4. Staff Responsibility to Address Domestic Violence	Experimental	5.69 (.79)	5.86 (.73)	within group effect, F=3.499, p<.063 behveen group effect, F=274, p<.60 1
	Comparison	5.61 (.68)	5.79 (.74)	
5. Self-Reported Behaviors	Experimental	4.46 (.97)	4.63 (1.15)	within group effect, F=8.392, p<.004 between group effect, F=5.846, p<.017
	Comparison	3.85 (.95)	4.39 (1.08)	
6. Staff Preparation	Experimental	4.07 (1.13)	4.58 (1.16)	within group effect, F=2.247, p<.135 between group effect, F=5.469, p<.020
	Comparison	3.72 (1.21)	4.14 (1.20)	
7. Victim Autonomy	Experimental	4.49 (1.06)	4.60 (.99)	within group effect, F=.939, p<.334 between group effect, F=3.103, p<.080
	Comparison	4.29 (.95)	4.32 (1.08)	

A General Linear Model Repeated Measures analysis was also performed to determine if staff from the Fairview.Southdale site had significantly different mean scale scores than staff from the other study sites, since the WomanKind program had been in place there the longest. For this purpose, the sample size was divided into three groups for comparison: 1) Fairview Southdale, 2) the remaining two experimental sites (Fairview Ridges and Fairview Riverside), and 3) the comparison sites. GLM Repeated measures analysis also allows one to conduct pairwise comparison simultaneously to examine whether there is a significant difference in the mean scores on any of the two scales. The pairwise comparisons indicated that on Scales 2 and 5, staff from the Fair-view Southdale site had significantly higher mean scores than staff from the Abbott and Waconia site. On Scale 6, staff from the Fairview Southdale site had significantly higher mean score than those from Fairview Riverside and from Abbott and Waconia.

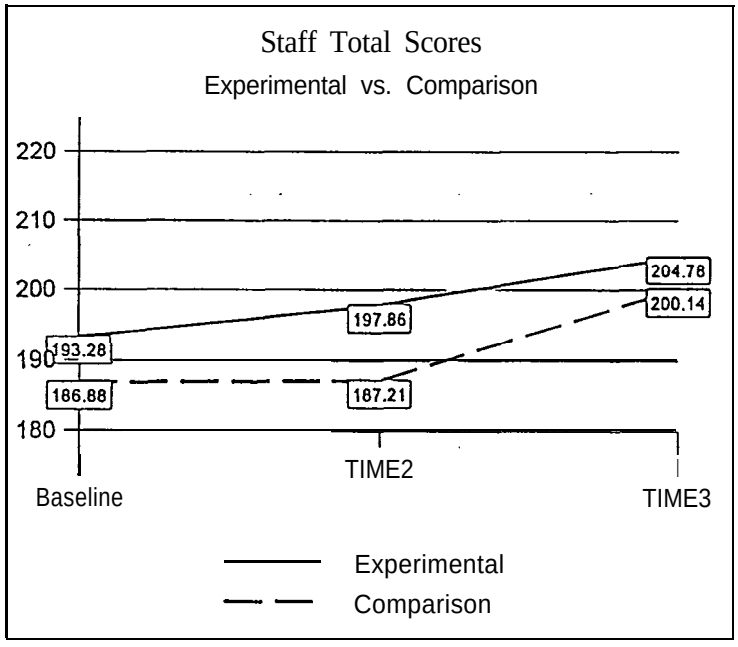
Exhibit V-17

Staff Mean Scale Scores by Hospital (N=135)

Scale	Site		Time 2	Time 3	F, p values
1. Self-Efficacy for Identification and Interaction	FSH	4.38 (.89)	4.50 (.86)	4.87 (.86)	within group effect, F=35.88, p<.000 between group effect, F=.123, p<.884
	FRH & FRMC	4.08 (.82)	4.34 (.76)	4.64 (.74)	
	Comparison	4.21 (.94)	4.21 (.98)	4.67 (.91)	
2. Self-Efficacy for Referral and Services	FSH	6.10 (.71)	6.13 (.69)	6.37 (.61)	within group effect, F=12.89, p<.000 between group effect, F=11.43, p<.000
	FRH & FRMC	5.76 (.91)	5.91 (.86)	6.13 (.80)	
	Comparison	5.21 (.92)	5.27 (.97)	5.76 (.84)	
3. Staff Understanding of Abusive Relationships	FSH	5.52 (.83)	5.70 (.67)	5.71 (.51)	within group effect, F=4.70, p<.010 between group effect, F=.019, p<.981
	FRH & FRMC	5.53 (.61)	5.50 (.70)	5.58 (.56)	
	Comparison	5.63 (.56)	5.52 (.72)	5.71 (.62)	
4. Staff Responsibility to Address Domestic Violence	FSH	5.80 (.71)	5.99 (.66)	5.93 (.58)	within group effect, F=2.718, p<.068 between group effect, F=1.63, p<.20
	FRH & FRMC	5.53 (.80)	5.70 (.74)	5.83 (.74)	
	Comparison	5.62 (.66)	5.57 (.77)	5.81 (.70)	
5. Self-Reported Behaviors	FSH	4.51 (1.06)	4.65 (1.12)	4.77 (1.14)	within group effect, F=7.58, p<.001 between group effect, F=4.17, p<.017
	FRH & FRMC	4.16 (.84)	4.46 (.82)	4.64 (1.02)	
	Comparison	3.76 (.91)	4.04 (.78)	4.33 (1.09)	
6. Staff Preparation	FSH	4.41 (1.16)	4.19 (1.32)	4.67 (1.24)	within group effect, F=17.12, p<.000 between group effect, F=1.86, .16
	FRH & FRMC	3.71 (1.02)	3.72 (1.39)	4.50 (1.15)	
	Comparison	3.64 (1.04)	3.65 (1.05)	4.11 (1.08)	
7. Victim Autonomy	FSH	4.48 (1.11)	4.69 (1.07)	4.56 (1.01)	within group effect, F=1.28, p<.279 between group effect, F=1.77, pc.174
	FRH & FRMC	4.59 (1.05)	4.77 (1.08)	4.84 (1.09)	
	Comparison	4.28 (.97)	4.26 (1.04)	4.41 (1.12)	

As previously discussed in the methodology section, total scores on the staff survey instrument were also computed for each study participant. Thus, a General Linear Model Repeated Measures analysis was used to assess differences in staff total scores over time. When controlling for the effects of EXPOSURE on staff total scores, significant between group differences were found indicating that staff total scores from the experimental sites were significantly higher than staff total scores from the comparison sites ($F=5.33$, $p<.02$). Significant within group differences were also found indicating that staff total scores significantly increased over time, as well ($F=38.751$, $p<.000$). Exhibit V-18 presents this information.

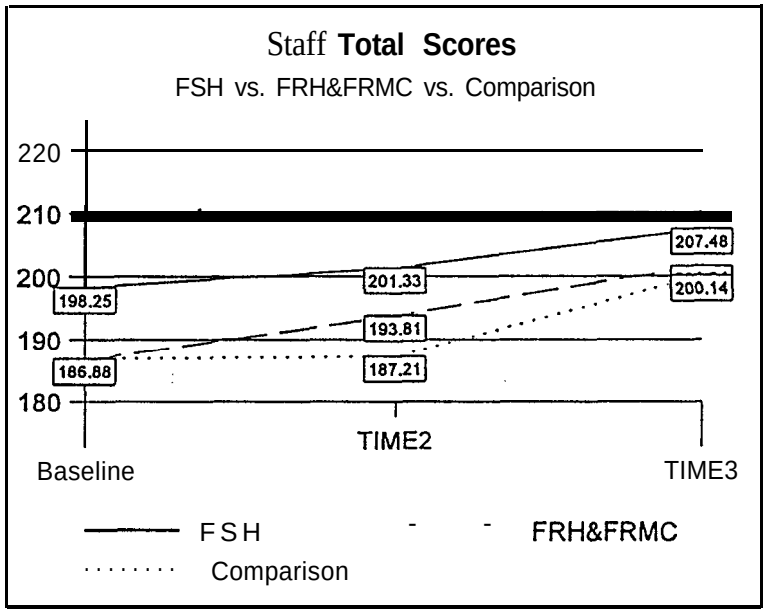
Exhibit V-l 8



Using staff total scores on the KABB, analyses also were performed to examine the differences between Fairview Southdale, the other two experimental sites, and the comparison sites.

As Exhibit V-19 indicates, significant within-group effects ($F=35.80$, $p<.000$) and significant between group effects ($F=4.98$, $p<.008$) were found. This suggests an effect of the institutionalization of the WomanKind program, as hypothesized.

Exhibit V-19



II. Hospital Staff Perceptions of the WomanKind Program

The KABB surveys helped us determine the effects of the WomanKind program on the knowledge, attitudes, beliefs and behaviors of health care providers regarding intimate partner violence in the experimental hospitals and provided us with an objective measure of these effects, We were also interested in learning what the hospital staffperceived as the effects of the program i.e. their opinions and insights into the value and benefits of the program.

A. Methodology

In February 1997, at the end of the study period, we. conducted a site visit to the five hospitals to collect qualitative data from hospital staff. Staff interviews were conducted in one-to-one conversations or during small group discussions. More than half of the interviews/discussion groups with staff were pre-arranged and lasted approximately one hour. The remaining interviews were conducted as intercept interviews, in which the interviewers visited the emergency departments, intensive care and perinatal units and, working with the nurse managers, conducted spontaneous interviews with staff on duty. These interviews were typically short in length, 15 - 20 minutes, but allowed us to ask important questions of a larger number of staff.

Three members of the evaluation team (two staff members from Macro International, one from CDC) conducted all of the interviews, using a facilitator guide to promote consistency across the interviews. A series of open-ended questions were used to elicit information from participants and allow for follow-up as needed. The specific interview questions that directly related to our core research question about the effects of WomanKind are listed below.*

For staff in all five hospitals:

- What do you see as your role in dealing with domestic violence?
- What resources are available to you in dealing with a victim of domestic abuse?
- Do you feel comfortable in making a referral to these resources? Why or why not?

For staff of the Fairview hospitals:

- What is yourperception of the WomanKind program in general? Of the WomanKind staff! Of the volunteer advocates?
- In what ways is the program valuable to the hospital? In what ways is it valuable to you?
- How are women helped by the program?
- Would you consider this program successful? Why or why not?

In conducting all of the interviews/discussion groups, the interviewers took steps to make the participants comfortable, to explain the purpose of the interview and to let them know that their names would not appear in any report that was generated from the discussions. Participants were asked to complete consent forms before the start of the interview, encouraged to ask any questions they had about the study, and reminded that their participation in the study was voluntary. In conducting the intercept interviews, care was taken to be as unobtrusive as possible while present in the hospital units and to fully respect the staffs time and obligations to their patients.

In an attempt to expand the number of hospital staff who could participate in the study, we made a deliberate effort to include staff who had not completed KABB surveys, as well as staff who had completed surveys. Fifty-seven percent of staff interviewed had not participated in the survey portion of the study. Exhibit II-20 presents the distribution of staff interviewed at each hospital.

* The facilitator guides and consent forms for these interviews appear in Appendix J.

Exhibit V-20
Interviews With Hospital Staff*

Department	Fairview Southdale	Fairview Ridges	Fairview Riverside	Waconia Ridgeview	Abbott Northwestern	TOTALS
Emergency Department	4 (3) MDs 8 (1) Nurses	4 (1) MDs 4 (1) Nurses 1 Station Clerk	3 (2) MDs 2 Nurses	5 (5) MDs 4 (4) Nurses	5 (4) Nurses 1 EMT	16 (11) MDs 23 (10) Nurses 1 EMT 1 Station Clerk
Intensive Care	6 (1) Nurses	4 (2) Nurses	—	3 (3) Nurses	3 (1) Nurses	16 (7) Nurses
Perinatal	6 (2) Nurses	3 Nurses	2 Nurses	3 (3) Nurses	Not in the study	14 (5) Nurses
Social Work	3	2	2	1	1	9
Volunteer Services	1	1	—	—	—	2
Residents	—	—	23 (15)	—	—	23 (15)
Family Practice	—	—	—	1	—	1
Occupational Health	—	1	—	—	—	1
Pastoral Services	1	—	—	—	—	1
Float Nurses	3	—	—	—	—	3
TOTALS	32 (7)	21 (4)	32 (17)	17 (15)	10 (5)	112 (48)

* Numbers in parenthesis represent interviewees also participating in KABB survey.

B. Findings

Health care providers in the three Fair-view hospitals who participated in interviews were overwhelmingly positive in their perceptions of the WomanKind program. All stated that they were comfortable referring women to the program, that there was a high degree of trust and confidence among staff because of the dependable, quick, and competent response of staff and volunteer advocates. Several thought the program was held in high regard among staff because "the program does what Susan Hadley said it would do."

Perceived Impact on Staff

When asked about the impact of the program on their own practice or on the staff in general, interviewees most often stated that interactions with patients have improved: they found themselves and their colleagues more sensitive, empathetic, and willing to listen. They believed that they were more aware of domestic abuse, including emotional as well as physical abuse, recognized it more often, and were more comfortable asking questions about abuse. A few stated that they found their colleagues to have somewhat more realistic expectations of abuse situations (especially that the woman may choose to continue in the relationship), and more of a willingness to listen and understand even if they didn't agree with her decision.

> *"/f's easier to interact with pafienfs. In the past we didn't know what to do, whaf to ask. Now we do."*
>
> -Nurse
> Emergency Department Fairview Southdale Hospital

Two nurses mentioned that there were still physicians who were judgmental toward women in abusive situations and did not refer to WomanKind, but that there were more physicians who were willing to refer. In fact, three other nurses remarked that they were amazed that most of the physicians did refer to the program, since they had not expected them to be attuned to the issue.

Most importantly, physicians and nurses made note of the fact that the program seemed to be "entrenched" in their departments and that everyone was aware of WomanKind.

A physician's comment reflected another common theme: "I feel like we have a chance to help-it's just a beginning-WomanKind is a way to complete the job. I'm able to do my job more effectively-to do prevention." A number of physicians and nurses thought that the existence of the WomanKind program made their jobs easier since they could call on someone with specific expertise and they could concentrate on the medical issues. Before

> *"WomanKind makes us beffer professionals, more likely to find out what's going on in a sifuafion, more likely to ask questions."*
>
> -Nurse
> Fairview Southdale Hospital

WomanKind, they would often not ask the question even if they suspected abuse, because they were unable-to provide assistance to their patients after abuse was detected. This corresponds with findings in literature regarding health care providers' reluctance to approach the subject when they feel that they have nothing to offer the victim. In the eyes of the staff of the Fairview system, WomanKind has been successful in providing them with a resource they are comfortable offering to patients and this, in turn, makes them more willing to identify cases of abuse.

In addition to physicians and nurses, a number of hospital social workers also participated in the interviews and offered a unique perspective on the program. Social workers also felt that medical staff were more willing to identify cases of abuse because of the WomanKind program and that the program offered a valuable resource to the staff. In addition, they reported that they often worked together with WomanKind to serve a woman, and that they appreciated the specialized expertise brought by the staff and the advocates. Several social workers believed that they could effectively address the needs of abused women if they needed to, but they often didn't have the time because they were expected to address so many additional needs.

Perceived Impact on Patients

When asked how WomanKind helps the women they refer to the program, hospital staff most often said that WomanKind makes the woman feel safe and gives her someone to talk to. One medical resident believed that when he asked questions about abuse and could offer access to WomanKind, it gave the women permission to admit that there was a problem and to ask for help.

> *"Until WomanKind, I was oblivious to the fact fhaf I see abuse. I learned to recognize domestic violence, learned how to respect fheir process, be understanding, and respectful. WomanKind has helped us identify domestic violence earlier, intervene earlier."*
>
> —Nurse
> Emergency Department
> Fairview Ridges Hospital

The responses to this question made it clear that while the existence of an in-house resource was a great benefit to the staff, they did not refer women to WomanKind simply out of convenience. Staff had faith in the caliber and value of WomanKind's services. For example, staff reported that WomanKind's counseling approach helped build self-esteem and strength among abused women, in addition to connecting them to resources in the community. As one stated so eloquently, "WomanKind offers hope and an option to despair."

A few staff expressed their desire to know more about the outcomes of cases they refer to WomanKind. While applauding the commitment to client confidentiality that they saw in staff and advocates, they would have liked to receive some information about the women and what WomanKind was able to do for them. It was clear that some WomanKind staff provided this kind of information on an informal basis, but what seemed to be requested here was more systematic information about WomanKind clients.

Perceived Impact on Hospital

Throughout its history, WomanKind's objective has been to bring about institutional change i.e., to improve the system's response to battered women. Hospital staff who were interviewed seemed to think that this was indeed occurring as they described improvements they had seen or benefits to the hospital. First and foremost, staff believed that within their departments, they were detecting more abuse cases than they had in the past. They also believed that patients received better care overall, as the program promoted a multi-dimensional, interdisciplinary approach to health and well-being and because it freed medical staff to provide more emergency medicine.

> *"WomanKind is a great resource to the community, reflects the values of Fait-view, an example of a program that is compassionate."*
>
> —Physician
> Emergency Department
> Fait-view Ridges Hospital

Interviewees also believed the program reflected well on the hospital and promoted the level of health within the community. A few mentioned community outreach as a benefit of the program, that through its interactions with community agencies and organizations and through educational activities, WomanKind increased the visibility of the hospital system and its commitment to addressing the health needs of the community.

Insights from the Comparison Hospitals

Staff in the comparison sites were also interviewed about their perceived role in addressing domestic abuse and the resources available to them. As with medical staff in the experimental hospitals, staff from these two hospitals described their role as identification and referral. Some staff, most notably physicians at Ridgeview, identified a number of community resources they used as referrals for women they identified as abused. Most often, medical staff indicated that they would refer cases to the hospital social workers, but pointed out that this was not an option at night or on weekends when it was most needed.

The most striking difference between staff in the comparison hospitals and the experimental hospitals concerned their comfort level in asking about abuse or discussing it with patients. Staff in the comparison hospitals described not knowing how to ask appropriate questions, feeling awkward or invasive in asking, and not being sure how to counsel the woman if it was brought up. While some staff, particularly emergency room physicians, expressed-'

confidence in approaching the subject, more staff indicated that they believed they and their colleagues needed more support and training in this area.

In contrast, staff from the experimental sites were more confident in their abilities to ask appropriate questions, discuss abuse with women, and make an appropriate referral to WomanKind or to a social worker. They believed that they and their colleagues now intervened in more cases than before WomanKind because they were more comfortable asking and because they had access to a readily available in-house resource.

Staff in the experimental sites were also more aware of a variety of clues or red flags in a situation that would lead them to pursue a discussion about abuse. Staff at the comparison sites certainly were able to identify a number of clues that they looked for, but many stated that there were probably more cases of abused patients in their hospitals that were missed,

A final observation regarding the comparison sites: many staff suggested that a number of factors had brought about a greater level of discussion about domestic violence and what the hospital staff should be doing to improve their responsiveness to this issue. These contributing factors include:

This Evaluation Study. Staff in both hospitals said that their participation in the study had made them think more about the issue and had raised the level of awareness and discussion among staff.

Recent Policy and Procedural Changes. Waconia Ridgeview developed policies regarding domestic abuse in the fall of 1996, then conducted briefings with the staff around the new policies. Abbott Northwestern staff recently began putting posters, brochures, and other literature on intimate partner violence in their examining rooms and waiting areas, at the request primarily of nurses who are seeing abused patients.

Media Coverage. Over the last 1½ years, the Minneapolis media has covered a number of stories involving domestic abuse. Recent coverage has examined the issue from a variety of perspectives including the impact on children and the high incidence of serious injury or murder when a woman tries to leave an abusive relationship.

WomanKind Training. Staff in both comparison hospitals were aware of the WomanKind program before they were approached about taking part in the study. Because there has been some activity in both hospitals directed toward improving their responsiveness to victims of abuse, administrators who made the decision to participate in the study were interested in having WomanKind training provided to their staff. Training was provided in both hospitals between Time2 and Time3 survey distributions. (This is discussed in more depth in Chapter IV of this report.)

III. Documentation of Domestic Abuse

The WomanKind program seeks to improve the health care response to victims of abuse by teaching medical and nursing staff to: recognize the signs and symptoms of possible abuse; ask questions about abuse; and refer cases of definite or suspected abuse to WomanKind. Through formal in-service training sessions and on-going consultations, WomanKind staffwork to increase awareness of abuse and reinforce that hospital staff do not have to confirm abuse themselves, they simply can ask a woman if she would like to discuss her situation with someone. If she does, they can refer her to WomanKind. Additionally, the importance of documenting information about abuse and referral in a patient's medical chart is highlighted in the training presented by WomanKind.

To determine if WomanKind's intervention makes a difference in assessment and documentation of abuse, we reviewed medical records of women who presented at hospital emergency departments of all hospitals participating in the study. One specific research question guided this effort.

Research Questions

Is there a significant difference in the rate of documentation of definite and suspicious cases of domestic abuse in the emergency departments of the experimental and comparison hospitals?

In this section of the evaluation report, we discuss our methodology for reviewing the medical records and our findings.

A. Methodology - Review of Medical Records

Victims of domestic abuse often seek treatment for their injuries from hospital emergency departments. In some case, abuse is obvious, but in many cases this is not true. Patients may present with less obvious injuries or vague symptoms that are not immediately associated with abuse. Our initial step in developing a procedure for reviewing emergency room records was to review how WomanKind staff teach medical and nursing staff to identify the victim of domestic abuse. The following information is drawn from materials used in WomanKind training (refer to Appendix H for more information).

Identification of the Victim of Domestic Abuse

1. Verbal and Nonverbal Behavior: Be aware of the behavior of the woman and her husband/partner

   * Battered Woman: agitated, evasive, ashamed, depressed, disoriented, hesitant, embarrassed, jumpy.

   * Husband/Partner: overly solicitous, overly affectionate, explains injury, answers all questions.

2. Frequent Presenting Injuries:

   A. Contusions, lacerations, abrasions, fractures...
      1. central part of body: breasts, soft tissues areas.
      2. injuries to the head, face and neck: fractured mandible, nasal fracture, perforated tympanic membrane.
      3. upper extremities: grab marks on upper arms, contusions on the lower arms raised in defense.

   B. Injuries may be consistent with burns, whip-like bruises, choke marks on the neck, wounds on the back of the head covered by hair, including gaps of hair pulled out of the head.

   c. Multiple injuries in various stages of healing.

3. Battering During Pregnancy: Battering may often begin or escalate during pregnancy, with injuries to the breasts, abdomen or genitals.

4. Mental Health Issues: anxiety, depression, panic attacks, and/or suicidal ideation or history of suicide attempts.

5. Hidden Signs: Patient may deny physical abuse but present with unexplained injuries.
   Delay between the time of injury and presentation for treatment.
   Discrepancy between patient's history and type and appearance of injuries.
   Patient's distress excessive in relation to injury.
   Repeat visits, chronic injuries, vague or nonspecific complaints.

WomanKind also encourages emergency department staff to:

- document definite or suspicious cases of domestic abuse
- ask these patients questions about their relationships and past history of abuse
- document questions asked and the patients' responses
- offer these patients a referral to the WomanKind program
- document that a referral was offered and the patients' response

Chapter V. Outcome Evaluation - Hospital Staff

Design We were interested in comparing documentation in patients' records between the experimental and comparison hospitals. Our hypothesis was that the experimental hospitals would have a higher rate of documentation of definite and suspicious cases of domestic abuse than the comparison hospitals, as a result of WomanKind training and the overall presence of the WomanKind program.

To obtain a large enough sample of cases to review and to account for any seasonal variation, we created a design to collect and compare medical records from all hospitals for four time periods. Baseline data was collected in January 1996. Additional data was then collected in three month intervals, i.e., April, July and October 1996.

Originally, we intended to collect data for a fifth time period, January 1997, but we were unable to do this for all of the hospitals.

instrumentation. We developed a instrument to abstract relevant information from emergency department records. This form was developed in consultation with WomanKind management staff and included the following items:

- Presenting problem
- Identification of domestic abuse - definite or suspicious
- Documentation of social history
- Documentation of the inquiry about domestic abuse
- Documentation of injuries
- Referral made for patient
- Type of referral

All items included a choice of responses, allowing us to abstract and code all information. The abstraction instrument appears in Appendix L.

Data Collection Procedures

Perhaps the most important aspect of collecting data for this segment of the evaluation was securing access to medical records from the institutional review boards or committees of each hospital. While all of our data collection efforts (surveys, interviews) had to be approved, the use of medical records for research is particularly sensitive because of the need to protect patient confidentiality. We developed procedures that would protect patients' identities, which included:

- WomanKind staff coordinators reviewed and abstracted the relevant medical records in the Fairview sites. Abstraction forms were sent to the research team with no patient identifiers. WomanKind coordinators regularly review patient charts within their respective hospitals as they work with hospital staff and patients, and, therefore were allowed access to the emergency room records for the months requested.

- The two comparison hospitals provided the research team with emergency department logs for the selected months of the study. On these logs we identified the records that we needed to review (the criteria is described below) and these records were then sent to us without patient names.

Given our resources, and our research question, we had to identify which medical records would be most relevant for us to review, Additionally, after an initial pilot test in which we reviewed all of the information in any given medical record, we had to narrow the scope of the material in the file that we would review.

We reviewed only records for women above the age of 12 who were possible victims of domestic abuse. Therefore, cases that were obviously not related to domestic violence were excluded. These included:

- motor vehicle accidents
- heart attacks, strokes
- cancer
- upper respiratory infections
- conjunctivitis
- recent surgery

Criteria for Review. Records were reviewed for female patients over 12 presenting at the emergency department with any of the following conditions/problems:

- Drug or alcohol use
- Suicide attempts or ideation
- Depression or mental health problems
- Addictive or obsessive - compulsive behavior
- Assault
- Fractures, lacerations, contusions
- Headaches, migraines
- Complications during pregnancy
- Sexually transmitted diseases or gynecological problems
- Rectal bleeding
- Loss of consciousness or faintness
- Falls
- Epistaxis (nose bleeds)
- Shortness of breath (unless caused by upper respiratory infection)

A difficult decision to make was what material in the patients' record to review. Obviously, all of the information in a woman's chart could be relevant to understanding her symptoms and identifying if they are related to domestic violence. For example, a woman who is admitted to the hospital may eventually be assessed by a physician or nurse in another unit as being a victim of domestic violence.:

However, we did not have the time or resources to conduct an exhaustive review of each record. Since our primary purpose was to determine if the attending physician and nurse in the emergency room assessed for abuse and documented it, we decided to review only the triage notes or face sheet, physician's dictated notes and nurses' notes (if any).

If, after reviewing this information, the reviewer found no reason to suspect domestic abuse or diagnosis was not identified as mental health problems, migraine/headaches, substance abuse, or injuries/complications during pregnancy, the case was set aside and not reviewed further.

Limitations of the Data. Information drawn from the medical records speaks to documentation of domestic violence. While this information does provide some insight into assessment or identification of domestic violence, it is only an approximate measure. In the records we reviewed, physicians or nurses may have asked about or suspected abuse and not recorded this information. They may have also made a referral to WomanKind (or to a social worker in the comparison sites) and not documented this referral.

A second limitation of these data is the fact that different hospitals organize their records differently, or records are not readily available from the emergency department. At two of the experimental hospitals (Fair-view Southdale, Fair-view Ridges), charts for patients who were admitted to other departments of the hospital were not available to the reviewers, while this was not true for the third Fairview site (Fairview Riverside). This fact undoubtedly affects the number of domestic abuse cases that could be identified through the chart review.

Data from the chart review cannot be used to draw conclusions about behaviors of individual physicians or nurses, since there was no tracking of individuals over time and no mechanism for linking the KABB surveys to the record review. We were interested in information on the response of the emergency department staff in aggregate, not individually.

Inter-rater Reliability. A total of eight people were used to conduct the medical chart reviews, Several steps were taken to ensure consistency among them, including:

- Training. Each person was provided training on how to use the abstraction form and what information to review. The training included definition and explanation of terms used in the abstraction forms, definition of commonly used medical terms or abbreviations, and caution about only using information found in the patients' record rather than assuming information. Training was provided by the data manager who created the abstraction form and reviewed records from all of the hospitals.

- Follow-up Consultation. Once training was provided, the reviewers began to go through the records and abstract data. Within the first week of this activity, the data manager or project manager consulted with the individual to answer questions, clarify instructions as needed, and review overall procedures.

- Reliability Check. A second reviewer conducted another abstraction of 10% of the records to check for consistency and reliability. Initially, the inter-rater reliability was 90%. After the follow-up consultations with the reviewers, the reliability rate was 96%.

B. Findings

A total of 2531 medical records were reviewed for this study. As discussed previously, a record was reviewed when the presenting problem suggested that domestic abuse was a possibility. Initial frequency distributions provided interesting overall information about these cases.

Analysis of Baseline Data. Tests of association were performed on baseline (January 1996) data to learn more about the relationship between hospital group (experimental and comparison) and the dependent variables ofdocumentation ofdefinite or suspected domestic abuse. Significant Pearson Chi-square values indicated that an association did in fact exist between these variables. Cross tabulation was performed to examine the distribution of the data, to determine how to construct a model for further analysis.

Differences Between Experimental and Comparison Hospitals. A Logistic Regression Analysis model was used to examine the differences between the experimental and comparison hospitals. This model also allowed us to examine changes over time for each group.

Variables Used in the Analysis

Independent Variables

The primary covariate of interest was status of the hospitals from which the case reports were drawn. Time was included as a covariate in the equations in order to test its possible confounding effect on the association between status and the dependent variable. Doctors at the experimental hospitals were given in-service training on domestic violence, and this might have affected their diagnostic patterns. The time variable was divided into three 6 month groups covering the duration of the data collection period. A dichotomous indicator variable was constructed for each period. A significant result for one time period would indicate that there was a significant change in the dependent variable between baseline and that particular follow up period.

Interaction terms were constructed to test for possible interactions between time and status. Three indicators were constructed as the product of the experimental and comparison status indicator and each of the three time period indicators respectively. Significant results for any of these would indicate that the changes between baseline and the particular time period were different for experimental and comparison hospitals.

Dependent Variables

Several variables weremodeled separately as dependent variables in order to test for possible effects of **the** covariates. In all cases the dependent variables are dichotomous. The first dependent variable indicated a definite diagnosis of domestic violence versus all other diagnoses. The second variable indicated a possible diagnosis versus all others. Since the warning signs of domestic violence are often present in the social history, and detailing a more complete social history was part of the experimental curriculum, a variable indicating whether or not a relevant social history was taken was modeled to detect this change. Frequently, a history or diagnosis of domestic violence rests simply on whether or not the doctor discussed domestic violence explicitly with the patient. Discussing domestic violence explicitly with patients was part of the experimental curriculum. An indicator of whether or not the doctor asked about or discussed domestic violence with the patient was modeled to catch this factor. A variable indicating whether or not a referral was made was also tested.

A logistic regression was run on each of the five dependent variables. The Wald chi-square was examined as an indicator of the statistical significance of the covariate in the model.

Findings

- Definite Diagnosis of Domestic Abuse. The experimental hospitals were consistently higher in the rates of documentation of definite cases, for all time periods. This difference was statistically significant overall (Wald chi-square value of 7.2947, significance level of .0069).

- Diagnosis of Suspected Domestic Abuse. Experimental hospitals showed a greater incidence of documentation of suspected abuse. This difference was statistically significant overall and for time periods 2 and 3. (Wald chi-square value of 21.9945, significance level of .OOOl).

- Social Historv. This variable reflected documentation of whether or not the ED physician had taken a relevant social history from the patient, including information about safety, home life, stress, personal relationships, substance abuse. Doctors at experimental hospitals took relevant social histories more often than at control hospitals. This difference was statistically significant. (Wald Chi-square was 67.9550, $p < 0.0001$).

- Asked about or Discussed Domestic Abuse. This variable reflected documentation of whether or not the ED physician or nurse asked the patient about domestic abuse or discussed the subject with her. For all time frames, the experimental hospitals evidenced higher rates of documentation than the comparison hospitals, though this difference was not shown to be statistically significant. (Wald chi-square = 1.3 126, $p=0.25$ 19).

- Type of Referral Made. Referrals were documented more often in the experimental hospitals. This variable indicated whether or not ANY referral was made, the type of referral was not differentiated. (Wald chi-square = 25.6357, $p < 0.0001$).

IV. Summary of Findings

introduction

In this component of the evaluation we were seeking to determine how the WomanKind program affects knowledge, attitudes, beliefs and behaviors of hospital staff. Data was collected through KABB surveys distributed to staff at three times over the course of the study, and through interviews and discussion groups conducted near the end of the study.

The KABB survey consisted of 51 items, using an anchored seven-point Likert scale, ranging from "Strongly Disagree" to "Strongly Agree". The individual items formed seven conceptual domains or scales, based upon a review of relevant issues from the professional literature on domestic violence, and the explicit objectives of the WomanKind program. The scales were empirically tested through factor analysis of the baseline surveys, which confirmed the conceptualized factor pattern. The resulting seven factors addressed the following areas:

- Self-efficacy for identification and interaction with victims of abuse: belief in their ability to identify victims of abuse and interact appropriately with them.
- Self-efficacy for referral and services: belief in their ability to make appropriate referrals for victims of abuse and their intent to do so.
- Staff understanding of abusive relationships: their understanding of the myths and realities and dynamics of abuse.
- Staff responsibility to address intimate partner violence: beliefs about the role of medical staff to identify and address domestic violence.
- Self-reported behaviors: behaviors related to asking patients about abuse an documenting how injuries occur in patients' charts.
- Staff preparation: beliefs around the extent to which medical staff have the training, time and knowledge to address domestic violence.
- Victim autonomy: attitudes and beliefs concerning victims' needs and rights to make their own decisions about their situations.

Findings

The most significant findings to emerge from the analysis of KABB survey data were:

1) Total scores on the KABB significantly increased over time, indicating that hospital staff in all hospitals experienced some positive change in their knowledge, attitudes, beliefs and behaviors related to domestic abuse. Mean scores for each of the scales also increased over time, indicating a level of change in all seven dimensions.

This finding is consistent with the fact that in all of the hospitals participating in the study, the role of health care providers in responding to domestic violence had become a more prominent issue during the course of the study. Reasons for this included(in addition to the operation of the WomanKind program in the Fair-view sites): recent policy and procedural changes; media coverage; WomanKind training at all sites; the research study itself.

2) Total scores on the KABB surveys were significantly higher for the experimental hospitals than for the comparison hospitals, at all time intervals during the study. In addition, significant between-group effects, showing higher mean scores for the experimental hospitals, were found on four scales:

1. Self-efficacy for referral and services
2. S.elf-reported behaviors
3. Staff preparation
4. Victim autonomy

This finding points to the effect of the WomanKind program on total scores and on the specific issues addressed by the scales. This would indicate that the staff in the hospitals where WomanKind operates are more confident in their abilities to make appropriate referrals and are more likely to ask questions about abuse or relationships and record relevant information in patients' charts.

A higher score on the scale of staff preparation would indicate that WomanKind is having some success in teaching hospital staff that they do have the knowledge, time and training to effectively address domestic violence because with an in-house program, their role is to identify, assess and refer, not provide counseling or other services themselves. Similarly, an higher score on victim autonomy would indicate that the WomanKind program is having some success in conveying the message that a victim of domestic abuse is going through a process and she has a need and a right to make her own decisions about how to deal with her situation.

3) When analyses were performed to examine the differences between Fairview Southdale hospital (as the initial WomanKind site), the other two Fairview hospitals, and the two comparison hospitals, significant within-group and between-group effects were found.

Chapter VI

Outcome Evaluation - WomanKind Clients

Introduction

In this component of the evaluation, we wanted to learn who is being served by the WomanKind program and what is being done to assist them. Specifically, we were interested in the following research questions:

> Research Questions
>
> How **many** clients are referred to WomanKind?
>
> How are these clients supported and served by WomanKind?
>
> Are there significant differences in the knowledge, attitudes, beliefs and behaviors of WomanKind clients over time?

The following sections describe our methods and findings with regard to these questions.

I. Clients Served by the WomanKind Program

A. Overall Growth of the Program

The WomanKind program began at Fairview Southdale hospital in June of 1986. In the first six months of operation (June - December), a total of 141 individuals were referred to the program. During the same period in 1996, with the program operating in three hospitals, a total of 644 individuals were referred to the program. As of March 1997, more than 15,000 clients have been served by WomanKind since its inception.

B. Source of Referrals

Anyone can confidentially self-refer or refer a client to WomanKind for services. To learn more about the referrals to the WomanKind program, we reviewed program statistics for the entire year of 1996. Exhibit VI- 1 presents information about the source of the referrals. The largest percentage of referrals were from the chemical dependency units of the hospitals, followed by the emergency departments.

Exhibit VI-I
Referrals to WomanKind
January - December 1996

	Fairview Southdale	Fairview Ridges	Fairview Riverside	TOTALS
Total Number of Referrals	469	298	531	1298
Referral source (Percent of Total)				
. Emergency Room	87 (18.6%)	55 (18.5%)	50 (9.4%)	192 (14.8%)
*Critical Care	—	45 (15.1%)	9 (1.6%)	54 (4.2%)
● PerinatalBirthplace	—	6 (2.0%)	55 (10.4%)	61 (4.7%)
*Pastoral Care	0	4 (1.3%)	2 (0.4%)	6 (.05%)
*Social Service	34 (7.2%)	7 (2.3%)	2 (0.4%)	43 (3.3%)
Other Hospital Department	73 (15.6%)	21 (7.0%)	35 (6.6%)	129 (9.9%)
*Chemical Dependency	63 (13.4%)	38 (12.8%)	151 (28.4%)	252 (19.4%)
*Mental Health	49 (10.4%)	0	106 (20%)	155 (11.9%)
·Fairview Employee	21 (4.5%)	5 (1.7%)	18 (3.4%)	44 (3.4%)
*community	80 (17.1%)	42 (14.1%)	21 (4%)	143 (11.0%)
*Professionals/Organizations	52 (11.1%)	64 (21.5%)	3 (0.6%)	119 (9.2%)
*Other	10 (2.1%)	11 (3.7%)	79 (14.9%)	100 (7.7%)

* Includes: Medical/surgical; recovery services; home health; outpatient services. For Fairview, Southdale, this category also includes critical care and perinatal.

C. Types of Client Contacts

Because WomanKind offers more than crisis intervention services upon referral into the program, it is important to look at various types of contacts that are made with clients through on-going case management. In the following exhibit (VI-2) contacts are categorized as initial (upon referral); repeat calls (when a client initiates contact after the initial referral); and follow-up (when WomanKind initiates contact after the initial referral). These statistics clearly demonstrate services that go beyond initial referral.

Exhibit VI-2

Client Contacts
January - December 1996

	Fairview Southdale	Fairview Ridges	Fairview Riverside	TOTALS
Initial Contacts	469 (44.2%)*	298 (38.9%)	531 (52.8%)	1298
Repeat Calls (Client Initiated)	144 (13.6%)	200 (26.1%)	209 (20.8%)	553
Follow-Up Calls (WomanKind Initiated)	448 (42.2%)	268 (35.0%)	265 (26.4%)	981
TOTALS	1061 (100%)	766 (100%)	1005 (100%)	2832

* Percentages are within hospitals

E. Demographic Information on Clients

The following Exhibit (VI-4) provides a demographic picture of the clients served last year by the WomanKind program. The largest percentage of clients served in this year are female (97%) Caucasian(84%), and between the ages of 20 and 39 (60%).

Exhibit VI-4
Demographic Information on WomanKind Clients
1 9 9 6

	Fairview Southdale	Fairview Ridges	Fairview Riverside	TOTALS
Total Initial Contacts	469	298	531	1298
• Female	453 (97%)	288 (97%)	519 (98%)	1260 (97%)
• Male	16 (3%)	10 (3%)	12 (2%)	38 (3%)
Ethnicity				
• Caucasian	434 (93%)	264 (89%)	386 (73%)	1084 (84%)
. African-American	20 (4%)	13 (4%)	93 (18%)	126 (10%)
• Native American	4 (1%)	0	26 (5%)	30 (2%)
• Asian American	4 (1%)	4 (1%)	11 (2%)	19 (1%)
• Hispanic	4 (1%)	5 (2%)	3 (1%)	12 (1 %)
• Other	3 (1%)	11 (4%)	12 (2%)	26 (2%)
Age				
• Teens	28 (6%)	25 (8%)	28 (5%)	81 (6%)
• 20-29	106 (23%)	78 (26%)	140 (26%)	324 (25%)
• 30-39	149 (32%)	111 (37%)	198 (37%)	458 (35%)
• 40-49	79 (17%)	56 (19%)	113 (21%)	248 (19%)
• 50-59	41 (9%)	14 (5%)	29 (5%)	84 (6%)
. 60-69	25 (5%)	7 (2%)	11 (2%)	16 (1%)
• 70-79	11 (2%)	2 (1%)	3 (1%)	43 (3%)
• 80-89	3 (1%)	0	0	1 (0%)
• 90-100	1 (0%)	4 (1%)	1 (0%)	8 (1%)
• Unknown	26 (6%)	1 (0%)	8 (2%)	35 (3%)

II. Impact of WomanKind on Client Knowledge, Attitudes, Beliefs and Behaviors

A. Evaluation Design and Methodology

A goal of the WomanKind program is to not only provide *immediate* crisis intervention and support during a crisis but to provide ***ongoing*** services through short-term counseling, case management, and community resource referral. Ongoing services are provided through follow-up phone calls, support groups, and one-on-one encounters with WomanKind program staff. Through these various services, the WomanKind program strives to facilitate victims' process of change-to assist them in taking incremental steps towards regaining power and control over their lives and, ultimately, to assist them in developing and implementing a safety plan. Part of the client phase of this study therefore involved surveying victims of intimate partner violence to determine whether the WomanKind program had any significant effects on the knowledge, attitudes, beliefs and behaviors of its clients over time.

Surveys were administered to victims of intimate partner violence (clients) at 3-month intervals over the course of the study, for a total of 5 data collection efforts. These clients were women who were referred to the WomanKind program (experimental sites) or to a social worker (comparison sites) and who agreed to participate in the study. A repeated-measures evaluation design was used to analyze data collected across the 5 time intervals.

Instrumentation

Survey Development. The client survey collected information on the following indicators thought to significantly affect client resolution of abusive relationships:

- Feelings of well-being
- Degree of isolation
- Depression
- Belief that abuse is not deserved
- Belief that victim is not alone
- Belief that options are available
- Belief that help is available
- Belief that resources are available
- Level of understanding about available options and resources
- Level of understanding about patterns of abuse
- Level of understanding about personal risk given a history of abuse
- Quality of current protection plan, if any

These indicators were identified through discussions with WomanKind management staff and through our review of relevant literature (A list of key references appears in Appendix M.)

It was hoped that through the collection of such information, more could be learned about both the psychological processes of victims of abuse over time and the potential impact of the WomanKind program on these processes. In addition, this survey effort sought to identify the key areas in which healthcare based domestic abuse services, such as WomanKind, could concentrate their efforts to help victims begin the process of taking steps to protect themselves and eliminate violence from their lives.

An 8-item "intake" survey was developed for administration during a victims' initial encounter with a WomanKind advocate or a social worker at the comparison sites. A subsequent 34-item "follow-up" survey was developed for administration during the 4 follow-up encounters with WomanKind or social work staff. This survey included the eight items from the intake survey. Copies of the surveys appear in Appendix N.

Five conceptual domains or scales were developed for the client follow-up survey, based upon the indicators previously described. Thirty-one of the 34 survey items belonged to five scales, which addressed the following areas:

1. Feelings of well-being, isolation, and depression
2. Belief that she does not deserve to be abused
3. Understanding of available options and resources
4. Understanding of patterns of intimate partner violence
5. Understanding of personal risk level

The remaining three survey items addressed the following issues:

- Beliefs and worries about the future
- Changes she would like to make to her life
- Current protection plan (if any)

The client survey used an anchored 7-point Likert scale, ranging from "Strongly Disagree" to "Strongly Agree." As with the surveys used for hospital staff, scales rather than individual survey questions or items were developed to improve reliability and validity, obtained from using multiple items to measure a given conceptual domain, High inter-item reliability increases the likelihood that the face-valid items are, in fact, measuring related facets of a single concept. The use of multiple items facets reduces error variance associated with the measurement of any given item.[12]

[12] Anastasi, A. Psychological Testing, Seventh Edition. New York: McMillan Publishing, 1993.

Some survey items were worded in the negative to provide some variety in the phrasing and reduce potential response bias. When combining these items with the others in their scales, it was necessary to reverse the scoring so that all survey items would be measuring the scale construct in the same direction. For example, the score on the item *"I have* nowhere *to turn for help"*. is reversed so that it corresponds with other items that measure positive aspects of understanding the available options and resources for victims of intimate partner violence.

Data Collection Procedures

Recruitment of clients began in February 1996 and continued until December 1996. All female victims of intimate partner violence (over the age of 12) presenting in the emergency departments of the experimental or comparison hospitals were eligible to participate in this portion of the study. However, recruitment of clients into the study hinged on two conditions: 1) the victims willingness to accept a referral to a WomanKind advocate or social worker (at comparison sites) and 2) her willingness to participate in the study. While there was a great desire to recruit as many women as possible to participate in the study, preserving the woman's safety, autonomy, and privacy were our overriding concerns. Thus, victims of abuse were not actively sought to participate in the study. The study was not advertised in any way and every effort was made to seamlessly fold the study into existing emergency department referral and support mechanisms.

As such, the intake survey was administered to clients by either a WomanKind staff person or volunteer advocate (WomanKind hospital sites) or a social worker (comparison sites)--the individuals to whom victims of abuse are generally referred. Volunteer advocates and social workers also received special training and instructions in administering the intake survey to clients. The instructions for administration are included in the Appendix N.

The client intake survey was deliberately kept short so as to be less intrusive and cumbersome and so that it could be easily and quickly administered. We also realized that the time in which the client would be asked to complete the survey would most likely be emotionally if not physically traumatizing. Thus, we sought to develop an intake survey that would not be too taxing.

Upon completion of the intake survey, clients were asked-to provide the volunteer advocates or social workers with a safe time and place where they could be reached to receive additional counseling and support services as well as complete follow-up surveys. The intake survey, along with the client's contact information, was then turned over to either the client study coordinator at the comparison sites (a hospital social worker hired to assist with the study) or the WomanKind coordinator.

Given the sensitivity of the information being collected, we thought it best to assign one specially trained .WomanKind staff person or social worker in each hospital site the responsibility of conducting all follow-up calls with study participants. Approximately one week after completing the intake survey, clients were contacted by these designated study coordinators and the follow-up survey completed.[13] The follow-up survey was generally administered to clients in conjunction with services offered by the WomanKind program such as short-term counseling (either in person or by phone, support groups, or one-on-one sessions). Most clients completed the follow-up surveys over the phone, at their convenience, or, in a few cases, in person if a meeting with a WomanKind program staff person had been scheduled. Similarly, at the comparison sites, social workers administered the follow-up surveys as a part of the general case management and follow-up services they provided to their clients.

Following completion of the first follow-up survey, at approximately 14-week intervals, study coordinators attempted to contact clients to complete three additional follow-up surveys.

Response Rate. A total of 52 intake surveys were completed over the course of the study (from all of the hospitals). Slightly more than 50 percent of these clients also completed the first follow-up survey (n=27). By the second follow-up, almost half (14) of the study participants were lost to follow-up. By follow-up3, only three surveys were completed and none were completed at final data collection effort, follow-up4. These attrition rates reflect the often unstable lives led by victims of intimate partner violence. In many cases, clients' phones had been disconnected or the numbers were changed. In other cases, study coordinators indicated that they could never reach clients at a time during which they felt safe to talk on the phone--clients' partners were either present or expected shortly. In other cases, clients stated that they did not wish to participate in the study because they no longer viewed themselves eligible-the abuse had "ended." And in a small number of cases, study coordinators were informed that the client had moved away and left no forwarding information.

Psychometric Analysis of the Instrument. A factor analysis of the client follow-up survey was not performed due to the small sample. size (n=27). However, internal consistency was assessed using the 27 surveys completed at the initial administration of the follow-up survey (completed 1 week after completion of the intake survey). Given the small sample size, it was not surprising to find that only two of the five scales demonstrated internal consistency ($\alpha \geq .60$). The remaining 3 scales evidenced extremely low Cronbach Alphas ($\alpha < .20$). In addition, the consistency coefficient for the total score was low, .5687.

[13] In order to maintain the highest level of privacy and safety for clients, all study coordinators contacted. clients using phones that could not be traced with mechanisms such as call-return or caller-id.

Given these findings and the small sample size, it was apparent that we needed to reconsider the analysis of these data. Analysis of the client surveys is confined to their responses to seven survey items that were used on the client intake survey as well as the 4 follow-up surveys, and responses to an item that asked them to identify their current protection plan.

B. Findings

Survey *Items*

A total of 52 victims of intimate partner violence agreed to participate in the study and completed an intake survey. As previously discussed, clients were asked to respond to eight items, seven of which were designed to assess their understanding of abusive relationships and feelings of well-being and isolation. Clients' responses to each of these seven items is presented below.

I believe I can leave this relationship. A mean response of 5.23 indicates that clients generally believed in their ability to leave their abusive relationships ($\bar{x} \geq 5.00$). However, approximately 20 percent of clients demonstrated some indecision in their ability to leave their abusive relationships ($\bar{x} \leq 4.00$), while an additional 15 percent were more definitive ($\bar{x} \leq 3.00$) in their belief that they ***could not*** leave their relationships. These scores indicate that close to one-third of clients did not feel confident in their ability to leave their abusive relationships.

My children are not aware of the violence in my relationship. This item was designed to assess the potential impact of children on clients' willingness to stay or leave an abusive relationship based upon the extent to which they believed their children were aware of the violence in their relationships. Overall, women expressed disagreement with this statement ($\bar{x}=3.32$), indicating that they believed that their children were aware of the violence in their relationships. In addition, over 40 percent of respondents expressed ***strong disagreement*** with this statement, $\bar{x} \leq 2.00$.

I have nowhere to turn for help. Clients expressed rather strong disagreement with this statement, $\bar{x}=2.67$, indicating that they believed that there was somewhere they could **turn** for help.

It's usually my fault when my partner acts violently towards me. This item was designed to explore respondents' feelings of blame for the violence inflicted upon them. Clients' mean response on this item was 2.82, suggesting that most clients did not feel that they were the cause of their partner's violence towards them. In fact, over half of the women responding to the survey expressed ***strong disagreement*** with this statement ($\bar{x} \leq 2.00$).

I can change my partner for the better. This item assessed clients' understanding of abusive relationships by exploring the extent to which respondents felt as if they could change their partner's behavior-in particular, their violent behavior. Clients' mean response on this item was 2.39, indicating that they did not feel as if they could change their partner's behavior. Less than 10 percent of clients felt as if they could change their partners for the better, ($\bar{x} \geq 5.00$).

I ***often feel lonely, isolated, hopeless.*** Clients' mean response on this survey item was 5.11, suggesting that most clients frequently feel a sense of isolation and hopelessness as a result of the abuse in their lives. In fact, over one-third of women expressed ***strong agreemenf*** with this statement ($\bar{x} \geq 6.00$).

