Background

Overview: Intimate Partner Violence

Intimate partner violence (IPV) is a substantial public health problem that has reached epidemic proportions resulting in serious consequences and costs for individuals, families, communities, and society.[1,2] The National Violence Against Women Survey (NVAWS) reports an estimated 5.3 million IPV victimizations occur among U.S. women ages 18 and older each year and this violence results in nearly 2 million injuries, more than 555,000 of which require medical attention (CDC, 2003). Estimates from the National Crime Victimization Survey (NCVS) indicate that approximately 1 million violent crimes are committed annually against persons by their current or former spouses, boyfriends, or girlfriends, with 85% of victims being women. On average, approximately 8 in 1,000 women and 1 in 1,000 men, age 12 or older, experienced a violent victimization perpetrated by a current or former intimate partner.[3]

The health care costs of intimate partner rape, physical assault, and stalking exceed $5.8 billion each year, nearly $4.1 billion of which is for direct medical and mental health care service which accounts for more than two-thirds of the total costs (CDC, 2003).

In 2003, there were over 194,000 domestic violence-related calls for assistance to law enforcement in the State of California. Approximately 52,000 of those calls occurred in Los Angeles County. In addition, there were over 48,000 arrests for spousal abuse charges in the state of California in 2003 and of those nearly 13,000 arrests occurred in Los Angeles County.

Medical providers may be the first non-family member to whom an abused woman turns for help; thus, they have a unique opportunity and responsibility to intervene.[4] To facilitate intervention on behalf of abused patients, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO-1992) has required that all accredited hospitals implement policies and procedures in their emergency departments and ambulatory care facilities for identifying, treating, and referring victims of abuse. The standards require educational programs for hospital staff in domestic violence, as well as elder abuse, child abuse, and sexual assault.

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[1]Bachman R, Saltzman LE. Violence against women: estimates from the redesigned survey, Bureau of Justice Statistics, Special Report. Washington, DC: US Department of Justice; August 1995.
[2]Greenfeld L, et al., editors. Violence by intimates: analysis of data on crimes by current or former spouses, boyfriends, and girlfriends. Bureau of Justice Statistics Factbook Washington, DC: US Department of Justice; March 1998. NCJ-167237.
[3] National Crime Victimization Survey, 1992 - 1996
[4] American Medical Association

In addition, most states have improved the legal remedies available to battered women, and a number of state health departments have developed protocols for health care providers. While almost all states have laws that require reporting certain injuries, California is one of six states -- including Colorado, Kentucky, New Hampshire, New Mexico, and Rhode Island -- with specific laws on reporting suspected cases of intimate partner violence. Most of these states have provisions for protecting victim identity, obtaining informed consent, or reporting to social service agencies. However, California Penal Code, section 11160 requires that health care professionals report cases when they suspect the patient is suffering from an IPV-related injury to law enforcement officials, with or without the patient's consent. [5]

Overview: Strategic Planning Background

Until recently, several California counties, including Los Angeles, had not developed standardized policies to ensure compliance with IPV laws. To address this issue, healthcare providers, often in conjunction with advocacy and law enforcement, met in several counties to address how best to comply with IPV laws. They developed protocols, on a county-by-county basis, that attempt to comply in a manner that is ethical and protective of patients, as much as possible, without minimizing the danger and criminal nature of the event.[6] As part of this effort, the Los Angeles County Department of Health Services (DHS), Injury and Violence Prevention Program (IVPP) was awarded a grant from the State Department of Health Services Epidemiology and Prevention for Injury Control (EPIC) Branch to develop a strategic plan for implementation of policies and procedures regarding Intimate Partner Violence and compliance with California Penal Code, section 11160.

