VIOLENCE AGAINST WOMEN PREVENTION

STATEWIDE STRATEGIC PLAN

A Public Health Approach to the Prevention of Violence Against Women

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Office of Women's Physical and Mental Health
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Recommendations for a Public Health Approach to the Prevention of Violence Against Women

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About the Kentucky Office of Women's Physical and Mental Health

The Office of Women's Physical and Mental Health (OWPMH), an executive agency of the Kentucky Cabinet for Health and Family Services, is the state's focal point for women's health issues. Created by the Kentucky Legislature in February 1998 under the Women's Health Bill (HB 864), the Office serves as a "repository for data and information affecting women's health and mental health" for analyzing and communicating trends in women's health issues and mental health; recommending data elements affecting women's health and mental health that should be collected, analyzed and reported; and administering a Women's Health Resource Center to focus on targeted preventive and comprehensive health education.

After becoming operational in October 2000, with the appointment of an Executive Director, the Office successfully launched a web-based, women's health resource center, with information, hotlines, statistics, and links on topics relevant to women's health, including violence against women. In addition to its website (www.womenshealth.ky.gov), the OWPMH publishes a number of Fact Sheets, plans and participates in numerous health fairs, conferences, training programs, and media events, and educates professionals and the general public on women's health issues. These services are provided to all women of all ages, and of all economic, racial and cultural backgrounds. This truly sets the OWPMH apart from other statewide health programs targeting specific populations, while augmenting existing efforts to improve the health of the Commonwealth. By partnering and collaborating with other agencies, the OWPMH strengthens its ability to touch thousands of lives each year.

In May 2002, the OWPMH published *Kentucky Women's Health 2002: Data, Developments, and Decisions*, highlighting trends and statistics on various women's health issues. This report, the first of its kind in the state, includes a chapter devoted specifically to the issue of violence. As a collaborative report representing all health services programs and initiatives targeting women, it brought important physical and mental health information into one document. For more information about this report, please contact the OWPMH at 502-564-9358 or visit our website at www.womenshealth.ky.gov.

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Executive Summary

While many forces have joined together to improve Kentucky's response to violence against women (VAW), we find the rates of domestic violence (DV) and sexual assault (SA) in the Commonwealth continue to exceed national rates. In 2000, 37% of adult women in Kentucky were victims of intimate partner violence compared to 25% of women nationally.

It is well documented that VAW has severe physical and mental health consequences. In 2001, 26% of adult women treated at Community Mental Health Centers (CMHC) across the state responded positively to being a victim of physical abuse, up from 19% in 1998. Additionally, 20% of the women served at CMHCs reported being a victim of rape, sexual assault or sexual abuse, up from 13% in 1998.

Clearly, VAW is a public health issue, the effects of which extend to every person, family, school campus, business, church and community throughout the Commonwealth. The Office of Women's Physical and Mental Health (OWPMH), an executive agency of the Kentucky Cabinet for Health and Family Services, recognizes that VAW affects both the physical and mental health of women in Kentucky, not just at the time of victimization, but often for a lifetime. This realization underscores the need for effective prevention strategies for VAW, by approaching the issue as a national and statewide public health priority.

In response to this realization, the OWPMH applied for, and received, a $50,000 planning grant for the prevention of VAW from the Centers for Disease Control and Prevention (CDC). Under the auspices of this grant, the OWPMH focused on the role of local health departments (LHDs) as a first line provider to many victims of violence, or those at-risk for victimization. LHDs are often the chosen provider for women receiving prenatal care, child and adult preventive care, immunizations, and family planning. In FY 2002-03, LHDs served over 460,000 women throughout Kentucky, providing literally thousands of opportunities for primary or secondary VAW prevention. With this understanding, the OWPMH choose to take a closer look at the role of LHDs, specifically LHD nurses, and their protocols and practices when serving clients experiencing DV or SA.

While there is no one sector of society that can single-handedly eliminate the scourge of violence on our communities, it was clear in our early planning efforts that taking a narrow focus would enable us to streamline our efforts and provide for the greatest impact with the limited time and resources available. The OWPMH explored the two levels of VAW prevention which were most applicable to the role of LHDs: primary prevention - preventing violence from occurring in the first place; and secondary prevention - focusing on the more immediate responses to violence through screening and referral in a healthcare setting.

Preliminary discussions and anecdotal analyses with public health nurses and administrators indicated that little was known among the Department for Public Health (DPH), as well as community agencies providing direct services to victims of violence, on

current policies, guidelines, and practices in use to educate, screen and refer victims, or potential victims. We learned there was a general lack of communication and collaboration between the LHD network and community agencies serving women, despite the fact that both entities are routinely used as resources for women victims of violence. Improving collaboration at the community level eventually emerged as a primary goal for the prevention of VAW in Kentucky.

An essential element to evaluating the level of communication and collaboration among community agencies was to provide a forum for discussion of this topic. In response, focus groups were conducted with DV shelters and rape crisis centers (RCCs) to identify programs and initiatives, and assess familiarity and collaboration with their LHDs. Among the findings, the directors of the RCCs and DV shelters both acknowledged a general lack of community awareness about victim services available at the local level. Both groups cited numerous efforts at improving their response to those needing services, such as collaboration with other agencies, client satisfaction surveys, public education and outreach, and use of data to monitor the effectiveness of their services and programs.

The second set of data collected for the VAW prevention grant was intended to assess the level of understanding and practices of our public health nurses in their day-to-day interactions with victims of violence. These data were obtained through a comprehensive survey delivered to over 1,000 public health nurses employed at LHDs. The survey assessed the nurses' practice patterns and general attitudes towards DV and SA, and further assessed the impact violence has on their respective practices.

Among the key survey findings was an encouraging 86% of nurses who believe identifying and referring victims of DV is an important part of their job. However, despite this belief, only 23% of nurses responded that they screen every patient for DV, despite mandatory screening policies. Several obstacles identified as major or minor barriers to a nurse's ability and decision to screen a patient for DV included a fear of offending the patient if they asked about DV; the patient lacked privacy; and the patient's primary language was not English. When referring a victim of DV, the majority of nurses (54%) refer to the Department for Community Based Services (DCBS). While many nurses provide referrals for their patients affected by DV, 14% responded that they do not routinely refer patients affected by DV.

Despite the variation in DV screening and referral practices among public health nurses, 87% of nurse respondents believe DV is a public health issue. Ensuring that our public health nurses are adequately trained to deal with DV/SA in their professional practice, eliminating obstacles to effective DV screening and referring, and improving collaboration among service providers are among the key priorities to this strategic plan.

Upon evaluation and analysis of data from the focus groups and the survey of public health nurses, the following **Priority Areas** emerged as key components to improve public health's response to VAW:

1. Need for improved DV and SA **training and education** for Kentucky's public health nurses;

2. Need for improved and **standardized DV screening protocols** and practices at LHDs;

3. Need for improved **information on DV/SA referral sources** at the community level;

4. Need for improved and sustained **community collaboration** to focus on the prevention of VAW.

Upon identification of the four priority areas, a statewide strategic planning meeting was held to develop corresponding recommendations. From this day-long planning meeting, consisting of approximately 30 VAW stakeholders, over 50 recommendations were developed. The following includes key recommendations in each area.