I do not think that my partner will **injure** ***me again.*** This statement assessed clients' understanding and beliefs about personal risk in abusive relationships. While clients' mean response was 2.44, nearly 60 percent of clients ***strongly disagreed*** ($\bar{x} \leq 2.00$) with this statement, indicating that most clients believed that their partners would injure them again. Because only a small percentage, 6 percent, of clients expressed any agreement with this statement ($\bar{x} \geq 5.00$), this finding suggests that the vast majority of clients clearly believed that they were at risk of future violence in their current relationships.

Current Protection Plans

In addition to responding to the previously discussed 7 items, clients were also asked to identify a protection plan to meet their immediate safety needs. Assisting a client in developing a protection plan (and revising it over time) is a critical part of the work advocates do with clients. This encourages them to gain input and new perspective into their situations and begins to move them away from being isolated from others. In order to allow clients the flexibility to design and revise their own protection plan, this survey item was left open-ended. Clients' responses were coded and placed into categories, based upon the commonality or frequency of responses.

At intake, 83 percent (43) of clients surveyed developed a protection plan. Only 9 clients had no protection plan at all. Exhibit VI-5 presents the responses to this question showing the array of items with at least one element.

Exhibit VI-5
. Client Intake Protection Plan (N=52)*

Protection Plan at Intake—Items	1st Item	2nd Item	3rd Item	4th Item	Total
1. Order of Protection	9	3	1	1	14
2. Domestic violence program (support group, counseling)	6	0	3	2	11
3. Stay with family, friends	6	3	1	0	10
4. Contact Police	4	2	1	0	7
5. Find safe place for the night	1	1	0	0	2
6. WomanKind	1	1	0	0	2
7. Moving away (won't tell him where)	7	3	0	0	10
8. Security measures (change locks, move to secure building, keep lights on)	4	3	1	0	8
9. Personal safety measures (keep someone around, keep an eye out)	0	1	2	0	3
10. Press charges	1	1	0	0	2
11. Other	4	6	1	0	11

* Number of clients who listed each item as an item in their protection plan.

Across client surveys, responses to this item were found to fall into one of eleven categories, ranging from contacting the police to moving away. Due to high attrition rates, this small sample size did not allow for any rigorous statistical analyses to be performed, such as changes in clients' protection plans over time or comparing the content of protection plans based upon client demographic factors. At follow-upl, only half of the clients responded to the survey (N=27) and by follow-up 2, surveys were collected from only one-fourth of the initial study population (N=13). Despite this small sample size, however, client responses suggested interesting findings.

Frequency distributions of client responses indicate that across all time intervals for which there is client data (intake, follow-up 1, follow-up 2, and follow-up3) "order *ofprotection"* and *"moving away"* were consistently selected as initial elements of a protection plan. However, for those clients who had more than one element in their plan, responses were almost evenly distributed among the following plans: counseling, stay with family/friends, security measures, and personal safety measures. While order of protection was most frequently selected as a current protection plan, neither contacting the police nor filing a complaint with the police was considered a viable option for most women responding to the survey, across all time intervals.

These findings suggest that while clients may seek legal assistance to address their situations, they shy away fi-om involving the police, perhaps because they view an order of protection as less punitive and less likely to anger their partners or incite future violence. In addition, while accessing services through a local domestic violence program ranked as the third most selected protection plan at intake, accessing services through the WomanKind program was one of the least identified protection plans, at both intake and across all time intervals. As a hospital-based intervention, perhaps clients felt as if WomanKind was only forwomenwho were at the hospital or was only for crisis situations, limiting what the program could do for them on a daily basis outside of the healthcare setting.

Client Demographics

At follow-up1 (and at subsequent data collection intervals), demographic information were collected from clients. Again, due to attrition, demographic data was only available for 27 clients. Of this sample, more than half (55.5 percent) of the clients were below the age of 30, a little more than half (55.6 percent) had jobs outside of the home, and 8 1 percent did not have college or post-secondary degrees. With regard to clients' living situations and relationship status, less than forty percent (37 percent) of clients lived with their partner and 63 percent were single. Nearly 80 percent of clients had children at home, with the majority of clients having only one child at home. Of those clients that had children at home, 71 percent had children under the age of 12. Exhibit VI-6 further describes the demographics of the clients who participated in the study.

Exhibit VI-6
Client Demographics (N=27)

Age	(N)	% of Sample
less than 20	1	3.7
20-24	7	25.9
25-29	7	25.9
30-34	3	11.1
35-39	5	18.5
40-44	3	11.1
45-59	1	3.7
Job	**(N)**	**% of Sample**
no job	12	44.4
job	15	55.6
Educational Background	**(N)**	**% of Sample**
did not complete high school	1	3.7
high school degree	5	18.5
some college/post-secondary	16	59.3
college/post-secondary	2	7.4
graduate work	2	7.4
Missing	1	3.7
Living Situation	**(N)**	**% of Sample**
Living with partner	10	37.0
Living with family member	11	40.7
Living alone	5	18.5
Missing	1	3.7
Relationship Status	**(N)**	**% of Sample**
Married	5	18.5
Divorced	3	11.1
Separated	2	7.4
Single	17	63.0
Vumber of children at home	**(N)**	**% of Sample**
0	6	22.2
1	10	37.0
2	5	18.5
3	2	7.4
4	3	11.1
7	1	3.7
Childrens' Ages	**(N)**	**% of Sample (n=21)**
under 5 years old	6	28.6
5 through 12	9	42.5
13 and above	2	9.5
under 5 and above 5	3	14.3
Missing	1	4.8

Implications for Future Research

As discussed above, it was our intention to use surveys to collect information about clients' process of change over time. For a variety of reasons, including a very real concern about doing anything to compromise the confidentiality or safety of an abused woman, this method of data collection proved too cumbersome and complex for this study. Women experiencing a crisis are not likely to understand or agree to a request for their help in a research effort. While the women who did agree to participate in the study seemed to have little difficulty with the intake survey, they did have problems with the follow-up surveys that contained more items and took more time and energy than they wanted to expend. Additionally, some of the questions appeared to be confusing as they were worded.

We would suggest that important information could be captured through notes that volunteer advocates and WomanKind staff make when they contact clients and this may be a better way to learn about changes the clients experience over time. Items that were included on the survey could be refined as used as a tool in working with the client, therefore becoming more integrated in the normal delivery of services.

III. Summary of Findings

Our objective for this aspect of the evaluation was to learn more about WomanKind clients and what services the program provides to them. We also wanted to learn more about the process of change that clients experience as they work with the WomanKind program.

WomanKind responds to referrals ofinpatients and outpatients, Fairview employees and community residents. Anyone can confidentially self-refer or refer a patient to WomanKind for services. The number of referrals to the program has grown from 141 in the first six months of operation at one hospital (June through December, 1986) to over 15,000 in three hospitals by March of 1997.

In reviewing program records for the entire year of 1996, we discovered the following:

- Almost 20% of the total referrals to the WomanKind program came from the chemical dependency units in the hospitals, followed by the emergency departments (15%), and mental health units (12%).

- The WomanKind program made a total of 2832 contacts with clients in 1996. This includes initial contacts (46%), client initiated repeat calls (20%), and WomanKind initiated follow-up calls (35%). This is a clear illustration that WomanKind services extend beyond crisis intervention into on-going case management and advocacy.

- WomanKind made a total of 2062 referrals to community services in 1996. The referrals made most often were to support groups (WomanKind support groups and others in the community), mental/chemical health services, and shelters. Other referrals included: legal services/law enforcement; county social services; and other services including Al-Anon, food banks, Alcoholics Anonymous.

- Ninety-seven percent of WomanKind clients in 1996 were women. Eighty-four percent were Caucasian, and sixty percent were between the ages of 20 and 39. These statistics were relatively similar across hospitals with one notable exception: clients at the Fairview University Hospital -- Riverside Campus were more ethnically diverse, with fourteen percent being African American, and seven percent Native American, reflecting the communities served by these hospitals.

A total of 52 clients agreed to participate in the study by completing KABB surveys, beginning with an initial "intake survey" that was administered during the first contact with WomanKind. A follow up survey was administered (typically by phone) approximately one week after the intake survey and subsequent surveys were administered at 14-week intervals thereafter. Unfortunately, many clients could not be contacted or were not in a position to respond to a survey during the follow-up and subsequent surveys so we effectively lost the ability to track a clients process over time. However, we did gain a better understanding of how the women perceived their situations at the time of the initial contact. In general, these findings included:

- Clients generally believed in their ability to leave their abusive relationships
- Clients believed that their children were aware of the violence in their relationship
- Clients believed that they had somewhere to turn for help
- Clients did not believe that it was their fault when their partner acts violently toward them
- Clients did not believe that they could change their partner for the better
- Clients characterized themselves as often feeling lonely, isolated, and hopeless
- Clients believed that their partners would hurt them again

In addition to asking about the items above, clients were asked to describe a protection plan for themselves. This is a cornerstone of the WomanKind program.-- advocates work with each client to develop (and revise over time) a plan for her safety. The fact that 43 out of 52 clients were able to articulate at least one item for a protection plan at the time of the intake survey seems to indicate that advocates are having some success in assisting clients to evaluate her situation and make decisions about how to protect herself. The most often cited items on a protection plan were "obtain an order of protection" and "move away".

Chapter VII

Process Evaluation

Chapter VII. Process Evaluation

Introduction

The intent of this part of the evaluation was to document and review the components or "processes" of the WomanKind program. The questions that guided our review and assessment were as follows:

> . Research Questions
>
> What are the goals and components of the program?
>
> How are the components of the WomanKind program implemented?
>
> What factors need to be considered for replication/adaptation of the program?

Research methods used to conduct the process evaluation included:

- A systematic review of WomanKind program materials

  Materials were collected and reviewed throughout the study, particularly materials on training for volunteer advocates and hospital staff, promotional and educational materials about the program, and WomanKind polices and procedures. As WomanKind is a continually growing and evolving program, materials were revised or developed during the study period, and every effort was made by the evaluation team to be inclusive and comprehensive in our review.

- Review of relevant literature on domestic violence and healthcare responses to domestic abuse.

  It was important for the evaluation team to be familiar with issues in this field to have a context for evaluating this particular program. The experience of the team members in related work obviously was a significant factor in this. Additionally, Appendix R contains a list of reference materials that were compiled as resources for this evaluation.

- Interviews with hospital staff and volunteer advocates.

  Members of the evaluation team interviewed hospital staff in all five participating hospitals and WomanKind volunteer advocates during each of five site visits to Minneapolis during the study period. Information from these interviews provided critical insight-into the implementation of the WomanKind program. The most'

extensive set of interviews were conducted in February of 1997 and were referred to in previous chapters of this report. The facilitator guides for these interviews appear in appendices E (volunteer advocate interviews) and J (hospital staff interviews).

- Interviews with WomanKind managers and coordinators.

The evaluation was conducted with a great deal of cooperation from the WomanKind staff. On-going communication between the evaluation team and Susan M. Hadley, founder and long-term director of WomanKind, was essential in the design and implementation of the overall evaluation. Additionally, the perspectives of Sherrie Eisele, current manager of WomanKind program services and the program coordinators at each site were gathered through interviews or group discussions during site visits. Appendix 0 contains the facilitator guides for the interviews/group discussions conducted with WomanKind staff.

In this chapter, we present the findings from this component of the evaluation, describing the WomanKind program in-depth and commenting on the strengths of its implementation and areas for improvement.

The WomanKind Program: Support Systems for Battered Women

WomanKind is a uniquely integrated model of health care response to domestic abuse which provides an ongoing, supportive connection between the victim of domestic abuse in the health care setting and the resources available in the community. The program was founded in 1986 by Susan M. Hadley, MPH, to respond to the need to better identify and treat abused women who access the health care system. The program vision: to integrate the issue of domestic abuse into the total health care of each patient, resulting in comprehensive system change.

The WomanKind Model

1. Public health model
   Early intervention is prevention
2. Supportive connection
   Immediate response; ongoing contact
3. Redefining success
   Understanding the victim's process
4. Integrated, in-house program
   Multi-disciplinary team approach
5. Resources and relationships
   Community connection
6. System change
   Universal screening, access and education"

-Susan Hadley, MPH
Founder, WomanKind

I. WomanKind Proaram Goals

- *Understanding that early intervention is ultimately prevention*

Women who are abused experience a lengthy process of losing their sense of self-worth and then regaining a sense of power and control in their relationships-a process that may take years or even a lifetime. Health care intervention has the potential to occur early in the woman's process of change and in fact may accelerate that process toward change and safety. This early intervention may ultimately lead to prevention of more serious injuries and medical symptoms, prevention of mental health and psychiatric symptoms, prevention of abuse during pregnancy, and prevention of abuse of children of these women.

- *Modifying the traditional medical approach*

Medical providers are trained and expected to solve problems relatively quickly but may be reluctant to address the psychologically complex and protracted problems presented by victims of domestic abuse. They often experience frustration in dealing with a woman who doesn't seem willing to take any immediate overt steps toward safety or change, or who may actually deny the problem. WomanKind helps hospital staff scale back their expectations of what can be accomplished to goals that are more in keeping with a woman's own timetable and individual situation and to recognize that the most valuable assistance they may be able to provide is to let the woman know that the health care setting is a safe place to return when she is ready.

- *Redefining success*

This goal reflects the recognition that the victim of domestic abuse is in a process, and that it is essential for the health professional to be aware of, support and respect this process, timetable, and decisions. WomanKind's goals for the victim may include strategies to help her rediscover a sense of self, build hope, reduce isolation, develop strength and direction, and acknowledge small steps toward change and safety. It is important for the victim to feel support and safety and, when she is ready, to talk about the violence, evaluate her situation, consider possible options and make necessary decisions, Health care professionals can help most by providing assessment for domestic abuse in a respectful, nonjudgmental manner.

> *"Sometimes making changes on fhe inside fakes* **help** *from the outside. Thanks fo WomanKind."*
>
> —WomanKind client

- *Influencing hospital policies and protocols*

Since the inception of the program, WomanKind staff have worked with hospital colleagues to influence hospital policies and protocols in order to make domestic violence assessment and intervention a routine aspect of patient care. There are now policies in place to ensure that **every** patient who comes to the Fairview Health Services is assessed for domestic abuse, child abuse and elder abuse by including these questions on the patient intake form. Acknowledgment ofdomestic abuse results in an automatic referral to WomanKind. Having policies in place facilitates an improved system response to domestic violence and leads to better, more integrated health care for patients. It also takes the onus off of hospital staff. Instead of singling out particular patients, staff can truthfully explain that they ask these questions of all patients.

- *Developing a supportive connection*

WomanKind functions as a bridge to help connect clients with community services. In this way the program is able to address the unique needs of individual clients and to enhance the visibility and involvement of the Fair-view system in the larger community. It is essential to build respectful working relationships with community service providers (battered women's shelters, mental health providers, job/career services, social service providers) and put protocols into place to meet the needs of clients.

- *Creating'an integrated, in-house program*

The heart of the WomanKind model is the prompt, on-site services provided by trained and respected WomanKind staff and volunteer advocates. This includes a respectful, trusting working relationship between the WomanKind staff, volunteer advocates and the health care provider (physician, nurse, medical social worker, etc.) While it is critical that the health professional reach the victim of domestic abuse while they are in the health system, it is important to remember that each health provider does not have to, and really cannot, solve this problem alone. Professionals acting alone, no matter how well-intentioned, simply do not have the time or the expertise to meet all of the needs of the victim of domestic abuse. Some of the pressure felt by the nurse or physician can be alleviated by utilizing a multi-disciplinary team approach to providing a variety and continuum of services to the victim of domestic abuse.

WomanKind became a department within the Fairview Health Services on July 1, 1992. As a department manager, the director of WomanKind attends the weekly middle/upper management meetings at each of the hospital sites, which increases visibility, credibility, and communication at all levels: middle management, upper management and staff level. It also increases the likelihood that WomanKind staff (and therefore domestic abuse issues) are included on hospital and department committees (Behavioral Services Care Committee, Medical-Surgical Discharge Planning Committee, Chemical Dependency Case Committee)..'

II: Components of the WomanKind Program

A. Education and Consultation for Health Professionals

In-service Training

The WomanKind program provides in-service training to health professionals throughout the hospitals they serve, to enhance providers' ability and willingness to identify and assess for domestic abuse and refer to the program. This training reflects the recognition that medical staff, like most people who are outside of a particular situation, may not understand the dynamics of an abusive relationship or may have a number of misconceptions that could make them judgmental and critical in their interactions with a victim instead of supportive and helpful. It may seem inexplicable that anyone would tolerate not just one but often repeated (and escalating) instances of abuse. The training emphasizes that abuse is a process. An abuser typically does not start out a relationship hitting his partner. Instead, he uses intimidation and threats to isolate and belittle her so that by the time he does hit her, she has come to believe that she deserves it and sees no way out. During training, WomanKind staff explain that abuse is about power and control; the violence is one effective way to accomplish this but is by no means the sole method of abuse. A broader definition of abuse is presented so staff come to understand the concepts of psychological, emotional, sexual, and economic abuse.

WomanKind staff also explain the overwhelming logistical and social obstacles that a woman faces in leaving a relationship; economic hardship; uprooting children to new homes and school districts; explaining to skeptical friends and family members that her wonderful husband hits her. Domestic violence typically occurs in cycles in which a violent outburst is followed by calm. For a number of reasons, including a genuine commitment to the relationship and to their partners, women hold to the idea that this calm period can be sustained. In actual fact, current research with batterers seems to be indicating that over time this calm period disappeared and the abuse and violence became nearly constant.

In addition to suspending judgement, hospital staff need specific skills in order fo help victims of domestic violence. These include recognizing obvious cues-repeated broken bones, bruises in different stages of healing, inconsistent stories about how an injury occurred-as well as less obvious ones. The latter might include a partner who refuses to leave the patient alone or a patient's anxiety or distress out ofproportion with her injury. As one nurse put it, the signal to staff may be not one specific cue but rather a package of cues. In her view, the WomanKind training helped her "put it all together."

Once a staffmember suspects that a patient might have been abused, the most difficult hurdle is asking her the question. Several suggestions are offered during training. In general, staff' are advised to take a gentle approach: "How did it happen?" instead of "Who beat you?" (Suggested ways of asking a patient about domestic violence are included in the handouts used in staff training. See Appendix H).

The educational program for hospital staff was evaluated in more depth as part of the training evaluation component of this research. Refer to Chapter IV of this report for more information.

On-going Education and Consultation

The WomanKind program staff recognize that training alone cannot fully address issues of knowledge, skill, and willingness to assess for domestic violence and refer to the program. They have become part of biweekly team meetings on the medical, surgical and behavioral services units. WomanKind staff also participate in the behavioral services patient lecture series and frequently attend hospital department meetings to discuss issues, problems, and services along with case study analyses. Staff make rounds to different departments throughout each week, making themselves available to medical, nursing, and social wdrk staff for consultations on patients, and reviewing patient charts for signs of abuse that may have been missed. WomanKind staff make notes in patient charts after consulting with the health care provider and the patient, often providing information that helps other health professionals provide better care.

> *"To be able fo educate the professional sfaff, you must have access to fhe professional staff. Being "'in the loop" provides unique opportunities that are available primarily fo those divisions/departments that are an accepted part of the health system."*
>
> -Susan M. Hadley
> Founder, WomanKind

These activities help WomanKind to affect the individual skills and attitudes of staff and to integrate the program and its philosophy more fully within the hospital. As one staff member put it, "They bring a different perspective and way of looking at the patient, they can trigger us to look deeper and therefore provide better care." WomanKind raises the awareness of domestic violence as a health issue and keeps it visible, provides an avenue for discussion on how it affects the lives of victims. Its presence challenges the medical community to look differently at patients and to treat the total person, which fits with the more holistic and prevention-oriented approach to health care that many healthcare settings are embracing.

> *"/t's easier to inferacf wifh patients. In fhe past we didn't know what fo do, what to ask. Now we do."*
>
> -Nurse
> Emergency Department
> Fairview Southdale Hospital

The WomanKind program staff understands most hospital staff cannot take on a case management or advocacy role for victims of domestic violence. They also understand that hospital staff will not ask about abuse if they do not feel that they can do something for the victim, since they will see no point in doing so. The WomanKind model addresses this issue by being clear that the responsibility of the health care provider is to identify and assess for abuse and by giving them a viable referral option. Hospital staff are not asked to verify that abuse occurs. Instead, if they suspect abuse, they ask the patient if she would like to speak with someone from WomanKind. The WomanKind volunteer advocate usually arrives within 30 minutes and is available to spend as much time as necessary comforting and counseling the patient. Resources (in this case, trained advocates) must be in place, because even the most cursory screening will reveal new cases. (Typically, WomanKind program staff respond to requests from all hospital departments during regular business hours, also responding within 30 minutes if possible or at a prescheduled appointments.)

WomanKind staff point out the importance of remembering that creating change in individuals and within a system takes time. A sustained effort at building relationships with staff that maximizes every opportunity to teach and bring additional insight is important to making such an effort successful. Hospital staffneed time to process information, to see for themselves what will happen if they change their practice, and to develop confidence in the response of the program. As these things happen and a greater trust and confidence develop, individuals will make changes in the way they relate to patients, often prompting others to do the same. Together with changes in policy or protocol, this behavior change can lead to institutionalization of the new practice.

Education and Ethical Responsibility

In contrast to programs that focus on educating health professionals to identify victims of abuse and provide them with information about community resources, WomanKind was conceptualized as an in-house program for educating staff and providing services to victims. As stated by Susan M. Hadley, this is seen as an ethical commitment:

> "If you provide education to a population of health care providers, WomanKind believes that you have an ethical responsibility to have an on-site, immediate service available to those health care providers. When they put into practice the tools you provide in workshops or training, when they assess and identify a patient who is in need of service, they should be able to make an immediate referral to an on-site program."

B. Case Management and Advocacy

WomanKind provides case management and advocacy services to individuals referred by the medical and hospital staff as victims of abuse (This may include inpatients, outpatients, or Fairview employees or commitment residents who self-refer). Through staff and volunteer advocates, WomanKind seeks to empower battered women to make positive decisions and to discover their own strength. Case management and advocacy is described further in WomanKind materials developed by Susan Hadley and summarized below. These materials are used in training for hospital staff and volunteer advocates.

The case management role is defined as:

- "achieving continuity of services to individuals or families
- through the process of connecting clients to...services
- coordinating the utilization of those services, and
- developing, implementing and monitoring a plan to meet the needs of an individual or family."

-Sheafor, Horejsi and Horejsi,
Techniques and Guidelines for Social Work Practice, 1994.

WomanKind case management services involve several phases of direct client services:

Phase I Level I - Crisis Intervention
Level II - Assessment and Evaluation

1. Assess domestic abuse issues
2. Evaluate immediate safety issues
3. Discuss symptoms and injuries
4. Identify mental health issues and suicidal ideation
5. Develop protection plan and follow-up contacts

Volunteer advocates are available by pager after regular business hours, 7 days per week for crisis intervention in the hospital emergency departments. WomanKind program staff provide intervention and assessment services to emergency department patients during business hours and to clients referred by other hospital departments or the community, and follow-up with all clients seen by volunteer advocates to provide additional case management and advocacy services as needed.

Phase II Short-Term Counseling, Education and Information

1. Provide ongoing support, validation and assistance
2. Explore dynamics, myths and effects of abuse
3. Discuss personal needs and concerns
4. Develop short and long-term goals
5. Reinforce protection plan and follow-up contacts

Staff advocates will maintain contact with women referred to the program in ways that are safe and comfortable for the woman. This may include calling the woman at specific times or meeting the woman in the office or another location. Advocates always take the lead from the woman on what is safe for her to pursue and what steps she is ready to take, while trying to present information and options to her. The program also offers a support group for women who are interested in working with others to deal with the problem of abuse. The support group meetings are facilitated by selected volunteer advocates who receive specialized training.

Phase III Community Resource Referral

1. Consider possible options
2. Explore community resources
3. Develop action plan, set priorities
4: Identify mental health issues and suicidal ideation
5. Make decisions, take small steps

Staff and volunteer advocates are knowledgeable about the resources that exist in the community and how to access these resources. This is critical in assisting women who may not have the strength to search out resources on their own or who likely do not even realize that there are resources that could assist them. This aspect of the services provided by WomanKind assists medical providers as well since it means that they do not have to know what resources exist. They can refer someone to WomanKind and trust that she will be connected to the appropriate resources.

Effective case management depends on recognizing that the victim of domestic abuse is actually experiencing a dual process of change, involving the following needs and goals:

- ***External process:***

  Feel support, safety, and affirmation
  Acknowledge the violence
  Evaluate the situation
  Discuss dynamics, myths, and effects of abuse
  'Develop protection plan and action plan

Define short- and long-term goals
Identify relevant intermediate outcomes
Explore community resources
Consider options, set priorities
Make decisions, take steps

- *Internal process:*

  Rediscover a sense of self
  Build hope and reduce isolation
  Develop strength and direction
  Acknowledge small steps

To further illustrate what is meant by "facilitating the victim's process of change", experienced volunteer advocates and WomanKind staffwere asked to discuss their short- and long-term objectives for clients. Regardless of the situation, the client's safety is always the first and most important priority. During training, for example, WomanKind staff emphasize that volunteers and hospital staff should not send brochures or other materials home with a patient; similarly, patients should be asked about whether or not it is safe to call them at home.

Short-term goals for the first session in the hospital or over the telephone most likely include the following:

- *Labeling the abuse and seeing it for what it is.* Many women see their situation as normal. They may not have witnessed or experienced a different type of interaction between men and women. In addition, women do not want to call themselves "abused" or call their partners "abusers." Women may take responsibility for the abuse, believing the abusers' message that they deserve or have somehow triggered what is happening to them. This leads to the false assumption that they have some control over and responsibility for the abuser's behavior. Therefore, an important message that advocates and WomanKind staff try to impart

Messages to Victims of Abuse

If you are not ready to ask for help:

- Have a safety plan.
- Keep resource numbers handy.
- Keep friends and acquaintances.

1. You do not deserve to be abused.
2. You are not responsible for the abuse.
3. You did not cause it. You did not provoke it.
4. You cannot fix it.
5. What happened to you is against the law.
6. You are not alone. There is help available.

-Susan M. Hadley
Founder, WomanKind

immediately is that no one deserves to be abused, and it's not her fault. The victim cannot control the abuser's behavior, but she can control her own response to his behavior.

- *Getting through the next hour.* When women are seen in the emergency room, they have been through both emotional and physical trauma. Volunteers and WomanKind staff try to providk immediate comfort and show concern for clients, while also trying to help them assess their immediate priorities. For example, women in this situation must decide whether or not they are going to return home.

- *Understanding that there are options.* A combination of isolation, intimidation, and fear leaves many women with the conviction that no one understands their situation or is available to help them. In some cases, ties to family and friends have been weakened. In others, victims of abuse may fear (with some justification) that family and friends will not believe that their charming neighbor or son-in-law is capable of abusing his partner. For these and many other reasons, victims of domestic violence become convinced that there is little or nothing that can be done. WomanKind advocates try to help their clients see that they do have options and that support is available whenever they choose to exercise them. The more options they see and take, the safer they can be.

The most important long-term goal is to help clients develop and implement a safety plan. A safety'plan includes specific measures to take when a woman feels endangered (e.g., identifying a friend to call or a place to go), as well as recognizing the cycle of abuse and the cues signaling each stage in the cycle: build-up; explosion; calm or "honeymoon" period. WomanKind staff and volunteers report that victims recognize this immediately and can usually pinpoint where they are in the cycle, as well as the markers of transition to the next phase. This information can then be used in crafting a safety plan that is unique to their situation and can help them reduce the physical violence in their lives. Unfortunately, psychological abuse is much more entrenched and difficult to change.

In addition to a safety plan, volunteers and staff work with women to begin rebuilding their self-esteem and confidence. This can include something as basic as doing something for herself--even for only 15 minutes a day-or reminding herself of a skill or talent. As one staff member put it, this is often a process of "one step forward, five steps back." A related long-term goal is to work on the client's rebuilding support systems in order to break down the isolation that victims experience.

Client outcomes clearly must differ from client to client since eadh is in a unique situation. WomanKind advocates and staff feel that they have accomplished what they set out to do if an abused woman recognizes that she is in an abusive situation, accepts that it is not her fault, develops a safety plan, see options for herself, and, above all, makes her life safer.

Support Groups

WomanKind offers confidential self-help support groups for women who have been or are currently living in a physically or emotionally abusive relationship. The groups are free and meet weekly. They are facilitated by volunteer advocates who receive specialized training. This is one aspect of the program that is currently undergoing assessment and revision by WomanKind staff as participation in the support groups has been declining in the last year. Staff are currently exploring options for assessing the needs that can be met in support groups and revising the training to be provided to facilitators.

As an example of how this aspect of the program is being thoughtfully revised, WomanKind has recently started a daytime support group involving women and men at the Fairview University Medical Center, Riverside Campus. This group focuses on messages learned as children relating to sex role stereotypes, communication and sexuality.

C. Program Services Staff

Currently, a program manager oversees the WomanKind program services and provides support and supervision to a program coordinator in each of the 3 hospitals where the program operates. The original founder and director of the program currently conducts marketing for the program. All staff have bachelors or masters degrees in social work or counseling which contributes to their acceptance within the professional medical community. The full-time program coordinators provide case management and advocacy services during the workday in addition to back-up support for the on-call volunteer advocates after hours. They also maintain communication with hospital staff and community service providers. An additional significant aspect of their role is to manage, supervise, train and support the volunteer advocates.

WomanKind staff participate on numerous multi-disciplinary teams at each of the hospital sites. Examples include the mental health unit team, chemical dependency case treatment, and the medical-surgical discharge planning team. Critical care rounds are made daily to the intensive care units. This certainly contributes to the goal of making WomanKind an integrated program and contributes to the overall care provided to patients. In interviews, medical staff commented on this aspect of the program as a strength, as it encourages them to view their clients in a new way.

Staff meet once per week to review resources, discuss cases, and note issues or events in their respective hospitals. These staffmeetings are important for: important in keeping staff current and up-to-date; sharing information; recognizing staff and program accomplishments; and, perhaps most importantly, ensuring a level of consistency in program implementation across the hospitals. While each staffcoordinator is expected to become thoroughly familiar with the operation and-culture of her hospital, and has a degree of flexibility in responding-

to the unique needs and circumstances of that hospital, the philosophy and principles of the WomanKind program, as well as all of the program components, are central to the program at each site.

When asked to describe the attributes and skills that are essential for their success as coordinators, WomanKind staff listed the following:

- Ability to help clients look at their own strengths and determine how they can use them to make changes in their lives.
- Respect for the process that women go through in dealing with an abusive situation and ability to support her decision-making.
- Respect for the process that health care providers go through as they begin to understand more about the dynamics of abuse; acceptance of providers' frustration and sense of futility, and willingness to help them move beyond these feelings to be supportive to patients.
- Willingness and ability to diplomatically confront health care providers when necessary; ability to advocate for a unique, and sometimes unwelcome, perspective.
- Ability to find concrete ways to teach health care providers what they can do for victims of abuse; and a willingness to deal with sensitive, emotional issues that may be uncomfortable for the providers.
- Skills in managing volunteers (training, supervision, monitoring, providing feedback).
- Ability to take care of your own mental health.
- Belief in the WomanKind program, philosophy, and services.
- Strength of purpose and commitment to the clients.

D. Volunteer Advocates

In a very real way, the volunteer advocates are the heart of the WomanKind program. The case management and advocacy services could not be delivered on the same scale without a cadre of strong volunteers. They are also ambassadors for the program, within the hospital as they interact with medical professionals, and within the community as they interact with friends and colleagues. As other programs that depend on a volunteer work force have discovered, the strengthofthis program component profoundly affects how well the program achieves its goals and% respected by those who are asked to use it.

In the last two years, WomanKind has operated with between 50 and 65 volunteer advocates in the program. Individual advocates work in one of the three hospitals and are managed and supervised by the WomanKind staffcoordinator in that hospital. All volunteer advocates are women, given the overwhelming prevalence of women clients in the program. Volunteer advocates range in age from 20 to 65, and about ⅓ are in a health related career. Most serve as emergency department on-call advocates, but a few serve in other or additional capacities such as staffing the client crisis line, providing office administrative support for program staff, facilitating support groups, and conducting marketing activities or public speaking on behalf of WomanKind.

In operating the volunteer component of the program, WomanKind program staff have hvo concurrent objectives: to provide competent and compassionate support and advocacy services to women in abusive situations and to provide a challenging and rewarding experience for the advocates. Careful attention is given to the structure of the advocates' experience and to training and supporting the volunteer advocates to enable them to deliver services effectively.

Critical elements of this structure include:

Screening

Individuals interested in volunteering for the WomanKind program complete an application and go through an interview with the program manager and a coordinator. The strengths and attributes the person would bring to the experience are explored along with their motivations for volunteering to work with abused women. Many individuals who apply to be advocates have experienced abuse in their own lives and staff try to determine how these issues have been dealt with and resolved, recognizing that someone who is still in turmoil will be of little assistance to someone else. As one volunteer put it "you have to have your own issues in order" before you can really listen and support another person in crisis.

Training

New volunteer advocates for all of the hospitals are required to participate in an intense, 30-hour training course in preparation for their role as advocates. This training is held in January of each year, with sessions held in the evenings over a two week period. Issues covered in the training include myths and realities, dynamics of abuse, power and control, various forms of abuse, the expectations of advocates and their role, and a set of specialized topics such as religion, the law/legal system, health care intervention and the effect of abuse on children. This training course was evaluated in more depth for this study. Please refer to Chapter III for more information and a complete description of the course.

While most volunteer advocates are recruited and accepted into the program in the beginning of a year and are able to participate in the training course, WomanKind also accepts advocates into the program at different times of the year. For these advocates, training is provided through individual sessions with their assigned coordinator who will use materials, videotapes and verbal presentations to review all of the information that was covered in the structured course.

It is important to note that the training offers another screening opportunity as coordinators interact with the advocates and assess their reactions and feelings about the issues being covered. If any individual appears to be having a particularly difficult time with any of the material, a coordinator can spend time with the person and, if necessary, suggest that WomanKind may not be the right volunteer opportunity to pursue at this time.

Monthly Meetings

Once advocates begin their on-call work in their respective hospitals, they meet regularly with the other advocates who work in that hospital. These meetings are considered educational and support opportunities, designed to reinforce and expand on the information advocates receive in their initial training and to provide a time for them to connect with other advocates and learn from each other's experiences. The meetings are facilitated by the staff coordinator and typically follow this format:

- Welcome, announcements
- Sign-up calendar for the next month
- Program statistics for the previous month, e.g., ER calls, other referrals
- Review of articles, a guest speaker, or a video
- Discussion of "on-call" cases
- Discussion of current projects (such as marketing activities) or review of policies/procedures

Content topics that were covered in meetings in 1996 included:

- Statistics on domestic violence in Minnesota
- Violence against adolescent women
- Federal Violence Against Women Act
- Older abused/battered women
- Poetry and other writings by abused women
- Battering in the gay and lesbian community
- Legal information, e.g., orders of protection and probable cause arrests
- Religious response to battering

Volunteer advocates expressed mixed reactions to the monthly meetings, with some stating that they didn't find them very useful and others finding them very valuable in giving them new information and support. Most advocates who were interviewed for the study found the discussion of cases valuable, as they could learn from how others handled different situations. A few advocates mentioned that themonthly meetings have recently become more structured, and this has increased their value since they feel more relevant topics are covered and the discussions are purposely facilitated. In addition to providing more structure for the meetings, the coordinators have also started encouraging the volunteer advocates to set the agenda for the meetings and to identify topics that they particularly want to cover.

On-going, Individual Support

Advocates are expected to call their staff coordinator the day after responding to an emergency call. They discuss the case and how they handled it, receiving immediate feedback and information. Additionally, a staff member is always available as a back-up to the advocates should they need immediate assistance at the time of the crisis call. Coordinators take seriously their role in providing supervision and support to the volunteer advocates; each spends approximately 1% hours per day on this activity. Advocates appreciate the connection with the coordinators, believe that they can approach them at any time with questions or issues, and trust them to provide direction and assistance as needed while encouraging them to take responsibility for their volunteer role. One advocate put it this way: "This is not a job you can make a mistake in; [the coordinator] will reign you in if she needs to." The coordinators are also concerned about bum out among the advocates and encourage them to take care of their own mental health.

Clear Expectations

WomanKind requires a one-year commitment from volunteer advocates and makes it clear that they are seen as an integral part of a professional team that provides services to women referred to the program. Written materials on the volunteer advocate job descriptions, and policies and procedures are given to advocates and reviewed in their initial training course. Copies of these materials appear in Appendix B. Advocates are expected to attend training, participate in monthly meetings, meet all of the hospital's health requirements, conduct their on-call duties in accordance with WomanKind policies, sign-up for on-call responsibility and complete and turn in a client log within 24 hours of responding to an emergency call. The WomanKind program has infrequently taken the step of asking advocates to leave the program in situations where the expectations have not been met or if the advocate does not function well within the emergency room setting.

Yearly Evaluation

In 1996, WomanKind staff began to conduct a formal year-end evaluation for each volunteer advocate. This provides an opportunity for advocate and coordinator to sit down face-to-face and discuss the experience the advocate has had in the year and to receive feedback on the advocate's performance. Many individuals who volunteer with WomanKind stay with the program beyond their initial one-year commitment, and this gives them the chance to reflect in a formal way about the experience and to set goals and educational objectives for the next year. This evaluation does not supplant the on-going consultations between coordinator and advocate, particularly in discussing performance and providing the advocate with feedback, but it provides an additional, more formal avenue for discussion of the advocate experience. In addition to helping the coordinators provide better support to individual volunteer advocates, these evaluations yield collective information about the educational needs of advocates which can be used to structure training and monthly meetings. A copy of the form used for the yearly evaluation appears in Appendix B.

Outcomes

The attention given to preparing volunteer advocates for their role in the program and to structuring their experience appears to pay off for WomanKind in several ways:

- Advocates report that they stay involved in the program because of the support they receive and because the experience is challenging and rewarding. They believe that they are helping people, which is most often their reason for volunteering.

- Hospital staff repeatedly referred to the WomanKind advocates as competent, professional, and well-trained. They trust that when they page WomanKind, the person who responds will be knowledgeable and will do whatever she can to assist their patient.

- The overall program enjoys a level of credibility within the hospitals as medical staff see that the volunteer advocates provide concrete support such as calming a woman down so medical procedures can be performed or helping the woman secure resources immediately, if necessary.

- A number of WomanKind clients have told program staff that what they remember about their experience in the emergency room is that someone was with them, someone who seemed to care and was willing to help.

E. Comprehensive Program Marketing

Accessibility to patients and visibility among health care staff are critical to the success of the WomanKind program. WomanKind program staff are continuously marketing:

1. The issue of domestic abuse
2. The role and services of the WomanKind program, and
3. The importance of health intervention for victims of domestic abuse.

Formal Marketing Techniques

WomanKind works with the Fairview public relations department to formulate and implement an annual marketing plan, employing a wide variety of marketing techniques to further hospital staff awareness of the relationship between health care, domestic abuse and WomanKind services, as well as to make patients and the community more aware of the program. The marketing techniques that are used in the program include:

- *Reaching Health Care Staff*

  Education and training
  Annual/biennial formal presentations
  Department seminars
  Patient lecture series
  Department updates and case study analysis
  Emergency department chart reviews
  Multi-disciplinary team meetings
  Publications and posters
  WomanKind Health Professional Reference Card
  Hospital newsletters

> *"WomanKind is a gift. That's how I see it."*
>
> —Nurse
> Intensive Care Unit
> Fairview Southdale Hospital

- *Reaching Patients and Community*

  Brochures
  Client/Patient poster with pull-off tabs with phone number
  WomanKind 8-step community card
  Speakers bureau
  Referrals and relationships with community resources
  Media

Informal Program Marketing

In addition to the more formal marketing techniques identified above, the WomanKind program is served by attention to aspects of marketing that are somewhat less well defined but perhaps even more critical to its success. These include:

- *Building strong working relationships*

  All WomanKind staff coordinators spend a great deal of time interacting with medical staff in the departments they serve. They maintain visibility by visiting the units each day, talking with staff informally, conducting "hallway conferences" with staff about specific referrals, meeting new hospital staff members, and just generally being available and accessible. This was mentioned often in the staff interviews as a positive aspect of the program and one of the reasons staff are comfortable making referrals to the program.

  This activity is also important in working with other health professionals in the hospitals, such as social workers. WomanKind staff are clear about the boundaries and limitations of the program and how their services fit together with other services. Issues of turf dynamics and how to work collaboratively to the benefit of the patients are dealt with diplomatically as WomanKind tries to present the program as a partner in the care of patients. The success of this approach is reflected in comments made by social workers in all three WomanKind sites about the value of working together with WomanKind and how WomanKind staff and volunteers encourage their involvement in cases as appropriate and respect their expertise.

  In addition to maintaining visibility within the hospital, WomanKind staff also spend time in the community, building relationships with service provider organizations and representing the hospital. Attending meetings, serving on task forces, and maintaining on-going contact with the organizations are strategies for encouraging referrals to the WomanKind program and for developing comprehensive knowledge of the resources that exist in the community which can assist WomanKind clients.

- *Professionalism of the WomanKind staff and volunteer advocates*

  Hospital staff cited professionalism as a key aspect of WomanKind, which influences their decisions to refer clients to the program. In interviews, physicians, nurses and social workers often referred to the competence and professional demeanor of the staff and volunteers. They commented on the extensive training that volunteer advocates receive, and the specialized expertise that they bring into a situation. WomanKind staff and volunteer advocates take work away from hospital staff instead of adding to it.

Just as important as the praise that was expressed for the staff and advocates, two nurses expressed concerns they had once had about specific volunteers and that they had discussed their concerns with the WomanKind director. They believed their concerns were heard, taken seriously and addressed in an appropriate manner.

- *Dependability of the program*

"The WomanKind program is successful because it does what they said it would do." This sentiment was expressed in a variety of ways by hospital staff who described the program operating as they had been led to expect it would, i.e., advocates come quickly when they are paged, they are helpful to medical staff and to the patient, and WomanKind staff offer a unique perspective in treating the patient and are available for consultation.

F. System Change

An achievement of the WomanKind program has been a comprehensive. system change where WomanKind services are integrated into the total care of every patient who is assessed and identified as a victim of domestic abuse.

WomanKind Domestic Abuse Policy

The "Domestic Abuse Policy Series" was added to the Fairview Hospital Policy Manuals in 1993 and revised annually with the "Scope of Service" policy added in 1997. Copies of the policies are included in Appendix P. This policy series includes:

- Domestic Abuse and Violence
- Scope of Service
- Definitions and Philosophy
- Assessment, Identification and Referral
- Case Management and Advocacy Services for Victims
- Photographing Injuries of Victims
- Documentation in the Medical Record
- Documentation of WomanKind Activity and Services
- Intra-hospital Relationships
- Confidentiality of Records and Reports
- Safety and Security

The importance of written policies is underscored by this statement by the founder of WomanKind:

> "Over the years, both the WomanKind program and the affiliated Fairview hospitals and clinics have had to adjust to one another. Instead of viewing hospital procedures and department affiliations as obstacles, the WomanKind program staff have worked with hospital colleagues to influence hospital policies and protocols in order to make domestic violence assessment and intervention a routine aspect of patient care."

New *Staff Nursing Orientation*

As in most health care settings, there is a department and/or hospital/clinic orientation for new nursing staff. In 1989, WomanKind became a formal component of that new staff orientation. During this 1½ hour presentation WomanKind program staff discuss:

- Statistics: general and medical
- Dynamics, myths and realities and effects of domestic abuse
- Unique aspects of health care intervention for victims
- Victim's process of change
- dids in identification
- Working with the WomanKind program

Program coordinators conduct the orientation in their respective hospitals using this as an opportunity to introduce themselves as well as the program.

Importance of Routine Screening

It is essential to remember that victims of abuse access the health care system for both abuse-related as well as routine care. The most important contribution health professionals can make to ending abuse and protecting the health of victims is to assess, identify and acknowledge the abuse. And the single greatest step health professionals can take in identifying victims of domestic abuse is to institute routine screening of all patients. With the implementation of the "Abuse Prevention Plan" and the commitment to the JCAHO Standards, it is essential to integrate routine screening into the total health care of every patient.

The policy or procedure that has had the greatest effect on the integration of WomanKind direct services into the health care delivery system was the "Abuse Prevention Plan." This structured plan for the assessment and identification of victims of domestic abuse and subsequent ieferral of those patients to the WomanKind program was implemented in the

metropolitan Fair-view Health Services hospitals in 1994. This policy called for the assessment by nursing staff of all patients for domestic abuse, elder abuse or child abuse. Every Fairview staff member is expected to complete the Abuse Prevention Plan with the patient under his/her care.

Knowing which women are experiencing abuse requires diagnostic and interviewing skills to detect not only the obvious cases (repeated fractures, inconsistent explanations of an injury, old bruises in various stages of healing), but also the less obvious cases (panic and anxiety attacks, suicide attempts, substance abuse or medication dependence).

Universal screening at intake accomplishes many goals at once:

1. "It tells a victim of domestic abuse that someone cares, even if the victim is not ready to or cannot acknowledge the abuse at that time. Victims will always remember not only that they were asked, but how they were asked, and where it is safe to return when she is ready to reach out for help." (Susan Hadley).

2. Asking the question is unlikely to offend those.who are not abused, as the question conveys a sense of concern. This is unlike questions about potential child abuse which could communicate a possible accusation.

3. Routine screening helps identify more subtle cases as well as the more obvious ones.

4. With the use of simple screening questions, victims of domestic abuse will come forward.

Multi-disciplinary Team Approach

Learning how to screen for abuse and to identify victims is important, but it is not enough. Once the suspected cases of abuse are identified, frontline health care staff who interact with patients need to offer support and have an immediate referral option in which they have a sense of professional faith-one that they know will benefit the patient. WomanKind gives health care staff an incentive to screen and identify patients, because they know they can turn their patient over to competent, trusted WomanKind staff who will help the patient-and who lessen the workload of the health care staff instead of adding to it.

III. Summarv

In this component of the evaluation, we reviewed the WomanKind goals and components in depth to document the conceptualization and implementation of the program and to identify key principles or lessons that would apply to other health care settings.

Perhaps the strongest aspect of the WomanKind program is that it offers both education and consultation to hospital staff and case management and advocacy services to victims of abuse. Educating medical, nursing and social work staff about the prevalence and dynamics of domestic abuse, and about the role they can play in identifying, intervening, and preventing such abuse would likely not have the same impact without an in-house, convenient and trusted referral service available. (WomanKind program materials that were reviewed for this evaluation appear in Appendix Q). Similarly, focusing only on providing services to clients misses the opportunity to enhance health care providers abilities to recognize women who need such services.

Essential elements of the WomanKind program structure include:

- In-service training and on-going education and consultation for‘hospital staff.

- Case management and advocacy services that extend beyond crisis intervention, and into assisting a client over time to evaluate her situation and to make decisions that will be best for her.

  Case management and advocacy services that are based on a strong theoretical and practical base, drawing from the fields counseling psychology and social work, and from the growing body of literature and research in domestic abuse and the health care response to it.

  A strong, professional program staff,

  A structured and well developed program for recruiting, screening, training, supporting and supervising, and evaluating volunteers.

  Comprehensive program marketing -- including formal and informal marketing activities.

- An understanding that improving the health care response to victims of domestic abuse means changing the health care system through policies, procedures, routine screening, and a multi-disciplinary team approach.

The final chapter of this report provides suggestions and insights for replicating or adapting the WomanKind program model-to other health care settings.

Chapter VIII

Summary of Findings

. Chapter VIII. Summary of Findings

The purpose of this research was to conduct an assessment of *WomanKind: Support Systems for Battered Women, an* innovative program for responding to the needs of victims of domestic abuse within a hospital setting. Through education and training, WomanKind creates a hospital-based network of physicians, nurses, social workers, and volunteers who work together to identify cases of intimate partner violence and channel them appropriately to existing community services.

A longitudinal, quasi-experimenta! research design was used to collect and compare information from the three hospitals where the WomanKind program operates and from two comparison hospitals where there was no formal program to address intimate partner violence.

The overall intent of this evaluation was to determine: 1) the extent to which the WomanKind program increases health **care** providers' capacity and motivation to identify cases of intimate partner violence and initiate a course of positive change through referral to WomanKind in-house services; and 2) the extent to which the WomanKind program provides assistance to the women referred. In addition to identifying the outcomes associated with the program, we assessed and documented the components of the program and how they are implemented, for purposes of replication and adaptation in other settings.

A longitudinal, quasi-experimental research design was used to collect and compare information from the three hospitals where the WomanKind program operates and from two comparison hospitals where there was no formal program to address intimate partner violence. To comprehensively assess the WomanKind program, we employed a variety of quantitative and qualitative research methods, including:

- Collection and analysis of statistical and survey data from hospital staff, volunteer advocates and WomanKind clients;
- Review of program materials;
- Observation of program activities i.e., training for hospital staff and volunteer advocates, monthly meetings with volunteer advocates;
- Review and abstraction ofmedical charts from hospital emergency departments; and
- Conduct interviews and group discussions withhospital staff, WomanKind volunteer advocates, and WomanKind program staff.

Using a variety of research methods allowed the research team to develop a more in-depth picture of the WomanKind program than would have been achieved otherwise. For example, anchored surveys that measured hospital staff knowledge, attitudes, beliefs and behaviors (KABB) provided aggregate outcome information on the effects of the program, while individual interviews with

hospital staff allowed us to further explore, on a more individual level, staffperceptions of their role in addressing domestic violence and their opinions about the value of the program. Taken together, the methods used in this study provide rich insight into an innovative and multi-faceted program.

Data collection activities took place over the course of two years, beginning in January 1995 with the development and pre-testing of instruments and an initial site visit to interview WomanKind program staff and volunteer advocates and hospital staff at all participating hospitals. Data were collected over the next two years through surveys and additional site visits, concluding in March 1997.

There were three components of the evaluation:

Training Evaluation - to determine the effects of the WomanKind training on hospital staff and volunteer advocates. This component also included a curriculum review.

Outcome Evaluation - to determine how the program affects knowledge, attitudes, beliefs, and behavior of hospital staff and clients referred to the program.

Process Evaluation - to document the components or "processes" of the WomanKind program.

In this chapter of the report, we present a summary of the findings from the evaluation.

I. Trainina Evaluation

A. Volunteer Advocates

Women who apply to become WomanKind volunteer advocates are required to complete a 30-hour training program before they are accepted. Training is conducted as ten 3-hour sessions held over a two week period. The stated training objectives reflect the expectations and responsibilities of volunteer advocates as presented in the job description and hospital policies. These objectives are clearly linked to the specific topics covered in the training.

Strengths of the Training Program

Essentially this training immerses the potential volunteer in the issue of domestic abuse and provides them with a rich and compelling picture of how pervasive the problem is and how it affects the lives of those who experience it. It is an intense, comprehensive educational program that demands a strong commitment from the volunteer. It is expected that the volunteer advocates will discover things that they didn't know, take anew look at things they thought they knew, begin to deal with their own attitudes and emotions around some very difficult issues, and begin to understand what they will be able to do when working with clients.