The strategic planning process was initiated in June 2003, and proceeded over the course of eighteen months. The main goal of the strategic planning process was to formulate a five-year comprehensive plan to implement standardized IPV policies and protocols within the 25 DHS clinics, health centers and hospitals, including a strategy to assure compliance with mandatory IPV reporting laws. The strategic planning process included the following five fundamental phases that allowed for flexibility and creativity, while providing a structured process for developing a comprehensive plan to address IPV with DHS healthcare facilities:

- Phase 1: Plan for Strategic Planning – During this phase, agreement was reached on initial critical issues and a detailed "plan for planning" was developed, which included process and procedures for all phases of planning, planning outcomes, activities, responsible personnel and timeframe.

- Phase 2: During phase 2, the planning committee developed a mission and vision statement.

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[5] Rodriguez M, et al. Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians. JAMA. August 1999. 282: 468-474.

[6] Shaping California's Health Policy for Victims of Intimate Partner Violence. Harvard Health Policy Review. Fall 2001: 2:2.

- Phase 3: Assessed the Environment – During this phase, appropriate data was collected from the DHS healthcare facilities to provide an explicit understanding of the current IPV practices and protocols and the degree of implementation of these procedures. This information was used to analyze the internal strengths and weaknesses within DHS, and its external opportunities and threats in regard to intimate partner violence

- Phase 4: Agreement on Priorities - During phase 4, the planning committee decided on the strategies to address the previously identified issues and established goals and objectives.

- Phase 5: Composed the Strategic Plan – During phase 5, the information collected in the previous phases was synthesized into one coherent, consolidated document that will act as a detailed blueprint for action, as DHS implements policies and protocols to address IPV within its healthcare facilities.

The overall purpose of the strategic planning process was to develop a plan to implement standardized policies, procedures and protocols to screen, treat, refer and report intimate partner violence, assuring compliance with the law and to prevent and reduce intimate partner violence, through training, education, and consultation of healthcare providers and staff. The objectives of the strategic planning process were to construct a plan to:

- Develop protocols to screen, treat, refer, and report victims of IPV in all DHS healthcare facilities.

- Identify and implement a universal screening tool for victims of intimate partner violence

- Develop uniform reporting and data collection systems within LAC DHS.

- Facilitate services and resource linkages to victims of intimate partner violence.

- Prevent and minimize collateral damage that accompanies IPV.

- Raise awareness, educate and train LAC DHS healthcare staff about IPV and compliance with the law.

Overview: Intimate Partner Violence Strategic Planning Coalition

The involvement of key stakeholders leads to an increased level of commitment to the strategic plan's goals and objectives by building a vision that is shared among all participants. In order to involve key stakeholders, the IVPP convened the Intimate Partner Violence Prevention Strategic Planning Coalition, which contained two main committees consisting of key staff within DHS, community based organizations and community leaders. The External Advisory Group consisted of community-based agencies and community leaders with expertise in intimate partner violence. The External Advisory Group functioned as an oversight committee, assuring that planning efforts were strategically focused while addressing the complexities of developing a plan for IPV within DHS.

The Internal Working Group consisted of administration and staff members from DHS SPAs (service planning areas), hospitals, clinics, and public health programs. The Internal Working Group was responsible for providing leadership, oversight and resources for the project. Members of the Internal Working Group were required to participate in at least one sub-committee, which focused on a specific aspect of the strategic planning process (see Table 2). Both the Internal Working Group and the External Advisory Group ensured that the strategic plan addressed the most important elements of IPV including screening, treatment, referral and reporting.