TRAINING/EDUCATION

- Identify and maintain documentation of public health nurses' training specific to DV.
- Explore the feasibility of securing legislation to require nurses applying for bi-annual re-certification to receive DV training prior to re-certification.
- Coordinate/collaborate with other public/private agencies providing DV training to increase DV training opportunities for public health nurses.
- Update/ensure that DV training for nurses and other allied medical professionals include a practical application component such as:
    - How-to steps in conducting psycho-social interviews;
    - Listing of community resources;
    - Cultural competency information;
    - Legal resources.
- Provide primary prevention information and training to other professionals and lay public working with individuals and families.
- Provide diversity training to include: rural/urban issues; ethnic issues; substance abuse; gay, lesbian, transgender issues; concerns of the hearing-impaired; and issues specific to Appalachia women.

SCREENING

- Update and revise the Public Health Practice Reference (PHPR) DV screening guideline to improve competency and comfort level of public health nurses when screening for DV.

- Make PHPR available and accessible to LHD personnel via the internet.
- Decrease cultural barriers when screening for DV.
- Provide specific training on how to interact with LHD patients when screening for DV/SA as well as how to look for identifiers of physical, social, and psychological abuse.
- Incorporate DV/SA screening into school wellness programs.

REFERRAL

- Ensure availability of DV/SA materials in every LHD.
- Designate a staff person in each DV/SA program to be the resource material contact for LHDs.
- Increase knowledge among LHD staff and general population about DV/SA resources, in an effort to improve referrals.
- Through training and education, dispel myths regarding DV shelters and other victim service agencies.
- Raise public awareness of DV/SA referral resources, focusing on use of media outlets.
- Increase availability and funding for transportation of DV/SA victims to LHD for health care services.

COMMUNITY COLLABORATION

- Create/expand Local Coordinating Councils on DV.
- Initiate memorandums of agreement (MOAs) between community partners for DV training and referral.
- Promote community awareness of VAW through outreach to all sectors of community - from early childhood to the elderly.
- Establish relationships with local social service providers.

This report is intended to serve as a guide for public health officials and VAW advocates in their individual and collaborative efforts to address VAW prevention. With a primary focus on the role of LHDs and the potential impact they have on VAW prevention in the Commonwealth, the goal of the plan is to improve and sustain public health's efforts to reduce and eliminate VAW in Kentucky. However, VAW cannot be eliminated by one sector of society alone. The OWPMH encourages our partners to continue their vigilance in protecting and assisting victims, holding perpetrators accountable, and training and educating the population as a whole on the harmful physical and mental health consequences of violence and the valuable resources available to those in need.

I. Background

A. Burden of Violence Against Women

Domestic violence (DV) and sexual assault (SA) represent significant burdens on the social, judicial, medical and financial sectors of this nation. It affects individuals, organizations, communities, and the world at large. Violence results in injury, disability, mental and emotional distress, and sometimes death. While men and women both suffer from violence and violence-related consequences, the disproportionate burden of intimate partner violence is borne by women.

According to the National Violence Against Women Survey (NVAWS), conducted from November 1995 to May 1996 by the National Institute of Justice and the CDC, women are significantly more likely than men to report being victimized by an intimate partner.[1] The NVAWS, found that 25% of women versus 8% of men reported intimate partner violence (IPV) at some time in their lives. The lifetime prevalence of physical assaults among women was 52%, with a 12-month prevalence rate of 2%. It is estimated that women nationally make nearly 700,000 visits to the health care system per year as a result of injuries due to physical assault.[2]

While it is apparent that violence against women is a national problem, data specific to Kentucky suggest higher rates of IPV than what is experienced nationally. Kentucky IPV surveillance data for 2000 indicate 37% of the women in Kentucky have been a victim of IPV during her lifetime, versus 25% of women nationally. Of the abused women in Kentucky, 72% reported at least one injury from the abuse, with 81% of those women reporting sustaining more than one type of injury. Of the women who sustained injuries as a result of their abuse, 30% sought medical attention, while an additional 74% of women reported psychological stress as a result of their abuse.[3]

Psychological stress, in addition to physical injuries sustained from abuse, places a significant burden on Kentucky's mental health care system. Data from Kentucky's Community Mental Health Centers (CMHC) indicate climbing utilization rates for women seeking mental health services who also report being physically abused. In 2001, 26% of adult women treated at CMHCs across the state responded positively to being a victim of physical abuse, up from 19% in 1998. An additional 20% of the women served at CMHCs reported being a victim of rape, sexual assault or sexual abuse, up from 13% in 1998. Clearly IPV, including sexual assault and rape, is a serious threat to the physical and mental health of the women in Kentucky.

B. Executive Support of Domestic Violence and Sexual Assault

Responding to the burden of abuse upon Kentucky's women, executive leadership of the Commonwealth has served as a champion for the rights of women and children who are victimized. Gov. Paul E. Patton and First Lady Judi Patton established an executive-level agency in 1995 known as the Governor's Office of Domestic Violence and Child

Abuse Services, and appointed Carol S. Jordan as its Executive Director. Under Ms. Jordan's leadership, this Office passed 20 pieces of legislation improving and protecting the rights of domestic violence victims. The Patton Administration's work did not stop there. During their tenure, they supported and participated in numerous task forces, conferences, and awareness campaigns, all designed to bring a very public focus to this often private issue. It is clear that from the political, judicial and social perspectives, much good work has been done. However, it is the goal of this plan to emphasize the role of public health as a key component to the prevention of VAW in Kentucky. Public health's leadership will facilitate a multi-disciplinary approach to violence prevention and bring key collaborators together to work towards a common goal.

C. Health Care Response to Violence Against Women

In addition to the immediate trauma caused by abuse, DV and SA contribute to a number of chronic health conditions, including depression, substance abuse, and chronic pain. It further interferes with a victim's ability to manage other chronic health conditions such as diabetes and hypertension.

The health care system is a valuable resource for women who have been victimized, yet studies indicate that less than 10% of primary care physicians routinely screen for DV during office visits.[4] Routine screening will improve the identification of DV and provide opportunities for education and intervention. It is not uncommon for providers to routinely screen for other conditions such as high blood pressure and diabetes. It is also not uncommon for providers to screen for conditions that affect the public's health, such as smoking. Screening for DV is a starting point to improving public health's response to VAW.

D. Public Health's Responsibility for Violence Against Women Prevention

Aside from a concern for violence-related health effects, public health agencies need to be involved in community planning for VAW prevention. While a coordinated response to VAW by local law enforcement, courts, medical and social services agencies protects the safety of victims and provides accountability for perpetrators, the public health focus on primary prevention holds great promise for reducing the cycle of VAW before it begins. Preventing violence requires a multi-disciplinary approach and must enlist many strategies. Public health provides leadership by integrating scientific disciplines and collaborating with organizations and communities to find effective solutions.

According to the national Institute of Medicine, in its 1988 report, *The Future of Public Health*, the core functions of public health are assessment of the health of a community, the development of comprehensive health policies to protect the community's health, and assurance to constituents that services will be available. Interpreting these core functions as they relate to DV and SA would include the following:

1. **Assessment -** Collect data on prevalence of DV and SA; analyze trends; disseminate data as appropriate.

2. **Policy Development -** Plan for community needs; establish effective policies at state and local levels, in collaboration with VAW stakeholders.

3. **Assurance -** Protect individual's health; prevent VAW; promote health; assist with access to services.

Public health must be accountable for its governmental role, as defined by the core functions listed above. Applying these core functions to address the unsettling rates of violence in Kentucky is a responsibility that must be addressed by Kentucky's public health system.