Indeed, volunteer advocates that participated in interviews conducted by the evaluation team were positive about the training experience and believed that it was helpful to them in understanding the issue of domestic abuse and how they could work with clients. Specifically, they mentioned that it helped them understand why women stay in abusive relationships, made them aware that they had accepted some of the myths about domestic abuse, and increased their sensitivity to the woman's overall process.

Volunteer advocates who participated in the January 1996 training program completed pre- and post-training KABB surveys. Results from the comparison of these surveys indicated that scores increased for three out of six conceptual scales: *Self-efficacy for Identification and Interaction; Self-efficacy for Referral and Services; Understanding of Abusive Relationships.* These findings would indicate that training does increase volunteer advocates' confidence in their abilities to identify and support victims of abuse, their knowledge of services to assist victims, and their confidence in being able to make appropriate referrals to these services. Additionally, these findings point out an increase in the volunteer advocates' understanding of the dynamics of abusive relationships. All of these are intended outcomes of the training.

The training program is well conceived and organized. Care is taken in selecting and preparing speakers to address different topics and WomanKind staff play a significant role in helping the volunteer advocates understand the program and the value of the volunteers. A reference manual that is distributed during the training is very comprehensive and provides volunteer advocates with articles and other materials that will support their work as advocates. Together, the topics presented in the training and the reference manual present a full and comprehensive picture of domestic abuse and reflect the most current practice and research in the field. WomanKind staff continually reviews both the training and the reference manual to determine where changes or updates are needed.

Suggestions for Strengthening the Training Program

Based on the observations of the evaluation team and the comments from the volunteer advocates, there are a few things that could be done to strengthen the training. These include:

- In the beginning of the training, review the objectives and the overall agenda, presenting a "roadmap" of the training. Periodically come back to this to through summaries of sessions to illustrate how sessions are building on one another and to help point out the connections between sessions.

- Build in time for group and individual processing, since the information is so intense and emotional. Training participants need the chance to discuss their reactions to videos or presentations, to ask questions or express concerns. Without this opportunity, they may not be able to continue to absorb new information or be able to put the information together in a way that will be useful to them.

- Build in more time for skill practice and feedback so advocates get a better sense of what to expect in working with clients and to increase their comfort level with their counseling skills.

- Integrate the reference manual into the training a bit more. Refer participants to specific materials that will reinforce or expand on information presented by a speaker. Look for ways to use the reference manual with volunteer advocates outside of the training, perhaps in monthly volunteer meetings.

Conclusion

The training program for the volunteer advocates is well designed and appears to meet its objectives in raising volunteers' awareness and understanding of the dynamics of domestic violence and preparing them to work with clients. Volunteer advocates receive on-going support in their work, through supervision from the WomanKind coordinators and monthly volunteer advocate meetings, but the training program provides the foundation of their experience and is an important element in their preparation to assume the role of advocate.

Perhaps the best endorsement for the advocate training program is the perception of the hospital staff in the Fairview hospitals. In interviews with the evaluation team, hospital staff repeatedly described the volunteer advocates of the WomanKind program as professional and *well-trained.* Obviously this contributes to the overall effectiveness of the program as the hospital staff have the confidence to refer patients to the program.

B. Hospital Staff

A goal of the WomanKind program is to provide education to health care staff to increase their knowledge and skills in identifying and treating victims of domestic violence. In this chapter we focused on the formal education program that has been developed for health care staff. The methods used to assess the education or training program included: a curriculum

review; interviews with health care staff who participated in the training; and pre- and post-test measures of knowledge, attitudes, beliefs and behaviors.

WomanKind has designed the professional educational program as a flexible program that can be adapted to the needs and demands of various hospital departments and other medical settings. Training can be delivered in 1-, 2- or 3-hour sessions, with follow-up sessions as needed and requested. The-training covers the basic topics of:

- Scope and prevalence of domestic violence
- Dynamics, myths and realities, cycle of violence
- Assessment, identification, and intervention
- Intervention and documentation
- WomanKind program and community connection
- Victim's process of change

The training is conducted largely as a knowledge building opportunity with presentations on each topic, supported by visual aids and handout materials. Presenters encourage questions and often use case studies to engage participants in discussion, though time restrictions often limit this type of interaction.

Hospital Staff Perceptions of Training

Hospital'staff (medical, nursing, social work staff) who participated in training described it as valuable and enlightening. Several made a point of saying that they were surprised or even shocked by things they learned, such as the prevalence of domestic abuse or that women are often abused during pregnancy. Individuals stated that the training made them more comfortable with the topic, taught them that there were things they could do for patients who are victims or abuse, and helped them understand what the woman is going through.

It was interesting to note in the interviews that many hospital staff used the language of WomanKind, i.e. "understanding the woman's process", "my role is to identify, assess and refer". Many stated that the training had raised their awareness of the problem, they look for it more often since the training.

Changes in Staff KABB Over Time

A 51-item KABB survey was used to measure the hospital staffs' knowledge, attitudes, beliefs, and behaviors related to domestic violence, administered at three different points during the study. To assess the impact of the training, we analyzed the surveys for those who had participated in the training, using the baseline survey as a training pre-test, and TIME3 survey as a post-training measure. The 5 1 items form seven conceptual domains or scales, which were used for the analysis.

Chapter VIII. Summary of Findings

When mean scores for baseline and TIME3 KABB surveys were compared for trained staff, the scores increased on all seven scales. Five of these were statistically significant increases:

- Self-efficacy for identification and interaction
- Self-efficacy for referral and services
- Staff responsibility to address domestic violence
- Self-reported behaviors
- Staff preparation

These findings suggest that the training is effective in helping staff develop confidence in their ability to recognize and communicate effectively with victims of domestic abuse and their ability to make appropriate referrals for these individuals. They suggest that the training positively affected their beliefs that hospital staff have a responsibility to address domestic violence and that they themselves are more likely to ask questions about abuse of their patients and document such information in their charts. Finally, an increase in the mean score for the last scale suggest that the training made them more likely to believe that hospital staff do have the knowledge, time, and training to assist victims of domestic violence.

These items very clearly reflect the primary focus of the training, which is to help hospital staff understand their role in identifying and intervening with patients who are in abusive situations and to show them that with an in-house referral service available to them, their intervention does not have to extend to counseling or other activities for which they feel they do not have the time nor expertise.

The analysis of KABB surveys also indicated that trained staff who had previous exposure to domestic violence issues (through other educational opportunities or personal experience) or who had also participated in WomanKind training prior to this evaluation period, had higher mean scale scores over time than those with no previous exposure. This is consistent with an expectation that someone who has been exposed to information about domestic violence from a number of sources over time, or has personally been affected by it, would have a greater understanding of the problem and stronger beliefs about intervening.

Strengths of the Training Program

This is an instructionally sound curriculum that responds to the identified needs of the targeted audience, i.e., health care providers' need to understand the prevalence and dynamics of domestic abuse and the role they can play in preventing and reducing abuse. There is a clear, direct connection between the learning objectives and the topics that are covered in the training. Consistency in the messages conveyed in the training is strong because so much of the curriculum exist in writing, including handouts that training participants take with them.

The curriculum is practical and straightforward in addressing the issue of domestic violence. It provides concrete information that health care providers can use as soon as they leave the training. It is obvious that the material presented is firmly grounded in real-life experience and reflects that most up-to-date information and research on domestic violence.

The curriculum design allows for modifications based on the time available, the specific characteristics of the audience, and their knowledge and experience with the subject. Since thetrainingpriorities are clearly identified within the objectives, the training can be delivered in total or broken into segments and delivered over two or three sessions.

Suggestions for Strengthening the Training Program

The training provides information on why and how to ask about abuse, but little or no opportunity to practice asking. The review of case studies does offer participants the chance to think through a situation and what they might do, but more practice would be beneficial. This is a consideration for future training, particularly second or third sessions with a particular group of participants,

A related consideration is the need to develop more "advanced" training for staff who have been exposed to the training. While the basic curriculum will remain appropriate for new staff members, more experienced staff will be ready to move into other topics related to intimate partner violence and to process their own experiences in more depth.

When staff who had participated in training were asked for suggestions for how the training might be improved, they offered the following ideas:

- Include role playing
- Let us bring patient scenarios and discuss them or act them out
- Give us more help in handling difficult cases, especially when children are also being abused
- Give us more specific how-to's, such as how to get the partner out of the room
- Help us deal better with the frustration of seeing them come in again and again

Conclusion

Formal training provided to hospital staff is a fundamental component of the WomanKind program and is linked to the goal of improving the health care providers' responses to victims of domestic violence. Our assessment of the training suggest that even brief (1 to 2 hour) training sessions have an impact on staffs' level of awareness of domestic abuse and their belief that they can do something about it.

II. Outcome Evaluation

A. Hospital Staff

In this component of the evaluation we were seeking to determine how the WomanKind program affects knowledge, attitudes, beliefs and behaviors of hospital staff Data was collected through KABB surveys distributed to staff at three times over the course of the study, and through interviews and discussion groups conducted near the end of the study.

The **KABB** survey consisted of 5 1 items, using an anchored seven-point Likert scale, ranging from "Strongly Disagree" to "Strongly Agree". The individual items formed seven conceptual domains or scales, based upon a review of relevant issues from the professional literature on domestic violence, and the explicit objectives of the WomanKind program. The scales were empirically tested through factor analysis of the baseline surveys, which confirmed the conceptualized factor pattern. The resulting seven factors addressed the following areas:

- Self-efficacy for identification and interaction with victims of abuse: belief in their ability to identify victims of abuse and interact appropriately with them.
- Self-efficacy for referral and services: belief in their ability to make appropriate referrals for victims of abuse and their intent to do so.
- Staffunderstanding of abusive relationships: their understanding ofthemyths and realities and dynamics of abuse.
- Staff responsibility to address intimate partner violence: beliefs about the role of medical staff to identify and address domestic violence.
- Self-reported behaviors: behaviors related to asking patients about abuse an documenting how injuries occur in patients' charts.
- Staff preparation: beliefs around the extent to which medical staffhave the training, time and knowledge to address domestic violence.
- Victim autonomy: attitudes and beliefs concerning victims' needs and rights To make their own decisions about their situations.

Findings

The most significant findings to emerge from the analysis of KABB survey data were:

1) Total scores on the KABB significantly increased over time, indicating that hospital staff in all hospitals experienced some positive change in their knowledge, attitudes, beliefs and behaviors related to domestic abuse. Mean scores for each of the scales also increased over time, indicating a level of change in all seven dimensions.

This finding is consistent with the fact that in all of the hospitals participating in the study, the role of health care providers in responding to domestic violence had become a more prominent issue during the course of the study. Reasons for this included(in addition to the operation of the WomanKind program in the Fairview sites): recent policy and procedural changes; media coverage; WomanKind training at all sites; the research study itself.

2) Total scores on the KABB surveys were significantly higher for the experimental hospitals than for the comparison hospitals, at all time intervals during the study. In addition, significant between-group effects, showing higher mean scores for the experimental hospitals, were found on four scales:

Self-efficacy for referral and services
Self-reported behaviors
Staff preparation
Victim autonomy

This finding points to the effect of the WomanKind program on total scores and on the specific issues addressed by the scales. This would indicate that the staff in the hospitals where WomanKind operates are more confident in their abilities to appropriately refer victims of abuse, more likely to ask questions about abuse or relationships and record relevant information in patients' charts.

A higher score on the scale of staff preparation would indicate that WomanKind is having some success in teaching hospital staff that they do have the knowledge, time and training to effectively address domestic violence because with an in-house program, their role is to identify, assess and refer, not provide counseling or other services themselves. Similarly, an higher score on victim autonomy would indicate that the WomanKind program is having some success in conveying the message that a victim of domestic abuse is going through a process and she has a need and a right to make her own decisions about how to deal with her situation.

3) When analyses were performed to examine the differences between Fairview Southdale hospital (as the initial WomanKind site), the other two Fairview hospitals, and the two comparison hospitals, significant within-group and between-group effects were found.

This finding suggest the effect of institutionalization of the WomanKind program. The WomanKind program was originated in Fairview Southdale in 1986, three years before the next Fairview site. The differences in scores between this hospital and the other hospitals supports our hypothesis that staff at Southdale would be more knowledgeable and positive about the role they play in addressing domestic violence since they have had the benefit of exposure to the program for a longer period of time. This finding also supports the assumption that the "presence" of the WomanKind program with its various components has a positive effect on the knowledge, attitudes, beliefs and behaviors of hospital staff.

4) We hypothesized that certain demographic variables may affect the KABB scores and we tested for these effects in the analysis. While variables such as age, sex, hospital, department and position were found to have significant effect on certain scale, the variable EXPOSURE was found to have a significant effect on all seven scales. This variable reflected whether a respondent had previous training or experience in domestic violence. On all seven scales, individuals who had previous exposure scored higher than those who had no previous exposure. Thus, this variable was used as a covariate in all of the analyses to control for this effect.

The effect of exposure is not surprising, since it would be logical to expect that anyone who has had a training seminar, worked as a volunteer in a domestic violence program, or had personal experience with domestic violence would be more aware of the dynamics of abuse and the role that health care providers can play in addressing it.

Hospital Staff Perceptions of the WomanKind Program:

In a series of interviews and group discussions with staff at the Fair-view hospitals we discovered that the perception of the WomanKind program is overwhelmingly positive. In conversations with over 70 staff across these three hospitals, all stated that they were comfortable referring patients to the program, and were confident that if they called WomanKind for help they would receive a dependable, quick, and competent response.

When asked about the impact of WomanKind on hospital staff, most responded that their interactions with patients have improved: they found themselves and their colleagues more sensitive, empathetic, and willing to listen. They stated that they were more aware of domestic violence and more comfortable asking questions about it.

A number of staff commented on the fact that the WomanKind program appeared to be everywhere, that it was "entrenched" in their departments and that everyone was aware of the program. Some comments underscored a central theme of the program as hospital staff described that they were more likely to ask a question about abuse since they had somewhere to refer the patient if needed.

Conclusion

Results from our evaluation indicate that the WomanKind program does have a positive effect on the knowledge, attitudes, beliefs, and behaviors of hospital staff, both in terms of their awareness of domestic abuse and their understanding of the role of the health care provider in addressing it. The presence of an in-house referral source, as well as the formal and informal educational opportunities that WomanKind offers to hospital staff, appears to make a difference in how confident staff feel about identifying and interacting and referring patients; Hospital staff at the Fairview sites where WomanKind operates are enthusiastic about the program, and more importantly, have developed a trust and confidence in the program.

B. WomanKind Clients

Our objective for this aspect of the evaluation was to learn more about WomanKind clients and what services the program provides to them. We also wanted to learn more about the process of change that clients experience as they work with the WomanKind program.

WomanKind responds to referrals of inpatients and outpatients, Fairview employees and community residents. Anyone can confidentially self-refer or refer a patient to WomanKind for services. The number of referrals to the program has grown from 141 in the first six months of operation at one hospital (June through December, 1986) to over 15,000 in three hospitals by March of 1997.

In reviewing program records for the entire year of 1996, we discovered the following:

- Almost 20% of the total referrals to the program came from the chemical dependency units in the hospitals, followed by the emergency departments (15%), and mental health units (12%).

  The WomanKind program made a total of 2832 contacts with clients in 1996. This includes initial contacts (46%), client initiated repeat calls (20%), and WomanKind initiated follow-up calls (35%). This is a clear illustration that WomanKind services extend beyond crisis intervention into on-going case management and advocacy.

- WomanKind made a total of 2062 referrals to community services in 1996. The referrals made most often were to support groups (WomanKind support groups and others in the community), mental/chemical health services, and shelters. Other referrals included: legal services/law enforcement; county social services; and other services including Al-Anon, food banks, Alcoholics Anonymous.

- Ninety-seven percent of WomanKind clients in 1996 were women. Eighty-four percent were Caucasian, and sixty percent were between the ages of 20 and 39. These statistics were relatively similar across hospitals with one notable exception: clients at the Fairview University Hospital -- Riverside Campus were more ethnically diverse, with fourteen percent being African American, and seven percent Native American, reflecting the communities served by these hospitals.

A total of 52 clients agreed to participate in the study by completing KABB surveys, beginning with an initial "intake survey" that was administered during the first contact with WomanKind. A follow up survey was administered (typically by phone) approximately one week after the intake survey and subsequent surveys were administered at 14-week intervals thereafter. Unfortunately, many clients could not be contacted or were not in a position to respond to a survey during the follow-up and subsequent surveys so we effectively lost the ability to track a clients process over time. However, we did gain a better understanding of how the women perceived their situations at the time of the initial contact. In general, these findings included:

- Clients generally believed in their ability to leave their abusive relationships
- Clients believed that their children were aware of the violence in their relationship
- Clients believed that they had somewhere to turn for help
- Clients did not believe that it was their fault when their partner acts violently toward them
- Clients did not believe that they could change their partner for the better
- Clients characterized themselves as often feeling lonely, isolated, and hopeless
- Clients believed that their partners would hurt them again

In addition to asking about the items above, clients were also asked to describe a protection plan for themselves. This is a cornerstone of the WomanKind program -- advocates work with each client to develop (and revise over time) a plan for her safety. The fact that 43 out of 52 clients were able to articulate at least one item for a protection plan at the time of the intake survey seems to indicate that advocates are having some success in assisting clients to evaluate her situation and make decisions about how to protect herself. The most often cited items on a protection plan were "obtain an order **of** protection" and "move away".

Conclusion

Program statistics and records clearly indicate that WomanKind is recognized and used throughout the Fair-view Hospitals -- client referrals come from all departments, particularly chemical health and emergency. Statistics also show that WomanKind does in fact provide more than crisis intervention services to clients, as evidenced by a large number of both client initiated and WomanKind initiated follow-up calls. Finally, program records also show that WomanKind consistently uses a range of community services as referral sources

for clients, reinforcing a basic tenet of the program which is to link with the community and not to create duplicate services.

WomanKind's impact on a client starts as soon as contact is made, the client is made to feel that someone is there for her, to listen to her and assist her as needed. As WomanKind staff and volunteer advocates work with a woman to evaluate her situation and begin to make decisions, an important step is the development of a safety or protection plan. Data collected from clients that participated in the study indicates that this work even in a crisis situation.

III. Process Evaluation

Perhaps the strongest aspect of the WomanKind program is that it offers both education and consultation to hospital staff and case management and advocacy services to victims of abuse. Educating medical, nursing and social work staff about the prevalence and dynamics of domestic abuse, and about the role they can play in identifying, intervening, and preventing such abuse would likely not have the same impact without an in-house, convenient and trusted referral service available. Similarly, focusing only on providing services to clients misses the opportunity to enhance health care providers abilities to recognize women who need such services.

Essential elements of the WomanKind program structure include:

- In-service training and on-going education and consultation for hospital staff.

- Case management and advocacy services that extend beyond crisis intervention, and into assisting a client over time to evaluate her situation and to make decisions that will be best for her.

  Case management and advocacy services that are based on a strong theoretical and practical base, drawing from the fields counseling psychology and social work, and from the growing body of literature and research in domestic abuse and the health care response to it.

- A strong, professional program staff.

- A structured and well developed program for recruiting, screening, training, supporting and supervising, and evaluating volunteers.

- Comprehensive program marketing -- including formal and informal marketing activities.

- An understanding that improving the health care response to victims of domestic abuse means changing the health care system through policies, procedures, routine screening, and a multi-disciplinary team approach.

The final chapter of this report provides suggestions and insights for replicating or adapting the WomanKind program model to other health care settings, based on the findings from the evaluation.

Chapter IX

Implications for Replication/Adaptation of the WomanKind Program

Chapter IX. Implications for Replication/Adaptation of the WomanKind Proaram

I. The Evolution of Support for WomanKind

Fair-view Southdale Hospital was the first WomanKind site, established 11 years ago. Although the program is now accepted and supported by the hospital, this was not always the case. The program's initial financial support came from the hospital auxiliary, which continues to provide support for WomanKind in all three Fair-view sites. For the first three years, funding was for expenses only, not salaries. The hospital's administrators did not initially see the benefit of the program and were also reluctant to let an independent person and a non-profit program operate within the hospital. This reluctance stemmed in part from a lack of awareness of domestic violence as a problem in the affluent suburb of Edina, where the hospital is located.

WomanKind staff believe that the change of heart among hospital administrators came from pressure from the frontline staff who had the most contact with victims, and who recognized the value of having an in-house resource for their patients. State health care reform efforts have also affected the hospital's view of its role in the community and have led to a more community and prevention-oriented approach, where health status is more'broadly defined than it has been in the past. As corporations, hospitals can place a greater value on services that enhance community health and reduce future health care costs, even if the services themselves do not generate revenues.

This experience underscores the importance ofcontinually marketing the program within the health care system at all levels. Not only is support from hospital administrators necessary when starting a program such as WomanKind, but there must be on-going attention paid to integrating the program into the philosophy and operations of the hospital and building strong commitment to the program. One of the strongest lessons is that there must be a champion for the program, someone who consistently and with persistence pushes the program and demonstrates its value at every opportunity.

Over the last decade, additional hospitals and associated clinics have been added: Fairview Ridges Hospital in 1989; Fair-view University Medical Center-Riverside Campus in 1994; and Fairview University Medical Center - University Campus in 1997. Fair-view Health services now sees WomanKind and domestic abuse as a priority and dedicates over $300,000 annually for its support.

II. Where to Start

The WomanKind program as described in this report is the result of 11 years of growth and evolution. A hospital or other health care setting that wants to improve its responsiveness to domestic abuse could read the description and conclude that such a program model is too ambitious. While it is probably unrealistic to think that the program could be implemented all at one time, it is important to look carefully at what has been most critical to WomanKind's success and the lessons that can be extracted and adapted for other settings.

A. Philosophy and Principles

WomanKind has a strong theoretical and professional base, grounded in the current literature and research on domestic violence and standard social work practice. Every aspect of the program is well thought out and reflective of a deep understanding of the dynamics of intimate partner violence, the barriers facing medical staff in addressing violence and abuse, and the intricacies of the managed care environment. The program is practical and driven by the belief that individual change produces policy change which results in system change. The WomanKind model is fundamentally case management client services combined with education and consultation for health professionals. Essential elements that make the WomanKind model unique and contribute to its success (as articulated by WomanKind managers and staff, hospital staff and WomanKind volunteer advocates, and/or as observed by the evaluation team) include:

- The ready availability oftrained, professional staff and volunteer advocates, 24 hours per day, seven days per week, to provide crisis intervention services to victims of abuse.
- On-going contact between the victim of abuse and the WomanKind staff - services that go beyond crisis intervention.
- Formal and informal educational opportunities for hospital staff that take into account their needs and concerns.
- Community connection-building a bridge between the domestic abuse victim in the health care setting and the community resources available to help her and her family.
- Integration of the domestic abuse issue into total health care, and integration of the program into the health care setting.
- A focus on system change enhancing the response of the medical system, not just the behaviors of individual medical professionals.

- Committed, charismatic and dedicated vision and leadership.
- Strong working relationships with other health professionals (including medical staff social workers, pastoral counselors, volunteer coordinators). WomanKind staff continually reinforce that they are partners in health care, that they are not trying to take over anyone else's job.
- On-going, continuous, marketing of the program.

B. Location of the Program

WomanKind was created as an independent non-profit program and has become a department of Fairview Health Services. The advantages to this include a higher level of credibility and access within the health system. However, the program could also be structured in other ways.

Hospital staff (including medical and social work staff) were asked in interviews to suggest ways a program like WomanKind could be implemented at other hospitals. Most pointed to the social work department as a logical and appropriate place for such a program. While these staffmembers stated that WomanKind as a separate program and department was ideal, locating the program within social work was a good alternative. They did stress that it would be best to have staff specifically dedicated to the domestic violence program since they have come to understand the value of this specialized expertise, and social workers must, by necessity in health care settings, be generalists.

C. Creating an On-Site Program

Getting a program such as WomanKind started takes planning, resources and a strong commitment. Susan Hadley, founder of WomanKind, shares the following steps for planning, developing and implementing an on-site program:

1. Establish a committed, collaborative multidisciplinary team.
2. Develop a strategic plan including vision, mission, program philosophy, goals, associated objectives and timeline.
3. Formulate staff job descriptions and recruit program coordinator.
4. Develop appropriate policies and procedures.
5. Establish working relationships with community resources.
6. Draft and institute routine assessment question(s).
7. Target departments for pilot program services and training.
8. Plan and institute structured staff education.

9. Institute comprehensive marketing plan.
10. Research and develop resource materials.
11. Provide responsive case management client services.
12. Evaluate program effectiveness, components and client services.

D. Assess Your Own Environment

The most important step in starting a program to improve health care response to victims of domestic violence is to carefully assess your own organization. Relevant questions include:

- Where would support likely come from for such a program? What about resistance?
- What support (administrative, etc.) would be essential for the program?
- What is the current organizational climate? Issues, concerns of staff? Status of morale? How would this likely affect a new initiative?
- What resources will be needed to launch the program?
- What kind of time will be needed to establish the relationships necessary to launch the program?
- What kind of staff is needed? Who could do the work?
- How does the program fit with other programs or initiatives already underway? Is there an opportunity to share resources?

Conclusion

The WomanKind model is a significant contribution to health care and could be adapted to other settings with careful planning and support. The important thing to remember is that the model must be tailored to the needs, structure, and organizational resources of the hospital or clinic.

Evaluation of the WomanKind Program: Support Systems for Battered Women

Appendices

on behalf of the

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Appendix A

Articles on WomanKind

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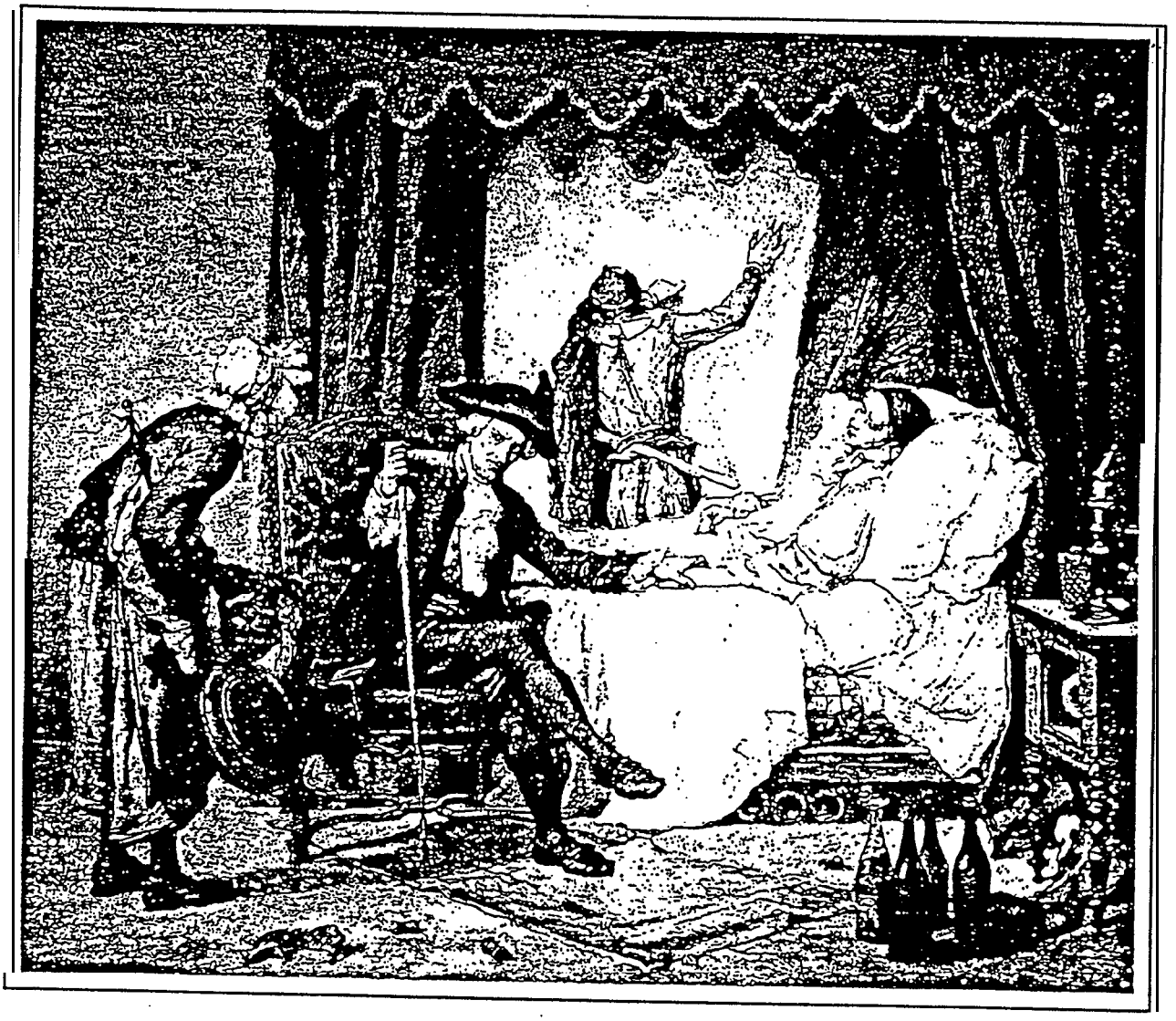

Hospital-Wide Program identifies Battered Women; Offers Assistance

POLICE OFFICERS say that responding to a cab involving domestic assault is one of the most dangerous aspects of their work. For physicians, it is no less a challenge. Treating the injury lies comfortably within the realm of medicine, but addressing the injury's cause can feel like trespassing in another's territory.

Physicians have been criticized for not asking about the cause of a woman's injuries, even when it is clear that she was deliberately hurt by another person. But if physicians do choose to ask, and discover the patient is a victim of abuse, what can they offer her?

Many physicians lack an effective way to connect these women with services that could help. Simply giving her the telephone number of a crisis center is rarely sufficient-battered women are not likely to call these numbers unless they are also receiving ongoing, personal support of some kind. Many are afraid that other5 will not believe them or understand their situation.

Fairview Southdale Hospital

Emergency physician David Justis, MD, introduces a patient to Susan Hadley. MPH, director of WomanKind. The WomanKind program provides a supportive connection between the battered woman in the hospital and the resources in the community available to help her. Within the last 5 years, the program has assisted almost 3000 clients.

As Many as One In Three

The dilemma is critical when one considers the profound influence domestic violence has on the health of women. Studies have shown that 22% to 35% of women who visit emergency departments are there for symptoms related to ongoing abuse, either because of an injury or as a manifestation of the stress of living in an abusive relationship (*JAMA*. 1984;251:3259-3264; Ann *Emerg Med*. 1987;18:651-653).

If one looks only for trauma, however, a vast majority of battered women will be overlooked. Violence in the home often manifests itself in anxiety, depression, chemical dependency, chronic headaches, abdominal pains, joint pains, muscle aches, complaints of sexual dysfunction, sleeping and eating disorders, and suicide attempts.

In short, physicians in nearly every field of medicine are in a distinct position to identify battered women, perhaps more than any other profession next to law enforcement. Directing these women to the appropriate resources could be the most important medical advice physicians can offer. But the medical community is still seeking appropriate and effective ways to do this.

In 1986, Susan Hadley, MPH, approached officials at her local hospital with a possible solution. She proposed that they allow her to train the emergency department staff to identify battered women and page her immediately on the patient's consent. She would offer the woman support, discuss her options, and refer her to the appropriate health care, law enforcement, legal, and social services available to help women living in violent relationships.

Assistance would be initiated in the hospital, but would continue for as long as the patient desired, The service would be free of charge, confidential, and available 24 hours a day (using a team of on-call volunteers).

Let's Not Discuss It

The hospital, Fair-view Southdale, in Edina, Minn, consented, but with some reservations as to the necessity of the program. After all, Edina was a conservative, affluent suburb southwest of -Minneapolis, and Hadley says the hospital administrators, like most people, probably didn't believe that domestic violence was a problem there.

Or, she says frankly, "certainly, abuse is a little bit of a problem, but for heaven's sake, let's not stand on the front steps of the hospital and talk about it." For the first 18 months, the program received no hospital funding, although the hospital did provide office space, supplies, and equipment.

Attitudes have changed considerably since that time. Today, the program, called WomanKind, is funded by both the hospital and the hospital auxiliary, with some church and private donations.

The staff consists of Hadley, .one part-time advocate/volunteer coordinator, and a cohort of 18 volunteers. These volunteers can be paged around-the-clock if a battered woman comes into the hospital.

As of July 1991, WomanKind has assisted nearly 3000 clients, and has far outstripped Hadley's original vision. "Through education [of the hospital staff], the program has grown from an

emergency department program to a hospital-wide program, which is really how it should be if we are treating the total patient," says Hadley, who is now executive director of WomanKind Inc, and a consultant on domestic abuse education and services within medical systems.

WomanKind receives 50 to 55 referrals a month, and patients from the emergency department now account for just one fifth of the total. Other referrals come from almost all the inpatient and outpatient services, pastoral care, social services, and from professionals and organizations outside the hospital.

Clients have also come from places Hadley didn't anticipate, Five percent of WomanKind's clients are hospital employees who are living in abusive relationships. One client is the wife of a hospital physician who is abusive. Two clients have been men who were abused by their wives.

To Hadley's knowledge, WomanKind is the only nonprofit program in the country that is hospital-based and extends to every area of the hospital. But she sees no reason why it could not be modified to suit the needs of any hospital, given the necessary support and resources.

Hadley attributes the program's success to its high visibility in the hospital and to continuous education of the hospital staff. Within the first month on the job, every new health care employee attends a training session on the myths, realities, and dynamics of domestic violence and how to identify battered women in the medical system. Hadley also meet5 frequently with the emergency department staff to update them on policies and procedures, provide follow-up, and review cases. She offers regular inservice training sessions in the mental health and chemical dependency units and in most other hospital departments.

Staff are trained to ask about physical signs of abuse in a nonthreatening, nonjudgmental way, even if the signs are not related to the presenting complaint. These may include bruises in various stages of resolution, hand prints on the wrists, neck, and upper arms, and bumps and cuts on the head, which are concealed by hair.

Abuse is particularly suspect in cases involving trauma and attempts at drug overdose. WomanKind's statistics indicate that these are the two primary reasons for a battered woman to be treated in the emergency department.

Perhaps the key to WomanKind's expansion has been the education of the hospital staff to recognize the subtle, nonphysical indications of abuse, either from the patient's present relationship or family of origin. When abuse is suspected, the staff is encouraged to provide a safe, confidential atmosphere and ask nondirect, open-ended questions. If the patient takes the opportunity to discuss her abuse, she is referred to WomanKind on her consent.

Asking a woman directly, "Are you an abused woman?" will rarely get an affirmative response, Hadley says. No person wants to assume that label's stigma. But sometimes the patient will hint at it by saying that she doesn't want to go home, or, "I'm concerned about the care I will get at home."

Llvlng In Isolation

Hadley suggests asking the woman if she spends time with her friends, or what she does with her spare time.

'You'll find that she is very isolated. She doesn't have a support system, she's not allowed to see her friends, and she has no hobbies. She pretty much stays home and does what she is told," Hadley says.

Linda Packard, RN, nurse manager for the mental health and chemical dependency units at Fairview Southdale, describes the "red flags" that suggest to her that patients may have been abused: "They have very low self-esteem. They are reluctant to talk about the details of their life, and often their story doesn't hold together. We find a lot of depression and suicide attempts with drug overdose, problems eating, not sleeping, and very labile mood." On a routine questionnaire filled out when counseling begins, the woman may write, concerning her marital relationship, "communication difficult."

Packard, who has had 25 years' experience in psychiatric nursing, estimates that 60% to 70% of the female patients in the mental health unit at Fair-view Southdale have "a history of some kind of abuse."

"That's taking into account some of our older patients who are not able to talk about family problems because they grew up in a time when these issues weren't discussed," she says.

About one third of WomanKind's referrals are now from the chemical dependency and mental health units.

To demonstrate the staff's sensitivity in detecting abuse, Hadley describes how nurses in the cardiac unit have begun to detect abuse of elderly women by observing the interaction when the husband comes into the room to visit. 'The nurses notice that the patient shows signs of anxiety and her heart rate increases on the monitor when he comes in the room. She also almost imperceptibly inches over to the other side of the bed. Later, when we talk with her in private, we find that in fact he has been verbally or physically abusive at home," Hadley says.

Lack of eye contact is another strong' indication. Hadley says, "A battered woman won't look at you. She is feeling a lot of shame because she feels responsible for what has happened. After all, her abuser blames her for his violent behavior and part of her believes him."

Kathy Kerber, RN, clinical *nurse* specialist in obstetrics at Fair-view Southdale, says she suspects abuse when a patient shows up at the unit several times in a week with minor complaints. Battering often begins during pregnancy, the dynamic being that the partner is very dependent on her and is threatened by the competition of the pregnancy and the new baby. He is also frightened or overwhelmed by the added responsibility of providing for a growing family.

Kerber has also found that pregnant women will talk about abuse at home when they are asked questions such as 'What are your feelings about this pregnancy?"; "How are your family members dealing with this experience?"; and "Is your husband excited about this baby?"

"Then I get these pieces," Kerber says. "He bit me, or he said this to me, or he said this but does this."

The husband's behavior can also suggest abuse, Kerber says. We encourage husbands to stay overnight [in the obstetrics unit) with their wives, but these dads are impatient, want to go home, and do not want their wives to stay in the hospital." Sometimes they are also verbally abusive to the hospital staff.

Too Solicitous

Sherrie Eiaele, advocate/volunteer coordinator for WomanKind, says abusive men can be solicitous, perhaps too solicitous, to the medical staff. They will insist on staying with their partner during her medical examination, which prevents her from revealing the true cause of her injuries.

'When an abuser is in the room, he controls the situation," Eisele notes. "She sits back, looks down, and lets him answer all the questions. She knows she has to. Whereas, if it is a healthy and equal relationship, the partner is also there as much as he can be. But a completely different kind of communication is going on."

WomanKind advocates are careful never to let the abuser know they have spoken with his partner, which could place the client in danger of further abuse. In a few urgent situations, the

advocates have worked with the hospital staff to concoct a medical alibi for the woman so that she could get back to the hospital without her partner's suspicion. Or the staff has waited to call the WomanKind advocate when the abusive partner steps outside for a cigarette, the only time he lets his partner out of his sight.

Mail from WomanKind is sent to the client's home only if it is safe to do so. It is more likely to be sent to her workplace, or to the home of a trustworthy relative or friend.

In the last few years, Fairview Southdale Hospital has developed a reputation in the community as being sensitive to domestic violence, which has brought about interesting consequences in the emergency department. David Justis, MD, an emergency physician at Fair-view Southdale, estimates that *one* fourth of the battered women who come to Fair-view Southdale's emergency department have already visited another physician, clinic, or emergency department.

'The women come in with wounds that are now a week old, 'and they are showing up for further consultations or a 'second opinion,"' Justis says. He suspects they come because they want to talk about their situation, but no one has asked them how they got their injury. Some women say they did tell their physician, but their physician simply responded by asking them what they had done to provoke the assault.

The hospital's reputation of being sensitive to abuse can cut both ways, however. Hadley suspects that some women who are not ready to deal with the abuse in their lives avoid going to Fairview Southdale in an emergency.

An Ounce of Prevention

Justis, who is active in the American College of Emergency Physicians, says he is convinced that the time he spends addressing violence in his patients' lives helps to prevent further injuries, and may *even* save lives. As a former "night rider" for the Hennepin County police force, Justis has accompanied law enforcement officers to the scenes of domestic assaults. He recalls being summoned to the same households weekend after weekend to progressively more violent situations. Yet often, the police did little more than ask the husband to walk around the block to "cool off."

Justis says some situations escalated to the point where "people were being shot with shotguns at close range. But if we had stopped it 6 months before, when the problem got going, maybe we could have prevented it."

Although the experience is 15 years in Justis' past, it has made him keenly sensitive to abuse in his patients. Before he conducts his physical examination, he sits down with the patient and encourages her to tell him how she was injured. He gently says things like, "Feel free to tell me what happened. Tell me in your own words." He asks open-ended questions such as "Now, what did he say?"; 'Then what did you do?"

With the patient's responses he "paints a mental picture" of what happened. He also asks, "Has that ever happened before?" to obtain a history of abuse.

Justis refrains from making judgmental *comments* about her partner, which the woman could interpret as criticism of her-she fell in love with her abuser, and has stayed with him.

After the physical examination, the woman's injuries are photographed, and a WomanKind advocate is called in. Justis writes a two-page chart, twice the standard length, that documents not only his physical findings but the woman's comments as well. He has relied on these notes many times in court, sometimes not until years later when the woman is ready to press charges.

The Advocate's Role

The WomanKind advocates assume a role that the physician cannot, due to the lack of time and training. They offer the client opportunities to explore her options and make decisions to end the violence in her life-when she is ready to do so. The basic premise of advocacy is to accept the woman as she is and to support her choices.

WomanKind's advocates say they frequently work in emotionally charged situations. They struggle to remain objective, but "some stay with you for months." No two are the same. None are easy.

Hadley says, "I can still remember those early years when I would get in the car at 2 (o'clock] in the morning, and I would think, What can I possibly offer this woman who has just been assaulted by someone she loves? By someone who says he loves her?' Sometimes I still think that, even after 5 years.

"I have learned to walk in and say, You have had a really hard night. You don't deserve to be hit.' Right then she knows I understand, she feels safe and the rapport develops."

Hadley reminds herself and the hospital staff of a comment one of the WomanKind volunteers once made to her. The woman's husband had physically assaulted her for many years, and WomanKind had helped her as a client.

Eventually she made some changes in her life and became a volunteer for WomanKind. The woman told Hadley: "I had been admitted into hospitals and visited emergency rooms many times. Each time I was terrified that someone would ask me how I got my injuries. And I was just as terrified that they wouldn't and I would have to go home and continue to deal with this without any help."-by Teri Randall

Tools Available for Health Care Providers Whose Patients Are at Risk for Domestic Violence

HEALTH CARE providers may be the first and only professionals in a position to recognize violence in their patients' lives. Physicians are advised to routinely discuss the problem of domestic violence with their female patients and make available written material with resource information.

Resources for Patients

The Michigan Coalition Against Domestic Violence provides information packets to health care providers nationwide that include brochures and stickers for use in the office. Physicians who use these materials say they cannot keep enough on hand. All the materials may be reproduced. (Write the Michigan Coalition Against Domestic Violence, PO Box 463100, Mount Clemens, MI 48046, or telephone (313) 954-1180.)

The best place to display the brochures is in the examination room, and not the lobby, says Shenie Eisele,

advocate/volunteer coordinator for WomanKind. If the brochuresarein'the lobby, Eisele explains, the woman has to "walk across the room and pick up a brochure that anyone who has glanced at knows is for abused women. That's a huge step to take. There's no way she is going to sit down and read it with people-maybe even her batterer—sitting nearby," *In* the examination rooms, there is privacy. The woman has time to read the brochure, and the physician can speak freely with her.

It is important to remember that, for some *women,* it is unsafe to bring home any material that deals with abuse, Eisele says. In this case, information can be mailed to the woman's workplace, *or the* home of a trustworthy relative or friend.

WORKING WITH BATTERED WOMEN IN THE EMERGENCY DEPARTMENT: A MODEL PROGRAM

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Clinical Articles Working with battered women in the emergency department: A model program

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An innovative program for battered women in a private, suburban hospital in the greater metropolitan area of Minneapolis-St. Paul, Minnesota, WomanKind is one of very few independent, hospital-based programs for battered women in the United States. This nonprofit corporation has a legal contract with each of its hospital sites to provide advocacy services and education to the battered women there, and to offer training to their health care professionals.

WomanKind, Inc., Support Systems for Battered Women, was registered as a nonprofit, tax-exempt corporation in the State of Minnesota in 1985. Major funding for the program is provided by the Fairview Hospital's Auxiliary and the Fairview Southdale Hospital. In addition, tax-deductible contributions are accepted from individuals, churches, and foundations. A board of directors sets policies, provides direction, and assists in fund-raising.

PHYSICAL AND MENTAL HEALTH STATISTICS: NEED FOR HOSPITAL-BASED INTERVENTION Many battered women who go to a hospital or medical office are not currently being identified as victims of abuse, nor are they receiving help in the form of advocacy services or resource referral. In the state of Minnesota, the United Way Task Force on Battered Women determined in 1977 that a battered woman will reach out to two places for help: (1) the police and (2) medical facilities.' This task force further found that assistance received at hospital emergency departments tends to be limited primarily to medical care. They learned that most health care professionals in medical settings have received little or no training in either identifying or serving battered women. The task force concluded that advocacy services are needed in metropolitan hospitals to aid battered women in makiig the necessary immediate and long-term decisions.

In 1985 Stark and Flitcraft,[2] pioneers in research and medical system intervention for battered women, reported that battering may be the single major cause of injury among women-more frequent than automobile accidents, muggings, and rapes combined. Their studies were among several that found that from **22% to 35%** of all ED visits by women are related to battering.[3-7]

Domestic violence should be considered when women seek treatment with either trauma or mental health problems. Data gathered during a S-year period by WomanKind substantiate that abused women seek treatment at the emergency department either suffering from injuries after an assault or with mental health problems, such as anxiety, depression, panic attacks, or suicide attempts. A full 33% of battered women have a diagnosis or treatment protocol associated with anxiety and depression. Of all women who attempt to commit suicide, 26% are victims of domestic violence.[7] Of hospitalized female psychiatric patients, 66% have a history of being physically abused as an adult.[8]

The National Crime Survey estimated that in 1980 there were 192,000 assaults within families, resulting in 39,900 visits to physicians,' 21,033 hospitalizations, 99,800 days of hospitalization, and *28,700 ED visits. These* data revealed total health care costs associated with battered women of approximately $44.4 million, with indirect costs of 175,500 days lost from paid work.[9]

PROGRAM HISTORY AND DEVELOPMENT Research for this program began in the fall of 1985, when I was completing a master's degree in public health at the University of Minnesota and volunteering on a crisis line for battered women. Many of the women with whom I talked on the crisis line had sought treatment at medical offices or hospitals where

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Services were offered initially only in the emergency department. However, with continual in-service training the hospital staff and the resultant requests for 'advocacy, program services were expanded to include the entire hospital.

the question of domestic abuse had never been raised. After studying the limited research on medical system intervention for victims of domestic violence, I realized that there was a need for a better system for identifying and treating battered women who seek help from the health care system. WomanKind, a hospital-based program for battered women's program, was conceived to respond to this need.

It was important to find a person within a hospital who was known and respected and who could champion the cause of this battered women's advocacy program. Such a person was the Fair-view Southdale Hospital director of pastoral care, Russell E. Comnick, who had been with the hospital since 1979. I met with Chaplain Comnick and discussed my ideas and vision for services to battered women. He was enthusiastic about the program concept and arranged a series of meetings with emergency services and nursing administration. The program was implemented at Fairview Southdale Hospital in 1986. I chose the name "WomanKind" because it represented strength, as well as support and sensitivity.

In the early days I provided the advocacy services (support, information, and referral) around the clock to battered women, as well as working on the marketing and development of program structure and services for WomanKind. Referrals to the program increased slowly but steadily; a half dozen volunteer advocates helped with the emergency calls after hours. Services were offered initially only in the emergency department. However, with continual in-service training of the hospital staff and the resultant requests for advocacy, program services were expanded to include the entire hospital. Initially between 15 and 20 women were referred to WomanKind each month. This number grew steadily to the current level of 55 to 60 women referred each month from throughout the hospital and surrounding community. More than 3000 women have received services since the program's inception in 1986. Services are provided 24 hours a day, 7 days a week, and are confidential and free. Advocacy services were expanded to a second site, Fairview Ridges Hospital, in 1989, at which time a half-time volunteer coordinator was added to the paid staff. With increasing requests for advocacy services and in-service training, adequate funding to provide staffing is an ongoing concern.

PURPOSES OF THE PROGRAM

Advocacy The first major purpose of WomanKind is to provide advocacy--support, information and education, and hospital or community resource referrals—to battered women during a safety or medical crisis. WomanKind is built around the advocacy concept. The basis of our advocacy is accepting the woman as she is, supporting her choices, and helping her explore her feelings, her options, and the possible consequences of her decisions.

The WomanKind advocate can support the battered woman in a number of ways. An advocate will stay with the woman while medical procedures are being conducted and will assist the battered woman in exploring the medical, law-enforcement, legal, and social service options available to her. The advocate will help her to sort options, set priorities, make decisions, and contact resources in the community. If the woman chooses to continue in the relationship at that time, the advocate can assist her in developing a plan for protection.

This process of empowering the battered woman only *begins* in the hospital-it must be coordinated with follow-up support and services as the woman works through her available options. WomanKind provides a supportive connection between the battered women and the resources in the hospital and community available to help her.

Education The second major purpose of WomanKind is to provide in-service training to hospital and health care professionals to enable them to identify battering in the women who come to the hospital, clinic, or medical office. This training is designed to increase the awareness and knowledge of hospital and ED personnel of this underrecognized problem, as well as to instruct them on how to use the WomanKind advocacy services effectively.

WomanKind works with the emergency nurses and physicians to document carefully each injury and record appropriate comments made by the woman in the medical record. Instant photographs of each injury

Our long-term follow-up has shown us that, *with support and information,* battered women do make changes and take the action necessary to protect themselves and eliminate the violence in their lives.

are taken and become part of the medical record. This is particularly important if the woman is not planning to go through the legal system at the time of the current injury.

SUPPORT GROUP WomanKind offers a confidential self-help group that provides support and information for women who have been or are currently living in a physically, emotionally, or sexually abusive relationship. Trained facilitators provide structure and guidance to the group, which is open both to hospital patients and to community members. The support group is free and meets weekly at the hospital.

VOLUNTEER **PROGRAM** More than 40 committed volunteers play active roles in the WomanKind program. Nurses, mental health professionals, and formerly battered women comprise most of the volunteer corps. Volunteers are on call to the emergency department after hours, facilitate the support group, see clients, and perform clerical work in the WomanKind office during the day. Emergency calls after hours are referred to the on-call volunteer through a paging system. The volunteer then comes to the emergency department within 30 minutes to meet with the battered woman for that important personal contact and to provide support and information. In fact, the volunteer advocate does not tell the battered woman anything she does not already know-the volunteer simply listens to her, believes in her, and validates her situation, while offering immediate and ongoing support as desired.

An intensive initial training program provides the volunteers with an understanding of domestic violence and a knowledge of community resources. Monthly meetings then offer support and ongoing education to the volunteers. The goal of the WomanKind Volunteer Program is to provide a challenging, rewarding experience for volunteers, as well as to offer services to victims.

DOMESTIC VIOLENCE **EDUCATION PROGRAM** An education program is designed both for program advocates and for health care professionals. Figure 1 is an outline of the 25-hour training program presented to the WomanKind advocates. This information is abstracted and presented in 2 hours when it is included in nursing orientation for new hospital staff. Selected topics are discussed regularly with the ED staff and in-service training is presented to other hospital departments as requested.

PROGRAM STAFF The WomanKind paid staff includes an executive director, who coordinates program services and administration and provides ongoing in-service training and workshops to hospital and medical office health care professionals. The executive director maintains communication with the hospital staff and networks with community resources to develop and implement coordinated services to battered women. The volunteer coordinator is responsible for recruiting, training, scheduling, and supporting the volunteer advocates. Both executive director and volunteer coordinator provide advocacy services during the day and provide back-up support for the on-call volunteer advocates after hours.