Table 2
Internal Working Group Sub-Committees

Sub- Committee Name	Description	Time-Frame
Policy Review Sub-Committee	The Policy Review Sub-Committee was responsible for coordinating the collection of DHS facilities' IPV policies, service statistics, organizational charts, resources, and other documents clarifying the organization's mandates, history, and operating trends.	July – September 2003
Mission/ Vision Statement Sub-Committee	The Mission/Vision Statement Sub-Committee was responsible for developing the Mission and Vision Statement for the IPV Prevention Strategic Planning Coalition.	September – October 2003
Survey Sub-Committee	The Survey Sub-Committee was responsible for developing the administrator and staff surveys to assess current IPV related policies, procedures and protocols, and to assess ideas for implementation of county-wide policies, procedures, and protocols.	November 2003 – February 2004
Data Collection Sub-Committee	The Data Collection Sub-Committee was responsible for coordinating the assessment of the DHS facilities to evaluate current IPV related policies, procedures and protocols. The Data Collection Sub-Committee provided feedback on the data analysis related to the information collected during the countywide assessment. This sub-committee also assessed current IPV policies within DHS.	March – June 2004
Strategies Sub-Committee	The Strategies Sub-Committee was responsible for choosing the criteria to guide the setting of priorities, and then selected the future overall core strategies so that the IPV Prevention Strategic Planning Coalition can achieve its purpose of implementing IPV-prevention policies, procedures, and protocols within DHS facilities.	July – August 2004
Goals and Objectives Sub-Committee	The Goals and Objectives Sub-Committee was responsible for developing overall goals, as well as specific and measurable objectives regarding the implementation of IPV-prevention policies, procedures, and protocols within DHS facilities. The Goals and Objectives Sub-Committee also reviewed IPV strategic plans from other California Counties.	September - November 2004

Mission and Vision Statements

Mission Statement

The mission of the Intimate Partner Violence (IPV) Prevention Strategic Planning Coalition is to prevent and reduce intimate partner violence in Los Angeles County through development of IPV policies, procedures, and protocols for LAC DHS in collaboration with the community agencies of Los Angeles County.

External Vision Statement

A safe and healthy environment in Los Angeles County, where all people can live without risk of intimate partner violence.

Internal Vision Statement

All clients (ages 13 and older) within the DHS system are screened, identified, treated, referred and reported for IPV.

Vision of Success

The IPV Prevention Strategic Planning Coalition will be successful in meeting its purpose if implementation of the strategic plan results in the following:

- Raised awareness about intimate partner violence among healthcare providers within LAC DHS.
- Increased knowledge, understanding, and law requirements associated with intimate partner violence for healthcare providers within LAC DHS.
- Decreased economic costs associated with utilization of judicial system, law enforcement and healthcare system.
- Early identification, effective intervention and treatment, and adequate referral services for victims of intimate partner violence.
- Implementation of universal screening for intimate partner violence for all clients within LAC DHS healthcare facilities.
- Promotion of primary prevention of intimate partner violence.
- Reduction in incidence and prevalence of intimate partner violence.
- Healthier, happier and safer families and communities.

Fundamental Values and Beliefs

Prior to creating the mission and vision statements, the IPV Prevention Strategic Planning Coalition identified the fundamental values and beliefs that guide the interactions between planning participants, as well as with the community. The IPV Prevention Strategic Planning Coalition also identified the major assumptions upon which the strategic plan was developed.

We believe:

- All people have the right to healthy relationships and safe environments.
- All people have the right to be free of IPV.
- All people should feel empowered to live to their full potential without fear of IPV.

We value:

- Integrity
- Collaboration and teamwork
- Education and knowledge
- Positive behavioral changes
- Basic human rights and dignity
- Empowerment
- A holistic approach
- Health, happiness and quality of life

We assume:

- There is a need to raise awareness of the domestic violence problem.
- There is a need for prevention and treatment of IPV.
- Prevention is possible and that it works.
- Behavior can be changed.
- Developed IPV policies, procedures, and protocols will be successfully implemented.
- All healthcare workers should be educated about domestic violence.
- We can build and facilitate collaboration among LAC DHS agencies.
- We can make a difference.

Initial Key Critical Issues

The Internal Working Group identified five key critical issues that assisted in focusing the strategic planning process. In addition to identifying the issues, the IPV Prevention Strategic Planning Coalition identified the potential barriers and benefits of addressing the key critical issues in the five-year comprehensive strategic plan to address IPV within DHS healthcare facilities.