E. Kentucky's Goal for Reducing Victimization

Healthy Kentuckians 2010, Kentucky's public health initiative, has set the following goals to reduce the burden of violence on our society:

- Reduce the rate of physical abuse by a current or former intimate partner to less than 23 per 10,000.
- Reduce the rate of forced sexual intercourse or attempted forced sexual intercourse of persons aged 18 and older to less than 6 per 10,000 persons.
- Reduce sexual assault other than rape to less than 0.3 per 1,000 people.

Achieving these goals will not be realized by the judicial or social responses to victimization alone. The public health care system must do its part by routinely screening women for DV and offering appropriate information and intervention to reduce or eliminate the cycle of violence. Public health offers many potentially effective intervention strategies such as parent training, home visitation, and educational curricula for violence prevention. However, routine DV screening provides an immediate opportunity to identify and assist a woman being victimized.

According to the Family Violence Prevention Fund[5], which recently released DV screening guidelines for health care providers, screening for DV should:

- Be part of a face-to-face health care encounter;
- Be direct and non-judgmental;
- Take place in private with no friends or relatives of the patient present during the screening and preferably no children over two years of age present;
- Be confidential with patients told of the confidentiality of the conversation and told of the limits of that confidentiality including the limits of confidentiality of medical records; and
- Use professional interpreters when needed, rather than a patient's friend or family member.

Ideally, screening for DV should also:

- Be included as part of a written health questionnaire; and
- Be conducted in the patient's primary language with use of professional interpreters when appropriate.

Historically, the health care system has been an integral partner in identifying and preventing public health problems. Routine screening, with the emphasis on early identification, is a starting point to reduce the prevalence of DV in Kentucky. LHDs, who serve as the primary provider to thousands of women and children, should play a role in this screening.

F. The Role of Local Health Departments

The OWPMH, working to improve the health and well-being of women in Kentucky, chose to respond to the alarming rates of VAW in Kentucky by emphasizing the importance of primary prevention by our public health system, specifically focusing on the role of our LHDs. (See Appendix F)

Currently, Kentucky's Public Health Practice Reference (PHPR) includes a mandatory DV screening tool designed for use with women aged 14 and older recieving an annual preventive health exam, who are seen in Kentucky's LHDs. (See Appendix G for screening tool) Additionally, in 1998, Kentucky implemented mandatory DV training curricula for all nurses licensed to practice in the Commonwealth. This training emphasizes not only the appropriate way to screen for DV, but also educates the nurses on the more interpersonal effects of violence and how it affects routine screening and referral. Effective screening for DV requires a specific set of skills and a degree of sensitivity towards the patient.

Public health, by definition, is directed to improve the health of a defined population, not necessarily that of any one individual. Taking a population-focused approach is often difficult with regard to violence, due to the very personal and individual experiences of victims of violence. Many factors impact a woman's vulnerability to violence, including poverty, low education status, geographic isolation, minimal social support, and other cultural norms and attitudes. Additionally, the risk of victimization increases when a woman is pregnant. According to the CDC, 4%-8% of women report violence during pregnancy. The CDC further asserts that violence during pregnancy may be more common than gestational diabetes, neural tube defects, and pre-eclampsia.

While no one is immune to violence, studies indicate higher victimization prevalence rates among women falling into the above categories.[5] Therefore, public health interventions should include a special focus on this population, which is considered at highest risk for violence. LHDs are often the provider of choice for thousands of pregnant women and women falling into the above-mentioned categories.

In FY 2002-03, over 464,000 women were served at LHDs throughout Kentucky, 41% of them during the peak reproductive ages of 18 to 44. These women received

various services including well-child services, family planning, STD/HIV screening, WIC, etc. Each visit to a LHD provides an opportunity for a public health professional to educate, identify and refer victims of violence. It is the ultimate goal of public health to prevent the violence from ever occurring or reoccurring, rather than treating the immediate consequences, although they may also play a role in that as well.

Kentucky's LHDs offer numerous education programs for disadvantaged or low-income individuals and families. Many times, these programs interweave messages on preventing violence from both the victims' and perpetrators' perspectives. One example includes the HANDS program (Health Access and Nurturing Development Series). HANDS is a voluntary, intensive home visitation program designed to assist parents at critical development points during their children's first two years of life. It is available to first time parents, from before the child is born until approximately three months after delivery. HANDS helps the parents develop healthy parenting skills, and further assists them with health services and any other needed resources. Healthy parenting often leads to healthy families and may reduce the likelihood of abuse. Public health programs like this represent opportunities to incorporate violence prevention messages into existing services and curricula.

"Thank you for the opportunity to participate in the VAW Strategic Planning Meeting. This was an eye-opening experience for me. I do want you to know I've spoken with my Director in Buffalo Trace to address the needs of public health nurses. I have several ideas and am sure my staff will have more."

Phyllis Konerman, MS, LSW
Strategic Planning Member

Education is a key component to prevention, however it is not the only component. Identification of victims is considered secondary prevention and an opportunity for intervention. However, anecdotal analyses indicate that DV screening in LHDs is not consistent or routine. Additionally, there were no readily available data from the health departments to provide baseline DV screening statistics. Due to lack of data, we are not able to quantify the number of clients who are screened, as well as the percent who screened positive for DV.

G. Collaboration with VAW Stakeholders

The OWPMH was awarded a $50,000 CDC planning grant (see Section II) to assess and plan for improvements to the public health response to VAW. This grant, effective from September 2002 to December 2003, enabled the OWPMH to assess existing victim services, including DV shelters, RCCs, and CMHCs and their relationships with LHDs and plan for a more coordinated approach to VAW prevention and intervention.

Part of developing a coordinated response to VAW includes building relationships between public and private agencies engaged in violence prevention and collaborating with these agencies to achieve a shared goal. Advocates, mental health professionals, researchers and policy makers, were all included in assessing and planning for the public health response to VAW. Understanding and respecting the roles and responsibilities of these VAW stakeholders is critical in developing a coordinated public health response to VAW.

- Advocates and shelters typically respond to the more immediate effects of violence, which often leaves them with little time and few resources to focus on prevention. However, prevention of violence is still a shared goal.

- Researchers and policy-makers likewise have a common goal to reduce the prevalence of violence and to incorporate policies that will protect victims and further reduce the cycle of VAW.
- Mental health professionals often see the long-term results of violence and while they often focus on reducing or eliminating the long-term emotional effects of violence, they too share in our goal to reduce or eliminate VAW altogether.

These partners represented our core strategic planning members whose expertise generated much of the information contained in this report. From their efforts we developed detailed VAW prevention recommendations, identified potential barriers, and defined specific directives to ensure a solid source of information and action that will assist those individuals and groups of individuals who together work to end violence.

It is widely accepted that a very important factor for prevention success is to have solid commitment at the state and local levels. So it is with this Strategic Plan, that we encourage community stakeholders, policy makers and advocates to take what they need, apply what they can, and share what they learn, in order that we may finally be able to say that our Commonwealth, and our women, are free from violence.

1 Tjaden, P and Thoennes, N, Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey. Nov 2000.

2 National Institute of Justice and Centers for Disease Control and Prevention. Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey. Washington D.C.: National Institute of Justice and CDC; 1998.

3 Hong and Fritsch, Travis A. (2003). Kentucky Intimate Partner Violence Surveillance Project: 2002 Population-Based Telephone Survey. Kentucky Injury Prevention & Research Center; Cabinet for Health and Family Services, Department for Public Health; Cabinet for Families and Children; and Centers for Disease Control & Prevention. Lexington, KY: Kentucky Injury Prevention & Research Center.