COMMUNICATION AND **NETWORKING** WomanKind tries to avoid duplicating any existing community services, but instead helps connect women with such services as the metropolitan area shelters and crisis services for battered women to provide the following services: (1) emergency food, clothing, and housing, (2) transportation, (3) relocation assistance (transitional and permanent), and (4) court advocacy (both civil and criminal). We communicate with mental health services, chemical-dependency treatment programs, emergency financial aid programs, job/career counseling programs, and public health agencies to coordinate services.

We have also developed strong relationships with the police in surrounding communities. We educate officers about battering, dealing with the frustrations of domestic abuse, and coordination of efforts to help enforce existing laws and intervene in the cycle of violence.

EVALUATION Our long-term follow-up has shown us that, *with support and information,* battered women *do* make changes and take the action necessary to

'The advocate will help-her [the abuse victim] to sort options, set priorities, make decisions, and contact resources in the community. If the woman chooses -to continue in the relationship at that time, the advocate can assist her in developing a plan for protection.

I. Education on domestic violence
   A. Definitions:
      Physical, emotional, and sexual abuse
      1. Statistics
      2. Myths and realities
      3. Dynamics of abuse
      4. Cycle of violence
      5. Responsibility of behavior
   B. Rationale:
      "Why does she stay?"/"Why does he do it?"
   C. Mental health issues
   D. Sexual abuse and assault
      1. Rape (marital, date, acquaintance)
      2. Childhood sexual abuse (incest)
   E. Chemical use, abuse, and dependency
      Separate issues: Drug abuse and domestic abuse
   F. Legal advocacy
      1. Definition and degrees of assault
      2. Domestic abuse statute
      3. Probable cause
      4. Restraining orders
         a. Order for protection
         b. Harrassment restraining order
   G. Working with men who batter:
      Characteristics of the abuser
   H. Other issues

II. Effects of violence on children
   A. Children from violent homes
   B. Child abuse

III. Resources
   A. Shelters and services for battered women
   B. Self-help support groups
   C. Counseling: Women, men, and children
   D. Other: Financial, job/career, housing

IV. Medical system recognition and response
   A. Identifying the battered woman
   B. Battering during pregnancy
   C. ED protocol
   D. Medical, legal, and law-enforcement options

V. Volunteer and program procedures
   A. Office and on-call procedures
   B. Confidentiality
   C. Role of the advocate
   D. Mandatory monthly meetings

FIGURE 1 Outline of educational program topics.

Domestic abuse is not a communication issue, it is a control issue. The abused womhn is afraid of and controlled by the abuser and will not talk with her partner. The abuser has most of the power and control, the abused woman has most of the fear-and both have low self-esteem.

protect themselves and eliminate the violence in their lives. The following comments testify to the help that has been provided:

"Without your help and concern, I would not have had the courage to take the steps I have always known were *necessary*. If I can ever be of any help to another who might need encouragement and support, it would be my pleasure to pass on the same kindness you gave to me."

"I have discovered making changes on the inside takes help from the outside. Thanks to you and WomanKind."

A comment by an emergency nurse, Sally Ayres, RN, reflects the relationship between WomanKind and the emergency department, "The emergency department staff is often reminded that the pain and wounds of our patients are deeper than meets the eye. Nowhere is this more obvious than when we treat the battered woman. The WomanKind advocates have become a vital part of the ED team. They provide the one-on-one care any hour of the day or night that is essential for this patient. This fills a practical need for the ED staff, since patient load often severely restricts the time we can spend with this traumatized patient."

Another emergency nurse, Kim Kammeier, RN, BS, believes that WomanKind has changed the way she views her care of patients. "It has expanded my assessment skills and broadened my care of the entire person."

WORKING WITHIN THE HOSPITAL: INSIGHTS GAINED One key to the program's success is *ongoing education*. According to one retrospective study of female trauma patients seen in an emergency department, "The introduction of educational programs, training programs and protocols for detecting battering is not sufficient for ensuring continued vigilance in detecting injuries caused by battering. In the absence of institutionalized policies and procedures for diagnosing and treating victims of domestic violence, staff revert to behaviors found prior to training and treat the woman's injuries and discharge her without diagnosing her more serious problem, chronic victimization."[5] The *program's visibility also* keeps reminding staff of the issue.

We have found that *separation* and *privacy are* extremely important. If the abuser has brought the woman to the hospital, she must be taken to a safe, private space where the underlying problems can be addressed. Domestic abuse is not a communication issue, it is a control issue. The abused woman is afraid of and controlled by the abuser and will not talk with her partner present. The abuser has most of the power and control, the abused woman has most of the fear—and both have low self-esteem.

The emergency nurse *must ask the question*, "Did someone hurt you?" or "Did you receive these injuries by being hit?" Many battered women have said that they never talked about the abuse because no one ever asked them how they were injured. A formerly battered woman who visited several emergency departments for care confided, "I was terrified that someone would ask me how I got my injuries. I was just as terrified that no one would ask and I would have to return home without talking to anyone about what was happening to me." In most medical facilities, physical injuries or medical problems are handled competently; however, it has become clear that in many emergency departments women are not asked how they received their injuries; if they are asked, their evasive, unconvincing answers are not explored. WomanKind has found that most abused women are in fact reaching out for help when coming to the emergency department for medical care, and are actually relieved to be asked about their situation.

An abused *woman is in a process*. She will move through that process when she has sufficient strength and safety to take that next step. It is important to accept where she is in that process. even though you may not agree with her decisions and may fear for her safety. This has been the most difficult concept for the WomanKind staff, volunteers, and emergency nurses to learn and incorporate.

Most of the more than 3000 women seen by WomanKind during the 5 years of its existence say that this was their first contact with any agency or program. Abused women seem to feel less stigmatized when

Even if a woman does provoke a feeling (anger), the abuser then chooses what to do with that anger (violence). All of us are responsible for our own behavior.

reaching out for help to a health care provider, where there may be less of a label of "battered woman" attached, than with a battered women's shelter.

The key to **recovery** is this: a woman will begin to gain strength and feel support when she hears the message, "You do not deserve to be hit. The person exhibiting the behavior is the person responsible for that behavior." The woman may be inappropriately asked, "What did you do to provoke him?" It is important to make a distinction between the feeling and the violent behavior. Even if a woman does provoke a feeling (anger), the abuser then chooses what to do with that anger (violence). All of us are responsible for our own behavior.

Simply giving the battered woman a brochure or the telephone number of a crisis center does *not* work, according to battered women with whom we have talked. Many say that they were aware of available crisis numbers or "hotlines," but just could not gather the strength to *make the* necessary call. Because of the emotional and physical dynamics of battering, the woman must have additional support before she will act.

BENEFITS TO THE HOSPITAL The media coverage that the Fair-view Hospitals have received because of WomanKind has portrayed the hospital as innovative, progressive, and community-service minded.

SUMMARY: THE FUTURE WomanKind, Inc., can be a prototype for every emergency department in every hospital across the country. Program services and delivery can be modified to fit the needs and resources of any facility. The mandate is to begin to address the underlying causes of ED visits by battered women.

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WOMEN'S HEALTH ISSUES

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ELSEVIER

Articles

WomanKind: An Innovative Model of Health Care Response to Domestic Abuse

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Until recently, domestic violence* has been a taboo subject. Awkwardness, shame, and disbelief have conspired to keep battered women from talking to relatives and friends about the violence in their lives. These same forces have prevented frank conversations about domestic violence between women and their health care providers. The WomanKind program creates opportunities for these conversations and trains health professionals to intervene appropriately. Grounded in the preventive tenets of public health, the WomanKind program is based on the belief that without such discussion health care providers will continue to treat the medical and mental health problems that bring women to their doors without addressing the underlying pattern of abuse that is the root cause.

The program's focus on prevention through early intervention has sparked the interest of hospital systems and their commitment to community health, and of health professionals who are frustrated by seeing the same patient return with recurrent—and preventable-injuries and symptoms. As WomanKind approaches the end of its first decade, it is useful to consider the progress the program has made toward health system integration of the issue of domestic abuse.

Domestic violence has been defined as a pattern of coercive control consisting of a physical, sexual, and/or psychological assault against a current or

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'Domestic violence and domestic abuse refer to violence and abuse between current or former intimate partners.

pital, an affluent suburban hospital. WomanKind has an annual budget of more than $200,000, and major funding is provided by the Fair-view Health System, the Fairview Hospitals Auxiliary, and the Fair-view Foundation.

Although the structure of the WomanKind model is the same at each of the three hospital sites, the program has evolved differently with associated barriers and problems due to the varying individuals, hospital cultures, and climate. Ongoing communication to build a respectful, collaborative working relationship between WomanKind and the hospital departments is necessary to provide a continuum of services to the victims of abuse.

Program Expansion

WomanKind has evolved to integrate case management/advocacy services for victims of domestic abuse, in addition to education and consultation for health professionals, Education is offered through inservice training, and consultation on individual cases is available to all hospital staff through trained advocates and WomanKind staff. Initially, WomanKind services were focused on the emergency department as the most visible and most likely point of interaction between victims of domestic violence and health care providers.[12,16] In order to reach and serve more abused patients, the program has since expanded throughout its hospitals to include perinatal services, medical/surgical and intensive care units, behavioral services (mental health and chemical dependency), and employee health service. In addition, numerous referrals are made to WomanKind from outside of the hospital setting. Health and mental health professionals in the metropolitan area frequently refer clients following assessment of patients at medical offices and clinics. Also, community residents often contact the program directly to request assistance (see WomanKind referrals, Figure 1).

PROGRAM COMPONENTS

Case Management and Advocacy

WomanKind provides case management and advocacy services, including crisis intervention, assessment and evaluation, and ongoing assistance to

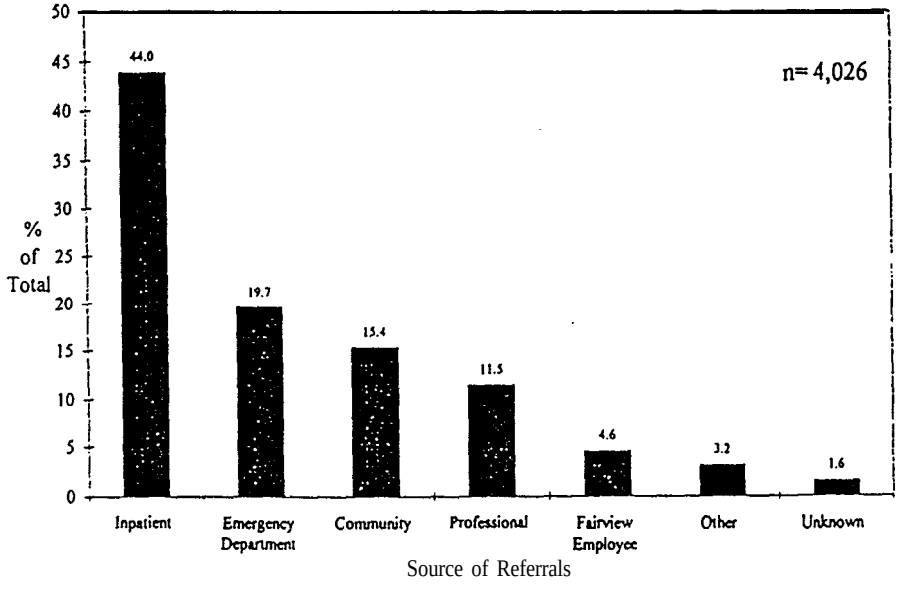

Figure 1. WomanKind referrals, Fairview Southdale Hospital, 1988–1994.

woman. A back-up staff person is always available to the on-call volunteer advocate for consultation and assistance. The Fairview Health System views the WomanKind volunteers as community ambassadors who further link the hospitals with the surrounding communities. The goals of the WomanKind volunteer program are to provide critical services to battered women and a challenging and rewarding experience for the volunteers.

PROGRAM GOALS

Working Within the Health System: Intervention Is Prevention

With the trend toward managed care and the increased emphasis on community health, a non-revenue-generating program like WomanKind is attractive because of its preventive, community-oriented approach. Similarly, the proactive focus on early intervention and prevention of injuries and ongoing symptoms prevents human suffering and its resultant costs.[14,15]

It is important for health providers to appreciate the relationship between early intervention and prevention. Women who are abused experience a lengthy process of losing (or never having) a sense of self-worth and then regaining a sense of power and control in their relationships. This process can take years-if not an entire lifetime. Health care intervention has the potential to occur early in the woman's process and may well accelerate her process toward change and safety. This early intervention may ultimately lead to prevention of more serious injuries and medical symptoms, prevention of mental health and psychiatric symptoms, and prevention of abuse to pregnant women and their children. Abuse during pregnancy is especially serious not only because it may adversely affect the mother and fetus,[19-21] but because it also may be an indication of what life holds in store for the unborn child. Research has shown a strong correlation between domestic abuse and child abuse.[22-27] Preventing this pain and suffering is reason enough to intervene, but the costs associated with increasingly severe injuries and chronic symptoms make intervention even more compelling.[14,15]

Redefining Success

The most difficult lesson learned over the years has been the recognition that the victim of domestic abuse is in a process, and that it is essential to respect her process, her timetable, and her decisions. WomanKind's goals for the victim may include strategies to help her rediscover a *sense* of self, build hope, reduce isolation, develop strength and direction, and especially acknowledge small steps toward change and safety. It is important for the victim to feel support and safety and, when she is ready, to talk about the violence, evaluate her situation, define goals, consider possible options and resources, and make necessary decisions. Health care professionals can help most by providing assessment for domestic abuse in a respectful, nonjudgmental manner, identifying and supporting the victim/survivor, and providing resources, as appropriate.

Modifying the Traditional Medical Approach

Fairview physicians and nurses often describe how the medical treatment model influences their approach to domestic violence. Medical providers are trained and expected to solve problems and may be reluctant to address the psychologically complex and protracted problems presented by victims of

or elder abuse to the appropriate Fairview service.* Several clinical pathways_. on the care of the female patients also include an assessment question on domestic abuse.

Hospital and medical staff need additional education to ensure appropriate use of the above assessment tools. For example, it is essential for staff to remember to interview in private, maintain separation from an accompanying partner, assure confidentiality, and provide privacy and anonymity to protect her safety. Abuse is not a communication issue; abuse is a control issue. The battered woman is afraid of and controlled by the abuser. She cannot talk with the abuser present. WomanKind has found that women who are living in an abusive relationship are often relieved to be asked about their home situation. One WomanKind volunteer, herself a formerly battered woman, stated, "I had been admitted into'hospitals and emergency rooms many times. Each time I was terrified that someone would ask me how I got my injuries. And I was just as terrified that they wouldn't, and I would have to go home and continue to deal with this without any help."" Generally, women who are not abused are not offended by being asked sensitively about this issue.

Community Connection

WomanKind provides a supportive connection between the battered woman in the health care setting and the resources available in the community. Woman&d must maintain ongoing communication with community service providers to assist the victim of abuse with the most appropriate resource. WomanKind does not duplicate services, but rather functions as a bridge to help connect the client with those community services available, when she is ready to take that next step. Numerous community agencies suggest that the health care-based WomanKind contact may smooth the way for clients by giving them the confidence that someone believed them and supported them-even if they do not act on that information for months or longer.[31] WomanKind compiles monthly and annual statistics on the initial, repeat, and follow-up contacts with victims of domestic abuse, as well as on the referrals made to community agencies, organizations, and service providers.

PROGRAM MARKETING TECHNIQUES

Reaching Health Care Staff

Accessibility to patients and visibility among health care staff are critical to the success of the WomanKind program. WomanKind works with the Fairview public relations department to formulate and implement an annual marketing plan. A wide variety of marketing techniques are used to further hospital staff awareness of the relationship between health care, domestic abuse, and WomanKind services. These include regularly scheduled workshops, a monthly column in emergency department and nursing support services newsletters., and specialized training and case study analysis with specific departments. The *WomanKind Health Professional Reference Card,* a pocket-accordion card, provides tips on assessment and identification including red flags and subtle signs, intervention techniques with questions/responses, documentation procedures, do's and don'ts, and resources for victims of domestic abuse.

'The *Fairview Abuse Prevention Plan* and other materials described in this article are available through WomanKind, Fairview Health System, 6401 France Ave. S., Minneapolis, MN 55435.

Multidisciplinary Team Approach

Although it is critical that the health professional reach victims of abuse while they are in the health system, it is also important to remember that each health provider does not have to, and really cannot, solve this'problem alone. Professionals acting alone, no matter how well-intentioned, simply do not have the time or expertise to meet all of the needs of the victim of domestic abuse and her children. Some of the pressure felt by the physician or nurse can be alleviated by using a multidisciplinary team approach to providing a variety and continuum of services to the victim of domestic abuse.

Producing the Paradigm Shift

Health professionals must address not only the presenting problem but also the underlying cause of the medical and/or mental health problem. The ultimate goal for health care providers is to integrate the issue of domestic abuse into the total health care of each patient. Normalizing the assessment of domestic abuse will go far to change medical care into health care and intervention into prevention. Health professionals must make the connection between a patient's health problems and the abuse and violence in her life. If our mission is assessing and treating the total health care needs of our patients, how can we not address the issue of domestic abuse?

ACKNOWLEDGMENT

As part of a broader effort to identify domestic abuse training models and curricula, the Centers for Disease Control and Prevention and its contractor, Macro International inc., are conducting an evaluation of the WomanKind program as a potential model to be replicated in other medical settings. This article stems, in part, from this research effort.

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Appendix B

WomanKind Volunteer Advocates
Job Descriptions,
Policies and Procedures

Fairview Health System
WomanKind Volunteer Job Description

Job Title: . Crisis Advocate - on-call position

Reports To: WomanKind Program Coordinator

Job Description:

1. Provide crisis advocacy, in the emergency department, to victims of domestic abuse who have consented to working with WomanKind.
2. Provide crisis advocacy to victims of domestic abuse, who have contacted the WomanKind program by telephone.

Responsibilities:

1. To provide crisis advocacy, documentation, support, education, safety planning, and referral and connection to community resources (as needed).
2. Inform program coordinator, as to whether the initial follow-up call will be provided by the volunteer who provided the crisis advocacy or by the program coordinator.
3. Provide WomanKind documentation of the crisis advocacy provided to the victim of domestic abuse.

Requirements:

1. Minimum of two 12 hour on-call shifts, pagers provided for the volunteer's shift.
2. Respond to the answering service, regarding a page, within ten minutes and arrive for an emergency department page within thirty minutes.
3. Contact back-up staff when the following conditions exist:
   a) any questions and/or consultation needed
   b) patient will be admitted to the hospital
   c) assault appears to be felony level

d) child protection issue
e) vulnerable adult issue
f) suicidal ideation
g) security concerns
h) emergency department page, but told that you do not need to come in to meet with the victim
i) interpreter is needed

4. To work with emergency department staff to provide patient with optimal health care and to inform staff when completed providing crisis advocacy and the victim care plan has been established.
5. To complete and submit a WomanKind log, to the program coordinator, within 24 hours of the page.
6. To complete the WomanKind volunteer training.
7. To meet the hospital health and criminal background check requirements.
8. To wear hospital photo identification and meet hospital dress code.
9. To maintain confidentiality.
10. When replacement coverage is needed, volunteer will find replacement and notify program coordinator and/or back-up staff of the change.
11. Attend monthly volunteer meeting, if unable to attend, to contact program coordinator of educational material discussed and on-call shifts available.

Benefits:

1. WomanKind volunteers are under the umbrella of the hospital's volunteer services department and receive all benefits available to hospital volunteers. These benefits include free parking, for a complete listing of benefits, please see hospital volunteer manual.

Commitment:

1. One year commitment.

Time Available:

1. Twelve hour shifts, shifts available:
   Monday - Sunday 7:00p.m. - 7:00a.m.
   Saturday, Sunday, & holidays 7:00a.m. - 7:00p.m.

Fair-view Health System
WomanKind Volunteer Job Description

Job Title: Support Group Facilitator

Reports To: WomanKind Program Coordinator

Job Description:

1. Co-facilitate an abused women's self-help support group; by providing support, education, and crisis advocacy in a structured and respectful environment.

Responsibilities:

1. To provide education, crisis advocacy, support, safety planning, and referral and connection to community resources (as needed), in a group setting.
2. Two WomanKind volunteers will facilitate the weekly support group.
3. Provide an environment which is arranged and set-up in a manner, which provides a non-judgmental, respectful, safe, and supportive group.
4. Provide documentation of issues discussed in group.

Requirements:

1. Co-facilitate support group for a one ten-week group per year.
2. Document issues discussed at weekly support group, within 24 hours.
3. If a women leaves group early and suddenly, a facilitator will follow her out to verify her situation.
4. If a women is an in-patient from the behavioral floors (mental health unit or chemical health unit) and she

decides she wants to leave early, a facilitator must call the floor and notify the unit's staff of the situation.

5. Facilitators will arrive a minimum of 1.5 minutes prior to the start of group, to arrange the room and material, and pick-up parking stickers and necessary supplies,

6. Contact back-up staff when the following conditions exist:
   a) suicidal ideation
   b) vulnerable adult
   c) child protection issue
   d) security concern

7. To complete the WomanKind volunteer training.

8. Experience in providing crisis advocacy and/or facilitating groups.

9. To meet hospital health and criminal background check requirements.

10. To wear hospital photo identification and meet hospital dress code.

11. To maintain patient/client confidentiality.

12. When replacement coverage is needed, volunteer will find replacement and notify program coordinator and/or back-up staff of the change.

13. Attend monthly volunteer meetings and quarterly facilitator meetings.

Benefits:

1. WomanKind volunteers are under the umbrella of the hospital's volunteer services department and receive all benefits available to hospital volunteers. These benefits include free parking, for a complete listing of benefits, please see hospital volunteer manual.

Commitment;

1. One year commitment

Time 'Available:

1. 2 hours per week for 10 weeks, site based hours:

Fair-view Ridges Hospital:
Thursday 5:45p.m.-7:45p.m.

Fair-view Southdale Hospital:
Tuesday 6:45p.m.-8:45p.m.

Fairview Health System
WomanKind Volunteer Job Description

Job Title: Client Contact - Office Support

Reports To: WomanKind Program Coordinator

Job Description:

1. Provide follow-up contact with client by telephone.
2. Provide crisis advocacy, by telephone, to victims of domestic abuse, who have contacted the WomanKind office.

Resnonsibiiities:

1. To provide crisis advocacy, support, safety planning, education, and referral and connection to community resources (as needed).
2. Provide WomanKind documentation of the client contact.

Reauirements:

1. Provide three hours of office- client contact twice monthly.
2. Refer to program coordinator when the following conditions exist:
   a) any questions and/or consultation needed
   b) child protection issue
   c) vulnerable adult issue
   d) suicidal ideation
   e) recent assault, previously not documented by Womankind, and appears to be felony level
3. To complete a Womankind log on each client contact or attempt of a client contact.
4. To complete the Womankind volunteer training.
5. To meet the hospital health and criminal background check requirements.
6. To wear hospital photo identification and meet hospital dress code.
7. To maintain confidentiality.
8. Attend the monthly volunteer meeting.

Benefits:

1. Womankind volunteers are under the umbrella of the hospital's volunteer services department and receive all benefits available to hospital volunteers. These benefits include free parking, for a complete listing benefits, please see hospital volunteer manual.

Commitment:

1. One year commitment.

Time Available:

1. Monday - Friday, 9:00a.m. - 4:30p.m.

Fait-view Health System
WomanKind Volunteer Job Description

Job Title: Clerical Support

Reports To: WomanKind Program Coordinator

Job Description:

1. Provide support to WomanKind program coordinator by filing, data entry, statistical computations, or any additional office support needed.

Responsibilities:

1. To provide office and clerical support.

Requirements:

1. Provide three hours of office support twice monthly.
2. Complete a modified volunteer training, focused on program and hospital policies, program history, and specific job duties.
3. Meet the hospital health and criminal background check requirements.
4. To wear hospital photo identification and meet the hospital dress code.
5. To maintain confidentiality.
6. Attend the monthly volunteer meeting.

Benefits:

1. WomanKind volunteers are under the umbrella of the hospital's volunteer services department and receive all benefits available to hospital volunteers. These benefits include free parking, for a complete listing of benefits, please see hospital volunteer manual.

Commitment: 1. One year commitment.

Time Available: 1. Monday - Friday, 9:00a.m.-4:30p.m.

Fair-view Health System
WomanKind Volunteer Job Description

Job Title: Health Fair Support

Renorts To: WomanKind Program Coordinator

Job Description:

1. To set-up, staff, and take down WomanKind health fair display, as requested by program coordinator.
2. Answer or refer questions regarding domestic abuse and program information to WomanKind staff.

Responsibilities:

1. To set-up, staff, and take down WomanKind health fair display.
2. To document and refer questions back to WomanKind program coordinator.

Requirements:

1. Minimum of four health fairs per year.
2. Complete a modified volunteer training, focused on program and hospital policies, program history, dynamics of domestic abuse, and specific job duties.
3. Meet the hospital health and criminal background check requirements.
4. To wear hospital photo identification and meet the hospital dress code.
5. To maintain confidentiality.
6. Attend the monthly volunteer meeting.

Benefits:

1. WomanKind volunteers are under the umbrella of the hospital's volunteer services department and receive all benefits available to hospital volunteers. These benefits include free parking, for a complete listing of benefits, please see hospital volunteer manual.

Commitment: 1. One year commitment.

Time Available: 1. Monday - Sunday, day and evening shifts - based on health fair requests.

WOMANKIND

Support Systems for Battered Women

WOMANKIND VOLUNTEER POLICY

I. On-Call

A. Emergency Room page
   1. Advocate must go into the E.R.

B. Page WomanKind staff when:
   1. Assault appears to be a felony.
   2. Patient will be admitted into the hospital.
   3. Patient will need follow-up next day,
   4. Patient has been moved to a floor in the hospital, advocate must page while advocate is still in the emergency room.
   5. Patient expresses suicidal ideation.
   6. If need to brainstorm for resources and/or support that can be given to the patient.
   7. When there is a Child Protection Issue.
   8. When there is an Adult Protection Issue.
   9. When interpreter is needed.

C. For all pages, advocate must:
   1. Respond to page within 10 minutes.
   2. Arrive at the emergency department within 30 minutes of page.
   3. All phone calls to clients connected through answering service.
   4. Call office next day.
      a. State name of client and brief summary of issues discussed.
      b. Turn in logs within 48 hours.

D. Changing scheduled on-call shift:
   1. Advocate should attempt to find replacement.
   2. Notify program coordinator of change.

E. WomanKind Advocates will provide support to the woman only in the Emergency Department area or the Fairview off site clinic. Back up staff must be notified prior to volunteer going to the Fairview off site clinic. Advocate must notify on-call staff if a request is made to accompany her in any other department within the hospital. Under NO circumstances does a WomanKind Advocate accompany the woman outside the hospital,

111. Volunteer Reauirements

A. Training
   1. Attend WomanKind's training.
   2. One-on-One consultation/evaluation.

B. Health
   1. Meet hospital's health requirements.

C. Meetings
   1. Monthly meetings mandatory.

D. Criminal background check.

THINGS TO REMEMBER WHEN GOING IN ON AN EMERGENCY DEPARTMENT CALL

The following is intended to serve as a quick guide to remembering what to do from the time you walk in the door of the Emergency Department until the time you leave, in order for you to feel as confident as possible and to ensure that our clients see WomanKind as a source of strength and support for them.

Prior to talking with the person:

1). Upon entering the E.D. area you may go directly through the doors and to the nursing station. If the admissions registrar asks you to identify yourself, do so discreetly.

2). Remember the importance of security, both your own and that of the person you are working with; review the attached Security/Safety Policy and Procedure for how to respond to potentially violent or threatening behavior.

3). Find the person who appears to be the station secretary (or whoever seems least busy), identify yourself by name and as the WomanKind Advocate, and say that you would like to speak with the doctor and/or nurse working with the person awaiting our services.

4). Do not let the staff person simply say "oh, you're here to see Pat Smith. Go ahead; Pat and a friend are waiting for you in #9." You should *only* go in to see Pat Smith after talking with whomever has been providing Pat with medical attention.

5). Pick their brains! Obviously we need to be aware of their time limitations, but ask the doctor and/or nurse for as much information as you can think of to see what they have to say. This may include, but is not limited to:

-how is the person doing medically, what is the extent of injury?
-how did the person get here, is it known if the perp. is present, what about children?
-were alcohol or drugs involved?
-have the police been involved, has the person said what they'd like to do?
do we know if this has happened before and if so, did the person get medical attention?
-how did the person respond when the services of WomanKind were offered?

Remember that you arc the expert hen about domestic violence and that it is ok for you to be as fully informed as possible. Keep in mind, however, that there is what the patient told the medical staff and there is *the staffs'* perception of what the person told them. We still need to go in with an open mind.

6). Find out if the patient is in a curtained area or exam room with a door and at what point they're at in being treated_ Let the doctor/nurse know that it would be best to be able to speak with the patient in an exam room or the Emerg. Dept. consultation lounge, if possible, depending on where they are in the process, If it is only possible to speak in a curtained area, be sure to talk quietly and ask the patient if they'd rather wait until you can talk behind closed doors (within the confines of the E.D. only).

7). Feel free to go into the WomanKind drawer and pull out a log form, perhaps the resource directory (although you may have notes written on your copy) and look it over to re-familiarize yourself with the type of information you should be looking to obtain.

8). Look at the back of the calendar to remind yourself of the circumstances under which you should contact your staff back-up so it is fresh in your mind when you are talking to the person. Look at the Monday of the week you are on call to be reminded of who is the staff back-up for that week so you'll be calling the right person if you need assistance.

Upon meeting and talking with the person:

1). Introduce yourself by first name only and as the WomanKind Advocate.

2). ***Before going beyond introductions, it is critical to be sure to tell the person the following:***

- ***we are*** here to listen to and support them
- we are here to offer information, resources, and sort out posssible options/plans of action
- this service is free and confidential; the only time we would ever give out any information to anyone outside WomanKind would be in the following cases:
  - if we had written consent or were subpoenaed
  - in cases of child abuse, incest, or neglect we are mandated reporters and as such have an obligation to help women to protect their children, and
  - if the person told us they were suicidal or homicidal we would have an obligation to obtain assistance for them

3). Remember that UNDER NO CIRCUMSTANCES **does a WomanKind** Advocate **accompany the person anywhere else in the hospital or outside the hospital. Be** reminded that YOU SHOULD PAGE YOUR STAFF BACK-UP UNDER THE FOLLOWING CIRCUMSTANCES:

a). when the PATIENT will be ADMITTED into the hospital
b). when you're still in the E.D. and the PATIENT has been MOVED TO A FLOOR
c). when you have QUESTIONS or need to BRAINSTORM
d). when the assault appears to be a FELONY
e). when there is a CHILD PROTECTION ISSUE
f). when the patient has expressed SUICIDAL IDEATION
g). when you get PAGED BUT are then TOLD YOU DO NOT NEED TO GO into the E.D.

***Note **a) through g)** are listed on the back of the monthly calendar.

4). Safety planning cannot be emphasized enough both for the victim and children (if there are any) and in terms of both emotional and physical well-being. See the attached for ideas, and be creative with the person. We can best empower by helping people to brainstorm for themselves the best options that suit their situation.

5). Please remember to find out if the person wants a follow-up call and be as specifc as possible on the log as to any special times that are preferred or should be avoided.

6). After talking with the patient, talk with the doctor or nurse in summary fashion about what you covered with them and tell them how the person is going to proceed after leaving the hospital. Remind the doctor/nurse that the staff Advocate/Volunteer Coordinator will be conducting follow-up with the person.

7). Use discretion in handout materials to give the person. Keep it pertinent and brief, making certain of course that it is safe for them to take it.

8). Please try to complete the log while still at the hospital; the information is at its freshest and if the person is still there while you are writing it and you have any questions you can clarify it with them

FAIRVIEW
WOMANKIND VOLUNTEER YEARLY AGREEMENT

Volunteer Name:_____ Volunteer Number:_____

Address Change: _____ Phone Number:_____(h)
_____ _____(w)

Volunteer Position(s) and Hours Provided:

On-Call*:total yearly hours

Number of shifts: _____
Number of client contacts_____

Group facilitating: _____total yearly hours

Marketing: _____total yearly hours
(i.e., health fairs, promotional/ed. material)

Office:_____total yearly hours

Volunteer meetings:_____(# attended per year)

Volunteer Continuing Education:

Training volunteer received at monthly WomanKind meetings:

_____
_____
_____
_____
_____
_____

*Additional training the volunteer has received, relevant to WomanKind volunteer position:

_____
_____
_____
_____
_____
_____

Evaluation of Volunteer's Role:

	1=needs improvement to 5=exceptional performance				
Volunteer maintains client/patient confidentiality:	1	2	3	4	5
Volunteer informs program coordinator of any changes in volunteer schedule:	1	2	3	4	5
Volunteer works professionally with hospital staff and clients:	1	2	3	4	5
On-call Advocates:					
Volunteer submits client logs in the appropriate amount of time:	1	2	3	4	5
Client logs are complete and objective:	1	2	3	4	5
Volunteer contacts back-up staff when appropriate:	1	2	3	4	5
Volunteer responds to page within ten minutes:	1	2	3	4	5
Volunteer arrives at the hospital in thirty minutes:	1	2	3	4	5
Volunteer has demonstrated knowledge of the dynamics of domestic abuse:	1	2	3	4	5
Volunteer discusses resource options and assists in prioritization:	1	2	3	4	5
Volunteer discusses protection plan with clients:	1	2	3	4	5

*What has been the most difficult case: _____

_____

_____

*What has been the most frustrating case or situation: _____

_____

Support Group Facilitating:

Volunteer is aware of group policies:	1	2	3	4	5
Volunteer submits a written group report:	1	2	3	4	5
Volunteer contacts program coordinator in regards to client concerns:	1	2	3	4	5

*What are your main concerns about facilitating: _____

_____

_____

*What do you believe should be added or changed: _____

_____

_____

Personal Volunteer Direction:

*Are you satisfied with your current level of volunteer commitment? yes no

*Are you satisfied with your current volunteer position? yes no

*Are there additional WomanKind volunteer positions you would be interested in?

(please circle): on-call office support group facilitating health fairs

marketing other _____

*What additional training and/or support would you need to be able to achieve these additional volunteer role(s)?

_____

_____

_____

_____

_____

Additional Information:

*Are there any concerns or issues you would like to discuss in regards to your role as a volunteer for WomanKind? _____

_____

*Are there any other ways in which I, as the Program Coordinator for this site, can offer you additional support in your role as a volunteer for WomanKind? _____

_____

*Additional Comments: _____

_____

_____

_____

_____

Volunteer Agreement:

1. I agree to continue my volunteer position with WomanKind for one year.

2. I agree to maintain my yearly mantoux testing, which will fulfill hospital health requirements.

3. I have received and understand the hospital's safety education packet and have submitted my safety education post test to the WomanKind Program Coordinator at my hospital site.

4. I understand that all information about a patient/client will be kept confidential. Information about a client will not be discussed outside the WomanKind program. I also understand that if I have reason to believe that abuse is occurring to a child or vulnerable adult, I will contact the back-up staff person immediately.

5. I agree to follow the WomanKind volunteer policies and procedures when working with a patient/client, which I received when I initially started volunteering for WomanKind.

6. I have read the above statements and agree to abide by them. I understand that violation of WomanKind and Hospital policies is grounds for dismissal from the WomanKind volunteer program.

Volunteer's Signature:_____ Date:_____

Program Coordinator's Signature:_____ Date:_____

Appendix C

WomanKind Volunteer Advocates
Training Schedule, January 1996

WOMANKIND

Support Systems for Battered Women

WomanKind Volunteer Training Schedule
Session I
January 8, 1996
6:00 p.m. - 9 p.m.
Dining Room A

6:00 p.m. - 6:30 p.m. I. Welcome and Introduction

A. Susan Hadley, MPH — Director
Sherrie Eisele, BA — Sr. Program Coordinator - FSH
Cheryl Grandlund, BSW — Program Coordinator - FRH
Barbara Vietor, BS, CDC — Program Coordinator - FRMC
Joanne Seaberg, BA — On-Call Staff

B. Volunteer introductions

C. Ask questions at any point

6:30 p.m. - 6:55 p.m. II. Role of Volunteer Advocate

A. Volunteer opportunities
B. Job description
C. Reflections from experienced WomanKind volunteer

6:55 p.m. - 7:20 p.m. III. WomanKind Program

A. History
B. Statistics
1. General domestic violence
2. WomanKind - Annual
C. 'Today Show' - video
D. WomanKind Today

IV. Training Schedule

7:20 p.m. - 7:30 p.m. BREAK

Fairview Ridges Hospital
201 East Nicollet Boulevard
Burnsville, MN 55337
(612) 892-2500

Fair-view Southdale Hospital
6401 France Avenue South
Edina. MN 55435
(612) 924-5775

Fairview Riverside Medical Center
2450 Riverside Avenue South
Minneapolis, MN 5545-1
(612) 672-2700

7:30 p.m. - 8:30 p.m.

V. Power & Control Wheel and Equality Wheel

VI. Checklist and Signs of Abuse

VII. Cycle of Violence

A. Continuum of abuse
B. Abuser is not out of control

VIII. Abuse is a Learned Behavior

A. AMA Auxiliary - video
B. Family
C. Society
D. Media
1. MMA campaign

8:30 p.m. - 9:00 p.m. IV. Questions and answers

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WomanKind Volunteer Training Schedule
Session 11
January 9, 1996
6:00 p.m. - 9:00 p.m.
International Room

6:00 p.m. - 6:50 p.m.

I. Video - 'One Hit Leads to Another' (15.00 minutes)

II. Myths and Realities

III. Responsibility for Abusive Behavior

IV. Barriers to Leaving Abusive Relationships

A. Economic
B. Fear
c. Self-esteem
D. Victim blaming
E. Love
F. Children
G. Religion
H. Terror

6:50 p.m. - 7:00 p.m.

V. Video - 'Just to Have a Peaceful Life' (10.21 minutes)

7:00 p.m. - 7:20 p.m.

VI. Questions and answers

7:20 p.m. - 7:30 p.m.

BREAK

7:30 p.m. - 9:00 p.m.

VII. Health Care Assessment, Identification and Intervention

Speaker: Susan M. Hadley, M.P.H.
Director of WomanKind

A. Statistics: Medical and Mental Health
B. Assessment and identification
C. Intervention techniques
D. Patient's process and timetable
E. WomanKind Policies: Domestic Abuse Series
F. Domestic Abuse: Role of Health Care System

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WomanKind Volunteer Training Schedule
Children and Adolescents
Session III
January 10, 1996
6:00 p.m. - 9:00 p.m.
Atlantic Room

6:00 p.m.- 6:30 p.m. I. 'It's Not Always Happy at my House' - Video

6:30 p.m. - 7:00 p.m. II. A. Discussion on Video
B. Questions and Answers

7:00 p.m. - 7:10 p.m. BREAK

7:10 p.m. - 7:30 p.m. III. 'Heart on a Chain' - Video (15.00 minutes)

7:30 p.m. - 7:45 p.m. IV. Discussion on Video

7:45 p.m. - 9:00 p.m. V. Effects of Violence on Children and Adolescents

Speaker: Diane Davis, LP, LGSW, MA
Domestic Abuse Project

A. Children from Violent Homes
B. Dating Violence

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WomanKind Volunteer Training Sehedule

Session N
January 11, 1996
6:00 p.m. - 9:00 p.m.
Atlantic Room

6:00 p.m.- 7:00 p.m. I. Chemical Health

Speaker: 'Barbara Vietor

A. 12 Step Programs
B. Alternative Programs

7:00 p.m. - 7:20 p.m. II. Questions and answers

7:20 p.m. - 7:30 p.m. BREAK

7:30 p.m. - 9:00 p.m. . III. Working with Men who are Abusive

Speaker: Scott Winker, LISW, Therapist with Family and Children's Services - Bloomington

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WomanKind Volunteer Training Schedule
Legal and Law Enforcement
Session V
January 15, 1996
6:00 p.m. - 9:00 p.m.
International Room

6:00 p.m. - 7:30 p.m. I. Legal Advocacy

Speaker: Marya Hart, Legal Advocate and Manager for Unity Center at Pillsbury Neighborhood Services

7:30 p.m. - 8:00 p.m. II. Questions and answers

8:00 p.m. - 8:15 p.m. BREAK

8:15 p.m. - 9:00 p.m. III. Law Enforcement

Speaker: Officer John Elder
Lakeville Police

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WomanKind Volunteer Training Schedule
Session VI
January 16, 1996
6:00 p.m. - 9:15 p.m.
Atlantic Room

6:00 p.m.- 7:30 p.m.	I.	Same Sex Battering/Homophobia, Racism and Systems of Oppression Speaker: Matthea Smith, Consultant with Parmiey & Associates
7:30 p.m.- 7:50 p.m.	II.	Questions and Answers
7:50 p.m.- 8:00 p.m.	BREAK	
8:00 p.m.- 8:15 p.m.	Video: Broken Vows: Religious Perspective on Domestic Violence	
8:15 p.m.- 9:15 p.m.	III.	Religion Speaker: Beth Bengston, Associate Pastor with Gustavus Adolphus Lutheran Church

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WomanKind Volunteer Training Schedule
Crisis Advocacy
Session VII
January 17, 1996
6:00 p.m. - 9:00 p.m.
Atlantic Room

6:00 p.m. 6:45 p.m.	I.	Active Listening Speaker: Matt Halley and Tom Soles
6:45 p.m. 7:15 p.m.	II.	Questions and Answers
7:15 p.m. 7:30 p.m.	BREAK	
7:30 p.m. 9:00 p.m.	III.	Working with Potential Suicidal Clients Speaker: Matt Halley and Tom Soles

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WomanKind Volunteer Training Schedule
Session VIII
January 18, 1996
6:00 p.m. - 9:00 p.m.
Atlantic Room

6:00 p.m. - 7:15 p.m. I. Volunteer Advocate's Role

A. Volunteer job descriptions
B. Volunteer Policy
C. Perspective from current WomanKind volunteer advocate & facilitator
D. Pagers

II. Security/Safety Policy and Procedure

A. Use first name
B. No name tags
C. Security/safety in E.D.
D. Phone calls and caller ID

7:15 p.m. - 7:30 p.m. BREAK

7:30 p.m. - 8:45 p.m. III. Working with women who are victims and survivors of abuse

Speaker: Chris Servaty, L.P., Therapist in Golden Valley

1. Depression
2. Victims/Survivors of abuse

8:45 p.m. - 9:00 p.m. IV. Questions and Answers

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WomanKind Volunteer Training Schedule
Session IX
January 22, 1996
6:00 p.m. - 9:00 p.m.
International Room

6:00 p.m. - 9:00 p.m. I. On-Call Procedures (Break to be determined)

A. Things to remember when going in on an Emergency Dept. call

B. Safety Planning Options

C. Logs

1. Type
   a. Initial/Repeat
   b. Repeat/Follow up
   c. Additional Information
   d. Suicide assessment checklist
2. Critical items
3. Time frame

D. Back up staff

1. Schedule
2. Notification procedures

E. Calendars

F. Replacements for On-Call Shift

1. Responsibility

G. Resource List

II. 'Case Point Analysis' - role play

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WomanKind Volunteer Training Schedule
Session X
January 23, 1996
6:00 p.m. - 9:00 p.m.
(held at respective sites)

6:00 p.m. - 6:20 p.m.	I.	Volunteer Services Director 1. Fairview Southdale Hospital 2. Fairview Ridges Hospital 3. Fairview Riverside Medical Center
6:20 p.m. - 6:45 p.m.	II.	Emergency Department Tour
6:45 p.m. - 9:00 p.m.	III.	Individual interviews with Volunteers

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Appendix D

WomanKind Volunteer Advocates
Reference Manual, Table of Contents

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Appendix E

Facilitator Guides and Consent Forms for Interviews/Group Discussion with WomanKind Volunteer Advocates

Discussion Groups with WomanKind Volunteer Advocates

Facilitator Guide

Introduction

(Introduce self and other Macro or CDC staff present). Thank you for taking the time to talk with us today. As you know, we are in the final phase of the evaluation of the WomanKind Program and wanted one more opportunity to hear from you about the program.

Our discussion here today will last approximately one hour. Before we get started, I'd like to distribute and review with you a consent form. We want to make sure that you understand that your participation in this group is completely voluntary. You can leave at any time. (Review form).

I will use a set of questions to guide our discussion. There may be times when we really get going on one question, and I'll have to move on to the next one so that we can cover everything. Please don't take it personally! We just want to make sure that we have the chance to hear from you on all of the topics. I'd also like to encourage everyone to participate. This doesn't mean that we need every person to answer every question, but we'd like to make sure that everyone has the chance to contribute.

To make sure that we have an accurate record of the discussion, we will be audio taping it and (note taker's name) will take notes for us. As with the surveys you've completed, the information that is generated in this discussion group (including the audiotape and the notes) will be managed by Macro International Inc. No one in WomanKind or in this hospital will receive any information that can be tied to a particular person.

Do you have any questions before we begin?

Discussion Questions

- How did you hear about the WomanKind program?
- Why did you volunteer for this program?
- How long have you been a volunteer? What has kept you involved? Would you volunteer again? Why or why not? Would you recommend this experience to others? Why or why not?
- How have your perceptions of domestic violence been affected by your experience with this program?

- How did the training prepare you for the work in this program?

- What other information would have been helpful for you to receive in your initial training?

- What is the usefulness of the monthly meetings of advocates with your coordinators? How would you improve these meetings?

- If you were refining this program what recommendations would you make concerning:

  support and supervision
  training
  other

- Consider the relationship of the advocates with the medical staff of the hospital. What works well? What doesn't work well? What might make the relationship better? What are the critical ingredients in a successful relationship with the staff?

- How well does the WomanKind program work for clients? In what ways are clients helped by the program?

- What does it take to be a successful volunteer in this program? (Focus on skills, capabilities, attitudes)

Closure

Thank you very much for taking the time to participate today and for the thoughtfulness you put into the questions we posed to you.

Informed Consent -- Volunteer Advocates

Evaluation of WomanKind: Support Systems for Battered Women

Thank you for participating in this research study being conducted by the Centers for Disease Control and Prevention (CDC). During the past year, we have asked you to complete surveys on the topic of domestic violence and your responses have contributed to this effort to learn about training needs among hospital staff and ways that services for abused women can be improved in the hospital setting.

You have now been asked to participate in discussion group with other volunteer advocates. This is your opportunity to provide more input into the research by discussing your experiences as an advocate and your perceptions of the WomanKind program.

We are purposely keeping these groups small to allow for greater participation from everyone. The groups will be facilitated by a representative of Macro International Inc or the CDC. An assistant to the facilitators will take written notes during the group and we will also audiotape the discussion to ensure that we have an accurate record for preparing our reports afterward.

Your name will not be used in any reports about this group and no quotes will be attributed to you, No one at this hospital or within the WomanKind program will receive any information about individual responses during the group discussion.

Participation in this group discussion is completely voluntary. You may choose to leave the group at any time for any reason.

Your signature below indicates that you understand the above and agree to participate in the discussion.

Signature _____

Witness _____

Date _____

Appendix F

Volunteer Advocates Training Assessment Surveys

Four-digit code: ___ ___ ___ ___

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

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WomanKind Volunteer Training

Volunteer Assessment of Session One

Please take a few minutes to respond to the following questions regarding this session of the volunteer training for the WomanKind Program. Your responses will be safeguarded to the fullest extent possible in accordance with applicable statutes. Your participation is voluntary, but your responses will greatly assist us in evaluating this program.

1. The components of this session are listed below. For each one:

Indicate how valuable it was to you

AND

Check the appropriate box if you think more time should have been spent on that item

		Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
a.	Welcome and introductions (Staff and volunteers)	☐	☐	cl	☐	☐	☐
b.	WomanKind history and statistics	☐	cl	cl	☐	☐	☐
c.	Training schedule	☐	☐	☐	☐	☐	☐

d.	WomanKind Volunteer Manual	☐ ☐	☐	☐	0	☐
e.	Power and control Wheel and equality wheel	cl	☐	0	☐	0	☐
f.	Checklist: signs of abuse	☐	cl	0	0	0	0
g.	Cycle of violence	☐ ☐	☐	☐	☐	☐
h.	Abuse is a learned behavior	☐	cl	0	0	0	0
I.	Questions & answers	☐	☐	0	0	0	0

2. For each of the following items, check the box that most closely reflects your opinion about the trainers:

		Strongly Disagree 1	2	3	4	Strongly Agree 5
a.	Presented information audibly and clearly	0	0	0	0	☐
b.	Established a comfortable learning environment	0	☐	0	0	☐
c.	Held the attention of participants	☐	0	0	cl	☐
d.	Encouraged participation and discussion	0	0	☐	0	☐
e.	Seemed well prepared for the session	0	0	0	☐	☐
f.	Used effective examples and illustrations	0	0	0	0	0
g.	Demonstrated sensitivity and respect when responding to questions or comments	0	0	0	0	0

3. Any additional comments about this session:

Four-digit code: ___ ___ ___ ___

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

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WomanKind Volunteer Training

Volunteer Assessment of Session Two

Please take a few minutes to respond to the following questions regarding this session of the volunteer training for the WomanKind Program. Your responses will be safeguarded to the fullest extent possible in accordance with applicable statutes. Your participation is voluntary, but your responses will greatly assist us in evaluating this program.

1. The components of this session are listed below. For each one:

Indicate how valuable it was to you

AND

Check the appropriate box if you think more time should have been spent on that item

		Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
a.	Video "One Hit Leads To Another"	☐	☐	☐	☐	☐	☐
b.	Myths	☐	☐	☐	☐	☐	☐
c.	Responsibility for abusive behavior	☐	☐	☐	☐	☐	☐

d.	Barriers to leaving abusive relationships	☐	0	0	0	0	☐
e.	Video -- "Just to Have A Peaceful Life"	☐	☐	☐	☐	☐	☐
f.	Health Care Assessment, Identification and Intervention	0	0	0	0	☐	0

2. For each of the following items, check the box that most closely reflects your opinion about the trainers:

		Strongly Disagree 1	2	3	4	Strongly Agree 5
a.	Presented information audibly and clearly	☐	0	cl	☐	0
b.	Established a comfortable learning environment	0	0	0	0	0
c.	Held the attention of participants	☐	☐	☐	☐	☐
d.	Encouraged participation and discussion	0	0	0	☐	☐
e.	Seemed well-prepared for the session	0	0	0	0	0
f.	Used effective examples and illustrations	0	0	0	0	0
g.	Demonstrated sensitivity and respect when responding to questions or comments	0	0	0	0	☐

3 How effective was the guest speaker in:

	Not at All Effective		Somewhat Effective		Extremely Effective
	1	2	3	4	5
a. Conveying information	☐	☐	cl	cl	☐
b. Holding the attention of participants	☐	☐	☐	☐	☐
c. Addressing questions	☐	0	☐	cl	0

4. Any additional comments about this session:

Four-digit code: - - - -

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

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Expiration Date: _____

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WomanKind Volunteer Training

Volunteer Assessment of Session Three

Please take a few minutes to respond to the following questions regarding this session of the volunteer training for the WomanKind Program. Your responses will be safeguarded to the fullest extent possible in accordance with applicable statutes. Your participation is voluntary, but your responses will greatly assist us in evaluating this program.