Screening/ Identification of Intimate Partner Violence

Without an initial IPV screening process, IPV victims would not be identified and prevention strategies could not be applied. Possible barriers to IPV screening include time constraints, cultural issues, personal fear, biases, attitudes and values, and lack of knowledge and information about addressing IPV within a healthcare facility. Requiring universal IPV screening of all DHS patients will result in better identification of suspected or known cases of IPV, allowing an opportunity for intervention and prevention of further harm and injury.

- Only 45% of DHS healthcare facilities reported having a policy to screen for victims of IPV.
- 21% of administrators/managers were unsure if an IPV screening policy existed in their facility.
- Only 43% of facilities reported that universal screening of men and women was required under the IPV policy.
- Of the administrators/managers working in facilities with Emergency Departments, most felt confident that IPV screening occurred there. However, of the respondents with OB/GYN facilities, 27% did not know if screening occurred in that area, and 44% didn't know if screening occurred in the outpatient department.

Intervention and Treatment

Timely intervention and early treatment can reduce the number and severity of injuries, prevent future incidents of IPV and save lives. Possible barriers to effective intervention include a lack of institutional or administrative support and training, insufficient staff, lack of bilingual staff, inadequate system to respond appropriately after identification of IPV, and a poor monitoring system for reinforcement of IPV policies.

- 33% of administrators/managers reported that their facility did not have a written policy for treating, intervening and referring IPV.

- 23% were unsure if their facility had a written policy addressing protocols for intervention with a patient identified as a victim of IPV.

- 16% of staff members reported that their facility does not have a policy for providing services to victims of IPV, while 29% were unsure if such a policy existed.

- Of the administrators/ managers who responded that their facility has an IPV policy (45%):

  - 20% of the policies do not describe how to appropriately intervene and treat a victim of IPV.
  - 35% of the policies do not describe how to document an intervention.
  - Only 24% of the policies required development of a safety plan.

Resources and referrals:

Appropriate resources may facilitate the process of breaking the cycle of violence and ensure safety for IPV victims. It may enable IPV victims to further seek what she/he needs to prevent future IPV.

- Of the 400 survey respondents whose facility provided direct services to patients, 39% of DHS staff responded that inadequate resources to help identified IPV victims was a perceived barrier to providing adequate services to victims of IPV.

- Of the administrators/ managers who responded that their facility has an IPV policy (45%), 17% do not describe how to refer victims of IPV.

- Of the 400 survey respondents whose facility provided direct services to patients:

  - 65% stated that their facility works with shelters for battered women.
  - 57% stated that their facility works with counseling service agencies.
  - 43% stated that their facility works with legal aid service agencies.

Reporting to Law Enforcement:

California Penal Code, section 11160 requires that health care professionals report cases for patients whom they suspect are suffering from an IPV-related injury to law enforcement officials, with or without the patient's consent. However, Los Angeles County DHS has not had a standardized policy to ensure mandatory reporting of IPV patients to law enforcement. Currently, there is not a judicial monitoring system to assess the effectiveness and level of implementation of this law. Other barriers to reporting may include a lack of follow-up system, slow response time, and inadequate level of support and cooperation from law enforcement.

- 37% of DHS staff were not aware of the standard countywide injury reporting form.
- Only 14% of DHS staff who were aware of the form stated that they have used this form to report IPV to local law enforcement during the past 12 months.
- 22% (183/823) of the respondents were not sure (or did not answer) if they were a mandated reporter for IPV.
- 33% (270/823) were not sure (or did not answer) if patient's consent was required to report IPV to law enforcement.
- 11% (93/823) incorrectly answered that patient's consent was required to report IPV to law enforcement.

Countywide Data Collection System:

Developing a data collection system is important because the epidemiology of IPV in Los Angeles is not completely known due to incomplete data.

- 22% (22/104) of administrators/managers stated that their facility collected IPV data. Of these:
  - 73% collect data on number of IPV cases identified.
  - 64% collect data on number of clients screened.
  - 55% collect data on number of IPV cases reported to law enforcement.