4 Rodriquez M., Bauer H., McLoughlin E., Grumback K. (1999). Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians. The Journal of the American Medical Association, 282, No.5, August 4, 1999.

5 Warshaw, MD, Carole and Ganley, PhD, Anne (1996) *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers*. Family Violence Prevention Fund.

6 Bachman R and Saltzman L, Bureau of Justice Statistics Special Report, Violence against Women: Estimates from the Redesigned Survey, National Crime Victimization Survey: August 1995.

II. Grant Activities

Acting as an agent of the Kentucky Department for Public Health, the OWPMH applied for and was awarded a one year $50,000 VAW prevention planning grant from the CDC, effective September 2002. Under this grant, the OWPMH embraced the belief that VAW is a public health issue and conducted a series of assessments and inventories in regard to VAW prevention activities in Kentucky. These consisted of:

A. Literature review

B. Assembly of Violence Against Women Advisory Committee

C. Site visit to Center for Women and Families, Louisville, KY

D. Focus Groups with Domestic Violence Shelters and Rape Crisis Centers

E. Survey of Kentucky Public Health Nurses

F. Statewide Strategic Planning Meeting

These activities, provided the OWPMH with sufficient qualitative and quantitative data necessary to develop an effective plan for the prevention of VAW in Kentucky.

A. Literature Review

The OWPMH began this project by first exploring the literature for research on the public health approach to VAW prevention. In addition to identifying the CDC's model for the prevention of violence (see Appendix H), other findings confirmed our suspicion that providers do not routinely screen their patients for DV and that most women will not volunteer that information unless asked. An article published in the *Journal of the American Medical Association* claimed that only 8 percent of women abused by their partners ever tell a doctor, and less than 50 percent ever tell anyone.[1] Additionally, only 10% of primary care providers routinely screen their patients for DV.[2]

B. VAW Advisory Committee

The second phase of our grant activities was the assembly of a Violence Against Women Advisory Committee consisting of professionals from the DV shelters, RCCs, Kentucky public health association, IPV surveillance project, and other key stakeholders. This Committee would ultimately shape the direction of grant activities, providing recommendations for strategic planning participants and provide valuable expertise through every phase of the project.

C. Site Visit to Center for Women and Families

In September 2002, OWPMH staff visited the Center for Women and Families (Center) in Louisville, Kentucky to learn more about the Center's work and how they assist victims

of DV/SA. While at the Center, OWPMH staff met with Darlene Thomas, Director for DV Programs who explained in detail the mission of the Center and what programs are available for victims. The Center offers four programs to assist victims, their families, and the community: The Domestic Violence Program; Rape Crisis Services; Economic Success Programs; and Community Education and Professional Training.

The Center offers residential housing for women and children leaving abusive situations, as well as numerous other DV/SA services for both residential and non-residential clients. These include case management; support groups; individual counseling and programming designed to build self-esteem and teach new coping, enrichment and safety strategies; immigrant services; and hospital and court advocacy. These valuable DV/SA services are offered at no cost to victims and their children. If you need assistance, call the Center toll free 24 hours at 1-877- 803-7577 for immediate help.

Additionally, the Center collaborates with the Jefferson County Health Department to provide their clients with important preventive and pre-natal care, as well as screenings and immunizations. These services are periodically available in-house at the Center, or the Center provides the victim with transportation to the health department to receive services.

D. Focus Groups

The third phase of the grant focused on our environmental assessments. This began by exploring the relationship of public health agencies with DV shelters and rape crisis centers. The intent of this assessment was to identify the extent to which these agencies collaborated with each other or at the very least, assess their familiarity with one another. Conducting focus groups with the DV shelters and rape crisis centers provided valuable data on the important issues affecting DV and SA community resources and regional responses to violence. The OWPMH worked closely with the Kentucky Association of Sexual Assualt Programs (KASAP) and the Kentucky Domestic Violence Association (KDVA) to form questions and gather information to conduct the focus groups.

With assistance from the University of Kentucky School of Public Policy, two separate focus groups were conducted with the directors of the 13 rape crisis centers and directors from the 15 DV shelters in Kentucky. The focus groups provided important qualitative data relative to the project and identified a lack of collaboration between local community agencies providing victim services and their respective county health departments. Focus Group findings are summarized in Appendices B & C.

E. Survey of Public Health Nurses

The second activity of our environmental assessment consisted of a professionally developed and delivered mail survey targeting all public health nurses employed throughout Kentucky. With a cover letter from First Lady Judi Patton, the confidential surveys were delivered to over 1,000 public health nurses throughout the state, assessing their professional experiences with DV and SA and further identifying any special programs or partnerships that health departments had developed to deal with violence in their own community. The

nurses responded to our survey with an impressive 46% response rate. This assessment provided valuable quantitative data for the grant. The survey findings are found in Section III of this report and the survey instrument is found in Appendix A.

The rationale for surveying every public health nurse was convincing. Kentucky has 120 counties and within each county is a LHD. In FY 2002-03 alone, LHDs throughout the Commonwealth collectively served over 464,000 women for various services. With nearly half a million women coming through the doors of our LHDs annually, there were literally thousands of opportunities for effective VAW prevention to occur. Opportunities existed for primary prevention through special programs and education, but also for secondary prevention through DV and SA screening and referrals.

In 1998, Kentucky passed legislation which mandated a 3-hour domestic violence training course for all nurses licensed to practice in Kentucky. Despite this, 16% of the nurses surveyed responded that they had never received training specific to DV. This finding from the survey lead to the first of four priority areas for which detailed recommendations were made. The priority areas include:

1. Education/Training
2. Screening
3. Referral
4. Community Collaboration

F. Strategic Planning Meeting

The final phase of input, the development of key recommendations for the four priority areas to improve the public health response to VAW, took place at a statewide strategic planning meeting held on July 22, 2003 in Lexington, Kentucky. The planning meeting was facilitated by Sarah Wackerbarth, PhD, a professional facilitator from the University of Kentucky Martin School of Public Policy. Approximately 30 participants gathered for one day to brainstorm and develop recommendations to address the four priority areas identified through our previous assessments.

Also participating at the planning meeting was Paul Schewe, PhD, Assistant Research Professor at the University of Illinois at Chicago and a nationally recognized expert in the primary prevention of violence. The OWPMH contracted with Dr. Schewe to provide consultation during the planning process and to provide the group with background information on primary prevention models. Dr. Schewe's work includes reducing teen dating violence through a school and community-based approach and evaluating DV and SA prevention services. Additionally, Jocelyn C. Wheaton, CDC Project Officer for the VAW Grant, was on hand to provide her expertise and guidance. Both of these individuals contributed their time and talents to assist in the strategic planning process.

The statewide strategic planning meeting exceeded expectations, as the participants worked cooperatively and dynamically to develop detailed recommendations in response

to the four priority areas. The strategic planning members expertise and commitment to VAW prevention are reflected in the following pages.

1 Rhodes and Levinson, "Interventions for intimate partner violence against women: Clinical applications", Feb 5, 2003, Journal of the American Medical Association 289(5), pp. 601-605.

2 Rodriquez M., Bauer H., McLoughlin E., Grumback K. (1999). Screening and Intervention for Intimate Partner Abuse: Practices and Attitudes of Primary Care Physicians. The Journal of the American Medical Association, 282, No.5, August 4, 1999.