1. The components of this session are listed below. For each one:

Indicate how valuable it was to you

AND

Check the appropriate box if you think more time should have been spent on that item

		Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
a.	Video- "It's Not Always Happy At My Home"	cl	cl	cl	cl	□	□
b.	Video- "Heart On A Chain"	□	□	□	□	□	□

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
c. Effects of violence on children and Adolescents	cl	☐	☐	cl	cl	☐

3. How effective was the guest speaker in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	☐	cl	cl	☐	☐
b. Holding the attention of participants	☐	☐	☐	☐	cl
c. Addressing questions	cl	cl	El	☐	☐

5. Any additional comments about this session:

Four-digit code: ___ ___ ___ ___

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

OMB Clearance Number: _____
Expiration Date: _____

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WomanKind Volunteer Training

Volunteer Assessment of Session Four

Please take a few minutes to respond to the following questions regarding this session of the volunteer training for the WomanKind Program. Your responses will be safeguarded to the fullest extent possible in accordance with applicable statutes. Your participation is voluntary, but your responses will greatly assist us in evaluating this program.

1. The components of this session are listed below. For each one:

Indicate how valuable it was to you

AND

Check the appropriate box if you think more time should have been spent on that item

		Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
a.	Active Listening	☐	☐	☐	☐	☐	☐
b.	Questions and answers	☐	☐	☐	☐	☐	☐

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
c. Working With Clients Who Have Suicidal Ideations	☐	cl	☐	0	0	☐
d. Questions and Answers		0	0	0	0	☐

3. How effective was the first guest speaker in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	0	0	0	0	☐
b. Holding the attention of participants	☐	☐	☐	☐	☐
c. Addressing questions	0	0	0	0	☐

4. How effective was the second speaker in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	0	0	0	0	☐
b. Holding the attention of participants	☐	☐	☐	☐	☐
c. Addressing questions	0	0	0	0	☐

5. Any additional comments about this session:

Four-digit code: ___ ___ ___ ___

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

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WomanKind Volunteer Training

Volunteer Assessment of Session Five

Please take a few minutes to respond to the following questions regarding this session of the volunteer training for the WomanKind Program. Your responses will be safeguarded to the fullest extent possible in accordance with applicable statutes. Your participation is voluntary, but your responses will greatly assist us in evaluating this program.

1. The components of this session are listed below. For each one:

Indicate how valuable it was to you

AND

Check the appropriate box if you think more time should have been spent on that item

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
a. Working with Men Who Are Abusive	☐	☐	☐	☐	☐	☐
b. Questions and Answers	☐	☐	☐	☐	☐	☐

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
c. Volunteer Advocates' Role	☐	☐	☐	cl	☐	☐
d. Security/Safety Policy and Procedures	☐	cl	☐	☐	☐	☐

3. How effective was the guest speaker in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	☐	☐	cl	cl	cl
b. Holding the attention of participants	☐	☐	☐	☐	☐
c. Addressing questions	☐	☐	☐	☐	☐

4. How effective was the trainer (advocates' role and policy and procedures) in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	☐	cl	☐	☐	☐
b. Holding the attention of participants	❑	☐	☐	☐	☐
c. Addressing questions	0	0	0	0	cl

5. Any additional comments about this session:

Four-digit code: . . . .

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

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WomanKind **Volunteer Training**

Volunteer Assessment of Session Six

Please take a few minutes to respond to the following questions regarding this session of the volunteer training for the WomanKind Program. Your responses will be safeguarded to the fullest extent possible in accordance with applicable statutes. Your participation is voluntary, but your responses will greatly assist us in evaluating this program.

1. The components of this session are listed below. For each one:

Indicate how valuable it was to you

AND

Check the appropriate box if you think more time should have been spent on that item

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
a. Chemical Health And Domestic Abuse	☐	☐	☐	☐	☐	
b. Questions and answers	☐	☐	☐	☐	☐	

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
c. Working with Women Who Are Survivors of Abuse	☐	cl	☐	El	☐	0
d. Questions and answers	0	0	0	0	cl	0

3. How effective was the first guest speaker in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	0	0	0	0	0
b. Holding the attention of participants	☐	☐	0	0	0
c. Addressing questions	0	0	0	0	0

4. How effective was the second speaker in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	0	0	0	0	0
b. Holding the attention of participants	0	0	0	0	0
c. Addressing questions	0	0	0	0	0

5. Any additional comments about this session:

Four-digit code: - a - - - -

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

OMB Clearance Number: _____
Expiration Date: _____

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, ATTN: PRA (0920-0377); Hubert H. Humphrey Bg., Rm 737-F, 200 Independence Ave., S.W.: Washington, D.C. 20201.

WomanKind Volunteer Training

Volunteer Assessment of Session Seven

Please take a few minutes to respond to the following questions regarding this session of the volunteer training for the WomanKind Program. Your responses will be safeguarded to the fullest extent possible in accordance with applicable statutes. Your participation is voluntary, but your responses will greatly assist us in evaluating this program.

1. The components of this session are listed below. For each one:

Indicate how valuable it was to you

AND

Check the appropriate box if you think more time should have been spent on that item

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
a. Law Enforcement			☐	☐ ☐ •I	☐	El
b. Questions and answers	☐	☐	☐	☐	☐	☐

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
c. Role Play	☐	☐	cl	☐	☐	cl
d. On-call Procedures	☐	☐	☐	•I	☐	☐

3. How effective was the guest speaker (law enforcement) in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	cl	☐	☐	☐	☐
b. Holding the attention of participants	☐	☐	☐	☐	☐
c. Addressing questions	☐	☐	☐	cl	☐

4. How effective was the trainer (role play and on-call procedures) in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. 'Conveying information	☐	☐	0	0	0
b. Holding the attention of participants	☐	☐	☐	☐	☐
c. Addressing questions	☐	☐	☐	☐	cl

5. Any additional comments about this session:

Four-digit code: ___ ___ ___ ___

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

OMB Clearance Number: _____
Expiration Date: _____

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, ATTN: PRA (0920-0377); Hubert H. Humphrey Bg., Rm 737-F, 200 Independence Ave., S.W.; Washington, D.C. 20201.

WomanKind Volunteer Training

Volunteer Assessment of Session Eight

Please take a few minutes to respond to the following questions regarding this session of the volunteer training for the WomanKind Program. Your responses will be safeguarded to the fullest extent possible in accordance with applicable statutes. Your participation is voluntary, but your responses will greatly assist us in evaluating this program.

1. The components of this session are listed below. For each one:

   Indicate how valuable it was to you

   AND

   Check the appropriate box if you think more time should have been spent on that item

		Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
a.	Court and Legal System	☐	☐	☐	☐	☐	☐
b.	Questions and answers	☐	☐	☐	☐	☐	☐

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
c. Religion and Domestic Abuse	☐	☐	cl	☐	cl	☐

3. How effective was the first guest speaker in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	☐	☐	cl	☐	☐
b. Holding the attention of participants	☐	☐	•I	☐	☐
c. Addressing questions	cl	cl	☐	☐	☐

4. How effective was the second speaker in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	☐	0	0	0	☐
b. Holding the attention of participants	☐	☐	☐	☐	☐
c. Addressing questions	0	0	☐	0	0

5. Any additional comments about this session:

Four-digit code: . - - -

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

OMB Clearance Number: _____
Expiration Date: _____

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, ATTN: PRA (0920-0377); Hubert H. Humphrey Bg., Rm 737-F, 200 Independence Ave., S.W.: Washington, D.C. 20201.

WomanKind Volunteer Training

Volunteer Assessment of Session Nine

Please take a few minutes to respond to the following questions regarding this session of the volunteer training for the WomanKind Program. Your responses will be safeguarded to the fullest extent possible in accordance with applicable statutes. Your participation is voluntary, but your responses will greatly assist us in evaluating this program.

1. The components of this session are listed below. For each one:

Indicate how valuable it was to you

AND

Check the appropriate box if you think more time should have been spent on that item

		Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
a.	Systems of Oppression	☐	0	0	0	0	0
b.	Questions and Answers	☐	0	0	0	0	0

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
c. On-call Procedures	☐	☐	☐	☐	•I	☐

3. How effective was the guest speaker in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	☐	☐	☐	☐	0
b. Holding the attention of participants	☐	☐	☐	☐	0
c. Addressing questions	☐	0	☐	cl	0

4. How effective was the trainer (on-call procedures) in:

	Not at All Effective 1	2	Somewhat Effective 3	4	Extremely Effective 5
a. Conveying information	☐	☐	☐	☐	0
b. Holding the attention of participants	☐	☐	☐	☐	☐
c. Addressing questions	☐	☐	☐	☐	0

5. Any additional comments about this session:

Four-digit code: ___ ___ ___ ___

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

OMB Clearance Number:_____
Expiration Date:_____

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, ATTN: PRA (0920-0377); Hubert H. Humphrey Bg., Rm 737-F, 200 Independence Ave., S.W.: Washington, D.C. 20201.

WomanKind Volunteer Training

Volunteer Assessment of Session Ten

Please take a few minutes to respond to the following questions regarding this session of the volunteer training for the WomanKind Program. Your responses will be safeguarded to the fullest extent possible in accordance with applicable statutes. Your participation is voluntary, but your responses will greatly assist us in evaluating this program.

1. The components of this session are listed below. For each one:

Indicate how valuable it was to you

AND

Check the appropriate box if you think more time should have been spent on that item

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
a. Meeting With Volunteer Services Director	☐	☐	☐	☐	☐	☐
b. Emergency Department Tour	☐	☐	☐	☐	☐	☐

	Not Valuable 1	2	Somewhat Valuable 3	4	Extremely Valuable 5	Needed More Time
c. Individual Interviews	☐	☐	☐	☐	☐	☐

5. Any additional comments about this session:

Appendix G

Volunteer Advocates KABB Surveys

Four-digit code: _ _ _ _

(Please write a number that is easy for you to remember, such as the last four digits of youi social security number.)

OMB Clearance Number: 0920-0379
Expiration Date: 01/99

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, ATTN: PRA (0920-0379); Hubert H. Humphrey Bg., Rm 737-F, 200 Independence Ave., S.W.: Washington, D.C. 20201.

WomanKind Volunteer Advocates KABB Survey

For each of the following statements, please indicate your response on the scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

Please be candid in your responses and try to record your first, instinctive answer, even if you don't think it is "politically correct". (Don't try to think about what your answers "should" be.) Your honest reactions to these statements will help us assess the need for hospital-based programs and training. These surveys are tracked by number, not by name, so feel free to answer honestly. Identifying information will be collected only to allow administration of follow-up instruments to the proper people. Lists associating names and identification codes will be maintained by Macro International, the contractor for this study, only until the study is complete,

The authority for collecting this data is Section 301 of the Public Health Service Act. Data will be safeguarded in accordance with the Privacy Act of 1974 and applicable Minnesota statutes. Your participation is voluntary, but your response will greatly assist us in evaluating this program.

Thank you for taking the time to fill out this questionnaire.

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
1. Domestic abuse is not as important as other health care problems.	I	2	3	4	5	6	7
2. Domestic violence is a significant problem in our society.	1	2	3	4	5	6	7
3. The high physical, emotional, and economic costs of domestic violence justify a stronger prevention effort.	1	2	3	4	5	6	7
4. Hospital staff who interact with patients are in a prime position to identify victims of domestic violence.	1	2	3	4	5	6	7
5. Hospital staff play an important role in addressing situations of domestic violence.	I	2	3	4	5	6	7
5. It is not appropriate for hospital staff to ask female patients about domestic violence.	1	2	3	4	5	6	7
7. Hospitals staff should not pressure patients to acknowledge that they are living in an abusive relationship	1	2	3	4	5	6	7
3. If a patient repeatedly refuses to discuss the real cause of presenting injuries, there is little hospital staff can do except treat the injuries themselves.	1	2	3	4	5	6	7
9. Hospital staff have a responsibility to talk to patients who are being abused about their situation, so that they can assess their situation, support them, and make a referral if appropriate.	1	2	3	4	5	6	7
10. Hospital staff need to be more persistent in helping patients address an abusive relationship.	I	2	3	4	5	6	7
1 1. Hospital staffs responsibility for domestic violence intervention stops with identification..	I	2	3	4	5	6	7

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
12. Hospital staff do not have the training required to assist individuals in resolving situations of domestic violence	1	2	3	4	5	6	7
13. Hospital staff do not have the time necessary to be of real assistance in resolving domestic violence	1	2	3	4	5	6	7
14. Hospital staff do not have the knowledge to be of real assistance in addressing domestic violence.	1	2	3	4	5	6	7
15. If a victim of abuse remains in the relationship after repeated episodes of violence, she must accept some responsibility for that violence.	1	2	3	4	5	6	7
16. The victim of abuse is not responsible for the abuse she receives.	1	2	3	4	5	6	7
17. Abusers can be provoked into becoming violent.	1	2	3	4	5	6	7
18. Victims of abuse have the right to make their own decisions about whether hospital staff can intervene.	1	2	3	4	5	6	7
19. If a victim of abuse refuses to acknowledge her problem, there is very little that volunteer advocates can do to help.	1	2	3	4	5	6	7
20. However frustrating it may be personally, volunteer advocates must allow abuse victims to make their own decisions about how to handle the situation.	1	2	3	4	5	6	7
21. Victims of abuse may have valid reasons for remaining in the abusive relationship.	1	2	3	4	5	6	7
22. I cannot understand why any victim of abuse would choose to remain in the relationship.	1	2	3	4	5	6	7
23. Sometimes there are justifiable reasons for a woman being hit by her partner.	1	2	3	4	5	6	7

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
24. It is not anger that is the problem with abusers, but the fact that abusers express their anger with violence.	1	2	3	4	5	6	7
25. In some situations, victims of abuse may provoke the abuse.	1	2	3	4	5	6	7
26. I am capable of identifying victims of abuse.	1	2	3	4	5	6	7
27. I can create an environment that builds trust, so that a patient can discuss domestic violence with me.	1	2	3	4	5	6	7
28. I have difficulty knowing how to respond when a patient minimizes or denies the abuse.	1	2	3	4	5	6	7
29. I can tell whether some is an abuser.	1	2	3	4	5	6	7
30. Hospital staff can identify most cases of domestic violence without specific training.	1	2	3	4	5	6	7
3 1. I can put victims of abuse at ease.	I	2	3	4	5	6	7
32. I don't have the necessary skills to effectively support a victim of abuse.	1	2	3	4	5	6	7
33. I am aware of legal requirements in Minnesota that I report suspected cases of abuse.	1	2	3	4	5	6	7
34. I can provide support to victims of abuse.	I	2	3	4	5	6	7
35. I can make appropriate referrals for victims of abuse.	1	2	3	4	5	6	7
36. Pregnant women are less likely than non-pregnant women to be hit by their partners.	1	2	3	4	5	6	7
37. If I detected an abusive situation with a patient, I would report it to the police.	I	2	3	4	5	6	7
38. There are services within our hospital for victims of domestic abuse.	1	2	3	4	5	6	7

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
39. There are services within our community for victims of domestic abuse.	1	2	3	4	5	6	7
40. The support services for domestic abuse victims in our community are fairly poor.	1	2	3	4	5	6	7
41. I feel comfortable discussing domestic violence with patients.	1	2	3	4	5	6	7
42. There are specific things that I can do to help a victim of domestic violence.	1	2	3	4	5	6	7

43. Respondent Profile:

Age:
- a < 20
- ❑ 20-24
- ❑ 25-29
- ❑ 30-34
- ❑ 35-39
- ❑ 40-44
- ❑ 45-59
- ❑ GO-64
- ❑ 65+

Gender: ❑ Male ❑ Female

Today's Date (month, date, year):

Profession: _____

Have you ever had any previous training/experience in domestic violence issues?

❑ Yes (please describe) _____

a No

Thank you for participating in this study.

Four-digit code: ___ ___ ___ ___

(Please use the same four digit code used on your fast survey, this is probably the last four digits of your social security number--if this is your first survey, choose a 4 digit code now)

OMB Clearance Number: 0920-0379
Expiration Date: 01/99

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, ATTN: PRA (0920-0379); Hubert H. Humphrey Bg., Rm 737-F, 200 Independence Ave., S.W.: Washington, D.C. 20201.

WomanKind Volunteer Advocates KABB Survey

For each of the following statements, please indicate your response on the scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

Please be candid in your responses and try to record your first, instinctive answer, even if you don't think it is "politically correct". (Don't try to think about what your answers "should" be.) Your honest reactions to these statements will help us assess the need for hospital-based programs and training. These surveys are tracked by number, not by name, so feel free to answer honestly. Identifying information will be collected only to allow administration of follow-up instruments to the proper people. Lists associating names and identification codes will be maintained by Macro International, the contractor for this study, only until the study is complete.

The authority for collecting this data is Section 301 of the Public Health Service Act. Data will be safeguarded in accordance with the Privacy Act of 1974 and applicable Minnesota statutes. Your participation is voluntary, but your response will greatly assist us in evaluating this program.

Thank you for taking the time to fill out this questionnaire.

PLEASE RETURN SURVEY BY MARCH 17, 1997

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
1. Domestic abuse is not as important as other health care problems.	I	2	3	4	5	6	7
2. Domestic violence is a significant problem in our society.	1	2	3	4	5	6	7
3. The high physical, emotional, and economic costs of domestic violence justify a stronger prevention effort.	1	2	3	4	5	6	7
4. Hospital staff who interact with patients are in a prime position to identify victims of domestic violence.	1	2	3	4	5	6	7
5. Hospital staff play an important role in addressing situations of domestic violence.	1	2	3	4	5	6	7
6. It is not appropriate for hospital staff to ask female patients about domestic violence.	1	2	3	4	5	6	7
7. Hospitals staff should not pressure patients to acknowledge that they are living in an abusive relationship	1	2	3	4	5	6	7
8. If a patient repeatedly refuses to discuss the real cause of presenting injuries, there is little hospital staff can do except treat the injuries themselves.	1	2	3	4	5	6	7
9. Hospital staff have a responsibility to talk to patients who are being abused about their situation, so that they can assess their situation, support them, and make a referral if appropriate.	1	2	3	4	5	6	7
10. Hospital staff need to be more persistent in helping patients address an abusive relationship.	1	2	3	4	5	6	7
11. Hospital staffs responsibility for domestic violence intervention stops with identification..	I	2	3	4	5	6	7
12. Hospital staff do not have the training required to assist individuals in resolving situations of domestic violence	1	2	3	4	5	6	7

Statements	Strongly Disagree	Disagree		Agree			Strongly Agree
13. Hospital staff do not have the time necessary to be of real assistance in resolving domestic violence	1	2	3	4	5	6	7
14. Hospital staff do not have the knowledge to be of real assistance in addressing domestic violence.	1	2	3	4	5	6	7
15. If a victim of abuse remains in:the relationship after repeated episodes of violence, she must accept some responsibility for that violence.	1	2	3	4	5	6	7
16. The victim of abuse is not responsible for the abuse she receives.	1	2	3	4	5	6	7
17. Abusers can be provoked into becoming violent.	1	2	3	4	5	6	7
18. Victims of abuse have the right to make their own decisions about whether hospital staff can intervene.	I	2	3	4	5	6	7
19. If a victim of abuse refuses to acknowledge her problem, there is very little that volunteer advocates can do to help.	1	2	3	4	5	6	7
20. However frustrating it may be personally, volunteer advocates must allow abuse victims to make their own decisions about how to handle the situation.	I	2	3	4	5	6	7
21. Victims of abuse may have valid reasons for remaining in the abusive relationship.	1	2	3	4	5	6	7
22. I cannot understand why any victim of abuse would choose to remain in the relationship.	I	2	3	4	5	6	7
23. Sometimes there are justifiable reasons for a woman being hit by her partner.	1	2	3	4	5	6	7
24. It is not anger that is the problem with abusers, but the fact that abusers express their anger with violence.	1	2	3	4	5	6	7
25. In some situations, victims of abuse may provoke the abuse.	1	2	3	4	5	6	7

Statements	Strongly Disagree	Disagree			Agree		Strongly Agree
26. I am capable of identifying victims of abuse.	I 2	3	4		5	6	7
27. I can create an environment that builds trust, so that a patient can discuss domestic violence with me.	1	2	3	4	5	6	7
28. I have difficulty knowing how to respond when a patient minimizes or denies the abuse.	1	2	3	4	5	6	7
29. I can tell whether some is an abuser.	1	2	3	4	5	6	7
30. Hospital staff can identify most cases of domestic violence without specific training.	1	2	3	4	5	6	7
3 1. I can put victims of abuse at ease.	1	2	3	4	5	6	7
32. I don't have the necessary skills to effectively support a victim of abuse.	1	2	3	4	5	6	7
33. I am aware of legal requirements in Minnesota that I report suspected cases of abuse.	1	2	3	4	5	6	7
34. I can provide support to victims of abuse.	1	2	3	4	5	6	7
35. I can make appropriate referrals for victims of abuse.	1	2	3	4	5	6	7
36. Pregnant women are less likely than non-pregnant women to be hit by their partners.	1	2	3	4	5	6	7
37. If I detected an abusive situation with a patient, I would report it to the police.	1	2	3	4	5	6	7
38. There are services within our hospital for victims of domestic abuse.	1	2	3	4	5	6	7
39. There are services within our community for victims of domestic abuse.	1	2	3	4	5	6	7
40. The support services for domestic abuse victims in our community are fairly poor.	1	2	3	4	5	6	7
4 1. I feel comfortable discussing domestic violence with patients.	1	2	3	4	5	6	7
42. There are specific things that I can do to help a victim of domestic violence.	1	2	3	4	5	6	7

Today's Date (month, date, year):

Age:

- ☐ < 20
- ☐ 20-24
- ☐ 25-29
- ☐ 30-34
- ☐ 35-39
- ☐ 40-44
- ☐ 45-59
- ☐ 60-64
- ☐ 65+

Profession:

What is your role as a volunteer advocate? (check all that apply)

- ☐ on call volunteer
- ☐ support group facilitator
- ☐ office assistant
- ☐ office follow-up with clients

When did you begin your work with WomanKind? (please check one)

- ☐ 1997
- ☐ 1996
- ☐ 1995
- ☐ 1994 or before (please include year)_____

How helpful are each of the following activities in enabling you to serve as a volunteer advocate?

Activity	Not at all helpful		Helpful		Very helpful
WomanKind Orientation Training	1	2	3	4	5
Monthly volunteer meetings	1	2	3	4	5
Support from WomanKind coordinator	1	2	3	4	5
Informal support from other-advocates	1	2	3	4	5

Have you had any previous experience or training in domestic violence? (check all that apply)

- ☐ WomanKind
- ☐ Other training (e.g. hospital in-service)
- ☐ Lecture or seminar in professional school
- ☐ Volunteer (at shelter, crisis line, counseling service, etc.)
- ☐ Personal experience
- ☐ Other (please describe)_____

In the past 12 months, how many times have you been either called in to work with a potential victim of intimate partner violence or talked to a woman on a crisis line?_____

Thank you for participating in this study.

Appendix H

Handout Materials Used in WomanKind Staff Training

WOMANKIND

Support Systems for Battered Women

GENERAL

* According to the F.B.I.: A woman is beaten every 12 seconds in the United States. Over 4,000 women are killed each year at the hands of their batterers. Battering is the most under-reported crime in the country. One out of every two American women will be beaten at least once in the course of an intimate relationship. 75% of women who are battered are divorced or separated from their abusers at the time of the incident. (U.S. Department of Justice. Report to the Nation on Crime and Justice: The Dala. Washinglon. D.C. October 1983.)

The Minnesota Department of Corrections estimates at least 132,000 domestic assaults occur annually, based on police reports submitted. Women murdered by husbands, partners or family members in the State of Minnesota for 1991 was 12 women; for 1992 was 3 1 women; and for 1993 was 28 women. (Minnesota Coalition for Battered Women)

PHYSICAL HEALTH

* Battering may be the single most common source of injury to women, more common than auto accidents, muggings, and rapes by a stranger combined. (E. Stark & A. Flitcraft. "Violence Among Inmates: An epidemiological Review" VN Hassell, el al. eds.. Handbook of Family Violence. New York. NY: Plenum Pub Corp: 1988: 293-318.)

EMERGENCY DEPARTMENT

* Studies have shown that 22% to 35% of women who visit emergency departments are there for symptoms related to ongoing abuse, either because of an injury or as a manifestation of the stress of living in an abusive relationship. (E. Stark. A. Flitcraft. & W. Frazier. "Medicine and Patriarchal Violence: The Social Conslruclion of a Private Event" in International Journal of Health Services. Volume 9. Number 3. 1979.)

BATTERING DURING PREGNANCY

* Much research reports that violence against women may begin or escalate during pregnancy. Estimates of physical assault of battering during pregnancy range from 7 to 11 %. One study found 37% of obstetric patients were physically abused during pregnancy. (A. Helton R.N.. "Battering During Pregnancy". American Journal of Nursing. August 1986. AM J Public Health 1987. 77:1337-1339.)

25% to 45% of all women who are battered, are battered during pregnancy. A battered pregnant woman is four times more likely to have a low birth weight baby and her chances of miscarriage are double. (Slark and Flitcraft. Wife Abuse in the Medical Setting. 1981.)

MENTAL HEALTH

* 33% of battered women suffer from anxiety and depression; 26% of all women who attempt suicide are victims of domestic violence. (E. Slark & A. Flitcraft. "Violence Among Inmates: An Epidemiological Review" In VN Hassell, el al. eds.. Handbook of Family Violence. New York. NY: Plenum Pub Corp: 1988: 293-318.)

* 64% of hospitalized female psychiatric patients have a history of being physically abused as an adult. (A. Jacobsen & B. Richardson. "Assault Experiences of 100 Psychiatric Inpatients: Evidence of the Need for Routine Inquiry". American Journal of Psychiatry. 144: 908-913. 1987.)

Fait-view Ridges Hospital
201 East Nicollet Boulevard
Burnsville, MN 55337

Fairview Southdale Hospital
6401 France Avenue South
Edina. MN 55435

Fairview Riverside Medical Center
2450 Riverside Avenue South
Minneapolis. MN 55454

WOMANKIND

Support Systems for Battered Women

DOMESTIC ABUSE AND HEALTH CARE

INTRODUCTION

Violence in families is a complex problem...one that has existed for centuries. In order to address this problem and work toward prevention, we must first understand the issue and then develop solutions. We need to recognize the framework in which violence occurs and examine how we as individuals and the systems around us respond to victims of abuse.

A statement in 1989 by then U.S. Surgeon General C. Everett Koop urged greater involvement and response by the medical system in domestic violence. "Physical abuse of women and children is "an overwhelming moral, economic, and public health burden."

ROLE OF THE HEALTH CARE SYSTEM

Statistics indicate that a significant number of battered women who go to a hospital or medical office are not currently being identified as victims of abuse, nor are they receiving help in the form of advocacy services or resource referral. Health professionals often intervene at a point where battering can be identified, support and information can be given, and the battered woman can learn of the community resources available to help her and her family. Early intervention by health care professionals can play an important role in ending the cycle of violence and preventing the long term effects of battering.

"Health care providers may be the first and
only professionals in a position to
recognize violence in their patients' lives."

Randall, T. Hospital-Wide Program Identifies Battered Women; Offers Assistance, *"Journal of the American Medical Association"* Vol. *266, No. 9,* September 4, 1991.

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WOMANKIND

Support Systems for Battered Women

MYTHS AND REALITIES OF DOMESTIC ABUSE

What is *Domestic Abuse.?* The use of--or threat to use--a variety of abusive behaviors (including physical, emotional, psychological, sexual and/or economic) within an intimate relationship to gain or maintain control over another person.

MYTH 1: The battered woman syndrome affects only a small percentage of the population.

REALITY: *Battering* **is** *the single major cause of injury to women--more frequent than auto accidents, muggings and rapes combined. Three to four million American women are battered each year by their husbands or partners.*

MYTH 2: Domestic violence occurs only in lower socio-economic classes and to poor minority women.

REALITY: Violence occurs in families from all social, economic, educational, racial, and religious backgrounds.

MYTH 3: The problem is really "spouse abuse"...couples who assault each other.

REALITY: Domestic violence is about an imbalance of power; it is rarely mutual. 95% *of serious assaults are male to female,*

MYTH 4: Alcohol and drugs cause abusive behavior.

REALITY: Chemical dependency and domestic violence are two separate issues. Chemical dependency is a disease, an addiction; abuse is ***a*** *learned behavior.* ..it can *be unlearned.*

MYTH 5: The abuser is just "out of control".

REALITY: The abuser is not out of control. He is making a decision when he chooses how, who, when and where he abuses.

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MYTH 6: Battered women deserve to be beaten. They provoke the beatings by pushing their man beyond the breaking point.

REALITY: ***The person exhibiting the behavior is the one responsible for that behavior. Each of us is responsible for our own behavior and we cannot transfer that responsibility to another person.***

MYTH 7: Marriage or couples counseling is a good recommendation for abusive relationships.

REALITY: ***Marital therapy is not only ineffective for the couple, it is unsafe for the a-bused woman.***

MYTH 8: Battered women must enjoy the violence, otherwise they would leave the abusive relationship.

REALITY: ***No one enjoys being hit or hurt. Battered women may make many attempts to stop the violence and/or leave the relationship. In fact, many*** women ***do leave their abusers.***

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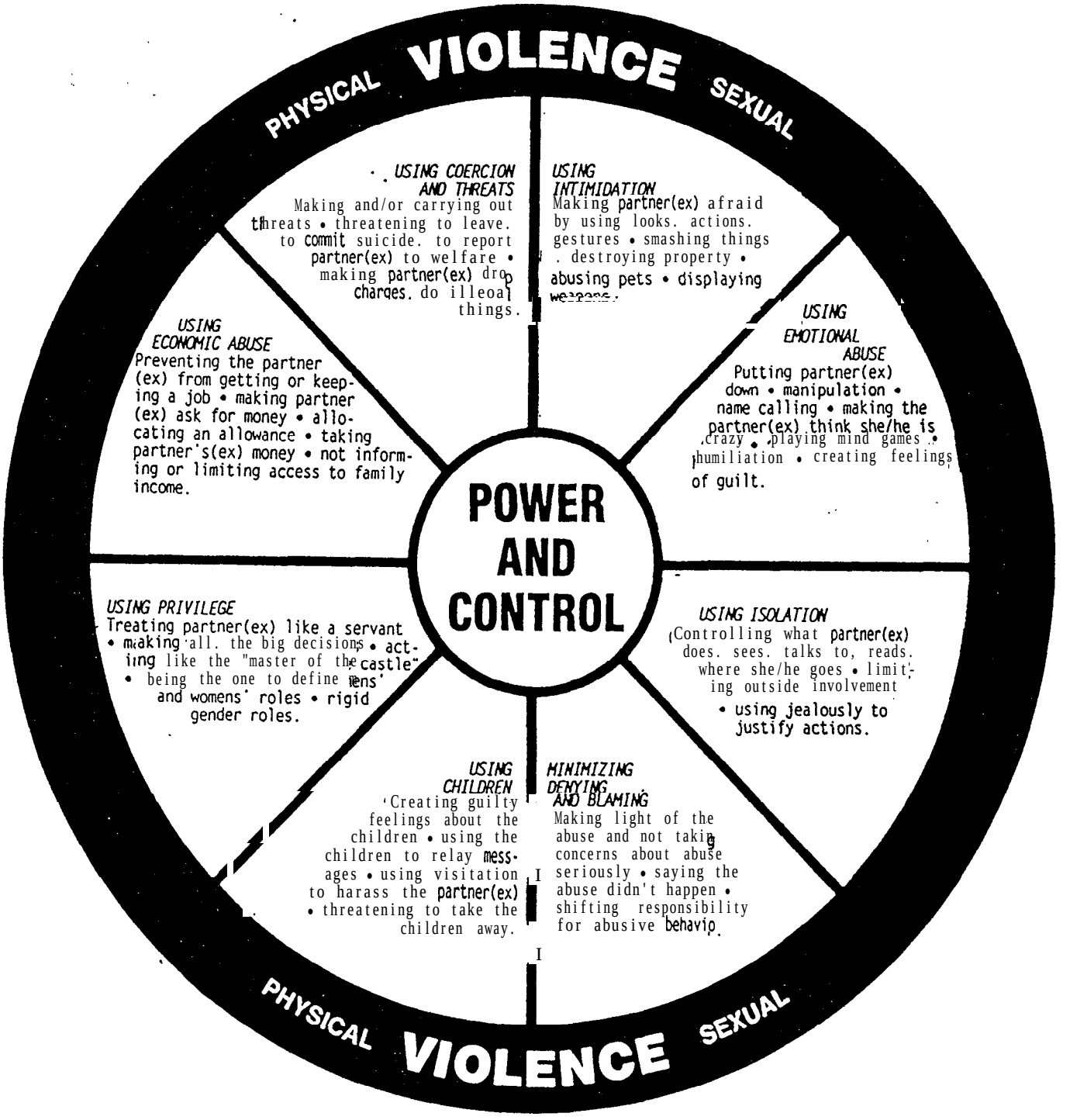

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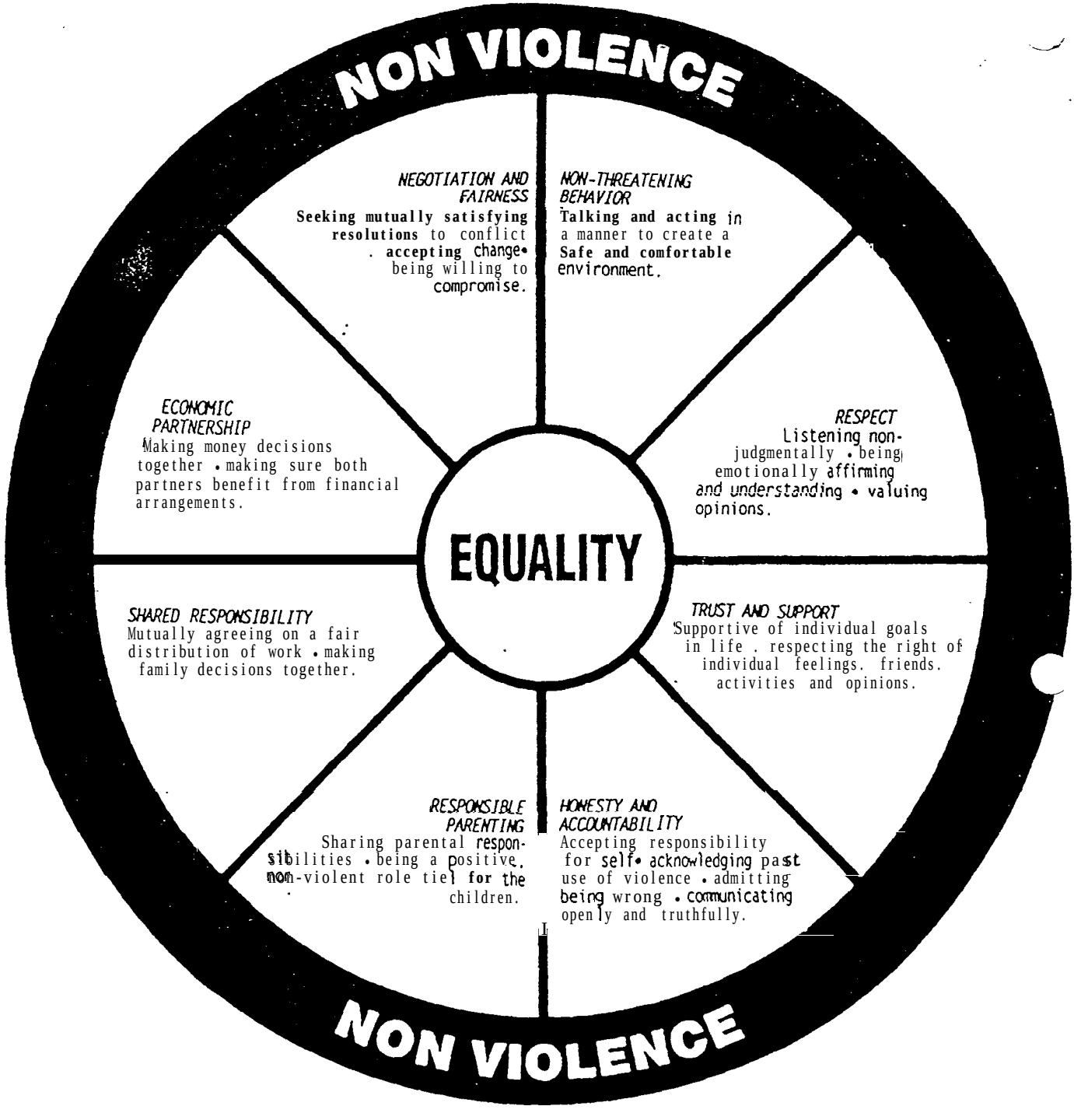
206 West Fourth Street Duluth MN 55806



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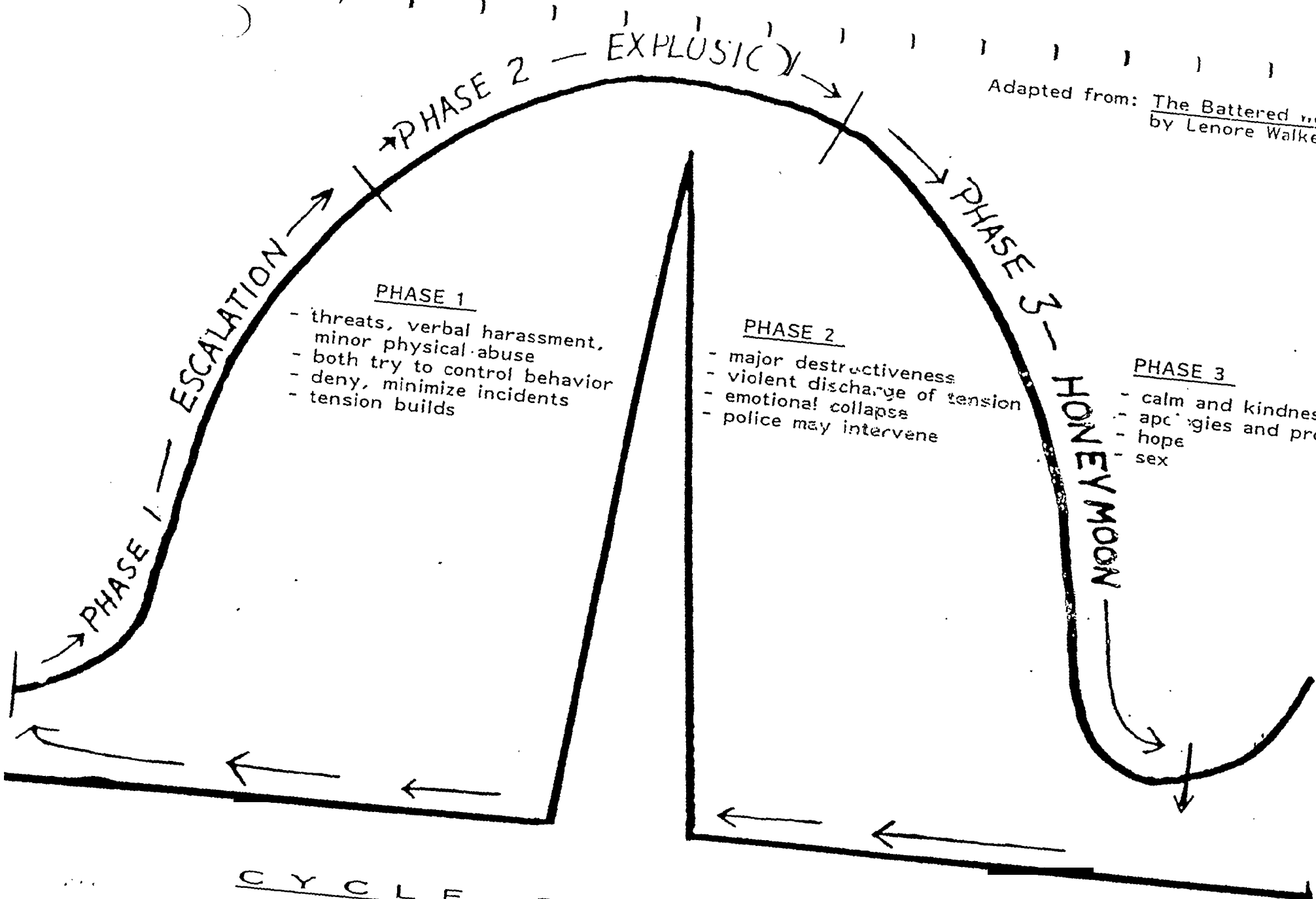

Adapted from: The Battered Woman by Lenore Walker

CYCLE OF VIOLENCE

WOMANKIND

Support Systems for Bartered Women

IDENTIFICATION OF VICTIM OF DOMESTIC ABUSE

1. Verbal and Nonverbal Behavior: Be aware of the behavior of woman and her husband/partner.

   A. Battered Woman: Agitated, evasive, ashamed, depressed, disoriented, hesitant, embarrassed, jumpy.

   B. Husband/Partner: Overly solicitous, overly affectionate, explains injury, answers all questions.

2. Frequent Presenting Injuries:

   A. Contusions, lacerations, abrasions, fractures...

      1. Central part of body: Breasts, soft tissue areas

      2. Injuries to the head, face and neck: Fractured mandible, nasal fracture perforated tympanic membrane.

      3. Upper extremities: Grab marks on upper arms, contusions on the lower arms raised in defense.

   B. Injuries may be consistent with burns, whip-like bruises, choke marks on the neck, wounds on the back of the head covered by hair, including gaps of hair pulled out of the head.

   C. Multiple injuries in various stages of healing.

3. Battering During Pregnancy: Battering may often begin or escalate during pregnancy with injuries to the breasts, abdomen or genitals.

4. Mental Health Issues: Anxiety, depression, panic attacks, and/or suicidal ideation or history of suicide attempts.

5. Hidden Signs:

A. Patient may deny physical abuse, but presents with unexplained injuries.

B. Delay between the time of injury and presentation for treatment.

C. Discrepancy between patient's history, and type and appearance of injuries.

D. Patient's distress excessive in relation to injury.

E. Repeat visits, chronic injuries; vague or nonspecific complaints.

6. **Documentation**

A. Physical findings, patient's history, patient's statements.

B. Photographs: Take two photographs of each trauma area.

7. Routine **Screening**

A. Abuse Assessment Screen

1. Include history of abuse in assessments of all female patients.

"Are you now, or have you ever been, in a relationship where someone has abused you physically, emotionally or sexually?"

B. Trauma - Ask specifically if she has been abused.

"Did someone hurt you?"
"Did you receive these injuries by being hit?"

C. Routine Screening: The single most important step health professionals can take is to incorporate the subject of domestic abuse into their routine history for all women,

identi.dom

Flitcraft A, Hadley S, Hendricks-Matthews M, McLeer S, Warshaw C, American Medical Association Diagnostic and Treatment Guidelines on Domestic Violence, March 1992.

WOMANKIND

Support Systems for Battered Women

ASKING THE QUESTION

Framing Questions

"Because abuse and violence have become so prevalent in our society, we've started to ask all of our patients about this issue."

"I don't know if this is a problem for you, but-because so many women we see are living in or recovering from abusive relationships, we've started to ask about it routinely."

"We now know that family violence or domestic abuse is a very common problem. About 25% of women in this country will experience abuse by a partner. Is this happening to you?"

Direct Questions

"When I see injuries like yours, it's usually because someone has been hit by another person. " Did this happen to you?" "Did someone hit you?" "Did you receive your injuries by being hit?"

"I'm concerned that your injuries/symptoms may have been caused by someone hurting you. Did someone hurt you?"

"Does your partner try to control you? Do you feel isolated from family or friends? Tell me about your support system."

"Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home today/tonight?"

"You seem overwhelmed...are you having a hard time lately? Who do you have to talk to when things pile up?"

"Have you been under any extra stress lately? Are you having particular problems or concerns with your partner...your children?"

"How are things going in your relationship/marriage? All couples disagree and argue. What happens when you disagree? Do you fight verbally...physically?"

"Couples have different ways of resolving their conflicts. How do you and your partner deal with conflicts? What happens when you disagree? What happens when your partner doesn't get his way?"

"You mentioned that your partner seems impatient and loses his temper with the children. Can you tell me more about that? Has he ever hit you or the children? Are you afraid of him...do you think the children are afraid of him?"

"You mentioned that your partner uses alcohol. How does he act when he is intoxicated? Does his behavior ever frighten you? "Does he ever become violent?"

Patient Denies Abuse

In some circumstances when a patient has denied or not acknowledged abuse, but you still feel it is a possibility, an indirect question or statement may be a good way to convey helpful support and information.

"If you or anyone you know were being abused, and needed help, would you know who to ask? What to do? Whereb go? If this is happening to you...or ever happens to you, please know that our office is a safe, confidential place to-talk about it."

Flitcraft AH, Hadley SM, Hendricks-Matthews MK, McLeer SV, Warshaw C. *AMA Diagnostic and Treatment Guidelines on Domestic Violence*, Chicago, March 1992.

WOMANKIND

support Systems for Battered Women

"Health care providers may be the first
and only professionals in a position
to recognize violence in their patient's lives."

Randall, T. "Hospital-Wide Identities Battered Women; Offers Assistance.
Journal of the American Medical Association, Vol 266, No 9, September 4, 1991

Mission - WomanKind was founded in 1986 with the mission to provide 1) case management/advocacy services to victims of domestic abuse and 2) education/consultation to health professionals through the health care system resulting in change in the health system's response to victims of domestic abuse.

Philosophy - WomanKind is based on the premise that health care professionals often intervene at a point where abuse and violence can be identified, support and education can be given, and the victim of domestic abuse can learn of options and community services available.

Early Intervention and Prevention - Routine assessment and identification combined wirh early intervention may ultimately result in prevention of more serious injuries, prevention of ongoing mental health and psychiatric symptoms, and prevention of abuse to children.

Goal - The ultimate goal of the WomanKind program is to integrate the issue of domestic abuse into the total health care of each patient resulting in overall system change.

PROGRAM SERVICES

Case Management/Advocacy -- The first purpose of WomanKind is to provide case management/advocacy services, crisis intervention and ongoing assistance to women who suffer from physical, emotional or sexual abuse by a current/former husband/partner. WomanKind services are available 24 hours a day, 7 days a week, are confidential and free of charge.

Education -The second purpose of WomanKind is to provide education and consultation to hospital staff and community health professionals in order to enable them to more readily identify and treat victims of domestic abuse and violence.

PROGRAM HISTORY

WomanKind, a hospital-wide domestic abuse program, was founded by Susan M. Hadley, M.P.H. as a non-profit corporation with the mission to provide domestic abuse services through the health care system. Program research indicated that a significant number of battered women who came to medical facilities were not being identified as victims of abuse, nor were they receiving help in the form of advocacy services or resource referral. It became apparent that there was a need to better identify and treat abused women who access the health care system. WomanKind was conceived to respond to this need.

WomanKind began providing services at Fairview Southdale Hospital in Edina in June of 1986 and at Fairview Ridges Hospital in Bumsville in November of 1989, both suburban locations. In March of 1994. WomanKind began providing services at Fairview Riverside Medical Center in urban Minneapolis. On July 1, 1992, WomanKind joined with the Fairview Health System in Minnesota, which has taken the lead across the country-in institutionalizing domestic abuse services as part of its mission of total health care.

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TARGET POPULATION

Nearly 100 clients are referred to WomanKind each month from inpatient and outpatient sources, as well as from the surrounding community, with more than 8000 women having received services since the program's inception. WomanKind's total initial contacts in 1995 through the three hospital sites, reached 1107 and, combined with repeat and follow-up contacts, resulted in over 2654 total client contacts for 1995. The ongoing support and assistance of WomanKind staff is significant in accelerating the victim's process toward increased strength and safety.

PROGRAM STAFF

Four full-time staff members are over 75 committed volunteers provide services 24 hours a day, 7 days a week. A vital aspect of the WomanKind case management/advocacy services is the ongoing contact of the WomanKind staff with the client, who continue to provide nonjudgmental support and assistance, (respecting her process, timetable and decisions) until the client is ready to take the next step. At that point, WomanKind facilitates the client's connection to the most appropriate community resource. Community Connection: WomanKind provides a supportive connection between the victim in the health care setting and the community resources available to help her and her family.

PROGRAM BUDGET

The annual budget for the WomanKind program is approximately $250,000 made up of staff salaries and benefits as well as expenses for the WomanKind education and training program and the extensive WomanKind volunteer program. Major funding for WomanKind is provided by the Fait-view Foundation, the Fairview Hospital's Auxiliary, and Fairview Health System.

EVALUATION AND RECOGNITION

WomanKind has been selected by the National Centers for Disease Control and Prevention in Atlanta to participate in a 2-year evaluation project on health system intervention for victims of domestic abuse and violence. The overall goal of the research is to assess the efficacy of the WomanKind program. Specifically, the evaluation research will assess the fundamental services provided by WomanKind staff and volunteers':

1) case management/advocacy services to victims of domestic abuse and violence
2) education, training and consultation with hospital, clinic, and medical office staff
3) communication and networking with community service agencies.

Nationally recognized as a model program, WomanKind has been profiled in numerous publications including the *Journal of the American Medical Association (JAMA), The Journal of Emergency Nursing, Hospitals, Minnesota Medicine, Medical Economics, Emergency Medicine News,* and *Women's Health Issues,* the official publication of the Jacob's Institute for Women's Health. The first program of its kind in the United States, WomanKind has been featured on the health care reports on the NBC *TODAY Show,* on *Physicians' Journal Update* on the Lifetime Channel, and on "Today's Breakthroughs, Tomorrow's Cures," a television news documentary featuring current medical programs and innovative solutions.

SYSTEM CHANGE

WomanKind has found that health care intervention is early intervention in the client's process toward change. Early intervention may ultimate be prevention of the patient's physical injuries and symptoms, as well as the mental health problems causes by domestic abuse and violence. Most importantly, WomanKind has brought about change in the medical systems's response to victims of domestic violence so that health professionals treat more than just the physical problem but also address the underlying causes of the medical or mental health problem.

WOMANKIND

Support Systems for Battered Women

Domestic Abuse: The Role and Response of the Health Care System

Case Studies

Case 1:

A 29 year old woman presents to the Emergency Department with the following complaints:

- Tender back
- Laceration on the back of the head
- Bruised and swollen knuckles

Patient states she fell backwards down the stairs, grabbing the railing while falling.

Case 2:

A 38 year old was admitted to the Intensive Care Unit after taking 14 Tylenol tablets and 10 tablets of her anti-depressant medication (Imipramine), along with five glasses of wine. The patient's husband is with her and expresses concern for her depression and her alcohol use.

Case 3:

A 22 year old woman delivered a 4 pound, 3 ounce baby boy who was five weeks premature. This is the patient's second child; the first child was also premature. The patient has had only three prenatal appointments prior to delivery. The father of the baby has been present during the entire labor. Although the patient has requested pain medication, he refuses to allow her to take any drugs because the medication could be harmful to the baby.

Case 4:

A 55 year old suburban woman, married 28 years, comes into your Family Practice office complaining of fatigue and headaches. In the past six months, this patient has been in for care five times without a specific diagnosis. During this examination, bruises are noted on her upper arm and lower left leg. When questioned, the patient speaks quietly with poor eye contact.

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Appendix I

Brochure Announcing WomanKind Staff Training'

To register :

Fair-view Health Wise

Phone: 672-7272,

Fax: 672-6248 or

E-Mail -healthwise

Internet:

healthwise@fairview.org

Fairview Riverside Medical Center

This program is sponsored by Fairview Riverside Medical Center Continuing Medical Education Committee

Support for this program is provided by Fairview Physician Associates

Accreditation:

Fait-view Riverside Medical Center is accredited by the Minnesota Medical Associationto sponsor continuing medical/ education for physicians.

The Fait-view Riverside Medical Center' Continuing Medical Education Committee designates this continuing medical education activity for 1.5 credit each in Category I of the Physician's Recognition; Award of the American Medical Association

For CME information please contact Fairview Riverside Medical Center Continuing Medical Education Committee, Fairview Riverside Medical Center, 2450 Riverside Avenue, Minneapolis, MN 55454, 672-4275.

It is the responsibility of other professionals ıo determine if these activities meet the requirements of theirprofessional board

Fairview

Fairview

Physician Associates

Presents

Domestic Abuse

a two part series

July 24, 1996

&

July 31, 1996

7 - 8:30 a.m.

Fairview Southdale Hospital

International Room

Speaker:

Susan M. Hadley, M.P.H.,
Founder and Director,
WomanKind
Fairview Health System

Date:

July 24, 1996 & July 31, 1996

Time:

7 - 8:30 a.m.

Location:

Fairview Southdale Hospital
International Room

This program is designed for Fair-view Physician Associates (FPA) OB & family practice physicians, and their staff who provide care for OB populations, i. e., nurse midwives, nurses, medical assistants

* Bring case studies for discussion

*The **WomanKind** Health Professional Quick Reference Card is now available.*

Session I

July 24, 1996 7 - 8:30 a.m.

Fairview Southdale Hospital

International Room

After the conclusion of this learning activity the participant should be able to:

1. *Describe unique aspects of intervention with victims of domestic abuse.*
2. *Recognize the "red flags and subtle signs" of domestic abuse among your OB population*
3. *Describe assessment and identification techniques with victims of family violence.*

Session II

July 31, 1996 7 - 8:30 a.m.

Fairview Southdale Hospital

International Room

After the conclusion of this learning activity the participant should be able to:

1. *Describe the personal bias and frustration health care professionals may feel in working with victims of family violence.*
2. *Describe the victim's process for change including the relationship, role and responsibility of the health care professional.*
3. *Discuss case studies relating to domestic abuse, including appropriate assessment questions and probable responses.*
4. *Describe appropn'ate documentation for domestic abuse in the medical chart.*

Appendix J

Facilitator Guide and Consent Forms for Interviews/Group Discussion with Hospital Staff

Discussion Groups with Hospital Staff

Facilitator Guide

Introduction

(Introduce self and other Macro or CDC staff present). Thank you for taking the time to talk with us today. As you know, we are in the final phase of the evaluation of the WomanKind Program and wanted one more opportunity to hear from you about the program.

Our discussion here today will last approximately one hour. Before we get started, I'd like to distribute and review with you a consent form. We want to make sure that you understand that your participation in this group is completely voluntary. You can leave at any time. (Review form).

I will use a set of questions to guide our discussion. There may be times when we really get going on one question, and I'll have to move on to the next one so that we can cover everything. Please don't take it personally! We just want to make sure that we have the chance to hear from you on all of the topics. I'd also like to encourage everyone to participate. This doesn't mean that we need every person to answer every question, but we'd like to make sure that everyone has the chance to contribute.

To make sure.that we have an accurate record of the discussion, we will be audio taping it and (note taker's name) will take notes for us. As with the surveys you've completed, the information that is generated in this discussion group (including the audiotape and the notes) will be managed by Macro International Inc. No one in WomanKind or in this hospital will receive any information that can be tied to a particular person.

Do you have any questions before we begin?

Discussion Questions

For all staff:

- What do you see as your role in dealing with domestic violence?
- What resources are available to you in dealing with a victim of domestic abuse?
- Do you feel comfortable in making a referral to these resources? Why or why not?

For staff who have received WomanKind iraining:

- What is your perception of the training? What was helpful? What was not helpful? What recommendations do you have for improving the training?

- How have your perceptions of domestic violence been affected by the training?

- How have your interactions with patients been affected by the training?

For staff who have not received WomanKind training:

- Are you aware that training in recognizing the signs of domestic violence was conducted at this hospital recently?

- If yes, what prevented you from attending the training?

- What would make it easier for you to attend this training in the future?

For staff of the Fair-view hospitals:

- What is your perception of the WomanKind program in general? Of the WomanKind staff? Of the volunteer advocates?

- In what ways, is the program valuable to the hospital? In what ways is it valuable to you? How are women helped by the program?

- Would you consider this program successful? Why or why not?

- What recommendations would you make for improving the program?

Closure

Thank you very much for taking the time to talk with us today and for your thoughtfulness in responding to the questions.

Informed Consent -- Health Care Provider Interviews

Evaluation of **WomanKind:** Support Systems for Battered Women

Thank you for participating in this research study being conducted by the Centers for Disease Control and Prevention (CDC). During the past year, we have asked you to complete surveys on' the topic of domestic violence and your responses have contributed to this effort to learn about training needs among hospital staff and ways that services for abused women can be improved in the hospital setting.

You have now been asked to participate in an interview to provide additional input into the research by telling us more about how you perceive and handle cases of suspected or definite partner abuse and your thoughts about training on this topic.

We are interviewing a small number of providers from your hospital to supplement the information we gain through the surveys. The interview will be facilitated by a representative of Macro International Inc or the CDC. An assistant to the facilitators will take written notes during the group and we will also audiotape the interview to provide us with an accurate record for preparing our reports afterward.

Your name will not be used in any reports about this study and no quotes will be attributed to you. No one at this hospital or in the WomanKind program will receive any information about your responses during the interview.

Participation in this interview is completely voluntary. You may choose to leave at any time for any reason.

Your signature below indicates that you understand the above and agree to participate in the interview.

Signature _____

Witness _____

Date _____

Appendix K

Hospital Staff KABB Surveys

Four-digit code: _ _ _ _

(Please write a number that is easy for you to remember, such **as the last four digits of your social security number.)**

OMB Clearance Number: 0920-0379
Expiration Date: 01/99

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, ATTN: PRA (0920-0379); Hubert H. Humphrey Bg., Rm 737-F, 200 Independence Ave., S.W.: Washington, D.C. 20201.

Medical and Hospital Staff **KABB Survey**

For each of the following statements, please indicate your response on the scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

Please be candid in your responses and try to record your first, instinctive answer, even if you don't think it is "politically correct". (Don't try to think about what your answers "should" be.) Your honest reactions to these statements will help us assess the need for hospital-based programs and training. These surveys are tracked by number, not by name, so feel free to answer honestly. Identifying information will be collected only to allow administration of follow-up instruments to the proper people. Lists associating names and identification codes will be maintained by Macro International, the contractor for this study, only until the study is complete.

The authority for collecting this data is Section 301 of the Public Health Service Act. Data will be safeguarded in accordance with the Privacy Act of 1974 and applicable Minnesota statutes. Your participation is voluntary, but your response will greatly assist us in evaluating this program.

Thank you for taking the time to fill out this questionnaire.

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
1. Domestic abuse is a significant problem in our society.	1	2	3	4		6	7
2. I cannot understand why any victim of abuse would choose to remain in the relationship.	1	2	3	4		6	7
3. Medical and hospital staff should not be responsible for identifying cases of domestic abuse.	1	2	3	4		6	7
4. Domestic abuse is less important than other health care problems.	1	2	3	4		6	7
5. I can put victims of abuse at ease.	1	2	3	4	5	6	7
6. Abuse victims need to make their own decisions about how to handle the situation.	1	2	3	4	5	6	7
7. Abuse can be caused by the use of drugs and alcohol.	1	2	3	4	5	6	7
8. Medical and hospital staff who see patients are in a position to identify victims of domestic abuse.	1	2	3	4	5	6	7
9. Sometimes there are justifiable reasons for victims being hit by their partners.	1	2	3	4	5	6	7
10. If a victim of abuse refuses to acknowledge the abuse, there is very little that hospital staff can do to help.	1	2	3	4	5	6	7
11. Medical and hospital staff should not pressure patients to acknowledge that they are living in an abusive relationship.	1	2	3	4	5	6	7
12. Abusers would not be violent if they weren't provoked.	1	2	3	4	5	6	7
13. Medical and hospital staff have a responsibility to ask all patients about domestic abuse.	1	2	3	4	5	6	7

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
14. Medical and hospital staff do not have the **training** to assist individuals in addressing situations of domestic abuse.	1	2	3	4	5	6	7
15. Medical and hospital staff do not have the **time** to assist patients in addressing domestic abuse.	1	2	3	4	5	6	7
16. Medical and hospital staff do not have the **knowledge** to assist patients in addressing domestic abuse.	1	2	3	4	5	6	7
17. If victims of abuse remain in the relationship after repeated episodes of violence, they must accept some responsibility for that violence.	1	2	3	4	5	6	7
18. Medical and hospital staff have an important role in addressing situations of domestic abuse.	1	2	3	4	5	6	7
19. If a patient repeatedly refuses to discuss the abuse, staff can only treat the patient's injuries.	1	2	3	4	5	6	7
20. Victims of abuse have the right to make their own decisions about whether hospital staff can intervene.	1	2	3	4	5	6	7
21. It is not appropriate for medical and hospital staff to ask patients about domestic abuse.	1	2	3	4	5	6	7
22. Victims of abuse may have valid reasons for remaining in the abusive relationship.	1	2	3	4	5	6	7
23. Sometimes there are justifiable reasons for a woman being hit by her partner.	1	2	3	4	5	6	7
24. Abusers are not always responsible for their violent behavior.	1	2	3	4	5	6	7
25. I am capable of identifying victims of domestic abuse.	1	2	3	4	5	6	7

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
26. I can create an environment that builds trust, so that a patient can discuss domestic abuse with me.	1	2	3	4	5	6	7
27. I am able to gather the necessary information to identify domestic abuse as the underlying cause of patient injuries.	1	2	3	4	5	6	7
28. I am able to gather the necessary information to identify domestic abuse as the underlying cause of patient illnesses.	1	2	3	4	5	6	7
29. I have difficulty knowing how to respond when a patient insists that suspicious injuries are not the result of abuse.	1	2	3	4	5	6	7
30. I can make appropriate referrals within the hospital for victims of domestic abuse.	1	2	3	4	5	6	7
31. I can make appropriate referrals to services within the community for victims of domestic abuse.	1	2	3	4	5	6	7
32. I can tell if someone is an abuser.	1	2.	3	4	5	6	7
33. Victims of abuse could leave the relationship if they wanted to.	1	2	3	4	5	6	7
34. Medical and hospital staff can identify most cases of domestic abuse without specific training.	1	2	3	4	5	6	7
35. The physical, emotional and economic costs of domestic abuse justify a stronger prevention effort.	1	2	3	4	5	6	7
36. I am aware of legal requirements in Minnesota regarding reporting of suspected cases of abuse.	1	2	3	4	5	6	7
37. I don't have the necessary skills to discuss abuse with a victim.	1	2	3	4	5	6	7
38. I review patients' charts to determine possible evidence of prior abuse.	1	2	3	4	5	6	7

Statements		Strongly Disagree		Disagree		Agree		Strongly Agree
39.	I can provide support to victims of abuse.	1	2	3	4	5	6	7
40.	I ask all female patients about problems in their relationships.	1	2	3	4	5	6	7
41.	Pregnant women are less likely than non-pregnant women to be hit by their partners.	1	2	3	4	5	6	7
42.	Victims of abuse are not responsible for the abuse they receive.	1	2	3	4	5	6	7
43.	Medical and hospital staff may need to make repeated attempts to help patients acknowledge an abusive relationship.	1	2	3	4	5	6	7
44.	I document in patients' charts their statements about how the injury occurred,	1	2	3	4	5	6	7
45.	I comply with the AMA recommendations and Joint Commission standards that require inquiries about domestic abuse of all female patients.	1	2	3	4	5	6	7
46.	I intend to provide support and appropriate referrals to any victims of domestic abuse that I encounter in my professional practice.	1	2	3	4	5	6	7
47.	There are services within our own hospital for victims of domestic abuse.	1	2	3	4	5	6	7
48.	There are services within the community for victims of domestic abuse.	1	2	3	4	5	6	7
49.	I am concerned about getting involved in an abused patient's case because of the time it may require.	1	2	3	4	5	6	7
50.	I feel comfortable discussing domestic abuse with my patients.	1	2	3	4	5	6	7
51.	There are specific things that I can do to help a victim of domestic abuse.	1	2	3	4	5	6	7

52. Respondent Profile:

Age:

❑ < 20	❑ 30-34	❑ 45-59
❑ 20-24	❑ 35-39	❑ 6--64
a 25-29	❑ 40-44	a 65+

Gender: ❑ Male ❑ Female

Position/Specialty: (e.g., *RN, Labor &Delivery)* _____

Hire date *(month/year)*: _____

Percent Full-time Equivalent (FTE): _____

Have you had any previous training in domestic violence issues? Please list any previous training below:

Thank you for par ticipating in this study.

Four-digit code: ___ ___ ___ ___

OMB Clearance Number: 0920-0379
Expiration Date: 01/99

Public reporting burden for this collection of information is estimated to average 10 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, ATTN: PRA (0920-0379); Hubert H. Humphrey Bg., Rm 737-F, 200 Independence Ave., S.W.: Washington, D.C. 20201.

Medical and Hospital Staff KABB Survey

For each of the following statements, please indicate your response on the scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

Please be candid in your responses and try to record your first, instinctive answer, even if you don't think it is "politically correct". (Don't try to think about what your answers "should" be.) Your honest reactions to these statements will help us assess the need for hospital-based programs and training. These surveys are tracked by number, not by name, so feel free to answer honestly. Identifying information will be collected only to allow administration of follow-up instruments to the proper people. Lists associating names and identification codes will be maintained by Macro International, the contractor for this study, only until the study is complete.

The authority for collecting this data is Section 301 of the Public Health Service Act. Data will be safeguarded in accordance with the Privacy Act of 1974 and applicable Minnesota statutes. Your participation is voluntary, but your response will greatly assist us in evaluating this program.

Thank** you for taking the time to fill out this **questionnaire.

PLEASERET-URNSURVEYBY:
MARCH 17, 1997

Four-digit code: ___ ___ ___ ___

Today's Date: ____/____/ 1997

Gender: ☐ Male ☐ Female	Age: ☐ <20 ☐ 30-34 ☐ 45-59 ☐ 20-24 ☐ 35-39 ☐ 60-64 ☐ 25-29 ☐ 40-44 ☐ 65+

Position: ☐ RN ☐ MD ☐ PA ☐ EMT ☐ Other _____

Department: ☐ ER/ED ☐ ICU/SCU ☐ Ob/Gyn

Specialty: ☐ Pediatrics ☐ Ob/Gyn ☐ Internal Medicine
☐ Emergency Medicine ☐ Surgery (or other surgery sub-specialty)

Date Hired: ____/ 19____ Number of years working in health care: _____ yrs

Percent Full-time Equivalent (FTE): ***(please check only one)***
☐ 100% (full time)
☐ ***50%*** to 90% (part time)
☐ Less than 50% (casual, as needed, etc)

How have you learned about domestic violence issues? ***(please check ALL that apply)***

	Approximate Dates
☐ WomanKind	____/ 19____
☐ Other training (e.g., hospital in-service)	____/ 19____
☐ Lecture or seminar in professional school	____/ 19____
☐ Volunteer (at shelter, crisis line, counseling service, etc.)	_____
☐ Personal experience	____/ 19____
☐ Other (please describe) _____	_____

Have you identified a victim of intimate partner violence within the last 12 months? ☐ Yes ☐ No

If yes, which of the following actions did you take with the patient? ***(please check all that apply)***

☐ Referral to WomanKind advocate or other social worker
☐ Discussed domestic violence with patient
☐ Counseled patient about community service options
☐ Other (please describe) _____

Statements	Strongly Disagree		Disagree		Agree		Strongl Agre
1. Domestic abuse is a significant problem in our society.	1	2	3	4	5	6	
2. I cannot understand why any victim of abuse would choose to remain in the relationship.	1	2	3	4	5	6	7
3. Medical and hospital staff should not be responsible for identifying cases of domestic abuse.	I	2	3	4	5	6	7
4. Domestic abuse is less important than other health care problems.	I	2	3	4	5	6	7
5. I can put victims of abuse at ease.	1	2	3	4	5	6	7
6. Abuse victims need to make their own decisions about how to handle the situation.	1	2	3	4	5	6	7
7. Abuse can be caused by the use of drugs and alcohol.	1	2	3	4	5	6	7
8. Medical and hospital staff who see patients are in a position to identify victims of domestic abuse.	1	2	3	4	5	6	7
9. Sometimes there are justifiable reasons for victims being hit by their partners.	1	2	3	4	5	6	7
10. If a victim of abuse refuses to acknowledge the abuse, there is very little that hospital staff can do to help.	1	2	3	4	5	6	7
11. Medical and hospital staff should not pressure patients to acknowledge that they are living in an abusive relationship.	1	2	3	4	5	6	7
12. Abusers would not be violent if they weren't provoked.	1	2	3	4	5	6	7
13. Medical and hospital staff have a responsibility to ask all patients about domestic abuse.	1	2	3	4	5	6	7

Statements	Strongly Disagree	Disagreee			Agree		Strrongly Agree
14. Medical and hospital staff do not have the training to assist individuals in -addressing situations-of domestic abuse.	1	2	3	4	5	6	7
15. Medical and hospital staff do not have the time to assist patients in addressing domestic abuse.	1	2	3	4	5	6	7
16. Medical and hospital staff do not have the knowledge to assist patients in addressing domestic abuse.	1	2	3	4	5	6	7
17. If victims of abuse remain in the relationship after repeated episodes of violence, they must accept some responsibility for that violence.	1	2	3	4	5	6	7
18. Medical and hospital staff have an important role in addressing situations of domestic abuse.	1	2	3	4	5	6	7
19. If a patient repeatedly refuses to discuss the abuse, staff can only treat the patient's injuries.	1	2	3	4	5	6	7
20. Victims of abuse have the right to make their own decisions about whether hospital staff can intervene.	1	2	3	4	5	6	7
21. It is not appropriate for medical and hospital staff to ask patients about domestic abuse.	1	2	3	4	5	6	7
22. Victims of abuse may have valid reasons for remaining in the abusive relationship.	1	2	3	4	5	6	7
23. Sometimes there are justifiable reasons for a woman being hit by her partner.	1	2	3	4	5	6	7
24. Abusers are not always responsible for their violent behavior.	1	2	3	4	5	6	7
25. I am capable of identifying victims of domestic abuse.	1	2	3	4	5	6	7

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
26. I can create an environment that builds trust, so that a patient can discuss domestic abuse with me.	1	2	3	4	5	6	7
27. I am able to gather the necessary information to identify domestic abuse as the underlying cause of patient injuries.	1	2	3	4	5	6	7
28. I am able to gather the necessary information to identify domestic abuse as the underlying cause of patient illnesses.	1	2	3	4	5	6	7
29. I have difficulty knowing how to respond when a patient insists that suspicious injuries are not the result of abuse.	1	2	3	4	5	6	7
30. I can make appropriate referrals within the hospital for victims of domestic abuse.	1	2	3	4	5	6	7
31. I can make appropriate referrals to services within the community for victims of domestic abuse.	1	2	3	4	5	6	7
32. I can tell if someone is an abuser.	1	2	3	4	5	6	7
33. Victims of abuse could leave the relationship if they wanted to.	1	2	3	4	5	6	7
34. Medical and hospital staff can identify most cases of domestic abuse without specific training.	1	2	3	4	5	6	7
35. The physical, emotional and economic costs of domestic abuse justify a stronger prevention effort.	1	2	3	4	5	6	7
36. I am aware of legal requirements in Minnesota regarding reporting of suspected cases of abuse.	1	2	3	4	5	6	7
37. I don't have the necessary skills to discuss abuse with a victim.	1	2	3	4	5	6	7
38. I review patients' charts to determine possible evidence of prior abuse.	1	2	3	4	5	6	7

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
39. I can provide support to victims of abuse.	1	2	3	4	5	6	7
40. I ask all female patients about problems in their relationships.	1	2	3	4	5	6	7
41. Pregnant women are less likely than non-pregnant women to be hit by their partners.	1	2	3	4	5	6	7
42. Victims of abuse are not responsible for the abuse they receive.	1	2	3	4	5	6	7
43. Medical and hospital staff may need to make repeated attempts to help patients acknowledge an abusive relationship.	1	2	3	4	5	6	7
44. I document in patients' charts their statements about how the injury occurred.	1	2	3	4	5	6	7
45. I comply with the AMA recommendations and Joint Commission standards that require inquiries about domestic abuse of all female patients.	1	2	3	4	5	6	7
46. I intend to provide support and appropriate referrals to any victims of domestic abuse that I encounter in my professional practice.	1	2	3	4	5	6	7
47. There are services within our own hospital for victims of domestic abuse.	1	2	3	4	5	6	7
48. There are services within the community for victims of domestic abuse.	1	2	3	4	5	6	7
49. I am concerned about getting involved in an abused patient's case because of the time it may require.	1	2	3	4	5	6	7
50. I feel comfortable discussing domestic abuse with my patients.	1	2	3	4	5	6	7
51. There are specific things that I can do to help a victim of domestic abuse.	1	2	3	4	5	6	7

Informed Consent--Medical and Hospital Staff
Evaluation of WomanKind: Support Systems for Battered Women

You are invited to participate in a research study of medical and hospital staff's knowledge, attitudes, beliefs, and behaviors regarding patients who are victims of domestic violence. We **hope to learn about training** needs among staff and ways that services for abused women can be improved in the hospital setting. You were selected as a possible participant in this research study because staff in your department are likely to see women whose medical histories and/or presenting injuries could be signs of abuse. The study is being conducted by the Centers for Disease Control and Prevention (CDC).

If you decide to participate, you will be asked to fill out the attached survey. The survey takes approximately 10 minutes to complete. The questions on the survey are about your personal views on domestic violence and the appropriate role of medical professionals. You may find some of the questions awkward or uncomfortable. **If you do not like a particular question, and** feel it is too personal or makes you uncomfortable, you do not have to answer that question. During the next year, you will be asked to fill out the survey two more times to see if your knowledge and opinions have changed during that time. You will be asked to provide a research firm, Macro International, with a name and address to which follow-up surveys can be mailed. Your name and address will not be shared with CDC or this hospital, and will be destroyed after the last questionnaire has been mailed. Your responses will never be reported to anyone by name. Any information that is obtained in connection with this research study and that can be identified with you will remain confidential during the study and will not be disclosed to anyone.

Your decision whether or not to participate will not prejudice your future relations with this hospital, your department, CDC, or any other organization and will involve no penalty or loss of benefits to which you would be otherwise entitled. If you have any questions, please contact Nicole Lezin at 404-321-321 1. You will be offered a copy of this form to keep. If you have any questions about your rights as a research study participant, you may contact the Institutional Research Committee at 612-863-5213.

You are making a decision whether or not to participate. Your signature indicates that you have read this information provided above and have decided to participate. You may withdraw at any time without prejudice after signing this form, should you choose to discontinue participation in this research study.

Signature _____ Date _____

Signature Of Investigator _____ Date _____

Appendix L

Abstraction Form for Review of Medical Records

Review of Medical Records

Presenting Problem (ENTER A NUMBER l-16)	

1=assault
2=contusion (bruise)
3=laceration
4=fracture
5=abrasion
6=sprain/strain
7=injury during pregnancy
8=complication during pregnancy
9=mental health issues (anxiety, depression, stress, crying spells, panic attack)
10=suicide ideation or attempt
11=migraines or headaches
12=dizziness, faintness
13=difficulty breathing
14=loss of consciousness
15=abdominal pain, stomach ache, gastroenteritis
16=chest pain
17=other (explain_____)

Presence of Domestic Abuse (ENTER A NUMBER l-6)	

1=DEFINITE
Reasons for DEFINITE diagnosis (check all that apply)

- ☐ patient admitted abuse
- 0 nurse of physician dx of abuse in chart
- ☐ police/EMS statement or documentation
- ☐ family member statement of abuse
- 0 other (explain_____)

2=SUSPICIOUS
Reasons for SUSPICIOUS diagnosis (at least 1 from group A and any from group B)

Group A

- ☐ multiple ER visits
- ☐ story is suspicious and/or doesn't match symptoms
- 0 multiple injuries (patient "seems" accident prone)
- 0 suspicious or unexplained injury during pregnancy
- ☐ doctor states he/she has suspicions
- 0 history of abuse (physical, sexual, etc)
- 0 troubles in personal relationship
- ☐ presents with husband, boyfriend, etc.
- ☐ patient is very upset, distracted, or anxious during exam

Group B

- 0 suicide ideation and/or attempt
- ☐ drug and/or alcohol use/abuse
- ☐ complication during pregnancy of unknown etiology
- ☐ other mental health issues (depression, anxiety, crying spells, panic attack)
- ☐ other (please state_____)

3=MENTAL HEALTH ISSUES (medical record only significant for mental health, no other indications of DV)

- 0 suicide ideation and/or attempt
- ☐ other mental health issues (depression, anxiety, crying spells, panic attack)

4=MIGRAINES/HEADACHES ONLY (medical record only significant for migraines/headaches)

5=SUBSTANCE ABUSE (medical record only significant for substance abuse, no other indications of DV)

6=INJURIES OR COMPLICATIONS OF UNKNOWN ETIOLOGY DURING PREGNANCY (medical record only significant for an injury or complication during pregnancy, no other indications of DV)

Documentation that physician asked/took a relevant social history (ENTER A NUMBER l-3) 1=Yes chart contains information about safety, home life, stress, personal relationships, substance abuse 2=No chart contains no information about patient social life OR only info about smoking, past medical history	1
Documentation that nurse or physician asked about or discussed DV with patient (ENTER A NUMBER l-2) l=yes 2=no	
Documentation of patient injuries, illness, or symptoms (ENTER A NUMBER l-3) l=Yes chart contains information about location of injuries, size, drawings, objects involved, etc. OR information about presenting illness or symptoms such as circumstances surrounding onset, duration, history, etc. 2=No chart contains no information about injuries	
CHART DOCUMENTATION that referral or follow-up plan was made (ENTER A NUMBER l-2) 1=yes 2=no 3=patient left AMA 4=patient admitted	
Type of referral or follow provided (ENTER A NUMBER 1-8, choose all that apply) REFERRALS/FOLLOW-UP 1=psych, social worker, counselor, or WomanKind program staff contacted 2=personal provider notified regarding patient 3=assisted patient in developing safety plan (family member contacted, etc) 4=police notified 5=gave patient number/address of outside agency or shelter 6=gave patient printed reading materials about domestic violence 7=patient told to contact personal provider 8=recommendations and/or support provided to patient but no follow-up/referral made by physician or hospital staff (e.g., “I told her she should leave, she said she would;” “I discussed DV with patient, provided support, but she declined assistance”) 9=no referral made	

Appendix M

Key References for WomanKind Instruments

Key References for WomanKind Instruments

Depression Measure:

Radloff, LS. *The CES-D scale: A self-report depression scale for research in the general population.* Applied Psychological Measurements. 1977; 1:385-40 1.

Physical Symptoms Index:

A

Miller, KI, Ellis, BH, Zook, E., & Lyles, JS. An integrated model of communication, stress and burnout in the workplace. *Communication Research.* 1990;17(3);300-326.

Self Esteem:

Wylie, RC. *The Self-Concept: A Review of Methodological Considerations and Measuring Instruments. 1974.* University of Nebraska Press.

Medical Staff Attitudes/Intervention:

Saunder, DG and P. Kindy. Predictors of Physicians' Responses to Woman Abuse: The Role of Gender, Background, and Brief Training. *Journal of General Internal Medicine.* 1993;8(24);606-609.

Sugg, NK and T. Inui. Primary Care Physicians' Response to Domestic Violence. *JAMA.* 1992;Vol. 267, No. 23; 3 157-3 160.

Tilen, VP et al. Factors that Influence Clinicians' Assessment and Management of Family Violence. *Am J Public Health.* 1994;84;628-633.

Jecker, NS. Privacy Beliefs and the Violent Family. *JAMA.*1993;269(6);776-780.

Bokunewicz, B. and LC Copel. Attitudes of Emergency Nurses Before and After a 60-minute Educational Presentation on Partner Abuse. *J Emergency Nursing.* 1992; 18(*1).*

Hamberger, LK; DG Saunders; M Hovey. *Prevalence of Domestic Violence in Community Practice and Rate of Physician Inquiry.* 1992. Fam Med;24:283-7.

Chez, N. Helping the Victim of Domestic Violence. *AJN. 1994.*

Appendix N

Client Intake Questionnaire, Client KABB Survey

Four-digit code: _ _ _ _

(Please write a number that is easy for the client to remember, such as the last four digits of her social security number.)

OMB Clearance Number 0920-0379
Expiration Date: 01/99

Public reporting burden for this collection of information is estimated to average 15 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, ATTN: PRA (0920-0379); Hubert H. Humphrey Bg., Rm 737-F, 200 Independence Ave., S.W.: Washington, D.C. 20201.

Client Intake Questionnaire

(to be administered in person by hospital staff)

"Now I will ask you some questions about your feelings and opinions. For each question I ask, please rate your responses on a scale from 1 to 7." Hand client the scale card. "Use this card to help you remember the scale. You see that 1 is 'strongly disagree,' 3 is 'disagree,' 5 is 'agree,' and 7 is 'strongly agree'. You can choose any number on this scale, not just the numbers 1, 3, 5, and 7. For example, if you agree somewhat, you can choose the number 6, or if you disagree somewhat, you can choose the number 2." Choose the number that is closest to how you really feel."

"Please be candid in your responses and try to record your first, instinctive answer. Don't try to think about what your answers "should" be. Your honest reactions to these statements will help us understand the types of problems you are experiencing."

"Thank you for taking the time to answer these questions."

Note to interviewer: If any questions do not apply (such as those about children), please check the "N/A" column.

Statement	Strongly Disagree		Disagree		Agree		Strongly Agree	N/A
1. I believe I can leave this relationship.	1	2	3	4	5	6	7	
2. My children are not aware of the violence in my relationship.	I	2	3	4	5	6	7	
3. I have nowhere to turn for help.	1	2	3	4	5	6	7	
4. It's usually my fault when my partner acts violents toward me.	1	2	3	4	5	6	7	
5. I believe I can change my partner for the better.	1	2	3	4	5	6	7	
6. I often feel lonely, isolated, hopeless.	1	2	3	4	5	6	7	
7. I do not think that my partner will injure me again.	1	2	3	4	5	6	7	

8. What is your current protection plan? (What can you do to protect yourself and feel safer?)

Four-digit code: ___ ___ ___ ___

(Please write a number that is easy for the client to remember, such as the last four digits of her social security number,)

OMB Clearance Number:0920-0379
Expiration Date:1/99

Public reporting burden for this collection of information is estimated to average 15 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to PHS Reports Clearance Officer, ATTN: PRA (0920-0379); Hubert H. Humphrey Bg., Rm 737-F, 200 Independence Ave., S.W.: Washington, D.C. 20201.

Client KABB Survey

Thank you for answering this survey. Your responses will help us understand how hospitals can help women in your situation. These surveys are tracked by number, not by name, so feel free to answer honestly.

Identifying information will be collected only to allow me to contact you to ask the same questions in three months and then again in six months. Lists associating names and ID codes will be maintained by WomanKind professional staff only until the study is complete. Only coded data that cannot be linked to you by name will be shared with CDC or their contractor, Macro. Data will be safeguarded in accordance with applicable Minnesota statutes. Your participation is voluntary, but your response will greatly assist us in evaluating the domestic violence program at this hospital.

First, I will ask you some questions about yourself and your living situation:

Age: ❑ *< 20* ❑ *30-34* cl 45-59
❑ *20-24* ❑ *35-39* cl *6--64*
❑ *25-29* ❑ *40-44* ❑ 65+

Race/Ethnicity: C l White/Caucasian ❑ African-American
❑ Asian/Pacific Islander ❑ Latin0
❑ Native American cl Other:

Relationship: ❑ Married Cl Divorced ❑ Separated

Living Situation: a Living with your partner a Living alone
a Living with another family member or friend

Number and ages of children at home:

Education (Highest Grade or Degree):

Professional Specialty/Occupation:

Client KABB Survey

"Now I will ask you some questions about your feelings and opinions. For each question I ask, please rate your responses on a scale from 1 to 7."

<u>If face-to-face interview, hand client scale card</u>. "Use this card to help you remember the scale. You see that 1 is 'strongly disagree,' 3 is 'disagree,' 5 is 'agree,' and 7 is 'strongly agree."'
<u>If phone interview</u>: "To help remember the scale, please get a piece of paper and a pencil." (Pause until client has paper and pencil.) " Now, write the numbers from 1 to 7 on the paper, and write the words 'Strongly Disagree' next to the number 1, 'Disagree' next to the number 3, 'Agree' next to the number 5, and 'Strongly Agree' next to the number 7."

"You can choose any number on this scale, not just the numbers 1, 3, 5, and 7. For example, if you agree somewhat, you can choose the number 6, or if you disagree somewhat, you can choose the number 2. Choose the number that is closest to how you really feel."

"Please be candid in your responses and try to record your first, instinctive answer. Don't try to think about what your answers "should" be. Your honest reactions to these statements will help us understand the types of problems you are experiencing."

"Thank you for taking the time to answer these questions."

Note to interviewer: If any questions do not apply (such as those about children), please check the "N/A" column.

Statement	Strongly Disagree		Disagree		Agree		Strongly Agree	N/A
1. I do not deserve to be abused.	1	2	3	4	5	6	7	
2. It's usually my fault when my partner acts violently toward me.	1	2	3	4	5	6	7	
3. If I could just avoid irritating my partner, he wouldn't hurt me.	1	2	3	4	5	6	7	
4. I can control the amount of violence I experience from my partner.	1	2	3	4	5	6	7	
5. My children are not aware of the violence in my relationship.	1		3	4	5	6	7	
6. My partner would never hurt the children.	1	2	3	4	5	6	7	
7. I feel I am alone in facing my partner's violence.	1	2	3	4	5	6	7	
8. In the past six months, I have mostly felt sad and blue.	1	2	3	4	5	6	7	
9. I cannot bring myself to change my situation in order to avoid the violence.	1	2	3	4	5	6	7	
10. I do not think that my partner will injure me again.	1	2	3	4	5	6	7	
11. There is no one who <u>really</u> understands my situation,	1	2	3	4	5	6	7	
12. I believe I can change my partner for the better.	1	2	3	4	5	6	7	
13. However much I might want to, there is no way I can leave this relationship.	1	2	3	4	5	6	7	
14. I have options to protect myself.	1	2	3	4	5	6	7	
15. I often feel lonely, isolated, hopeless.	1	2	3	4	5	6	7	

Statement	Strongly Disagree		Disagree		Agree		Strongly Agree	N/A
16. There is nothing I can do to avoid the violence I experience.	1	2	3	4	5	6	7	
17. I know at least one person or agency that can help me.	1	2	3	4	5	6	7	
18. I feel good about myself.	1	2	3	4	5	6	7	
19. No matter where I go, my partner will find me.	1	2	3	4	5	6	7	
20. In the past six months, I have mostly felt happy, content, relaxed.	1	2	3	4	5	6	7	
21. I believe I can leave this relationship.	1	2	3	4	5	6	7	
22. I have nowhere to turn for help.	1	2	3	4	5	6	7	
23. I have been sleeping well and I feel rested when I wake up.	1	2	3	4	5	6	7	
24. I believe there is support available for me.	1	2	3	4	5	6	7	
25. I believe that my partner will probably injure me again.	1	2	3	4	5	6	7	
26. I don't have much energy these days.	1	2	3	4	5	6	7	
27. I can tell when my partner is about to blow up.	1	2	3	4	5	6	7	
28. Nothing seems to give me pleasure anymore.	1	2	3	4	5	6	7	
29. Sometimes there are justifiable reasons for a woman being hit by her partner.	1	2	3	4	5	6	7	
30. Abusers are not always responsible for their violent behavior.	1	2	3	4	5	6	7	
31. Victims of abuse are not responsible for the abuse they receive.	1	2	3	4	5	6	7	

32. What is the worst thing you think might happen to you in the near future? What do you worry about the most?

33. What changes, if any, would you like to make in your life?

a. Attend counseling.
b. Reduce number of arguments.
c. Reduce physical violence within the relationship.
d. Reduce the verbal abuse within with relationship.
e. Leave the relationship.
f. Get help for my kids.
g. Feel safe.

34. What is your current protection plan? (What can you do to protect yourself and feel safer?)

WOMANKIND VOLUNTEER PROCEDURE FOR THE CRC STUDY:

For all emergency department calls volunteers need to follow the procedure stated below:

1. Volunteer picks up survey questions from the WomanKind drawer in the emergency department.

2. Volunteer obtains information on the patient from the nurse and/or doctor.

3. Volunteer provides general support and concern for the patient but does not discuss abuse or the situation which has brought the patient to the emergency dept. until steps three through six have been completed. NOTE EXCEPTION STATED BELOW.

4. Volunteer explains the eight questions -- see survey script. Note - it would be preferable to be familiar with this script so that you do not have to read the script.

5. Volunteer has patient read and sign the consent form.

6. Volunteer reads the eight questions to the patient and records her response.

7. Volunteer proceeds with advocacy services.

8. Volunteer leaves completed survey in file provided (WomanKind drawer) the same day that patient is seen.

EXCEPTION: If patient is in extreme crisis or in emotional distress that needs immediate advocacy, do not attempt to gather the CDC survey information. We depend on your judgement to implement this survey.

CENTER FOR DISEASE CONTROL
WOMANKIND VOLUNTEER SURVEY SCRIPT

I understand that it has been a difficult day/night for you and I want you to know that the reason I am here, is to help you look at options to take care of yourself.

In order to better meet the needs of victims of domestic abuse we are asking all of our clients to respond to eight questions. We would like you to participate but always remember this is voluntary.

Here is the consent form I would like for you to read and sign if you are comfortable with answering these questions.

Informed Consent--Patients_,
Evaluation of WomanKind: Support Systems for Battered Women

You are invited to participate in a research study of the kinds of problems experienced by women who are in abusive relationships. The study is being conducted by the Centers for Disease Control and Prevention (CDC). We hope to learn more about ways to improve services for abused women who come to hospitals for treatment. You were selected as a possible participant in this research study because the Emergency Department staff believe that your partner may have hurt you.

If you decide to participate, you will be asked to answer eight questions. The survey takes approximately 10 minutes to complete. The questions on the survey are about your feelings about the abuse you have experienced in your relationship. You may find some of the questions painful or uncomfortable. If you do not like a particular question, and feel it is too personal or makes you uncomfortable, you do not have to answer that question. During the next year, you will be asked a longer set of questions three more times to see if your situation has changed during that time. You will be asked to provide a hospital social worker with a number or address where it would be safe to get in touch with you. Your responses will never be reported to anyone by name. Any information that is obtained in connection with this research study and that can be identified with you will remain confidential during the study and will not be disclosed to anyone.

Your decision whether or not to participate will not affect your ability to get services in this hospital or anywhere else. If you choose not to participate, there is no penalty or loss of benefits to which you would be otherwise entitled.

If you have any questions, please contact Nicole Lezin at 404-321-321 1. You will be offered a copy of this form to keep. If you have any questions about your rights as a research study participant, you may contact the Institutional Research Committee at 612-863-5213.

You are making a decision whether or not to participate. Your signature indicates that you have read this information provided above and have decided to participate. You may withdraw at any time without prejudice after signing this form, should you choose to discontinue participation in this research study.

Signature Date

Signature of Investigator Date

Appendix 0

Facilitator Guide and Consent Forms for interviews with WomanKind Program Staff

Interviews with WomanKind Staff

Facilitator Guide

Introduction

(Introduce self and other Macro or CDC staffpresent). Thank you for taking the time to talk with us today. As you know, we are in the final phase of the evaluation of the WomanKind Program and wanted one more opportunity to hear from you about the program. We will be talking with each WomanKind staff member individually while we are here because we are interested in your perspectives about how the program works and any ideas you may have about how others could implement such a program. This interview will take about 30 minutes and while I have some specific questions to ask you, I encourage you to share with me anything that you think is important about WomanKind as we talk. Before we begin, I'd like to review a consent form with you and have you sign it to indicate that you agree to participate in the interview.

Interview Questions

Please describe your role in WomanKind. Be specific about your responsibilities in these areas:

Administration
Interacting with the medical staff of the hospital
Managing the volunteer advocates
Interacting with clients

What do you see as the major accomplishments of WomanKind?

What makes WomanKind successful?

What, if anything, prohibits WomanKind from being more successful?

If you were teaching another hospital to implement WomanKind, what would you tell them?

Closure

Thank you again for your time and your thoughtfulness in responding to our questions.

Informed Consent -- WomanKind Staff

Evaluation of WomanKind: Support Systems for Battered Women

Thank you for participating in this research study being conducted by the Centers for Disease Control and Prevention (CDC). During the past year, we have asked you to help with the research in a number of ways such as providing us with information about the trainging you conduct with your volunteer advocates.

We now would like to interview you to gain more information about your perspective on the WomanKind Program and how it works. We will be conducting an interview with each staff member of WomanKind for this purpose.

Your name will not be used in any reports about and no quotes will be attributed to you. No one at this hospital or in the WomanKind program will receive any information about individual responses we receive during the interviews.

Participation in this group discussion is completely voluntary. You may choose to leave the group at any time for any reason.

Your signature below indicates that you understand the above and agree to participate in the interview.

Signature _____

Witness _____

Date _____

Appendix P

WomanKind Policies

This policy is used at:

Fairview Southdale Hospital	[x]
Fairview Ridges Hospital	[x]
Riverside Medical Center	[x]

PURPOSE:
To provide guidelines in the identification and referral to WomanKind of suspected physical, emotional and sexual abuse and/or violence of adult women by current or former intimate partners.

POLICY:

I. INTRODUCTION

Domestic abuse and violence is increasingly recognized as a widespread community health problem which the health care system must address. Statistics indicate that a significant number of battered women who go to a hospital or medical office are not currently being identified as victims of abuse, nor are they receiving help in the form of advocacy services or resource referral.

WomanKind is based on the premise that health professionals often intervene at a point where domestic abuse can be identified, support and education can be given, and the victim of abuse can learn of possible options and the community services available. WomanKind provides a supportive connection between the battered woman in the health care setting and the resources available in the community to help her and her family,

II. LEGAL REQUIREMENTS

The JCAHO requirements relating to Domestic Abuse must be followed. Refer to the following standards from the JCAHO 1996 Standards for Victims of Domestic Abuse:

Joint Commission on Accreditation of Healthcare Organizations 1996 Standards - Victims of Domestic Abuse

JCAHO Standards -Assessment of Patients

Standard PE. 5 Criteria are used to identify possible victims of abuse or neglect.

Standard PE5.1 Victims of alleged or suspected abuse or neglect are assessed with the consent of the patient, parent or legal guardian, or as otherwise provided by law.

Standard PE5.2 The organization collects, retains, and safeguards evidentiary material released by the patient.

Standard PE5.3 Notification and release of information are provided to the proper authorities as required by law.

Standard PE5.4 Victims of abuse are referred to private or public agencies that provide or arrange for the evaluation and care.

JCAHO Standards - Management of Human Resources

Standard HR.1 Leaders of functional areas define qualifications and job expectations for their staff, and establish a system for evaluat ing job performance.

Orienting, Training and Educating Staff

Standard HR.4 New staff orientation provides initial job training and information and assesses the staffs ability to perform job responsibilities.

Standard HR.4.1 Ongoing in-service and other education and training maintain and improve staff competence.

JCAHO Standards - Continuum of Care

Standard CC.1 Patients have access to the appropriate type of care.

Standard CC.5 Care is coordinated among health care professionals and settings.

Few states have explicit mandatory reporting laws for domestic abuse, and it is not clear that mandatory reporting would best ensure the safety of competent adult victims or connect them with needed resources.

In State of Minnesota: The only circumstances under which law enforcement must be contacted concerning domestic abuse is in circumstances where a weapon has been used to inflict the injury, specifically a knife or gun.

The following cases are REPORTABLE to the Police Department:

1. Injuries caused by firearms.
2. Knife wounds inflicted by another person or occurring under suspicious circumstances .
3. Sexual assault if the patient signs a waiver. (See sexual assault protocol.)

III. WOMANKIND SERVICES

1. WomanKind provides case management/advocacy services, crisis intervention and ongoing assistance to victims of domestic abuse who suffer from physical, emotional or sexual abuse by a current or former husband or partner. Services are especially important for women with a past history of abuse as many continue to struggle with the effects of that abuse and (with the patient's consent) should be referred to WomanKind for ongoing support and services.

2. WomanKind provides education and consultation with hospital and community health professionals in order to enable these health care professionals to more readily identify and treat abused women who come to them for care.

   The WomanKind Educational Program is designed to increase the awareness of hospital, medical office, and other health professionals to this under recognized problem, as well as to instruct them on how to effectively utilize the WomanKind program services.

   WomanKind services are available 24 hours a day, 7 days a week. If you are in need of a WomanKind staff or volunteer advocate, call the WomanKind office at Fairview Southdale Hospital: 924-5775, at Fairview Ridges Hospital: 892-2500 and at Fairview Riverside Medical Center: 672-2700.

   If you reach voice mail, you will receive instructions to contact the WomanKind answering service at 924-8200 and they will page a WomanKind advocate. The WomanKind staff advocates are available during the day, and the volunteer advocate are available after hours. There is always a WomanKind staff person on back-up to the volunteer on call.

IV. DEFINITIONS

<u>ABUSE</u>

The use of or the threat to use physical, emotional, sexual, psychological and/or economic behaviors by a current or former intimate partner in order to gain or maintain control in the relationship.

DOMESTIC ABUSE

Domestic abuse and violence is an ongoing, debilitating experience of physical, emotional, psychological, and/or sexual abuse in the home, associated with increased isolation from the outside world and limited personal freedom and accessibility to resources.

PHYSICAL ABUSE

Physical abuse is usually recurrent and escalates in both frequency and severity. It includes any forceful, physical behavior.

It may include the following:

1. Pushing, slapping, hitting, pushing, shoving, biting, punching, kicking or choking.
2. Assault with a weapon
3. Holding, tying down, or restraining her
4. Leaving her in a dangerous place
5. Refusing to obtain medical help when she is sick or injured

EMOTIONAL/PSYCHOLOGICAL ABUSE

Emotional Abuse

Emotional abuse may precede or accompany physical violence as a means of controlling the victim verbally through fear, humiliation and degradation,

Psychological Abuse

This form of abuse that exists when there is the threat of violence and/or when there has been at least one act of physical or sexual abuse against the partner. The victim of abuse now feels fearful because she never knows when the violence will occur again.

The purpose of the emotional/psychological abuse is to render the partner, fearful, emotionally helpless, and insecure about her own self worth or ability to escape further abuse. Emotional and psychological abuse can have long term debilitating effects. The victim of this abuse becomes increasingly isolated, eventually losing a sense of herself and her identity.

Emotional and psychological abuse may include, but are not limited to, the following:

1. Threats of harm
2. Physical and social isolation
3. Extreme jealously and possessiveness
4. Intimidation
5. Degradation and humiliation
6. Calling her names and constantly criticizing, insulting and belittling her.
7. False accusations, and blaming her for everything
8. Ignoring, dismissing, or ridiculing her needs
9. Lying, breaking promises, and destroying trust
10. Driving fact and recklessly to frighten and intimidate her

Sexual Abuse

Sexual abuse in violent relationships is often the most difficult aspect of abuse for women to discuss. It may include any form of forced sex or sexual degradation, such as:

1. Any non-consenting sexual act
2. Forcing her into sexual behaviors when she is particularly vulnerable: when she is not fully conscious, is not asked, is afraid to say no, is sleeping, drugged, or intoxicated.
3. Trying to make her perform sexual acts against her will.
4. Hurting her physically during sex or assaulting her genitals, including the use of objects or weapons intravaginally orally or anally.
5. Criticizing her and calling her sexually degrading names.
6. Treating her like a sex object.

Developed by: Susan M. Hadley
Development Date:
Distribution: Patient Care Manual
Ref. #: Rev. 10/96

Note: This policy reflects language written for clients in a heterosexual relationship. Statistically, 90-95 % of abuse perpetrated in this population is from male abuser to female victim. It should also be understood that abuse and violence exists in homosexual relationships. WomanKind provides services for all victims of domestic abuse, male or female, gay or straight.

Adapted from the WomanKind Domestic Violence Protocol: Identification and Intervention Through the Health Care System, 1987, Revised 1994.

Adapted from the AMA Diagnostic and Treatment Guidelines on Domestic Abuse and Violence, Chicago, Illinois, March, 1992.

Copyright: S.M. Hadley, WomanKind, FH System, 1997.

DATA BASE PART II

Medical Diagnosis/Case Type _____

Significant History/Surgery/Information _____

_____ Procedure/dates ___

Have you had any recent exposure to communicable/infectious diseases?
☐ yes ☐ no explain: _____
Do you have any chronic infections ? ☐ no ☐ yes Explain: _____

Immunizations current? ☐ yes ☐ no/unknown ☐ Information Sheet given

Self Care Ability ☐ I = independent ☐ D = dependent/needs help
Assistive devices/equipment needed _____

History of falls? _____

Patient Information
Family aware of hospitalization/illness? ☐ yes ☐ no
Next of Kin
Name _____ Relationship _____
Phone (H) _____ (W) _____
Person to release information about your(pt) condition if other than next of kin?
Name _____ Relationship _____
Phone Number (H) _____ (W) _____
Name _____ Relationship _____
Phone Number (H) _____ (W) _____
Cultural or Religious preferences _____
Occupation _____

COMMENTS:

Date

INTER DISCIPLINARY DISCHARGE PLAN
With whom do you live? _____
Who can help you after discharge? _____
What Community Resources are you currently using?

Return to ☐ house ☐ apartment ☐ other _____
Do you have any concerns about any of the following:
☐ none ☐ finances ☐ transportation ☐ home help ☐ stairs
☐ living arrangements ☐ medications ☐ meals
☐ child/dependent care
☐ equipment _____ ☐
other _____

ONGOING DISCHARGE PLAN
Has the patients self care ability changed and how? _____

Referrals made to:
☐ Care Coordinator _____ ☐ Social Worker _____
☐ Chaplain ☐ Home Care ☐ Other _____ ☐
Discharge Rounds/Plan _____

Teaching/Educational: Verbalizes understanding/asks questions regarding: ☐ therapy ☐ disease ☐ hospitalization ☐ procedure
See : ☐ Progress Record ☐ Education Record ☐ Clinical pathway for documentation of patient teaching

ADL belongings Check if present on admission
☐ glasses
☐ dentures upper/lower
☐ Hearing aids 1 or 2
☐ walking aids _____
☐ other _____
Any medications brought into hospital?
☐ yes ☐ no
Disposition: _____
☐
Allergy band applied

Start Date	Clinical Pathway/Nsg Diagnosis Std/Collaborative Std	Stop Date

☐ Is Side 2 completed?