III. Survey Findings

A. Background of Survey of Public Health Nurses

To assess screening protocols and practices among public health nurses, it was necessary to acquire quantitative data. To do this, a professional questionnaire was developed, with technical assistance from the University of Kentucky Survey Research Center. This survey was distributed to approximately 1,000 public health nurses employed at our LHDs. (See Appendix A)

The survey tool sought to assess not only nurses screening and referral practices, but to also assess their personal and professional understanding of DV and SA and the impact that understanding has on their professional practice. The survey was divided into two primary sections:

1) Domestic Violence

2) Sexual Assault and Rape

Respondents were asked a series of questions regarding their professional experiences with victims of DV and SA, as well as their screening and referral practices and general attitudes towards DV and SA. Responses to questions related to DV/SA are reported collectively under the corresponding priority area. Additional information was collected regarding each nurse's credentials, levels of DV training, and geographic area of practice.

B. Definitions of Domestic Violence and Sexual Assault

For many people, defining violence is not an exact science, but a matter of judgment. Behavior that is considered unacceptable varies from individual to individual, and is influenced by cultural, social and other norms and values specific to that individual. While there are many possible ways to define violence, our study required a succinct definition that was applicable within the public health context rather than defined so broadly as to lose its meaning. While we acknowledge that more forms of violence exist than are included in our definition, our intention is to define violence in the most common terms and on an interpersonal basis, primarily consisting of a female victim and male perpetrator. With consensus from the VAW Advisory Committee, for purposes of this survey, the following definitions were used:

Domestic Violence is actual or threatened physical or sexual abuse by someone with whom the patient has, or has had, an intimate or romantic relationship.

Sexual Assault and Rape is a sexual act, without consent, with a person who is a non-intimate partner (ie. acquaintance or stranger).

C. Survey Methodology

The survey was distributed to each nurse currently employed at a local health department within Kentucky. Mailing lists for were obtained through a personnel software system, from

the Department for Public Health. The mailing lists for the independent health departments of Northern Kentucky, Lexington-Fayette County, and Jefferson County, were obtained independently by the respective health department. The surveys were delivered to each nurse, at her home, with a detailed cover letter and confidential, postage-paid, return envelope. Every effort was made to ensure the confidentiality of responses while encouraging each respondent to provide open and honest responses. Approximately two weeks after the initial mailout, reminder post-cards were delivered to each nurse encouraging their participation. Additionally, a second mailing was delivered to each nurse not responding within a month of the initial mailout. The survey was delivered to 1,022 nurses (n=1022) with 427 completed and returned surveys representing a 46% response rate. Of those responding, 86% were licensed as RNs, 7% were ARNPs, and 5% were LPNs.

D. Data Analysis

Aggregate and detailed analyses of the survey data were performed by the University of Kentucky Survey Research Center. Frequencies and bi-variate analyses of the data were obtained using the SAS statistical analysis tool, which provided quantitative data for our project. Additionally, open-ended questions were asked which provided qualitative data for the project.

E. Findings

The survey asked a series of questions regarding nurses' training specific to DV, their knowledge of public health practice guidelines for screening for DV, obstacles to screening; their personal comfort level with screening and referring victims of DV; obstacles to referrals; their overall experience with DV and SA in the clinical setting; and special programs/ efforts at addressing violence within their respective community. A brief summary of findings is provided below, categorized by the general attitudes and the four priority areas of Training/Education, Screening, Referral, and Community Collaborations.

1. Public Health Nurses' General Attitudes/Awareness of Domestic Violence

- 87.3% of respondents believe DV is a public health issue
- The majority of respondents felt that they very rarely or never had reason to suspect their patient was a victim of DV (32.8% rarely suspected; 26.9 never suspected; 26.5 only occasionally suspected)
- 75.6% of respondents strongly or somewhat believe that DV is a problem in their patient population; 17.8% do not believe DV is a problem in their patient population
- 85.9% of respondents believe it is important that they make time to ask about DV; 6.6% did not feel it was important to ask about DV
- 87.6% of respondents disagreed with the statement that "a patient's experience with DV is none of my business"

- 85.5% of respondents believe identifying and referring patients experiencing DV is an important part of their job
- 41.9% of respondents feel they may offend a patient if they ask about DV; 50.6% did not feel they would offend a patient
- 75.1% of respondents believe a patient's health condition is often related to DV

2. Priority Area: Training/Education

- 15.7% of respondents have not received training specific to DV
- 90.9% of respondents were aware of Kentucky's mandatory reporting law, with 51% believing it had a positive impact on their practice (22.5% said no impact and 8.3% said negative impact)
- 58.7% of respondents felt they were not adequately trained to deal with DV; 34.9% either strongly (6.3%) or somewhat (28.6%) felt they were adequately trained
- 85.5% of respondents believe identifying and referring patients experiencing DV is an important part of their job
- 75.1% of respondents believe a patient's health condition is often related to DV

3. Priority Area: Screening

- Obstacles to identifying victims of DV included:
    - Patient does not mention abuse during history (54.6% say major problem)
    - Patient's primary language not English (53% say major/minor problem)
    - Patient is under the influence of drugs/alcohol (30.2% minor problem)
    - Patient lacks privacy (73.5% say major/minor problem)
    - Patient denies abuse as cause of injury (64.9% cite major/minor problem)
    - Patient fears being identified as abused (68.7% cite major/minor problem)
    - Cultural norms interfere w/discussion of abuse (66% say major/minor problem)
- When seeing a patient for health-related event, 23.2% of nurses screen every patient; 36.3% frequently screen; 9.4% never screen
- 48.6% of nurses responded that they always follow the DPH Practice Guidelines when screening for DV; another 19.6% say they often follow them; while 15.8% are not aware of the guidelines
- 79.4% of respondents found the PHPR guidelines very/somewhat helpful

- 41.9% of respondents feel they may offend a patient if they ask about DV; 50.6% did not feel they would offend a patient
- 66% of respondents responded that they rarely or never suspected sexual assault or rape when seeing a patient w/in the past 3 months; 20.6% suspected SA only occasionally; 4.9% suspected fairly often
- 58.1% of respondents say patients being screened for STDs rarely or never disclose that they have been raped; 20.1% said they occasionally disclose they have been raped
- 26.7% of respondents say they always or often ask patients being screened for STDs if they have been raped; 15.2% occasionally ask; 27.5% rarely or never ask
- 34.2% of respondents say they always or often ask a patient being screened for HIV if they have been raped; 34% say they rarely or never ask; 10.5% occasionally ask

4. Priority Area: Referrals

- 71% of respondents cited keeping DV brochures/pamphlets in their common areas; 63.7% have DV shelter numbers and hotlines available
- 40.5% of respondents have brochures on SA/Rape; 47.5% have Rape Crisis Center numbers and hotlines
- Obstacles to referrals:
    - 54.1% of respondents believe there are adequate community resources available; 37.3% felt the lack of community resources was a major/minor problem
    - 41.2% felt community agencies were not difficult to access; 46.8% felt it was a major/minor problem to access agencies
    - 50.8% of respondents did not feel they were too busy to deal with DV; 33.1% felt time was a major/minor problem
    - 78.9% of respondents reported abused patients do not want a referral
    - 48.2% of respondents feel resources are available only at a distance; 39.1% feel that is not a problem
- When referring a patient, the majority of respondents, 54.3%, cite the Department for Community Based Services (DCBS) as their routine referral; 44.7% routinely refer to mental health counseling; 45.9% routinely refer to DV programs; 13.8% of respondents report they do not routinely refer patients
- 48.7% of respondents rarely or never provide information on the long-term physical and mental consequences of sexual abuse; 21.5% always or often do; 21.8% occasionally do

- 71.6% of respondents rarely or never refer their patients to Rape Crisis Centers
- 51.8% of respondents are not aware of the services provided by Rape Crisis Centers

5. Priority Area: Community Collaboration

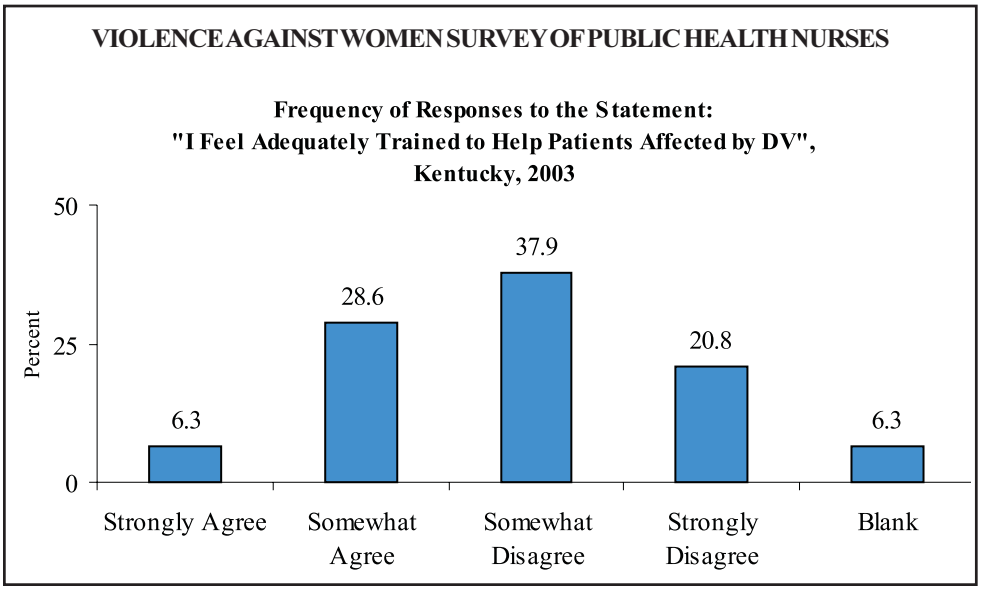
- 71% of respondents cited keeping DV brochures/pamphlets in their common areas; 63.7% have DV shelter numbers and hotlines available
- 40.5% have brochures on SA/Rape; 47.5% have Rape Crisis Center numbers and hotlines
- When referring a patient, the majority of respondents, 54.3%, cite DCBS as their routine referral; 44.7% routinely refer to mental health counseling; 45.9% routinely refer to DV program; 13.8% of respondents report they do not routinely refer patients
- 51.8% of respondents are not aware of the services provided by Rape Crisis Centers

IV. Priority Area Recommendations

A. *Priority Area #1*
Training and Education

Central to any prevention effort is appropriate and effective training and education. For public health nurses in Kentucky, appropriate domestic violence (DV) and sexual assault (SA) training is paramount to ensuring the delivery of effective prevention strategies to the women they serve. Our survey of public health nurses identified a lack of DV training among some nurses, ranging from no training at all to insufficient training to perform their job. (Fig. 1) According to KRS 194A. 540, nurses licensed to practice in Kentucky must receive three hours of mandatory DV training. Survey findings indicated that 16% of public health nurses lack this training.

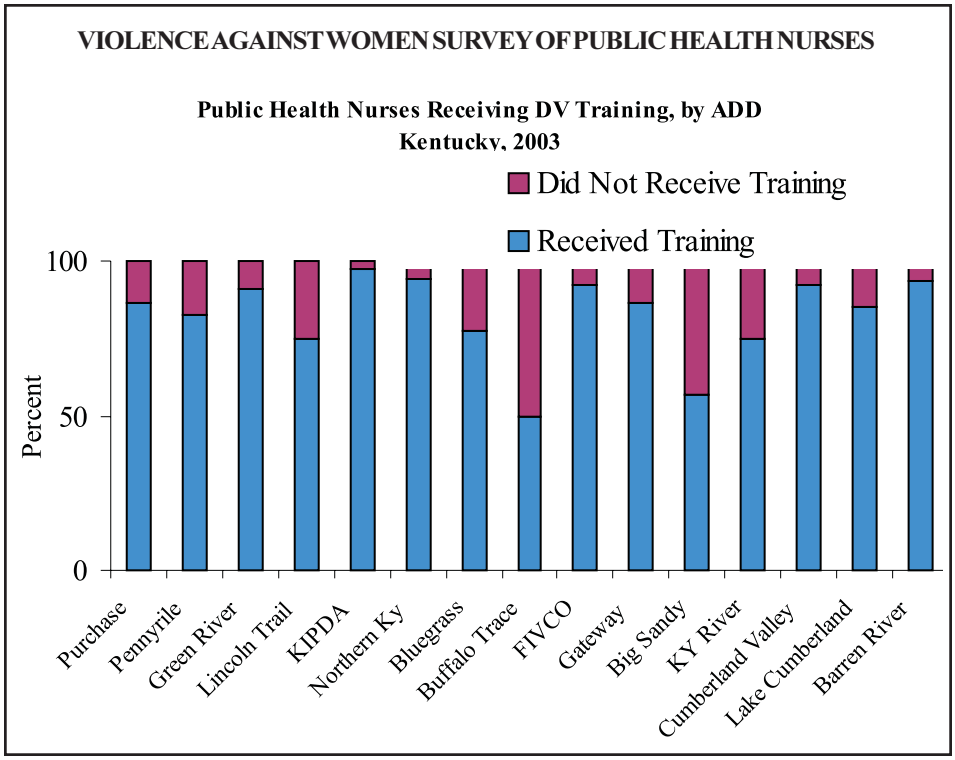
Fig. 1



Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

It was further identified through the survey that regional gaps in DV training existed. This realization will assist future training efforts in targeting areas of greatest need. As indicated in Fig. 2, the greatest proportion of nurses without DV training are in the Buffalo Trace and Big Sandy Area Development Districts. Both of these districts are located in Eastern Kentucky.

Fig. 2



Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

An important finding related to training/education was the need for more cultural competency and diversity training relative to DV screening. Local health departments (LHDs) are often the primary health provider for Kentucky's growing Hispanic/Latino population. According to the U. S. Census, Kentucky's Hispanic population has grown 173% during the past 10 years (1990 - 2000). Many of these individuals speak no English yet routinely utilize their LHD for preventive and primary care services. Training in cultural competency and additional sensitivity training may benefit nurses in their professional response to DV.

Upon evaluation of the survey findings, the strategic planning team developed recommendations aimed at improving DV and SA training/education for public health nurses.

Recommendations for Training/Education

Recommendation 1: Identify and maintain documentation of public health nurses' training specific to domestic violence (DV).

KRS 194A.540 -Training courses for mental health and health-care providers - provides that nurses and selected health professionals receive a three-hour training course on DV within three years of the date of their initial licensure or certification. Public health officials and health department administrators should work together to identify nurses who are required to complete, but have not yet completed, the mandatory DV training. It is also encouraged that additional DV training be available to those nurses who feel under-trained to deal with DV in their professional practice. LHDs should work closely with the Department for Public Health (DPH) to ensure that public health nurses are in compliance with the statute's requirements for training.

Recommendation 2: Explore the feasibility of securing legislation to require nurses applying for bi-annual re-certification to receive DV training prior to re-certification.