Date

Risk Assessment and Plan
RN's (or identifies professional's) assessment of patient's risk for potential of dangerous behavior: _____

If risk factors are assessed to be present, recommendations for prevention strategies, alternatives, treatment plan interventions arc:

Date

Abuse Prcvcntion Plan
VULNERABLE ADULT/CHILD ABUSE/DOMESTIC ABUSE ASSESSMENT

Abuse and violence: are you now or have you ever been in a relationship where you have been abused physically, emotionally or sexually?
☐ no ☐ yes - refer to social worker
☐ If domestic abuse or violence - refer to WomanKind
☐ patient refixed referral

Is there any reasonable cause to believe the patient has been abused, assaulted or is self - abusive?
☐ no ☐ yes - refer to social worker
☐ If domestic abuse or violence - refer to WomanKind

Is there reasonable cause to believe the patient's person, property of finances have been neglected, self-neglected, or exploited?
☐ no ☐ yes - refer to social worker

Is the patient displaying signs of mental health issues, mental retardation or chemical dependency?
☐ no ☐ yes
If yes:
1. ☐ Implement " Potential for injury" or other appropriate nursing diagnosis standard.
2. Cl Refer to social worker.
3. ☐ If domestic abuse or violence, refer to WomanKind.

FOR MINORS: **If the child has sustained injury, is the story given by parents, guardians, or caregivers consistent with the injury?**
☐ yes ☐ no - refer to social worker

Does the child appear to receive necessary food, clothing, shelter, education, medical care or other care required for his/her physical or mental health? ☐ yes ☐ no - refer to social worker

Date

PATIENT RIGHTS - All patients.

Patient received the Bill of Rights?
☐ yes ☐ no

Minors and adult patients who never were competent (mentally retarded, etc.) STOP HERE.

Continue for all other patients.

Patient received the Patient Self-Determination Act information?
Cl Yes

"Do you have a living will, durable power of attorney for health, mental health advance directive, or guardianship or conservatorship?'
☐ yes ☐ no

☐ Living Will
☐ Durable Power of Attomcy
☐ Mental Health Advance Directive
☐ Guardianship
☐ Conservatorship
If yes, obtain a copy or indicate how it will be obtained: _____

If no "Do you want further information?'
☐ yes •I No
If yes contact:
☐ Social Worker
☐ Chaplain
☐ Nursing Supervisor

COMMENTS:

Signature | Signature | Signature

Signature | Signature | Signature

DEPARTMENT: WOMANKIND

SUBJECT: Scope of Service

Policy Applies At:
Fairview Southdale [x]
Fairview Ridges [x]
Fairview -University Medical Center [x]

DISTRIBUTION: Department Policy Manual

JCAHO FUNCTIONAL AREA: PE

PURPOSE

To provide guidelines to health care professionals for the assessment, identification and referral of individuals who are or have been emotionally, physically, or sexually abused by a current or previous partner. The WomanKind Department provides client services to patients, Fair-view employees, and to people in the community of any age or sex, who have a history of or are currently a victim of domestic abuse. WomanKind staff also provide education to health care professionals pertaining to the dynamics of abuse and the assessment, identification,intervention, and documentation regarding victims of domestic abuse.

POLICY

1. WomanKind services are available to all patients, employees, volunteers, and members of the community who are or have been a victim of domestic abuse. These services are provided to abuse victims for no charge. WomanKind Services are provided through the following methods:
   a. Direct Services: WomanKind services may be provided directly to the client (i.e., patient, Fair-view employee, and people of the community).
   b. Group Work: Facilitate a domestic abuse women's group to provide education, support and advocacy for WomanKind clients.
   c. Consultation: Consultation with health care professional to provide an understanding of factors pertaining to domestic abuse which may affect the client's process.
   d. Community Work; Collaborate with community agencies to meet the needs of domestic abuse victims and to address the issues of domestic abuse within the community.

2. Documentation
   a. WomanKind activity is documented in the patient's medical chart.
   b. Patient's medical chart should contain the following information, which is documented by physician, nursing staff and/or other health care professionals working with a person who is suspected to have been abused:
      (1) presenting complaint of domestic abuse and description of abusive behavior, using patient's words rather than a generalized assessment, "my partner hit me with a closed fist to my jaw, one time". is preferable to "patient has been abused."
      (2) complete medical history

(3) relevant social history
(4) a detailed description of the injuries, including type, number, size, location, resolution, possible causes and explanations given. When applicable, the location and nature of the injuries should be recorded on a body chart or drawing.
(5) a professional opinion on whether the injuries were adequately explained
(6) results of all laboratory and other diagnostic procedures
(7) if the police are involved, the name of the police officer and any actions taken by the police
(8) imaging studies and photographs. Photographs, when applicable, should use the following procedures:
    (a) Physician-nurse or WomanKind advocate should ask for permission to take photographs.
    (b) Use Polaroid camera with color film.
    (c) Taken prior to medical treatment, when possible.
    (d) Use lighting which will maximize visibility of injury in the photo.
    (e) Hold up an object (i.e., coin, ruler) to illustrate the size of injury.
    (f) Take two pictures of every visible injury.
    (g) Include the patient's face in at least one photograph.
    (h) Write patient's name and date on paper and include in every photograph.
    (i) Mark each photograph with date, patient's name, initials of photographer and location of injury.
    (j) Photographs are mounted on the chart page and made part of the patient's medical record.
    (k) Consent form should be kept near the photographs in the patient's chart.

3. WomanKind staff hours are Monday through Friday, 7:00 a.m. to 7:00 p.m., and as back-up to the volunteers. WomanKind staff provides domestic abuse services to patients on the floors and volunteers provide domestic abuse crisis advocacy in the emergency department and by telephone. The WomanKind volunteers hours are Monday through Sunday, 7:00 p.m. to 7:00 a.m.; and Saturday, Sunday and holidays 7:00 a.m. to 7:00 p.m.

4. The core functions of the WomanKind Department are:
    a. Domestic Abuse Assessment. Identification and Intervention: Gathers information about current and past abuse client has experienced as a child and as an adult; assessing and analyzing how abuse is/has affected the client. Works with client to prioritize and establish a plan of action to address the issue of domestic abuse.
    b. Information and Referral; Provide domestic abuse referrals of hospital and community resources. May facilitate the referral procedure.
    c. Discharge Planning Work with client to establish a safety plan. When needed, facilitate locating a shelter for the client.

d. Education: Educate the client/family on the issue @domestic abuse. Educate health care professionals on the dynamics of domestic abuse, assessment, identification and intervention through the means of workshops, written materials, staff meetings and individual case discussions.

e. Interdisciplinary Team Collaboration: Interact with various disciplines and community resources.

f. Counseline and Advocacy: Provide short term counseling to clients regarding the issue of domestic abuse. Advocate for the client regarding domestic abuse issues.

g. Crisis Intervention; Provide crisis advocacy and safety planning around domestic abuse.

h. Volunteers: Provide education, support and supervision of WomanKind volunteers who provide crisis advocacy on-call and facilitate women's abuse group.

PROCEDURE

1. Referrals from hospital staff, community professionals, patients, Fair-view employees, volunteers, families, members of the community and community agencies.

2. Patients/clients may also be seen to assess for domestic abuse, when abuse is suspected.

3. WomanKind staff participates in various team meetings throughout the hospital.

4. Referrals may be made to the WomanKind office. After hours and crisis or imrnediate need referrals may be made through the hospital's answering service (924-8200).

5. When a referral is received the WomanKind staff will provide support and assessment regarding the issue of domestic abuse. This may include contacts with the family, data from the chart, patient care staff, and community resources (family and community contacts require WomanKind to obtain a release of information from the client). After this initial assessment is completed, WomanKind staff will document the following information in the patient's medical chart, specifically as related to abuse: data, assessment, proposed plan and referral resources.

6. WomanKind staff will continue to be available to the client through the means of follow-up calls placed by WomanKind staff or repeat calls from the client to the WomanKind office.

SIGNATURES:
[X] Administration Dorothy M Jury
[X] Department Manager Sherrie A Eisele
[] Medical Director/Chair
[.] Chief of Staff

Developed: 7/94 Reviewed:

Revised: 6/97

z:\user\mgilles\hospolb.001

DEPARTMENT: WOMANKIND

POLICY NO.

Policy Applies At:

FAIRVIEW SOUTHDALE [X]
FAIRVIEW RIDGES [X]
FAIRVIEW RIVERSIDE [X]

SUBJECT: DEFINITIONS AND PHILOSOPHY OF DOMESTIC ABUSE AND VIOLENCE

DISTRIBUTION: Administration, Emergency Department, All Hospital Departments and Nursing Units, Clinics, Medical Offices

PURPOSE: To provide a working definition of domestic abuse and philosophy of the WomanKind Department relating to domestic abuse and violence

POLICY: The following definitions'and philosphy of domestic abuse and violence are understood and followed by the WomanKind Department.

--the use of--or threat to use--a variety of abusive behaviors (including physical, psychological, sexual or economic) within an intimate relationship to gain or maintain control over another person.

--an ongoing, debilitating experience of physical, psychological and/or sexual abuse in the home, associated with increased isolation from the outside world and limited personal freedom and accessibility to resources.

--characterized as a pattern of coercive behaviors that may include physical, sexual, economic, emotionaland/or psychological abuse of one family member by another; include progressive social isolation, deprivation, and intimidation.

--perpetrated by someone who is or was involved in an intimate relationship with the victim; abuse or violence perpetrated by current or former intimate partner of the victim.

--victim's independence compromised by abuser's need to dominate and control; to restrict access to food, clothing, money, friends, family, transportation, health care, social services or employment.

PHILOSOPHY

Domestic abuse and violence affects people in every racial, ethnic, and socioeconomic group and includes people of all ages who currently live together, have lived together or who have had an intimate relationship.

Domestic violence is recurrent and often escalates in severity and frequency over time and can have serious health and psychological. ramifications.

Perpetrators of domestic violence have a goal--to establish power and control over their partners and/or other family members. The victim's independence compromised by abuser's need to dominate and control; to restrict access to food, clothing, money, friends, family, transportation, health care, social services or employment.

In working with battered women it is important to recognize that battering is a crime. . . A victim is never responsible for the batterer's violence. No one has a right to threaten or hurt another person.

The goal for intervention is to empower women with information, resources and support. The decision to call the police, to pursue legal action, or to take any immediate or long-term action should rest with the battered woman alone.

Despite the criminal nature of domestic violence, there is not a mandate to report as there is in the case of child or elder abuse. Unlike children, battered women are independent and fully capable of making decisions that best meet their needs.

In the State of Minnesota: The only circumstances under which law enforcement must be contacted concerning domestic abuse and violence is in circumstances where a weapon has been used to inflict injury, specifically a knife or gun.

The following cases are REPORTABLE to law enforcement:

1. Injuries caused by firearms
2. Knife wounds inflicted by another person or occurring under suspicious circumstances
3. Sexual assault if the patient signs waiver in the Emergency Department (See E.D. Sexual Assault Protocol)

SIGNATURES:

[X] Administration
[X] Department Manager
[ ] Medical Director/Staff
[ ] Chief of Staff

DEVELOPED: 1993
REVISED:

REVIEWED: 9-94

DEPARTMENT: WOMANKIND

POLICY NO,
PAGE 1 OF 4

Policy Applies At:

FAIRVIEW SOUTHDALE [X]
FAIRVIEW RIDGES [X]
FAIRVIEURIVERBIDE [X]

SUBJECT: PROTOCOL FOR ASSESSMENT, IDENTIFICATION AND REFERRAL OF VICTIMS OF DOMESTIC ABUSE

DISTRIBUTION: Emergency Department Policy Manual, WomanKind Department Policy Manual, Hospital Policy Manual

PURPOSE: To provide guidelines for the assessment, identification and referral of victims of domestic abuse to WomanKind.

Note: Refer to policy - Abuse and Violence: Domestic

POLICY: Hospital and Emergency Department Staff will identify and refer potential victims of domestic abuse and violence to WomanKind.

INTRODUCTION

Emergency Department

The emergency department is the point of entry into a hospital system for many victims of domestic abuse and violence. Domestic abuse victims come to the emergency department in a state of pain, fear, confusion and despair.

The battered woman will frequently present with:

1. trauma (following an assault, either physical or sexual)
2. mental health issues (anxiety, depression, panic attacks, suicide attempts)
3. in-jury or anxiety and depression during pregnancy.

Health **Care System**

While the emergency department is the point of entry into the hospital for many victims, patients who are currently or formerly abused may access the health care system at any point, inpatient and outpatient setting.

Universal Screening

Utilizing routine assessment, it is important for all health professionals in the hospital, urgent care, clinic, medical office, and home health care setting to assess each patient for domestic abuse and violence.

PROCEDURE

1. If her partner brought her to the hospital, INTERVIEW PATIENT PRIVATELY AND MAINTAIN A SEPARATION (say you need to take an x-ray, do medical procedure and the partner can wait in the lobby). She is afraid of and controlled by her abuser and will not, cannot talk with the partner present.

2. ASK THE QUESTIONS DIRECTLY AND SENSITIVELY

   "Did someone hurt you?
   "Did you receive these injuries from being hit?"

   Battered women have said they never talked about the abuse because no one ever asked the questions. Most women are relieved to talk about the living situation if they sense a supportive, nonjudgmental environment with no coercion for change.

3. Contact HOSPITAL COMMUNICATIONS DEPARTMENT
   The WomanKind Answering Service will page WOMANKIND immediately when you have identified the woman as a victim of domestic abuse. A WomanKind Staff Advocate will respond during the day. A WomanKind Volunteer Advocate will respond after hours. There is always a back-up staff person available to the on-call volunteer advocate for assistance and consultation.

   The advocate will then come to the hospital within 30 minutes to be with the woman. She will remain with the woman, provide support, information, community referrals (if appropriate), and will facilitate the completion of the domestic abuse protocol.

   The WomanKind Staff Advocate will follow-up with the patient during the next business day and will continue ongoing contact until the patient is ready to take that next step.

   NOTE: Refer to policy - Advocacy and Case Management Services for Victims of Domestic Abuse and Violence

4. PHOTOGRAPHS should be taken in order to document visible injuries on all patients. The photographs should be signed or initialed and dated by the photographer, The photos should be attached to a separate page and, with the emergency department papers, made a part of the patient's permanent medical record. The consent to photograph form (if signed separately from the consent for treatment) should be kept near the photographs in the patient's record, The photographs can only be released to the police or the prosecutor with the patient's permission.

   This documentation could be useful to obtain an Order for Protection, to file a police report or press criminal charges and/or can be used at a later date to substantiate previous abuse and/or violence.

NOTE: Refer to policy - Photographing Injuries of Victims of Domestic Abuse and Violence

5. Always carefully DOCUMENT IN THE MEDICAL RECORD

   1. physical findings
   2. patient's history
   3. patient's statements
   4. photographs

NOTE: Refer to policy - Documentation in the Medical Record of Potential Cases of Domestic Abuse and Violence

6. The WomanKind advocate will ask her if she would like to file a POLICE REPORT. If she gives her consent, the WomanKind advocate will contact the police in the community where the assault took place, and the police may then come to the hospital. Filing a report is the basis for pressing charges, but does not mean that either the police will press charges or that she must press charges. It is important for her to file the report as a means of documenting the incident.

7. The WomanKind advocate will ask if she has a SAFE PLACE to go. If she does not want to return home the advocate will find safe housing. If she chooses to return home at this time, the WomanKind advocate will help her create a PROTECTION PLAN.

8. If she DOES NOT ACKNOWLEDGE THE ABUSE and gives a questionable explanation of her injuries, tell her "that you are concerned for her and fear that someone will hurt her, because it would be difficult to sustain these injuries based on her explanation."

9. If she still denies partner abuse, give her the WomanKind brochure IF IT IS SAFE TO DO SO and the appropriate hospital telephone number and say to her, "I would like you to have this just in case you, or sbmeone you know, might need it sometime in the future." This will let her know you are sensitive to her situation and that someone does indeed care.

REMEMBER: -- .

1. She believes that she is responsible for the abuse. Let her know that the person exhibiting the behavior is the person responsible for that behavior.

   She is not responsible for the abuse. She did not provoke it. She did not cause it. NO ONE DESERVES TO BE ABUSED.

2. ACCEPT HER WHERE SHE IS . ..She may not want to call the police, go to a shelter, or do any of the things YOU believe SHE should do.

She is in her own process on her own timetable. You can help her most by providing a safe and supportive environment, Listen to her, believe her, offer support, acknowledge her situation, validate her experiences, and if appropriate, offer resources.

3. The battered woman may be reluctant to have an advocate come to the hospital in the middle of the night. "I don't want to wake or both anyone." Let her know that the WomanKind is available to help her 24-hours-a-day, 7-days-a-week. An advocate is on-call and will come to the hospital within 30 minutes at any time and talk with her.

4. ACCEPT and RESPECT -
PATIENT'S TIMETABLE, PROCESS, AND DECISIONS.

SIGNATURES:

[] Administration _____
[ ] Department Manager _____
[ ] Medical Director/Staff _____
[ ] Chief of Staff _____

DEVELOPED: 1992
REVISED: 1994
1995

REVIEWED: _____
_____

Flitcraft A, Hadley S, Hendricks-Matthews M, McLeer S, Warshaw C. *Diagnostic and Treatment Guidelines on Domestic Abuse,* American Medical Aeaociation, Chicago, Illinois, March 1992.

Hadley, S.M., Working with Battered Women in the Emergency Department: A Xodel Program, Journal of *Emergency Nursing,* Vol. 18, No. 1, p. 18-23, February 1992.

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DEPARTMENT: WOMANKIND

POLICY NO.

Policy Applies At:

FAIRVIEW SOUTHDALE [X]
FAIRVIEW RIDGES [X]
FAIRVIEW RIVERSIDE [X]

SUBJECT: CASE MANAGEMENT/ADVOCACY SERVICES FOR VICTIMS OF DOMESTIC ABUSE AND VIOLENCE

DISTRIBUTION: Hospital Policy Manual, Emergency Department Policy Manual, WomanKind Department Policy Manual

PURPOSE: To provide guidelines on the provision and structure of advocacy and case management services for victims of domestic abuse and violence as provided by the WomanKind Department

POLICY: Advocacy and case management services for victims of domestic abuse and violence will be provided on-site by the WomanKind Department, 24-hours-a-day, 7-days-a-week.

CASE MANAGEMENT/ADVOCACY SERVICES PROVIDED BY WOMANKIND STAFF

PHASE I: Crisis Intervention, Assessment and Evaluation

1. Assessment of presenting issues
2. Evaluation of domestic abuse issues
3. Evaluation of immediate safety issues
4. Evaluation for presence of old/new injuries.
5. Identification of mental health issues, chemical dependency issues and suicidal ideation.

PHASE II: Education and Information

1. Provide support, listen, affirm, and validate
2. Explore dynamics, myths, and realities of domestic abuse.
3. Explore and discuss short- and long-term effects of abuse
4. Discuss the impact on and effects of abuse on children

PHASE III: Action and Protection Plan, Resource Referral

1. Discuss and prioritize possible options and available resources
2. Develop action plan, protection plan and follow-up contacts
3. Provide information to allied health professionals, as appropriate

ADVOCACY SERVICES PROVIDED BY WOMANKIND VOLUNTEERS

1. Establish initial connection with victim of domestic abuse in the Emergency Department
2. Provide support, listen, affirm and validate
3. Explore options and resources as appropriate
4. Communicate with WomanKind staff who will continue ongoing contact with the victim.

SIGNATURES:

[ ] Administration _____
[ ] Department Manager _____
[ ] Medical Director/Staff _____
[ ] Chief of Staff _____

DEVELOPED: 1 9 9 3
REVISED: 1994
1995

REVIEWED: _____
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DEPARTMENT: WOMANKIND

POLICY NO.
PAGE 1 OF 2

Policy Applies At:

FAIRVIEWSOUTBDALE [X]
FAIRVIEW RIDGES [X]
FAIRVIEWRIVERSIDE [X]

SUBJECT: PHOTOGRAPHING INJURIES OF VICTIMS OF DOMESTIC ABUSE AND VIOLENCE

DISTRIBUTION: WomanKind Department Policy Manual, Emergency Department Policy Manual, Hospital Policy Manual, Clinics, Medical Offices

PURPOSE: To describe procedure and technique for photographing victims of domestic violence
Refer To: Abuse and Violence: Domestic

POLICY: Photographs should be taken of all injuries caused by potential domestic violence.

PHOTOGRAPHS

1. Photographs should be taken of visible injuries on all patients. Explain to the patient that:

   a. This is a routine but important procedure.

   b. The photographs will become part of the patient's medical record and can only be released to the police or the prosecutor with the patient's permission.

   c. If the assailant is subsequently prosecuted, the photographs will be very useful as evidence.

   d. A good Polaroid-type camera with color film and flashbulbs would be kept in a designated place in the emergency department. The photos should be taken in the brightest light available. Although they should be taken at the closest possible range to specific injury photographed, each picture should ideally contain an identifiable feature of the patient, such as a hand or the face.

   e. If extensive bruising is expected to appear at a later date, the patient should be advised to return or to have additional photos taken elsewhere (physician's office, or the police station, or WomanKind Office.)

f. The back of each photograph should be signed and dated by the photographer. The photos should be placed in a sealed envelope and made part of the permanent medical record. The photograph consent form (if signed separately from consent for treatment) should be kept near the photos in the medical record.

SIGNATURES:

[1 Administration _____

[1 Department Manager _____

[1 Medical Director/Staff _____

[] Chief of Staff _____

DEVELOPED: 1993 REVIEWED: 1995

REVISED: _____ _____

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1995

DEPARTMENT: WOMANKIND

POLICY NO.
PAGE 1 OF 4

Policy Applies At:

FAIRVIEW SOUTHDALE [X]
FAIRVIEW RIDGES [X]
FAIRVIEW RIVERSIDE [X]

SUBJECT: DOCUMENTATION IN THE MEDICAL RECORD OF POTENTIAL CASES OF DOMESTIC ABUSE AND VIOLENCE

DISTRIBUTION: Emergency Department, Administration, All Hospital Departments and Nursing Units, Clinics, Medical Offices

PURPOSE: To describe appropriate professional documentation by health professionals in the medical chart relating specifically to cases of potential domestic abuse and violence

POLICY: Health professionals will provide appropriate documentation in the medical chart relating to cases of domestic abuse and violence.

MEDICAL RECORD

The medical record can be an invaluable document in establishing he credibility of the battered woman's story when she seeks legal aid or when the abuser is being prosecuted for the domestic assault.

It is important to clearly document:

1. History
2. Physical Findings
3. Patient's Statements

DOCUMENT HISTORY AND PHYSICAL FINDINGS

1. Does the medical history reveal many "accidents"? Are there indications that past injuries were of suspicious origin?

2. Document as many details of the history and physical as you can, even if you are unsure of the importance of a finding.

"Patient states she was hit in the face with her mate's closed fist, punched in the stomach two times, and hit with a screwdriver he grabbed off the table."

"Patient states her husband said three times he was going to kill her."

3. Keep in mind that the lack of extensive history should not automatically relieve suspicion. A battered woman may not return to the same facility each time a beating occurs or may be prevented from receiving treatment by the abuser.

4. Maintain Detailed Records

In the future, the patient may be more willing to accept help and may decide to.pursue prosecution of the abuser. A continuing record of abuse will then be very helpful to the prosecutor.

Exam: "...a 3 cm swollen ecchymotic area on the left shoulder consistent with a wound from a punch...3 linear ecchymotic areas on each side of the neck consistent with strangulation marks."

Lab: Record data in the same way, even if the results are negative.

"...x-ray of the left humerus obtained to rule out fracture sustained from episode of reported domestic violence was WNL..."

5. Bodv Map

Use a body map whenever possible--outline the areas with bruises and number them or make comments about them as above.

6. Pattern

You are trying to establish a pattern. Ask for names of all physicians and health care providers that she has seen for medical care or medications.

7. Previous Records

Battering is usually an ongoing problem which tends to escalate in frequency and severity and which is accompanied by a range of behavioral and psychosocial problems. If victim has received prior treatment in your facility, the previous records should be examined.

8. Two considerations are especially important:
   1. Avoid subjective interpretation of the data
   2. All data should be as exact, detailed, and as complete as possible.

   You are recording:
   1. What Was Stated
   2. Your Professional Medical Impression.

MEDICAL RECORD OF IDENTIFIED BATTERED WOMEN SHOULD:

1. specifically describe location and extent of injury, including pain reported.
2. describe treatment, intervention by health care provider.
3. include photograph of injury (written permission, or refusal)
4. specify any potential long term damage or need for follow up.
5. specify any follow up care given (x-rays, surgery, consultations)
6. include woman's statement of how injuries occurred.
7. include statements of any past battering incidents (direct quotes).
8. include statement that injuries are consistent with statement of how injuries occurred.
9. include contact persons other than health care providers, for ex: consultations with advocates, social workers, lawyers.
10. include interaction with batterer, including telephone calls to health care facility or provider.

NOTE: Patient chart, including photographs, x-rays, related documents become part of the medical record.

NOTE: The more the battered woman makes contact with those outside the home/the more options she has.

LEGAL LIABILITY OF HEALTH PROFESSIONALS Refer to: Abuse and Violence: Domestic, Patient Care Manual

1. You cannot be sued or held liable for recording the patient's statement or for recording facts, or your professional opinion. A health care professional is expected to record her/his expert medical opinion. No legal liability can be incurred by recording the medical facts of a case--that is, in fact, a professional's responsibility.

2. Bear in mind that by reporting a suspected incident of abuse to the police or any other agency without the patient's consent, you may be further endangering the patient. It is helpful to trust the patient's instincts and superior knowledge of the alleged abuser.

3. Two exceptions to this are the reporting of all cases of suspected child abuse and the mandatory reporting of suspected abuse of vulnerable adults.

SIGNATURES:

[X] Administration
[X] Department Manager
[ ] Medical Director/Staff
[ ] Chief of Staff

DEVELOPED: 1993
REVISED: 1994

REVIEWED: _____

Helton, A.S., "Protocol of Care for the Battered Woman," March of Dimes, 1986.

Hadley, S.M., "Working with Battered Women in the Emergency Department, A Model Program," Journal of Emergency Nursing, Vol. 18, No. 1, p. 18-23, February 1992.

4/2/92

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DEPARTMENT: WOMANKIND

POLICY NO. _____
PAGE 1 OF 3

Policy Applies At:

FAIRVIEW RIVERSIDE [X]
FAIRVIEW SOUTHDALE [X]
FAIRVIEW RIDGES [X]

SUBJECT: DOCUMENTATION_. OF WOMANKIND ACTIVITY AND SERVICES

DISTRIBUTION: WomanKind Department Policy Manual

PURPOSE: To provide and promote organized, consistent, timely and meaningful communication with members of the health care team; to meet legal, professional, and JCAHO requirements for documentation of services; and for quality monitoring purposes.

POLICY: The DAP Format will be used for documentation in the medical chart by WomanKind Department staff.

REFER TO: Policy on Advocacy Services

›manKind documents intervention and activity in the medical chart and the womanKind records utilizing the Data - Assessment - Plan (DAP) format as follows:

D - Data - Reason for referral; statements made by patient/family/ physician/others addressing the nature of the problem, concerns or preferences in post-hospital planning or problem resolution; direct statements should be quoted when meaningful; systematic collection and review of patient specific data necessary to determine patient care and treatment needs.

Description of home and social situation, including degree of isolation; support system in place; lab and clinical data relating to patient's psychosocial/discharge planning situation; behavioral observations; evidence of counseling provided.

Actions taken in regards to the stated problem, including contacts with relevant hospital and community resources or facilities;

Uninterpreted facts and or items collected during an assessment activity.

Information: Interpreted sets of data that can assist in decision making related to the significance of data.

A - Assessment - Evaluation/analysis of behavior/situation/coping drawn from "D" entry including indication of patient/family strengths and weaknesses; recommendation of a safe/adequate/appropriate plan; names of resources/agencies/facilities recommended; patient and/or family involvement agreement/disagreement/understanding of suggested plan.

P - Plan - Further action steps to be taken towards resolving the identified problem or completing the stated suggested plan; state each action step in the protection plan; steps may be diagnostic, therapeutic or educational as relates to the situation; Closing statement.

General DAP Guidelines

All notes must include the date of writing (month, day, year), the time of writing in military time, and the department designation.

All notes must be signed with the writer's name and degree.

A closing statement is not necessary if the patient expires and there has been no further WomanKind intervention since the last note.

DAP Progress notes are written to identify a new situation, identify a change in the status of a situation, document resolution of a situation or provide additional information regarding a situation.

DAP is to be used whenever possible on the initial entry and on subsequent progress notes. However, just "D" may be used when that configuration best reflects the content of a particular entry.

Notes must be concise and legible, and must include all relevant and important information. However, specific content should reflect only what is relevant and appropriate to the current intervention.

"If you didn't chart it, you didn't do it."

Only abbreviations found on the Medical Records abbreviation list will be used. Use of abbreviations should be minimized.

General Medical Records Guidelines

WomanKind staff notes are to be written on the Progress Record with notes of the physician and other health care professionals on the Clinical Pathway.

Only black pen is to be used on chart documentation.

All progress note sheets must have the patient identifying information stamped, labeled or written on both sides of the sheet.

or late entries: Write the note exactly as it would have been written].

Policy Applies At:

FAIRVIEW RIVERSIDE [X]
FAIRVIEW SOUTHDALE [X]
FAIRVIEW RIDGES [X]

originally, except write "Late entry" in the left margin with the reason for the late entry (chart not available, etc.).

To correct errors: Cross out the word/s with one or two lines so that the error is still readable, initial the error and add the date and the word "error", then write the correction. Do not make corrections in the margins or in between lines or words.

When a note carries over onto the back of the sheet: Write "con't" at the end of the note on the front, and write the date and "con't" to the left of the note on the back.

When a note continues onto another sheet: Write "con't" at the end of the note on the first sheet, and write the date and "con't" to the left of the note on the second sheet.

Outpatient Documentation

Outpatient documentation is to be completed on the form most appropriate to the situation, including Progress Record, Brief Contact and Assessment Form and/or statistics data sheet and/or letter to the patient's physician.

SIGNATURES:

[X] Administration
[X] Department Manager
[ ] Medical Director/Chair
[] Chief of Staff

DEVELOPED: 7/94 REVIEWED: _____ _____ _____
REVISED: _____

DEPARTMENT: WOMANKIND

-POLICY NO. _____

Policy Applies At:

FAIRVIEW RIVERSIDE [X]
FAIRVIEW SOUTHDALE [X]
FAIRVIEW RIDGES [X]

SUBJECT: INTRA-HOSPITAL RELATIONSHIPS

DISTRIBUTION: WomanKind Department Policy Manual

PURPOSE: To explain the role of the WomanKind Department as it inter-relates with other hospital departments and services.

POLICY: Collaborative working relationships shall be maintained with all other hospital departments to maximize benefits of hospital services to patients and their families, as well as employees.

PROCEDURE:

1. Open communication with other hospital departments and services shall be maintained through charting, as well as verbal exchange, when there has been WomanKind intervention with a patient.

2. Participation as a team member shall be utilized as a communication and marketing tool with other hospital disciplines represented on a team.

   EXAMPLES: Social Work Services, Pastoral Care Department, Nursing Units, Behavioral Services

3. Involvement on standing committees in the hospital system offers a method of maintaining cooperative and collaborative relationships with representative disciplines.

   FSH Community Health Committee
   FRH Community Health Committee
   CART
   FSH Coordinating Council
   FRH Coordinating Council

SIGNATURES:
[] Administration _____
[] Department Manager _____
[] Medical Director/Staff _____
[] Chief of Staff _____

DEVELOPED: 1994 REVIEWED: _____ _____ _____
REVISED: _____ _____ _____ _____

DEPARTMENT: WOMANKIND

POLICY NO. _____
PAGE 1 OF 1

Policy Applies At:

FAIRVIEW RIVERSIDE [X]
FAIRVIEW SOUTHDALE [X]
FAIRVIEW RIDGES [X]

SUBJECT: CONFIDENTIALITY OF RECORDS AND REPORTS

DISTRIBUTION: WomanKind Department Policy Manual

PURPOSE: To explain the importance in regard to maintaining confidentiality of records and reports.

POLICY: The privacy and rights of the patient shall be safeguarded through careful attention to confidentiality of information on patient's charts and material shared verbally with the WomanKind staff member.

PROCEDURE:

1. All information in the medical record will be regarded as confidential and will be released only to the extent appropriate for provision necessary services, and then only with the consent of patient or legal guardian.

2. Any written reports to other agencies or institutions require a signed release of information form and must comply with Medical Records Department procedure.

3. WomanKind staff advocate and volunteer advocates shall consider it appropriate to tell the patient before an interview begins about the purpose for which information is being gathered.

4. Clinical students in domestic abuse have access to charts of patients with whom they are working, under the supervision of the Volunteer Coordinator and Department Director and adhere to the policy of confidentiality, .

5. Any request from an insurance agent or lawyer for information about a patient via WomanKind, shall be referred to the Medical Records Department.

SIGNATURES:

[] Administration _____
[] Department Manager _____
[] Medical Director/Staff _____
[] Chief of Staff _____

DEVELOPED: 1994 REVIEWED: _____ _____ _____
REVISED: _____

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DEPARTMENT: WOMANKIND

POLICY NO.

Policy Applies At:

FAIRVIEW SOUTHDALE [X]
FAIRVIEW RIDGES [X]
FAIRVIEWRIVERSIDE [X]

SUBJECT: SAFETY AND SECURITY

DISTRIBUTION: Hospital Policy Manual, WomanKind Department Policy Manual

PURPOSE: To assure that WomanKind department personnel maintain a current knowledge of appropriate safety, security and infection control procedures.

POLICY: Department personnel will cooperate with other departments to provide and maintain a safe environment for patients, visitors and employees.

WomanKind Staff see both hospital inpatients and outpatients. WomanKind Staff provide back-up support to the Volunteer Advocates who are on-call to the emergency department and the crisis line after hours. WomanKind Staff and/or Director may see hospital inpatients and outpatients after hours as necessary. WomanKind Volunteers only see emergencydepartmentpatients, onevenings/weekends.

During orientation and annually thereafter each department employee will participate in safety and infection control education, and must demonstrate competence in appropriate practices on an ongoing basis. Additional education may be required by the director based on incident reports, performance evaluations or other mechanisms.

Department personnel are responsible forr

1. Knowing and following requirements for infection control; employee health, hospital and department disaster plans, Employee Right to Know, general hospital safety rules and regulations, and WomanKind safety and security procedures.

2. Reporting to the director or to other appropriate department management per policy when unsafe situations are observed.

3. Participating in safety and infection control education programs and documenting attendance.

Department director is-responsible for:

1. Identifying needs and providing opportunities for safety, security, and infection control education.

2. Maintaining records of employee participation in safety, security, and infection control education programs.

3. Documenting knowledge of safety, security and infection control practices as part of the performance evaluation process.

Department Volunteers: EMPLOYEE OCCUPATIONAL HEALTH POLICY WILL BE FOLLOWED REGARDING:

1. Pre-volunteering health clearance.
2. Immunization status and follow through
3. Blood/body fluid post exposure follow through

Department Staff and Volunteer SECURITY/SAFETY POLICY AND PROCEDURE

When providing advocacy services to a client in the Emergency Department and/or within Fairview Health System, and you have reason to believe that there is a potential for violent and/or threatening behavior, the security procedure is as follows:

1. Leave patient room and alert the Nurse and/or Doctor of the situation.

2. Volunteer: notify the back-up WomanKind Staff of the situation.

3. WomanKind Staff: notify the WomanKind Director.

4. Nurse and/or Doctor will call the Nursing Supervisor, as appropriate. (Note: Nurse and/or Doctor could skip this step and call security directly.)

5. Nursing Supervisor will contact hospital security.

In addition to the above security procedures, there may be other options available to maintain safety.

1. Move the woman to a more secure examination room.
2. Security can provide constant surveillance.

The first priority for the WomanKind Staff and/or Volunteer is to alert hospital staff of safety and security concerns.

SIGNATURES:

[] Administration _____
[] Department Manager _____
[ ] Medical Director/Staff _____
[ ] Chief of Staff _____

DEVELOPED: 1995 REVIEWED: _____
REVISED: _____ _____

DEPARTMENT: WomanKind

POLICY NO. _____
PAGE 1 OF 1

Policy Applies At:

FAIRVIEW RIVERSIDE [X]
FAIRVIEW SOUTHDALE [X]
FAIRVIEW RIDGES [X]

SUBJECT: HOLIDAY, VACATION AND BACK-UP SCHEDULING COVERAGE

DISTRIBUTION: WomanKind Department Policy Manual

PURPOSE: To provide guidelines on the methods and structure of holiday, vacation and after-hours back-up scheduling.

POLICY: Holiday, Vacation and after-hours back-up coverage at all hospital sites will be scheduled by all WomanKind staff so that all hours are covered.

1. Each WomanKind staff member is responsible for covering the after-hours back-up schedule as assigned or arranged.

2. Each WomanKind staff member is responsible for covering the holiday(s) schedule as assigned or arranged.

3. Each WomanKind staff member is entitled to appropriate annual vacation according to Human Resource standards. When that vacation time falls on a previously assigned weekend of back-up responsibilities, the staff person is responsible for arranging replacement coverage.

4. It is expected that the WomanKind staff person will make an exchange request of other staff when arranging for after-hours coverage.

5. It is expected that all WomanKind Department employees will be flexible and make a sincere effort to help fill exchange requests.

6. The director is notified of any changes in the original schedule.

SIGNATURES:

[X] Administration — Dorothy M Long
[X] Department Manager — Susan M Hadley
[ ] Medical Director/Staff _____
[] Chief of Staff _____

DEVELOPED: 1994 REVIEWED: _____
REVISED: _____ _____

olvac.pol

DEPARTMENT: WOMANKIND

POLICY NO.

Policy **Applies At:**

FAIRVIEW **SOUTHDALE** [X]
FAIRVIEW RIDGES [X]
FAIRVIEW **RIVERSIDE** [X]

SUBJECT: **ORIENTATION OF NEW EMPLOYEES**

DISTRIBUTION: WomanKind Department Policy Manual

PURPOSE: **To** assure that new employees are properly oriented to Fairview and to the WomanKind Department.

POLICY: **New** employees participate in an orientation program of sufficient duration and substance to enable them to effectively provide services within their job role and function. The specific duration and content **of** the standardized orientation program will be tailored to the needs of the new employee.

PROCEDURE:

1. The new employee will attend the next scheduled All-Hospital Orientation, attend the Benefits Conference, complete the Health Service review, and complete the Human Resources checklist for new employees. The new employee will review the Hospital Policy Manual and the Patient Care Manual. The new employee will become thoroughly knowledgeable with the WomanKind Department Policy and Procedure Manual and the WomanKind Volunteer Manual,

2. The new employee will be introduced to other department and facility personnel, with particular attention to those with whom the employee will have a close working relationship.

3. The new employee will complete the orientation objectives. By the end of the identified orientation period, the new employee **will be able to:**

   a. Describe the mission and philosophy of Fairview, and the mission, philosophy, and role of WomanKind.

   b. Describe and participate in Continuous Quality Improvement efforts.

   c. Identify and perform the duties and responsibilities of her job (position description questionnaire) and the role in her primary hospital with specific responsibities to other WomanKind hospital sites,

staff and volunteers, as designated by the department director.

d. Define the role of other hospital departments and describe how they interface with the client population, with WomanKind and with each other.

e. Demonstrate professional work skills needed to function in her job.

f. Identify relevant community resources and describe how to properly utilize them.

4. The new employee will complete an orientation evaluation at the end of the identified orientation period.

5. The new employee will complete an informal assessment of performance at the end of the identified probation period.

6. The new employee will complete a performance appraisal at the end of one year of employment.

SIGNATURES:

[] Administration _____

[ ] Department Manager _____

[ ] **Medical Director/Staff** _____

[ ] Chief of Staff _____

DEVELOPED: 1994 REVIEWED:

REVISED: _____ _____

FAIRVIEW CLINICS
GUIDELINE

Guideline Number 4017

Category: PATIENT CARE SERVICES - GENERAL

Effective Date:

Subject: Abuse and Violence, Domestic

Purpose: To provide guidelines in the identification and referral to WomanKind of suspected physical, emotional and sexual abuse and/or violence of adults by current or former intimate partners.

Note: This guideline reflects language written for clients in heterosexual relationships. Statistically, 90-95 % of abuse perpetrated in this population is from male abuser to female victim. It should also be understood that abuse and violence exists in homosexual relationships. WomanKind provides services for all victims of domestic abuse, male or female, homosexual or heterosexual.

Guideline: Fairview Clinics health professionals will assess and intervene in cases of suspected domestic abuse and violence and refer to the WomanKind services.

Domestic abuse and violence is increasingly recognized as a widespread community health problem which the health care system must address. Statistics indicate that a significant number of battered adults who go to a hospital or medical office are not currently being identified as victims of abuse, nor are they receiving help in the form of advocacy services or resource referral.

Continued

Applicable Departments: All Health Professionals

Reference: WomanKind Domestic Violence Protocol: Identification and Intervention Through the Health Care System, 1987, Revised 1994.

AMA Diagnostic and Treatment Guidelines on Domestic Abuse and Violence, Chicago, Illinois, March, 1992.

JCAHO Standards: PE.5 thru 5.4, HR.3, CC.l, CC.4, CC.5, CC.6.1

Approval:

Source/Accountable Person: Susan Hadley and Sherrie Eisele, WomanKind

WomanKind is based on the premise that health professionals often intervene at a point where domestic abuse can be identified, support and education can be given, and the victim of abuse can learn of possible options and the community services available. WomanKind provides a supportive connection between the battered adult in the health care setting and the resources available in the community to help them and their family.

Definitions:

Abuse

The use of or the threat to use physical, emotional, sexual, psychological and/or economic behaviors by a current or former intimate partner in order to gain or maintain control in the relationship.

Domestic Abuse

Domestic abuse and violence is an ongoing, debilitating experience of physical, emotional, psychological, and/or sexual abuse in the home, associated with increased isolation from the outside world and limited personal freedom and accessibility to resources.

Physical Abuse

Physical abuse is usually recurrent and escalates in both frequency and severity. It includes any forceful, physical behavior.

It may include the following:

1. Pushing, slapping, hitting, shoving, biting, punching, kicking or choking.
2. Assault with a weapon
3. Holding, tying down, or restraining
4. Leaving them in a dangerous place
5. Refusing to obtain medical help when they are sick or injured

Emotional Abuse

Emotional abuse may precede or accompany physical violence as a means of controlling the victim verbally through fear, humiliation and degradation.

Psychological Abuse

This form of abuse that exists when there is the threat of violence and/or when there has been at least one act of physical or sexual abuse against the partner. The victim of abuse now feels fearful because they never know when the violence will occur again.

Continued

The purpose of the emotional/psychological abuse is to render the partner, fearful, emotionally helpless, and insecure about their own self worth or ability to escape further abuse. Emotional and psychological abuse can have long term debilitating effects. The victim of this abuse becomes increasingly isolated, eventually losing a sense of themself and their identity.

Emotional and psychological abuse may include, but are not limited to, the following:

1. Threats of harm
2. Physical and social isolation
3. Extreme jealously and possessiveness
4. Intimidation
5. Degradation and humiliation
6. Calling them names and constantly criticizing, insulting and belittling them
7. False accusations, and blaming them for everything
8. Ignoring, dismissing, or ridiculing their needs
9. Lying, breaking promises, and destroying trust
10. Driving fast and recklessly to frighten and intimidate them

Sexual Abuse

Sexual abuse in violent relationships is often the most difficult aspect of abuse for women to discuss. It may include any form of forced sex or sexual degradation, such as:

1. Any non-consenting sexual act
2. Forcing her into sexual behaviors when she is particularly vulnerable; when she is not fully conscious, is not asked, is afraid to say no, is sleeping, drugged, or intoxicated.
3. Trying to make her perform sexual acts against her will.
4. Hurting her physically during sex or assaulting her genitals, including the use of objects or weapons intravaginally, orally or anally.
5. Criticizing her and calling her sexually degrading names.
6. Treating her like a sex object.

Procedure:

I. Reporting Requirements

The following cases are REPORTABLE to the Police Department under Minnesota law.

1. Injuries caused by firearms.
2. Knife wounds inflicted by another person or occurring under suspicious

circumstances.

3. Sexual assault if the patient signs a waiver.

Continued

II. Referral to WomanKind Services

A. WomanKind provides case management/advocacy services, crisis intervention and ongoing assistance to victims of domestic abuse who suffer from physical, emotional or sexual abuse by a current or former husband or wife or partner. Services are especially important for victims with a past history of abuse as many continue to struggle with the effects of that abuse and (with the patient's consent) should be referred to WomanKind for ongoing support and services.

B. WomanKind provides education and consultation with hospital and community health professionals in order to enable these health care professionals to more readily identify and treat victims of domestic abuse who come to them for care.

The WomanKind Educational Program is designed to increase the awareness of hospital, medical office, and other health professionals to this under recognized problem, as well as to instruct them on how to effectively utilize the WomanKind program services.

C. WomanKind services are available 24 hours a day, 7 days a week. If you are in need of a WomanKind staff, call the WomanKind office at Fairview Southdale Hospital: 924-5775, at Fairview Ridges Hospital: 892-2500 and at Fairview Riverside Medical Center: 672-2700.

If you reach voice mail, you will receive instructions to contact the WomanKind answering service at 924-8200 and they will page a WomanKind staff person. The WomanKind staff advocates are available during the week day hours and available by pager after hours.

D. WomanKind staff will talk with the victim and make an immediate assessment of needs and support. The WomanKind staff will set up follow up appointments in WomanKind office. If the care is to be transferred to the Emergency Department, WomanKind staff may provide an escort for the victim.

Domestic Abuse.
Referral Procedure --

1. Contact the **WomanKind** office closest to your clinic.
   a. FSH 924-5775
   b. FRH 892-2500
   c. FUMC-Riverside 672-2700

2. If there is an immediate need to reach the **WomanKind** staff -
   a. urgent situation or
   b. patient at the clinic

   Call **WomanKind** Answering Service at 924-8200 to page WK staff member.

3. **WomanKind** staff will -
   1. Speak with clinic staff
   2. Speak with patient immediately
      a. Provide crisis advocacy by phone
      b. Make an appointment to meet with client, either by telephone or at the **WomanKind** office.

Appendix Q

WomanKind Program Materials

WOMANKIND

Support Systems for Battered Women

HEALTH CARE INTERVENTION FOR DOMESTIC ABUSE

WomanKind is based on the premise that health professionals often intervene at a point where battering can be identified, support and education can be given, and the battered woman can learn of the community services available. Community Connection: WomanKind provides a supportive connection between the battered woman in the health care setting and the resources available in the community to help her and her family.

Advocacy -- The first purpose of WomanKind is to provide advocacy services, crisis intervention and ongoing assistance to women who suffer from physical, emotional or sexual abuse by a current/former husband or partner.

Education -- The second purpose of WomanKind is to provide education and consultation to hospital staff and community health professionals in order to enable them to more readily identify and treat battered women.

PROGRAM DEVELOPMENT

WomanKind, Inc., a hospital-wide domestic abuse program, was founded in 1986 by Susan M. Hadley, MPH, LGSW as a non-profit corporation with the mission to provide advocacy services to victims of domestic abuse through the health care system. Program research indicated that a significant number of battered women who came to medical facilities were not being identified as victims of abuse, nor were they receiving help in the form of advocacy services or resource referral. It became apparent that there was a need to better identify and treat abused women who access the health care system. WomanKind, Inc. was conceived to respond to this need.

WomanKind began providing services at Fairview Southdale Hospital in Edina in June of 1986 and at Fairview Ridges Hospital in Burnsville in November of 1989, both suburban locations. In March of 1994, WomanKind began providing services at Fairview Riverside Medical Center in urban Minneapolis. Between 60-70 clients are referred to WomanKind each month with more than 7000 women having received advocacy services since the program's inception. Four full-time staff members and over 100 volunteers provide services 24 hours a day, 7 days a week. An Advisory Committee meets quarterly and provides input from health care and community members. All services are confidential and free of charge.

On July 1, 1992, WomanKind joined with Fairview Hospital and Healthcare Services. The Fairview Hospital System in Minnesota, through its WomanKind Department, has taken the lead across the country in institutionalizing services to victims of domestic abuse within the hospital structure as part of its overall mission of total health care. Major funding for WomanKind is provided by the Fairview Hospital and Healthcare Services, the Fairview Hospitals Auxiliary, and the Fairview Foundation.

INNOVATIVE PROGRAM

Nationally recognized as a model program, WomanKind has been profiled in numerous publications including the Journal of the American Medical Association (JAMA), the Journal of Emergency Nursing, Hospitals, Minnesota Medicine, Medical Economics and Emergency Medicine News. The first program of its kind in the United States, WomanKind has been featured on **the** health care reports on the NBC TODAY Show, on Physicians' Journal Update on the Lifetime Channel, and on "Today's Breakthroughs, Tomorrow's Cures", a television news documentary featuring current medical problems and innovative solutions.

WomanKind has brought about change in the medical system's response to victims of domestic violende so that health care professionals treat more than just the physical problem and also address the underlying causes of the medical or mental health problem.

WOMANKIND

support Systems for Battered Women

-- DOMESTIC ABUSE AND HEALTH CARE

INTRODUCTION

Violence in families is a complex problem...one that has existed for centuries... In order to address this problem and work toward prevention, we must first understand the issue and then develop solutions. We need to recognize the framework in which violence occurs and examine how we as individuals and the systems around us respond to victims of abuse.

A statement in 1989 by then U.S. Surgeon General C. Everett Xoop urged greater involvement and response by the medical system in domestic violence. "Physical abuse of women and children is "an overwhelming moral, economic, and public health burden."

ROLE OF THE HEALTH CARE SYSTEM

Statistics indicate that a significant number of battered women who go to a hospital or medical office are not currently being identified as victims of abuse, nor are they receiving help in the form of advocacy services or resource referral. Health professionals often intervene at a point where battering can be identified, support and information can be given, and the battered woman can learn of the community resources available to help her and her family. Early intervention by health care professionals can play an important role in ending the cycle of violence and preventing the long term effects of battering.

"Health care providers may be the first and
only professionals in a position to
recognize violence in their patients' lives."

Randall, T. Hospital-Wide Program Identifies Battered Women; Offers Assistance, *"Journal of the American Medical Association" Vol. 266, No. 9,* September 4, 1991.

Fairview Ridges Hospital
201 East Nicollet Boulevard
Burnsville, MN 55337
(612) 892-2500

Fairview Southdale Hospital
6401 France Avenue South
Edina, MN 55435

Fairview Riverside Medical Center
2450 Riverside Avenue South
Minneapolis, MN 55454

WOMANKIND

Support Systems for Battered Women

The WomanKind Domestic Abuse Guide for Health Professionals

This easy-to-use pocket guide, developed by the nationally recognized WomanKind program of the Fairview Health System in Minnesota, eliminates the hours of work you normally would need to develop a quick reference system for assessing and addressing domestic abuse and violence in your health care setting.

This quick reference booklet provides concise guidelines and practical techniques that allow you and your staff to be more knowledgeable, sensitive, and effective in responding to victims of domestic abuse. Designed for physicians, nurses, medical social workers, mental health providers, and health educators working in a hospital, clinic, medical office, home health or private practice setting

Areas of domestic abuse assessment and intervention addressed by this guide include:

- Abuse and Violence - Power and Control Wheel (Duluth)
- Statistical Data
- Redefining Success - Understanding victim's process
- Intervention Tips
- Safety Planning Options
- Legal Liability of Health Professionals
- JCAHO Requirements
- References and Resources
- Abuse Assessment Screen (J. McFarlane)
- Questions to Ask
- Red Flags and Subtle Signs
  - Physical
  - Pregnancy
  - Mental/Emotional Health
  - Behavioral
  - Indicators of Escalating Danger
  - Abuser
- Documentation - Injuries and Symptoms

WomanKind is a uniquely integrated program providing case management/advocacy services to victims of domestic abuse, in conjunction with education/consultation for health professionals. WomanKind has been profiled in the national media and in numerous professional publications including the Journal of the American Medical Association, the Journal of Emergency Nursing, Hospitals, Emergency Medicine News, and Women's Health WomanKind is currently involved in a two year evaluation research project with the Centers for Disease Control and Prevention in Atlanta, Georgia.

Orders can also be placed by calling I-800-544-8207 or faxing This order form to 6 12-672-4980. Purchase Orders, MasterCard, Visa, Discovery Card, checks, and money order payments are Accepted.

Fairview Press, 2450 Riverside Avenue S., Minneapolis, MN 54454

Fairview Ridges Hospital
201 East Nicollet Boulevard
Burnsville MN 55337

Fairview Southdale Hospital
6401 France Avenue South
Edina MN 55435

Fairview Riverside Medical Cenrer
2450 Riverside Avenue South
Minneapolis MN 55454

5. Pack and hide an "escape bag" with essential personal belongings and documents.
6. Crisis telephone numbers of friends, relatives, shelters, churches and hospitals.
7. Give friends, neighbors, relatives permission to call police. Set up communication signals that you are in danger.
8. Copies of important papers
   a. Birth certificates, insurance policy, bank papers, social security card(s), tax statements, insurance policies, medical records, photographs of injuries and property damage, recent photo of perpetrator, investment papers and assets.
   b. Keep important documents in a safe deposit box or with a trusted neighbor, friend or relative.

EMOTIONAL
1. Maintain journal.
2. Self-help support groups.
3. Individual or group counseling
4. Give yourself daily positive messages and self-esteem affirmation.

XERCISE CAUTION IN GIVING PATIENT WRITTEN
VTERIAL ON DOMESTIC ABUSE AS ABUSER MAY
:TER EXAMINE PATIENT'S BELONGINGS

:AL LIABILITY OF HEALTH
)FESSIONALS

/ho must report? Health care professionals
ho administer treatment to any person
ffering a gunshot, stab wound or other
rious bodily injury that the physician
spects has resulted from a criminal act.
In most states, it is mandatory for health professionals to report suspected cases of child abuse and abuse of vulnerable adults. Few states have explicit mandatory reporting laws for domestic abuse.

- substantial risk of death.
- causes serious permanent disfigurement.
- causes protracted loss or impairment of the function of any bodily member or organ.

3. Is patient consent required to report? Patient consent is not necessary if the report is made in compliance with state statutes.

The AMA recommends physicians inform the patient of the legal responsibilities to report, explain investigation procedures and address the risk of retaliation by the abuser.

NOTE: IT IS IMPORTANT FOR HEALTH PROFESSONALS TO BECOME FAMILIAR WITH COUNTY AND STATE LAWS AND RELEVANT STATE STATUTES PERTAINING TO ABUSE AND VIOLENCE.

VII. JCAHO REQUIREMENTS

Refer to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards which provide structured guidelines for improvement of a health system's response to victims of abuse and violence.

VIII. REFERENCES — PARTS I AND II

Domestic Abuse Intervention Project, 206 West Fourth Street, Duluth, MN 55806.

Flitcroft A, Hadley S, Hendricks-Matthews M, McLeer S, Warshaw C. AMA Diagnostic and Treatment Guidelines on Domestic Violence, American Medical Association, Chicago, Illinois, 1992.

Improving the Health Care Providers Response to Domestic Violence, Family Violence Prevention Fund, San Francisco, California, 1995.

JCAHO 1995 Comprehensive Accreditation Manual for Hospitals, Vol I. Oakbrook Terrace, IL: Joint Commission Accreditation of Healthcare Organizations, 1994.

McFarlane J, Parker B, Soeken K, Bullock L, Assessing for Abuse During Pregnancy, JAMA, June 17, 1992, Vol. 267, No. 23.

Minnesota Medical Association, Stop the Violence: Physician Resource Guide, 1994.

Physician's Reference Card, Recognizing and Treating Victims of Domestic

Randall T. Hospital-Wide Program Identifies Battered Women; Offers Assistance, JAMA, Vol. 266, No. 9, September 4, 1991.

Substance Use and Domestic Abuse During Pregnancy, A Health Care Professional's Guide to Screening, Assessment and Intervention, HealthPartners, Center for Health Promotion,, Bloomington, Minnesota.

WomanKind, Domestic Abuse Policy Series, Fairview Health System, Minneapolis, Minnesota, 1996.

ACKNOWLEDGEMENT—University Family Physicians-Smiley's Clinic, Minneapolis, Minnesota for assistance provided.

IX. RESOURCES

National Domestic Violence Hotline
1-800-799-SAFE (7233)

1-800-787-3224 (TDD)

Add local community resources below

WOMANKIND™

Support Systems for Battered Women

HEALTH PROFESSIONAL QUICK REFERENCE CARD

PART ONE

©WomanKind,
Fairview Health System, 1996

"Health care providers may be the first and only professionals in a position to recognize violence in their patients' lives."

Randall, T., JAMA, September 4, 1991.

Fairview

The ılth care system provides a prime opportunity for intervention.

Heath care intervention is early intcrvcntion.

Early intervention is ultimately prevention:

- Prcvcntion of more serious injuries and medical symptoms
- Prevention of mental health and psychiatric symptoms
- Prevention of nbusc ıo the children

I. ABUSE AND VIOLENCE

Definition of Abuse

Domestic nbusc is the use-or the thrcnt to use—verbal, physical or sexual behavior to gain or maintain control in the relationship. Domestic nbusc exists on a continuum of power and control, often escalating in frequency and severity of abusive and violent behavior.

The Power and Control Wheel

II. STATISTICAL DATA

A. Adult

Physical Health

22-35 percent of women who visit emergency departments are there for symptoms related to ongoing abuse, either for:

1. injury or trauma from an assault.
2. manifestation of the stress of living in an abusive relationship. *(Stark, Flitcraft and Frazier, International Journal of Health Services, 1979)*

Abuse during pregnancy

An estimated six to 17 pcrccnt of all pregnant women are battered by themen in rhcir livcs. *(CDC, The Atlanta Journal and Constitution, 1994; Hilliard, Obstet Gynecol, 1985; Amaro, Fried, Cabral, Zuckerman. AJPH,* 1990; *McFarlane, Parker, Socken, Bullock, JAMA, 1992)*

A battcrcd pregnant woman is four times mote likely to have a low birthweight baby and her chances of miscarriage are double. *(Stark and Flitcraft, Wife Abuse in the Medical Setting, 1981)*

Mental health

33 percent of battcrcd women suffer from anxiety and depression; 26 pcrccnt of all women who attempt suicide are victims of domestic violence. *(Stark and Flitcraft, Handbook of Family Violence, 1988);* 64 percent of hospitalized female psychiatric patients have history of being physically abused as an adult. *(Jacobsen and Richardson, American Journal of Psychiatry, 1988)*

B. Children

Child abuse

As violence against women in the home becomes more frequent and more severe, children experience a 300 percent increase in physical violence by the male batterer. *(Strauss and Gelles, Physical Violence in American Families, 1 990)*

70 percent of men who batter women also batter their children. *(Rosenbaum, Aghiseth and*

Witnessing Children

Children and youth who witness abuse of their mothers display as much or more physical and verbal aggression, sleep disturbance, and general anxiety as those who are direct recipients of abuse. *(Jaffe, Wolfe and Wilson, Children of Battered Women, 1990)*

C. Adolescents

21 percent of college students admit involvement in violent relationships. *(Makepeace, Family Relations, 1981)*

D. Gay and lesbian

In a 1986 study, 25 pcrccnt of lesbian respondents reported being physically abused by their partner, compared to 27 percent of the heterosexual female respondents. *(Brand and Kidd, Psychological Reports, 1986)*

E. Elder Abuse

81 percent of elder abuse victims are female over the age of 75 years. *(Black and Sinnott, University of Maryland Center on Aging, 1979)*

III. REDEFINING SUCCESS-UNDERSTANDING THE VICTIM'S PROCESS

Goals for the victim of domestic abuse

- Feel support and safety.
- Talk about the violence.
- Evaluate the situation.
- Develop protection/action plans.
- Define short-long term goals.
- Consider possible options/resources.
- Set priorities/make decisions/take action.

Respect her process, timetable and decisions.

1. Rediscover a sense of self.
2. Build hope and reduce isolation.
3. Develop strength and direction.
4. Acknowledge smell steps.

IV. INTERVENTIONTIPS

Step 1—establish a safe, secure environment

1. Interview in private.
2. Maintain a separation.
4. Provic ,acy and anonymity.
5. Rcspcct victim's fcnr of retaliation.

Step 2—inquire in a sensitive, resp non-judgmentalmanner

1. Listen and respect.
2. Provide non-judgmental support.
3. Acknowledgethe abusive situation
4. Validate the experiences, feelings a

Step 3—validate the experiences, i and fears

1. 'You do not deserve to be abused.'
2. 'You arc not responsible for the ab
3. 'You did not cause it. You did not
4. 'What happened to you is against
5. "There is help available. You arc n

Step 4-ask appropriate questions

1. Bc alert for the "red flags and subtl
2. Institute *routine screening* on all pa

Step 5—document injuries, sympto statements

1. Physical findings.
2. Patient's history.
3. Patient's statements.
4. Photographs.

V. SAFETY PLANNING OPTIONS

A. Legal/law enforcement opti

1. Order for protection-carry. all times.
2. Harassment restraining order
3. Law enforcement.
4. Attorney or legal aid.
5. Mcdicnl documentation.

B. Personal

1. Change the locks; install out lights.
2. Answering machine/voice m
   a. screen calls/save messages cvidcncc.
3. Money
   il. quarters for phone calls.

intoxicated, difficult, angry, defensive, anxious, agitated, jumpy, fearful, noncompliant, depressed, flat affect, poor eye contact, disoriented.

2. Subtle signs
   - Delay between onset of injury and presentation for treatment.
   - Discrepancy between patient's history and the type/appearance of injuries.
   - Denial or minimization of signs of violence.
   - Patient's distress extreme in relation to injury.
   - Reluctance to speak or disagree in front of partner.
   - Intense jealousy or possessiveness expressed by the partner or reported by patient.
   - Exaggerated sense of personal responsibility for relationship and/or partner's behavior.

3. Control in the relationship
   - Limited access to routine and/or emergency medical care.
   - Missed or cancelled appointments.
   - Noncompliance with treatment.
   - Not being allowed to obtain or take medication.
   - Lack of independent transportation, access to finances, use of phone.
   - Failure to use contraceptive methods.
   - Changes in health care provider

Abuse is not a communication issue. Abuse is a control issue.

A victim of abuse is afraid of and controlled by the abuser and cannot talk with the abuser present.

Indicators of escalating danger
- Increase in frequency /severity of assaults.
- Increase or new threats of homicide or suicide by the partner.
- Threats to children.

- Appear overly solicitous/affectionate.
- Answer all questions or patient defers to partner to answer questions.
- Hover; won't leave patient unattended.
- Explain the injury or symptoms.
- Appear controlling, jealous or possessive.
- Isolate partner from family and friends.
- Be charming and affectionate in public; public image often differs from private image.
- Appear immature with a low tolerance for frustration.
- Deny the existence of or minimize the violence.
- Refuse responsibility for abuse.
- Hold rigid and traditional views of sex roles and parenting

III. DOCUMENTATION—INJURIES AND SYMPTOMS

Well-documented, detailed medical records are essential for establishing a history or pattern of abusive or violent behavior and may be crucial in subsequent law enforcement or criminal justice proceedings.

RECORDS SHOULD INCLUDE:

A. Patient's history and statements
   - Presenting problem: medical, mental health or trauma.
   - Description of abusive incident.
     - Use direct quotes.
     - Include explanations provided.
     - Include patient's statement of how injury occurred.
   - Include relevant mental health and social history.
   - Include statements of any past abuse.
   - Include patient's behavior and emotional state.
   - Include companion(s) behavior and emotional state.
   - Review previous charts.

B. Physical findings
   - Use body map.
   2. Type, number, size, location, extent, resolution and possible causes of injuries.
   3. Include results of laboratory, imaging and diagnostic procedures.

C. Photographs
   - Assure patient routine but important procedure.
   - Take duplicate photographs <u>before</u> medical treatment given.
   - Hold up coin/ruler to show size of injury.
   - Include patient's face, hand or identifiable feature.
   - Use instant camera with color film/flash.
   - If extensive bruising likely to develop, patient should have additional photos taken at a later date.
   - Label photographs; photographer should initial and date, include name of patient and location of injury.
   - Consent to photograph form signed, dated and stored near photos in the medical record.
   - Duplicate photographs become part of permanent medical record and released only with patient's permission.

D. Contacts
   - Other health care providers, advocates, social service, spiritual health, attorneys, police, child protective services.
   - If police called; officer name, badge number, case number, action.
   - Family members, friends, alleged abuser.

E. Medical interpretations
   - Legal liability of health professionals
     - Health providers cannot be held liable for recording patient's statements, recording facts, or their professional opinion.
   - Include professional opinion that injuries are consistent or inconsistent with explanation given.
   - Specify potential for long-term damage or further medical treatment.
   - Describe plan for follow-up care.

WomanKind™

Support Systems for Battered Women

Health Professional Quick Reference Card

Part Two

©WomanKind,
Fairview Health System, 1996

"If our mission is assessing and treating the total health care needs of our patients, how can we not address the issue of domestic abuse?

Fairview

I. ASSESSMENT - ROUTINE SCREENING

T. critical. Reach the victim while in your setting. A hospital or clinic setting may bc one of the few places a woman can go unaccompanied hy the husband or partner.

Institute routine assessment. Screen for domestic abuse as part of the medical and/or social history.

Scr up a follow-up appointment. Let patient know the hospital/office is a safe place to talk about relationships and the situation at home.

Respect victim's process, timetable and decisions.

The victim is in a process and will move through that process when she/he has the strength and support to do so.

Trust the patient's assessment of the situation. The patient *is* the expert *on* the relationship.

A. ABUSE ASSESSMENT SCREEN

(J. McFarlane et al, JAMA, June 17, 1992)

1. Have you ever been emotionally or physically abused by your partner or someone important to you? Yes No

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? Yes No
   If yes, by whom:
   Husband Ex-husband Boyfriend
   Stranger Multiple
   Total number o f times

3. Since you've been pregnant, have you been hir. slapped, kicked, or otherwise physically hurt by somconc?
   If yes, by whom:
   Husband Ex-husband Boyfriend
   Stranger Multiple
   Total number of times

Mark the area of injury on a body map.

Score each incident according to the following scale:

(If any descriptions for the higher number apply, use the higher number.)

1=Threats of abuse, including use of a weapon.

or continuing pain.

4=Beaten up, Severe contusions, broken bones.

5=Head, internal and/or permanent injury.

6=Use of weapon, wound from weapon.

4. Within the last year, has anyone forced you to have sexual activity? Yes No
   If yes, by whom:
   Husband Ex-husband Boyfriend
   Stranger Multiple
   Total number o f times

5. Arc you afraid of your partner or anyone you listed above? Yes No

B. QUESTIONS TO ASK

1. "Because abuse and violence have become so prevalent in our society, we've started to ask all of our patients routinely about this problem."

2. 'I don't know if this is a problem for you, but bccnusc so many women we see arc living in or recovering from an abusive relationship, wc arc asking about it routinely."

DIRECT QUESTIONS

1. "Arc you now or have you ever been in a relationship where you have been abused or abusive, either physically, emotionally or sexually?"

2. 'Have you been under any stress lately? Do you have any particular problems or concerns with your partner...with your children? You seem overwhelmed? Who can you talk to for support?"

3. 'Wc all argue or disagree at home. What happens when you and your partner disagree? What happens when your partner doesn't get his/her way? Is it safe for you to disagree? Do you 'tiptoe" or walk on eggshells?

4. "You mentioned that your partner uses

5. "You mentioned that your partner seems inpatient and/or loses his temper with the children. Can you tell mc more about that? Has your partner ever hurt/hir you or the children? Arc you or the children afraid?"

6. 'Does your partner try to control you? Is your partner jealous and possessive of you? Arc you isolated from family and friends?"

7. 'Has your partner threatened to commit suicide?'

DIRECT QUESTIONS

INJURY ASSAULT OR TRAUMA

1. 'I notice you have a number of bruises. Could you tell mc how they happened?

2. 'When we see injuries like yours, it's usually because someone has been hit or hurt. Did this hnppc" to you?

DENIES ABUSE

If the patient denies abuse, let patient know that your hospital, clinic or medical office is a safe place to talk about domestic abuse.

II. IDENTIFICATION

RED FLAGS AND SUBTLE SIGNS

A. PHYSICAL

1. LOOK FOR A PATTERN OF BEHAVIOR, INJURIES AND SYMPTOMS
   - Unexplained injuries or symptoms.
   - Prior history. trauma or injury.

2. MEDICAL SYMPTOMS
   - Pain-chronic or acute, for which no etiology is apparent.
     Headaches, atypical chest pain, back pain, abdominal or Cl pain.
   - Gynecologic problems—vaginal or urinary tract infections. pelvic pain, sexual dysfunction, STD, PID.
   - Repeat visits or chronic symptoms, vague or nonspecific complaints.

3. TY INJURIES
   - sions, lacerations, abr fractures.
   - Central part of body - "1-pi swimsuit."
   - Head, face, neck;
   - Upper extremities.
   - Multiple or chronic injuries stages of healing.
   - Repeat visits for minor trau
   - Human bites.

B. PREGNANCY

1. DIRECT EFFECTS
   - Injuries to breasts, abdomer genital area.
   - Post pregnancy complicatio spontaneous abortion; pre-t bleeding, labor, birth; poor gain. low birth weight. infa abruptio placentae.
   - Fetal injury, fetal death.

2. INDIRECT EFFECTS
   - Physical and psychological
   - Inadequate maternal nutriti
   - Delayed or sporadic prenata
   - Behavioral risks including a drug use and cigarette smok
   - Excessive worry about healt unborn child.
   - Battering during pregnancy an indication of what life he store for the unborn child.

C. MENTAL/EMOTIONAL HEALTH SYM

- Isolation.
- Depression.
- Increased fatigue, dccrcascd en
- Decreased interest in family/fri activities.
- Difficulty concentrating/maki decisions.
- Inability to cope, overwhelmed
- Sleep or appetite disturbance.
- Anxiety symptoms or panic att
- Post traumatic stress disorder.
- Suicide ideation or attempts
- Difficult patient

REMEMBER: Assess for Abuse upon Admission.
Contact WomanKind Immediately.

FAIRVIEW RIVERSIDE MEDICAL CENTER WOMANKIND 672-270

HOURS: 24 HOURS A DAY, 7 DAYS A WEEK.

WOMANKIND STAFF:
1. Available to hospital staff for consultation and patient case management/advocacy services.
2. Available as back up support to on-call volunteers.

VOLUNTEERS: Available after hours and weekends on-call to emergency department and to WomanKind client crisis line.

1. Establish a safe, secure environment.
   Interview patient ALONE.
   Provide nonjudgmental support.
   Provide privacy and confidentiality.
   Respect patient's fear of retaliation.

2. Validate experiences, feelings and fears.
   You do not deserve to be abused.
   You are not responsible for the abuse.
   You did not cause the abuse.
   What happened to you is against the law.
   There is help available. You are not alone.

3. Be alert for "red flags and subtle signs".
   Institute ROUTINE SCREENING.

4. Ask appropriate questions.
   Because abuse and violence have become so common in our society, we've started to ask all of our patients routinely about this issue.

   At any time, has your partner hit, pushed, grabbed, slapped, kicked or otherwise hurt or frightened you?

   Ask appropriate questions (continued)
   You seem overwhelmed. Who do you talk with for support?

   I noticed you have some bruises. Could you tell me how they happened?

   When we see bruises or injuries like yours, it's usually because someone has been hit or hurt. Did this happen to you? Did someone hurt you? Did you receive these injuries by being hit?

5. Document injuries, medical symptoms and statements.
   Patient's history and statements
   Physical findings and photographs

6. What if the PATIENT DENIES ABUSE.
   If patient denies, let patient know that the hospital, clinic, emergency_ department, or medical office is a safe place to talk about domestic abuse.

7. RESPECT HER PROCESS, TIMETABLE AND DECISIONS.

cardlist.2

Volunteer Corner Conti...
Fairview Southdale Hosp.

Sarah Prasher has been an on-call advocate for WomanKind since March of 1992. Sarah stated that back in 1992, she was looking for a volunteer experience where she would work directly with a population in need and volunteering with WomanKind was a perfect fit. Sarah said when she first started volunteering, while she felt it was very rewarding, she was concerned she was not doing enough for these women. But now Sarah said she realizes that just being there for the woman and validating that no one deserves to be abused; provides a bridge for the woman to be able to look at her options on her timetable. Sarah works full time as a Toddler Teacher at a daycare for the last five years and is also attending school at Normandale Community College, possibly considering the Nursing field. Sarah spends a great deal of her free time with her nephew and her new born niece. She also loves to spend her time skiing and traveling.

VOLUNTEER INPUT

Volunteer Advocates this is your corner and needs your input, thus the title. We are looking for a volunteer from each program site to be the contact person to gather your information. This information could include an article you have written, read, or researched; poems; affirmations; a personal message; or anything you would like to share with your associates at WomanKind. If you would like to be that contact person, please notify the appropriate Program Coordinator.

HAPPY FIRST BIRTHDAY WOMANKIND RIVERSIDE PROGRAM
(March 21, 1994)!!!!!

Fairview Ridges Hospital
201 East Nicollet Boulevard
Burnsville, MN 55337
(612) 892-2500

Fairview Southdale Hospital
6401 France Avenue South
Edina, Minnesota 55435
(612) 924-5775

Fairview Riverside Medical Center
2450 Riverside Avenue South
Minneapolis, MN 55454
(612) 672-2700

WOMANKIND
Support Systems for Battered Women

WomanKind Volunteer Newsletter

WELCOME

Welcome to the new WomanKind Volunteer Newsletter! As you can see—we need your help in naming this newsletter. Use your imagination and phone in your ideas. This will be a quarterly publication and relies on your contributions, suggestions, and readership.

UPCOMING EVENTS

New Volunteer Training will be held on the following dates: Jan. 9, 10, 12, 17, 18 & 19th. This training is open to all volunteers, new and established. Notify your program Coordinator of which session(s) you would like to attend.

QUESTIONS AND ANSWERS

Q. What if the client does not speak English?

A. If the client is Spanish speaking, call CASA DE ESPERANZA. (CASA will speak with the client over the phone, they don't come in.) If client is accompanied by a female friend, establish who this person is. If she trusts this companion it may be okay to have her interpret. For the hearing impaired, contact the MN Relay Service (for telephone calls) and in ER utilize the TTY with MN Relay: 297-5353. For any other language barriers contact Back-up Staff person.

Q. What do I do if I get called in for a client who has been a victim of sexual assault by a stranger?

A. If you aren't sure if it's an appropriate referral or you have any questions or concerns, call Back up staff.

BIRTHDAYS:

Fairview Ridges Hospital

January:	
5	Stephanie Link
February:	
27	Brenda Duke
March:	
6	Sally Renish
13	Denise Harju
22	Tracy Goodwin

Fariview Riverside Medical Center

January:	
13	Kryss Brown
February:	
1	Shari Johnston
3	Susan Leonard
March:	
5	Kathy Conrad
7	Andrea Bible
8	Lois Francis-Wolf
22	Christina Masica

Fairview Southdale

January:	
16	Colleen Duggan
16	Kirsten Obermeyer
17	Amy Elholm
19	Kim Dwinnell
February:	
2	Sheila Morgan
4	Eileen McCarthy-Harness
9	Beth Sawinski
12	Candy Lewis-McComb
24	Suzanne Peterson
25	Sherrie Eisele
March:	
23	Lisa Foslien
29	Colette Galagher
30	Mary Jo Jeppesen

Questions & Answers Continued . . . .

Generally, WomanKind Staff or Advocates will come to the ED when we are paged.

Q. What if you call around and find that all the shelters are full?

A. If you have called all the shelters on your Resource List, contact Cornerstone, again, and ask them if they can put her up for a few days. Refer to Shelter alternatives on your Resource List. Or, work with the client to see if there are any family or friends that they can stay with until they can find space in a shelter. If all else fails, call Back-up Staff.

WOMANKIND VOLUNTEER WELCOME WAGON

Laurie Beaudry	FRMC
Andrea Bible	FRMC
Kathy Conrad	FRMC
Kim Dwinnell	FSH
Mary Faulkner	FSH
Connie Frankenberg	FRMC
Bobbie Larson	FSH
Nancy Lorey	FRH

TIP OF THE MONTH
IDENTIFICATION OF THE BATTERED WOMAN - MENTAL HEALTH PROBLEMS

Battcrcd woman often present to the ED complnining of symptoms of anxiety, depression, panic attacks, and suicidal ideation. These symptoms could include decreased energy, increased fatigue, inability to sleep, loss of appetite, feeling hopeless and overwhelmed, labile and inability to concentrate or cope with life.

These women may appear suicidal. Check for history of previous suicide attempts. It is important to ask , "Have you thought about taking your life? Have you thought about committing suicide? Do you have a plan?"

DOMESTIC VIOLENCE STATISTICS

*** 33% of all battered women suffer from anxiety and depression; 26% of all women who attempt suicide are victims of domestic violence. (Stark & Flitcraft, 1988.)

*** 64% of hospitalized female psychiatric patients have a history of being physically abused as an adult. (Jacobson & Richardson, 1987.)

WITH GREAT SADNESS
WE SAY GOODBYE .....

Sheila Coggins	FRMC
Rachel Fleming	FRMC
Kelly Horowitz	FRMC
Marge Kranz	FRH
Amie Lemonds	FRMC
Gayle Nielsen	FRMC
Kathy Polhamus	FRMC
Judy Sellers	FRMC

DO YOU KNOW THIS RESOURCE?!
CRISIS NURSERY
Dakota Co. 43 l-2424

Eligibility
** Families in crises
Parental conflict, sudden illness, housing problems, unemployment, domestic abuse
** Ages newborn through 12 years old
* • Parents are only ones who can place their children

Services Provided
• * 24 hour crisis helpline
* • Day & night emergency childcare - up to three (3) days
• • Crisis daycare - up to ten (10) days
* • Crisis counseling and support

Fees - none

Resource Continued ...
Minneapolis 824-8000

Eligibility
* • Children in HCM. Co. up to their 7th birthday
• • Parents define their own crisis
• * Parents are the only ones who can place their children

Services Provided
* • 24 hour crisis helpline
* • Day & night emergency childcare - for up to three (3) days
* * Daycare -- provided when funding available

Fees - none

Ramsey /Washington/Anoka Counties:
641-1300

Eligibility
* • Children in above counties up to their 7th birthday
* * Parents define their own crises
* * Parents, legal or physical guardians (proof needed) are the only ones who can place them

Services Provided
• • Children may be placed for up to three (3) days
* * Daycare provided for five (5) to ten (10) days
• • 24 hour crisis hclpline

Fees - none.

VOLUNTEER CORNER
LET'S CET TO KNOW YOU!!

Fairview Ridges Hospital

Barbara Bumgarner will be our newest Ridges Volunteer Representative on the Advisory Board come January 1995. Barbara resides in Apple Valley and has two daughters. a son, and two grandsons. Barbara has been a Medical Technician for many years. She currently works for Group Health and has approximately ten years. Barbara has volunteered her time and energies in the past to such organizations as the Befriender Ministry, which is a part of the outreach of her church to its congregation, and as a Friend to Friend volunteer at the Shakopcc Women's Correctional Facility. Barbara became interested in the WomanKind program when she saw a newspaper article showcasing the program. She believes it ties in with past personal and professional experiences and sees the need for her type of advocacy at Fairview Ridges Hospital.

Fairview Riverside Medical Center

The Riverside WomanKind program is fortunate to have volunteer Laura Alexander as one of its advocates. Laura currently lives in Southeast Minneapolis. She spent her childhood years in the Apple Valley area. She has been with WomanKind since the start of the Riverside program, March 1994, and is also the Riverside Volunteer Rcprcscntativc for the WomanKind Advisory Board meetings during 1995. Laura spends most of her free time reading or involved in sporting activities. During the winter she is an avid hockey fan and follows the Minnesota Moose Hockey team. In the summer you arc most likely to find her on the golf course. In the past , Laura has given her time providing volunteer services to the Fellowship of Christian Athletes and taught nutrition classes IO elementary school children. Laura spends a great deal of time focusing on nutrition since she works as a dietetic technician at the Fairview Riverside Medical Center.

WomanKind "Tips" published monthly in Emergency Department Newsletters to E.D. staff at FSH FRH FRMC

January, 1995

WomanKind "Tip of the Month"

VIOLENCE AT HOME HAS EFFECT ON THE WORKPLACE

Often, an abused woman is a working woman. Women who have been abused take the violence with them to work, and it shows -- in lost productivity, stress, increased health care costs, employee absenteeism and turnover. The annual cost to business ranges as high as $100 million.. Some estimates place the price tag companies in American pay for violence in the home between $3 to $5 billion annually.

Despite statistics. pointing to its alarming prevalence, domestic violence is not an issue that has been high on the corporate community's agenda until relatively recently. Even though almost half of the workforce in this country is made up of women, only a handful of corporations have taken leadership roles on this issue in the last decade. But that is changing, as a growing number of corporate leaders recognize the serious impact of domestic violence on both their employees' lives, and their bottom lines.

According to a recent survey conducted by Roper Starch Worldwide on behalf of Liz Claiborne, Inc, 57% of corporate leaders believe domestic violence is a major problem in society and 40% are personally aware of employees in their companies who have been affected by domestic violence.

Family Violence Prevention Fund, 1994

JANUARY, 1994

MYTH: Domestic abuse occurs only in lower socio-economic classes and to poor minority women.

This myth allows us to ignore and **deny the widespread occurrence of domestic abuse by thinking that it only happens** in "those neighborhoods". It allows us to distance ourselves by believing: "it's not us, it's them".

Sometimes our own preconceptions blind us to signs of abuse. If you believe that abuse and violence happens only to the low income population, you may not notice signs of

abuse in the well-dressed professional woman.

REALITY: **In fact, domestic abuse and violence occur** in families from all social, economic, educational, racial and religious backgrounds.

It is simply more hidden, a better kept secret, in the suburbs.

FEBRUARY, 1994

MYTH: Alcohol and drugs cause abusive, violent behavior. This myth allows the batterer to blame alcohol and drugs for **his violent behavior.** This myth is often used by the batterer to free himself of responsibility for his actions. He believes "It's the alcohol: If I just get sober, I won't hit her again."

REALITY: In fact, chemical abuse and domestic abuse are two separate problems. Chemical dependency is a disease, an addiction. Abuse is a learned behavior. The abuser may learn to be abusive, controlling, or violent from several sources: his family of origin, the media, our culture, and from-gender role stereotypes.

Because both of these issues are so widespread, they are often present **in the same family. Chemical abuse may be a contributor to the domestic abuse. Chemical abuse does not cause domestic abuse.**

Treatment for an abuser who is also using chemicals often begins with a chemical dependency treatment program followed by individual therapy for the abuser which will focus on his abusive, controlling behaviors. Abusive behavior can be unlearned.

MARCH;1994

Myth: Marriage or couples counseling is a good recommendation, for abusive relationships.

When anyone we know is having problems at home, often the first possible solution we think of is "counseling". However, when-abuse is present in a relationship, couples counseling is rarely the immediate answer.

It is important to remember that abuse is not a communication issue. Abuse is a control issue. The abused woman is afraid of and controlled by the abuser. She cannot talk safely and openly if he is present.

REALITY: Marital therapy or couples counseling is not only ineffective for the couple, it is unsafe for the abused woman.

Individual treatment or counseling is the treatment of choice. Individual therapy, specifically involving behavior modification, can be effective in changing abusive and violent behavior.

Only when the abuse and violence has stopped for a period of time and after the abuser has taken responsibility for his violent behavior can couples counseling be helpful.

Abuse is a learned behavior. It can be unlearned. Abuse and control issues lie within the individual. This creates marital problems. Marital problems do not cause abuse.

APRIL, 'I 994

Just a reminder to ED staff: WomanKind would like to see anyone who Is a current or former victim of domestic abuse. **This is often seen with patients who are experiencing mental health problems.**

The patient may present to the ED with anxiety or ongoing, increasing symptoms of depression. Panic attacks, especially when the battered woman anticipates another beating, may also bring her to the ED.

If the patient presents with anxiety, panic attacks or depression, it is important to investigate the underlying causes of these symptoms. A common cause of these mental health problems is feeling fearful, trapped, and hopeless while living in an abusive and violent relationship.

Please remember to ask these patients about any current or former abuse and violence affecting their lives. You play a crucial role in identifying these patients and helping them reach WomanKind **for crisis intervention and ongoing assistance in their domestic abuse issues.**

JULY, 1994

Domestic abuse affects every one of us in some way--as women, men, children, relatives, neighbors, friends; and co-workers.

WomanKind has just written "DOMESTIC VIOLENCE: HOW YOU CAN HELP--8 STEPS TO SUPPORT AND SAFETY. While these "STEPS" offer helpful ideas to health professionals, they are actually designed for any one of us who would like assistance in talking to someone about domestic abuse and violence.

DOMESTIC VIOLENCE:
HOW YOU CAN HELP

8 STEPS TO SUPPORT AND SAFETY

1. Find a safe time and place to discuss the situation.
2. Build trust by listening and supporting her in a nonjudgmental manner.
3. Provide practical assistance: transportation, child' care, financial assistance.
4. Acknowledge the potential danger in her situation.
5. Validate her experiences, feelings, and fears.
6. Discuss options and plans for safety.
7. Explore with her the available community resources.
8. Respect her process, her timetable and her decisions.

AUGUST, 1994

THE WOMANKIND VOLUNTEERS

WomanKind will be celebrating the work of its volunteers with a Potluck Dinner to be held at the Fait-view Cottage on August 10.

Over 100 committed WomanKind volunteers play an active role in providing advocacy services after hours through FSH, FRH, FRMC. Emergency calls after hours are referred to the volunteer on call through a paging system. WomanKind volunteers facilitate the support groups and work in the WomanKind office during the day.

An initial intensive training program provides the volunteers with an understanding of the issues of domestic abuse and violence, as well as a knowledge of community resources. Additional training for the volunteers who facilitate the support groups is held annually. These trainings are supplemented with monthly meetings which offer both support and ongoing education for volunteers. Volunteers are on call to the Emergency Department after hours. They come to the E.D. to meet with and establish the initial connection with the battered woman. In the Emergency Department they provide support, listen and validate her experiences. They may explore options and resources as appropriate. There is always a back-up staff person available to the on-call volunteer for consultation and assistance.

The goals of the WomanKind Volunteer Program are to provide much needed services to battered women and a challenging and rewarding experience for the volunteers.

SEPTEMBER, 1994

DOMESTIC VIOLENCE: WORKING WITH LAW ENFORCEMENT

In cases of domestic assault, we often hear "she didn't press charges against him". It is not up to the victim to press charges against the assailant. Law enforcement officers can play an active role in arresting the perpetrator of a violent assault.

PROBABLE CAUSE ARREST FOR DOMESTIC ASSAULT

Under Minnesota State statute "a police officer may arrest a person anywhere without a warrant, including at the person's residence, if the police officer has probable cause to believe that the person within the preceding four hours has assaulted, threatened with a dangerous weapon, or placed in fear of immediate bodily harm the person's spouse, former spouse...even though the assault did not take place in the presence of the police officer. (Minn. Stat. 629-341)

A battered woman often comes to the E.D. following an assault. The WomanKind staff, volunteer advocate or E.D. staff, with the woman's consent, may contact the police. WomanKind encourages the police officer from the involved department (where the assault occurred) to come to the E.D. in order to take a police report, and working within the 4-hour window, find and arrest the perpetrator. The 4-hour window provides a sense of urgency for the police to act promptly in finding and arresting the assailant. However, despite the criminal nature of domestic violence, there is not a mandate for health professionals to report domestic assault, as there is in the case of child or elder abuse. Unlike children, battered women are independent and fully capable of making personal decisions that best meet their needs.

REPORTABLE CASES

In the State of Minnesota: The only circumstances under which law enforcement must be contacted concerning domestic violence is in circumstances where a weapon has been used to inflict injury, specifically a knife or gun. These cases often result in a felony assault versus 5th degree misdemeanor assault.

The following cases are REPORTABLE to law enforcement:

1. Injuries caused by firearms
2. Knife wounds inflicted by another person or occurring under suspicious circumstances
3. Sexual assault if the patient signs waiver in the Emergency Department (See E.D. Sexual Assault Protocol)

OCTOBER, 1994

OCTOBER IS DOMESTIC VIOLENCE AWARENESS MONTH. .

Researchers estimate 25% to 37% of all women experience battering in their lifetime--an estimated 382,000 to 566,000 women in the State of Minnesota.

Domestic abuse is increasingly recognized as a widespread community health problem. The health care system offers a prime opportunity for intervention with victims of domestic abuse and violence.

The Emergency Department is the point of entry into the health system for many victims. Numerous studies have found that 22% to 35% of women who visit emergency departments are there for symptoms related to ongoing abuse. The battered woman will frequently present with:

1. trauma (assault, either physical or sexual)
2. mental health issues (anxiety, depression, panic attacks, suicide attempts)
3. battering during pregnancy (injuries often to breasts, abdomen or genitals)

It is important for health care professionals to rediscover the relationship between intervention and prevention. Early intervention by health professionals can interrupt the cycle of violence, prevent more serious injuries, and prevent the mental health problems associated with long-term abuse.

The Fair-view Health System provides services for victims of domestic violence through WomanKind: Support Systems for Battered Women, a nationally recognized model program which provides:

1. advocacy services, crisis intervention and ongoing assistance to battered women; and
2. education and consultation with hospital staff and community health professionals.

WomanKind provides a supportive connection between the battered woman in the health system and the resources available in the community to help her and her children, WomanKind services, provided 24-hours-a-day, 7-days-a-week, are free and confidential.

The WomanKind program is located at Fair-view Southdale Hospital 924-5775; Fair-view Ridges Hospital 892-2500; and Fairview riverside Medical Center 672-2700. There is a full-time staff person available at each WomanKind office. Contact the WomanKind Answering Service after hours at 924-8200 to reach a staff person or volunteer advocate.

WATCH FOR THE WOMANKIND BULLETIN BOARD DISPLAYS AT EACH HOSPITAL DURING OCTOBER:

DOMESTIC VIOLENCE AWARENESS MONTH

NOVEMBER, 1994

THE RELATIONSHIP BETWEEN DOMESTIC ABUSE AND CHILD ABUSE: The Effect of Mother's Abuse on Children

Experiencing Abuse

All members of the family suffer as result of domestic violence. Programs for battered women have been in the forefront in discovering and reporting how both witnessing or experiencing domestic abuse can affect children. There is a strong correlation between domestic abuse and child abuse. Research has found that in half of the families where the mother is abused, the children are abused as well. One study found that, in general, 70% of men who batter women also batter their children, making the presence of spouse abuse the single most identifiable risk factor for predicting child abuse (Bowker, 1989).

Witnessing Abuse

Results of research on what are often called "witnessing" children, children who have not been abused themselves, but who have seen their parents in violent conflicts, are becoming available. Boys who grow up in homes where there is violence, are more likely to batter their female partners as adults, than boys raised in nonviolent homes (Stark & Flitcraft, 1985). Children and youth who witness abuse of their mothers display as much or more physical and verbal aggression, sleep disturbance, and general anxiety as those who are direct recipients of the abuse (Jaffe, Wolfe, Wilson, 1990). Erickson and Henderson found that the fear, uncertainty and sadness which these children describe, together with the powerlessness which they feel and their acceptance of violence as an appropriate response to conflict, have significant implications for their current and future mental health (Erickson and Henderson, 1992). Children who witness domestic violence are vulnerable to emotional and developmental problems later in life. Tomorrow's violent offenders are being raised in today's violent homes.

DECEMBER, 1994

THE RELATIONSHIP BETWEEN DOMESTIC ABUSE **AND CHILD ABUSE:** The Effect of Mother's abuse on Children

Many parents minimize or deny the presence of children while the mothers are being assaulted. However, interviews with children of battered women reveal that they have seen and heard, and can describe detailed accounts of violent behavior that their mother or father never realized they had witnessed (Jaffe, Wolfe & Wilson, 1986). Events can be witnessed in many ways, not just by sight. Children may hear their mother's screams and crying; the abuser's threats; sounds of fist hitting flesh, glass breaking, wood splintering, cursing and degrading language. Children also witness the consequences of the physical and emotional abuse after it has occurred -- their mother's bruises and torn clothes, holes in walls, broken furniture, their mother's tears. The children may sense the tension in the house, in their mother (National Center on Women and Family' Law, 1990). As violence against women becomes more frequent and more severe in the home, children experience a 300% increase in physical violence by the male batterer (Straus & Gelles, 1990).

The Fairview Health System through its WomanKind program has taken the lead across the country **in providing coordinated services for victims of family abuse and violence. The health care system has an** ethical responsibility and offers a prime opportunity for intervention with victims of domestic and child abuse. It is important for physicians, nurses and other health professionals to rediscover the relationship between intervention and prevention. Routine assessment for abuse of all patients who enter the health system will greatly improve the identification and subsequent intervention for victims of family abuse and violence.

WomanKind works closely with the Child Abuse Response Team at FSH and with Social Work Services at FRMC and FRH in identifying and reporting suspected oases of child abuse and neglect. Child Protective Services then determines if maltreatment has taken place.

a:monthtip.,mon

JANUARY, 1993 .

There are times when we suspect domestic abuse in some of the injuries or suicide attempts we see in the Emergency Department:

There often is a level of discomfort, however, in bringing up the subject with the patient. As uncomfortable as it may be, it is a kindness and a necessary service to our patients to inform them of WomanKind, the program in our hospital which can directly benefit them. Many women actually report being relieved to be asked about suspected abuse.

We offer these examples of questions that could be asked of a patient in order to introduce the possibility of calling a WomanKind advocate. You, no doubt will be creative in your own way. These are only suggestions.

1. "Did someone hurt you? Did you receive these injuries by being hit?"

2. "I'm concerned about your injury. When I see injuries like this, they are often a result of one person hurting another. Could that have happened to you?"

3. "Are you in a relationship in which you are physically or emotionally hurt?"

4. "Has your partner hit, slapped, kicked or otherwise hurt you?"

5. "Does your partner try to control you...are you afraid of him?"

And then...

"There is a program here at the hospital called WomanKind. It is a very supportive place to talk about a variety of issues. It is safe and non-judgmental and you can talk about, some of the options available to you and get some "t.l.c." There is an advocate available 24 hours a day. I'd like to call one for you now. She can be here within 30 minutes."

FEBRUARY, 1993

Identifying the Abused Woman

It is often difficult for Emergency Department staff to identify domestic violence victims. She won't necessarily present with burns, broken bones or easily visible bruises, However, being sensitive to certain clues or presenting symptoms can be helpful.

Patients who are victims of domestic abuse rarely explain the cause of their injury or anxiety. Patients may describe in a hesitant, embarrassed, or evasive manner the circumstances surrounding the alleged "accident". Is she unable to look you in the eye? Does she appear to be guilty or ashamed, jumpy or frightened, disoriented or depressed?

It is important to ask the question. Did someone hurt you? WomanKind has found that abused women are relieved to be asked about their injuries. A formerly abused woman who is now a WomanKind volunteer stated that she had been to several Emergency Departments with injuries from violence during her marriage. She was always afraid that someone would ask her how she got her injuries She was just as afraid that no one would ask, and she would have to go home and continue to cope with the abuse along.

MARCH, 1993

Identification of the Battered Woman-Mental Health Problems

Battered women often present to the E.D. complaining of symptoms of anxiety, depression, panic attacks, and suicidal ideation. These symptoms could include decreased energy, increased fatigue, inability to sleep, loss of appetite, feeling hopeless and overwhelmed, labile and inability to concentrate or cope with life.

These women may appear suicidal. Check for history of previous suicide attempts. It is important to ask "Have you thought about taking your life? Have you thought about committing suicide? Do You have a plan?"

APRIL, 1993

Identification of the Abused Woman-Mental Health Issues

33% of all battered women suffer from anxiety and depression; 26% of all women who attempt suicide are victims of domestic violence.
Stark and Flitcraft, 1988

64% of hospitalized female psychiatric patients have a history of being physically abused as an adult.
Jacobson and Richardson, 1987

There is a strong connection between domestic abuse and mental health problems. It is important to treat not only the presenting problem of mental health symptoms but also address the underlying cause which may often include domestic abuse issues. WomanKind is available 24 hours a day, 7 days a week to come to the E.D. to talk with someone experiencing abuse at home.

MAY, 1993

Battering During Pregnancy

Research indicated that a significant number of women are beaten while pregnant, and that abusers often strike or kick women in the breasts or abdomen with the stated intention of causing a miscarriage.

38% of obstetric patients were physically abused during pregnancy.
Helton, "American Journal of Nursing", 1986

25% to 45% of all women who are battered are battered during pregnancy. A battered pregnant woman is four times more likely to have a low birthweight baby and her changes of miscarriage are double.
Stark and Flitcraft, Wife Abuse in the Medical Setting, 1981.

Abuse often begins or escalates during pregnancy and may result in:

- Pregnancy Loss
- Preterm Labor
- Low Birth-Weight
- Fetal Injury
- Fetal Death

Most important to remember, battering during pregnancy may be an indication of what life holds in store for the unborn child. identification and intervention with the battered pregnant woman could be vital in the protection of both the woman and her fetus.

JUNE, 1993

Repeat Visits or Chronic Injuries
Vague or Nonspecific Complaints
Patients who frequently seek emergency or medical treatment for seemingly minor injuries or vague, non-specific problems may not be hypochondriacs or "chronics", but abuse victims seeking help. The emergency department may be the only place she is allowed to go and hopefully will feel safe enough to talk with you about her situation.

The patient's medical history may reveal many "accidents" or contain remarks by a nurse or physician indicating that previous injuries were of suspicious origin.

Note that women beaten at regular intervals may come to a clinic or hospital with psychosomatic or mental health complaints just before they anticipate another beating. Previous files on the patient should always be checked for repeat visits.

JULY, 1993

Identification of the Battered Woman
Discrepancy Between Patient's History and the Type and Appearance of Injuries

Be observant--Do the patient's injuries match her story? Be alert for familiar explanations, such as "I walked into a door" or "I had a tooth pulled." You may have to play the role of detective in determining the cause of her injury.

Look for multiple bruises in various stages of resolution. Does she have fresh or resolving contusions on the trunk, or on her arms, which she may have raised to defend herself? Does she seem ashamed of them?

Are there old wounds that haven't been properly attended to? I remember seeing a woman several years ago who had a large raised area on the front of her tibia. That injury was caused by a kick to her lower leg. The patient was not allowed to obtain medical treatment and this probable displaced fracture healed without appropriate medical care.

AUGUST, 1993

BE ALERT TO THE BEHAVIOR OF HUSBAND OR PARTNER WHO MAY--

1. Be Overly Solicitous
2. Be Overly Affectionate
3. Explain the Injury
4. Answer all Questions

The partner or husband often accompanies the patient and insists on staying close to her. She may flinch whenever he makes a sudden move. Be wary of the overly solicitous partner or husband who won't let his wife out of his sight. He may be solicitous--too solicitous, and seems eager to explain the injury and answer all the questions asked of her. They may appear to be extraordinarily affectionate for a public place. Remember, she must respond to him as he expects/demands or he may retaliate at a later time.

SEPTEMBER, 1993

It is vital that you interview the battered woman alone. Remember; Abuse is not a communication issue. Abuse is a control issue. She is afraid of and

controlled by the abuser, and cannot talk safely with him present.

This is the primary reason that couples counseling is not recommended for most couples where there is domestic abuse. Couples counseling is not only ineffective. It is unsafe for the battered woman.

NOVEMBER, 1993

ASK THE QUESTION!

In questioning the patient, gentle tactful probing is required. Be direct, but sensitive with your questions or comments. Battered women have said they never talked about the abuse or violence because no one ever asked them about their injuries. Or if asked, their evasive or doubtful answer was not investigated further to determine the true cause of their injuries.

Many battered women **who at first deny the** true source of their injuries are willing, in fact relieved, to talk about the abuse if asked directly in a supportive, nonjudgmental environment.

The following statements and questions may be helpful in talking with a battered woman: "When I see injuries like yours, I'm concerned that someone may have hit or hurt you. Did someone hurt you? Did you receive your injuries by being hit?"

DECEMBER, 1993

RESPONSIBILITY FOR BEHAVIOR

It is often heard, "What did she do that made him hit her?" or "What did she do to provoke him?" It is important to differentiate between anger (which is a feeling) and violence (which is a behavior). The battered woman may, in fact, say or do something to make him angry. She can provoke a feeling, such as anger. He then has a choice and makes a decision as to what to do with that anger, and he often chooses to be violent.

Most battered women feel guilty and ashamed, as they are taking responsibility for someone else's inappropriate behavior. She believes that she is responsible. It is important that we tell her that she is not responsible for the abuse and violence used against her. She did not provoke it. She did not cause it. She does not deserve to be abused.

ANGER IS A FEELING
VIOLENCE IS A BEHAVIOR

THE PERSON EXHIBITING THE BEHAVIOR IS THE PERSON RESPONSIBLE **FOR THAT BEHAVIOR**

WOMANKIND

Support Systems for Battered Women

Domestic Violence: How You Can Help

8 Steps To Support & Safety

1. Find a safe time and place to discuss the situation.
2. Build trust by listening and supporting her in a nonjudgmental manner.
3. Provide practical assistance: transportation, child care financial assistance.
4. Acknowledge the potential danger in her situation.
5. Validate her experiences, feelings and fears.
6. Discuss options and plans for safety.
7. Explore with her the available community resources.
8. Respect her process, her timetable and her decisions.

No one deserves to be abused for any reason.
There is help available. You are not alone.

WomanKind , a hospital-wide domestic abuse program, is offered through the Fairview Health System. The first program of its kind in the United States, WomanKind was founded in 1986 to better identify and treat abused women who use the health care system. WomanKind—providing a supportive connection between the battered woman in the health care setting and the resources available in the community to help her and her family.

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Minneapolis, Minnesota

Fairview Ridges Hospital
201 East Nicollet Boulevard
Burnsville, MN 55337

Fairview Southdale Hospital
6401 France Avenue South
Edina, MN 55435

Fairview Riverside Medical Center
2450 Riverside Avenue South
Minneapolis, MN 55454

Appendix R

Intimate Partner Violence References

Intimate Partner Violence References

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