In an attempt to ensure that every nurse licensed to practice in the Commonwealth is in compliance with KRS 194A.540, an amendment may be added which links mandatory DV training to re-certification of one's nursing license. Many nurses may not be aware of the potential role they play in preventing violence against women (VAW). By ensuring they have received mandatory DV training, they will have a better awareness of their role and how to effectively deal with DV in their professional practice. The Office of Women's Physical and Mental Health (OWPMH) should coordinate with the Kentucky Board of Nursing and Kentucky Nurses Association to explore the feasibility of this legislative change.

Recommendation 3: Coordinate/collaborate with other public/private agencies providing DV training to increase DV and Sexual Assault (SA) training opportunities for public health nurses.

By coordinating with other public/private agencies offering DV/SA training, public health nurses will have more opportunities to receive appropriate DV/SA training and education. There are many DV/SA training opportunities provided by agencies such as the Kentucky Domestic Violence Association (KDVA), Kentucky Association of Sexual Assault Programs (KASAP), Kentucky Public Health Association (KPHA), Governor's Office on Child Abuse and Domestic Violence Services, and other medical/professional organizations. Offering electronic learning and teleconferencing opportunities will further increase the likelihood that LHD nurses practicing in rural and geographically isolated regions of the state will receive training. Agencies providing DV/SA training are encouraged to advertise their training to LHD personnel and/or work with the DPH to coordinate training opportunities.

Recommendation 4: Update/ensure that DV training for nurses and other allied medical professionals include a practical application component such as:

- How-to steps in conducting psycho-social interviews;

- Listing of community resources;
- Cultural competency information; and
- Legal resources.

Many professionals, including mental health providers and social workers, work with clients suffering from the effects of DV. Where appropriate, these professionals should receive training with respect to DV/SA screening and referral. While KRS 194.540 requires training in some of the areas mentioned above, it is suggested that a practical application be included within the training.

Recommendation 5: Provide primary prevention information and training to other professionals and lay public working with individuals and families.

Many non-medical professionals and lay people routinely come into contact with families or individuals experiencing violence. Ministers, 4-H leaders, childcare providers, attorneys, and public health educators represent just a few of the many individuals who may potentially influence VAW in their communities. DV and SA organizations should seek out opportunities to provide useful information and/or training (such as Life Skills curricula for youth) to these individuals, in an effort to promote violence prevention. Additionally, Area Health Education Centers (AHECs) can play a useful role in coordinating with DV/SA organizations to distribute information to other health professionals.

Recommendation 6: Provide diversity training to include: rural/urban issues; ethnic issues; substance abuse; gay, lesbian, transgender issues; concerns of the hearing-impaired; and issues specific to Appalachia women.

With an increasingly diverse population, it is helpful for health care providers, including public health nurses, to receive sensitivity and diversity training to improve their ability to care for and treat their patient population. Sensitivity and diversity training with respect to DV/SA screening and referral will improve LHD nurses' ability to effectively respond to the needs of their patients with unique concerns. An example would be language appropriate training and resources for Spanish speaking LHD clients. Modifying existing diversity training curricula will reduce duplication of effort and provide opportunities for collaboration with other agencies offering diversity training.

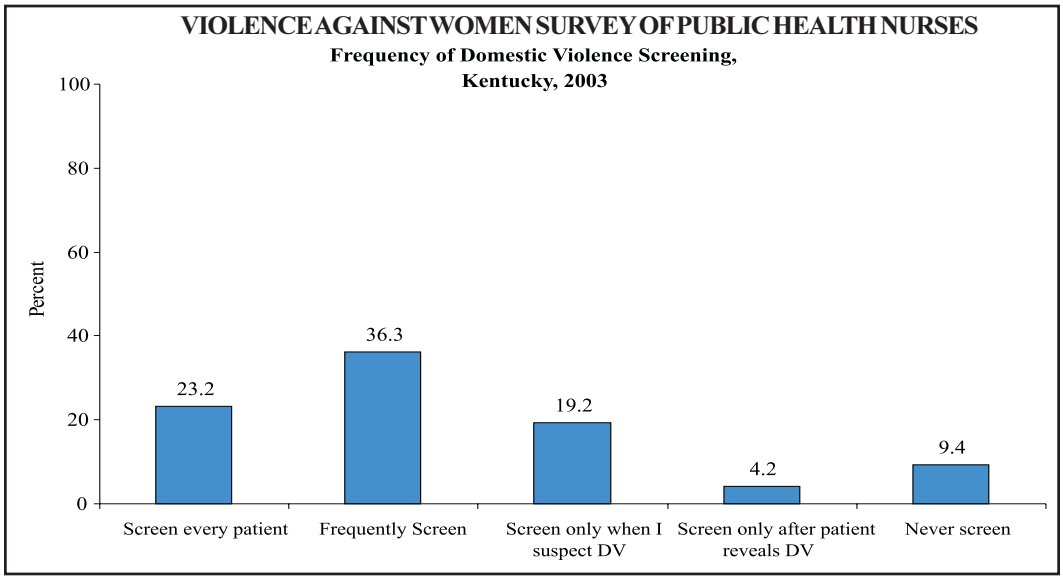
B. *Priority Area #2*
SCREENING

The second priority area to be identified through our assessments was DV screening. Screening refers to the identification of DV using a standard assessment tool. Current public health protocol requires public health nurses to screen for DV using the Public Health Practice Reference (PHPR) DV screening tool (see Appendix G for DV screening tool - no guidelines exist for SA screening). While the survey results indicated that public health nurses believe DV is a public health issue (87% responding positively that DV was a public health issue), the DV screening rates did not necessarily correspond. 23% of respondents reported that they screened every patient for DV, while 9% responded that they never screen. (Fig. 3)

Additionally, adhering strictly to the existing DV screening protocol was positively correlated with the amount of training and/or level of licensure held by the public health nurse. (Figs. 4 & 5) In general, more training and higher credentialed nurses were more likely to screen every patient than those without training or with a less advanced licensure status. Of the nurses responding to the survey, 86% were registered nurses (RNs); 7% were Advanced Registered Nurse Practitioners (ARNPs); and 5% were licensed practical nurses (LPNs).

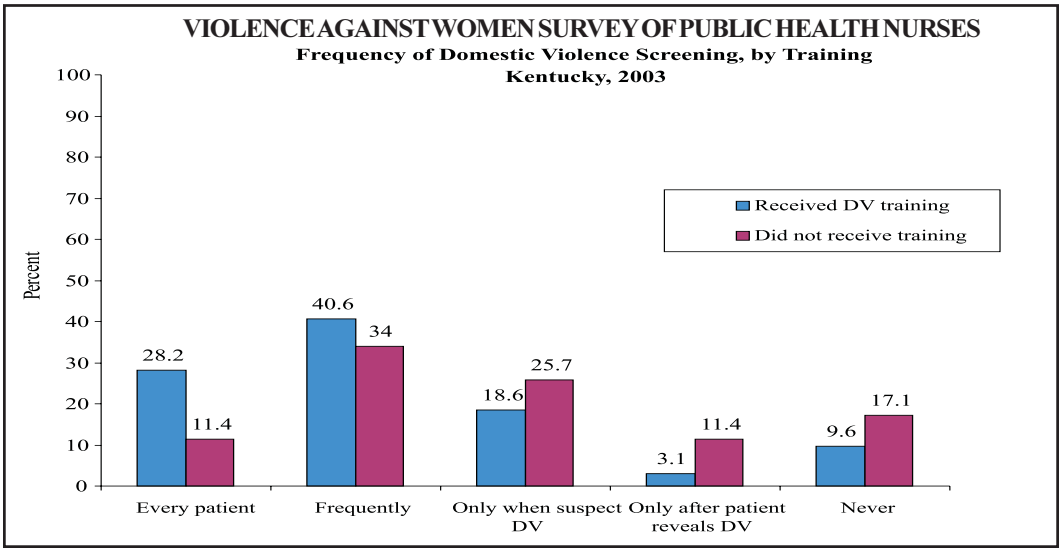
Many of the respondents reported multiple obstacles to screening, including lack of privacy, language barriers, and a patient's reluctance to admit or discuss the abuse. Noting the positive relationship between training and appropriate screening, and upon identifying obstacles to effective screening, the planning group developed a set of screening recommendations to improve public health's response to VAW.

Fig. 3



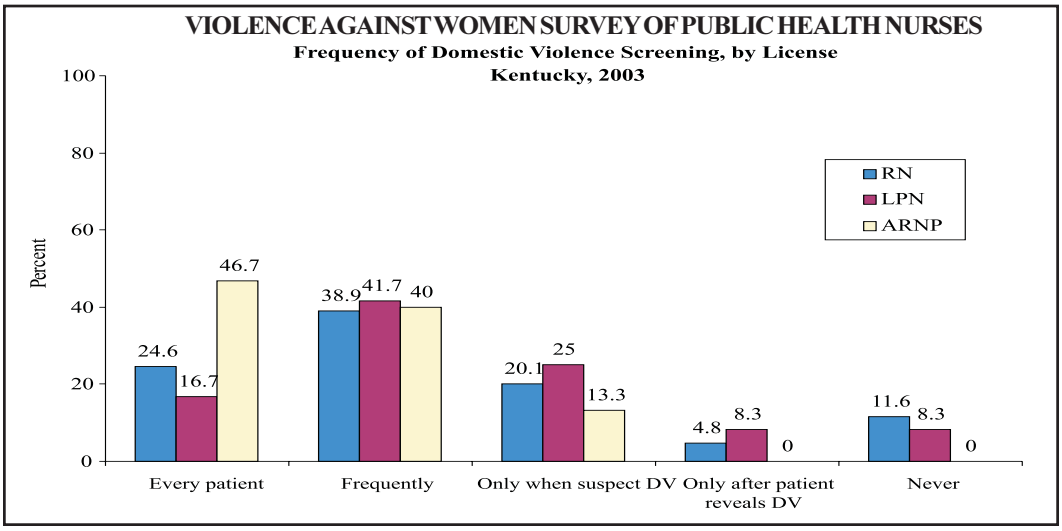
Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

Fig. 4



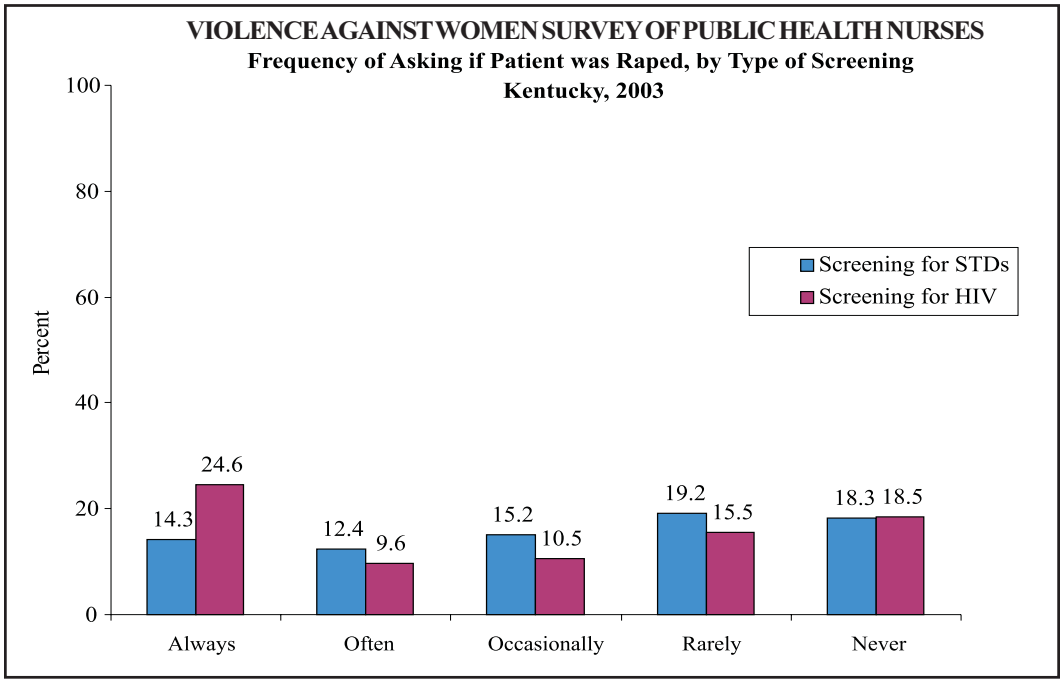
Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

Fig. 5



Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

Fig. 6



Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

Recommendations for Screening

Recommendation 1: Update and revise the Public Health Practice Reference (PHPR) DV screening guideline to improve competency and comfort level of public health nurses when screening for DV.

The clinical DV screening guideline found in the PHPR should be updated and revised, as necessary, to ensure its usefulness and applicability to public health nurses when screening for DV. The Office of Women's Physical and Mental Health (OWPMH), the Kentucky Board of Nursing, and the Kentucky Nurses Association can work collaboratively with the PHPR committee to review and update the DV screening guideline and suggest revisions. The PHPR committee must approve any changes made to the PHPR, which occurs twice a year in January and July.

Recommendation 2: Make PHPR available and accessible to LHD personnel via the internet.

While DPH has made the PHPR available electronically, via the internet, some LHD personnel do not have access to the internet. Providing electronic access to the PHPR may improve its accessibility and usability among LHD staff.

Recommendation 3: Decrease cultural barriers when screening for DV.

Cultural barriers, such as language, impede LHD nurses from effectively screening for DV. Having translators and interpreters available, particularly for Hispanic and non-English speaking clients, will improve nurses' ability to interact with a culturally diverse population. Cultural competency training will further improve nurses' ability to treat their patients medically, while respecting their cultural norms and attitudes. Factors such as low-education status and poverty may affect a nurse's ability to interact effectively. LHDs may partner with culturally diverse stakeholders and child/adult education and literacy efforts to improve their ability to respond to cultural barriers.

Recommendation 4: Provide specific training on how to interact with LHD patients when screening for DV/SA as well as how to look for identifiers of physical, social, and psychological abuse.

Training curricula for DV/SA screening techniques should include practical, how-to steps for screening rather than just theory. Collaboration among DV shelters, RCCs and the DPH Training Branch will provide opportunities for improved training techniques to be implemented, as well as assist in identifying and funding a DV/SA screening expert to facilitate such training.

Recommendation 5: Incorporate DV/SA screening into school wellness programs.

Dating violence, family violence and SA remain important issues among youth. Incorporating DV/SA screening into existing school wellness programs will provide opportunities to identify and intervene on behalf of students experiencing violence. School

nurses, teachers, and/or counselors should be offered training on age-appropriate DV/SA screening techniques. While school resources are limited and violence is often a sensitive subject, the DPH and Department for Education are encouraged to collaborate together on school-based initiatives addressing violence.

C. *Priority Area #3*
REFERRAL

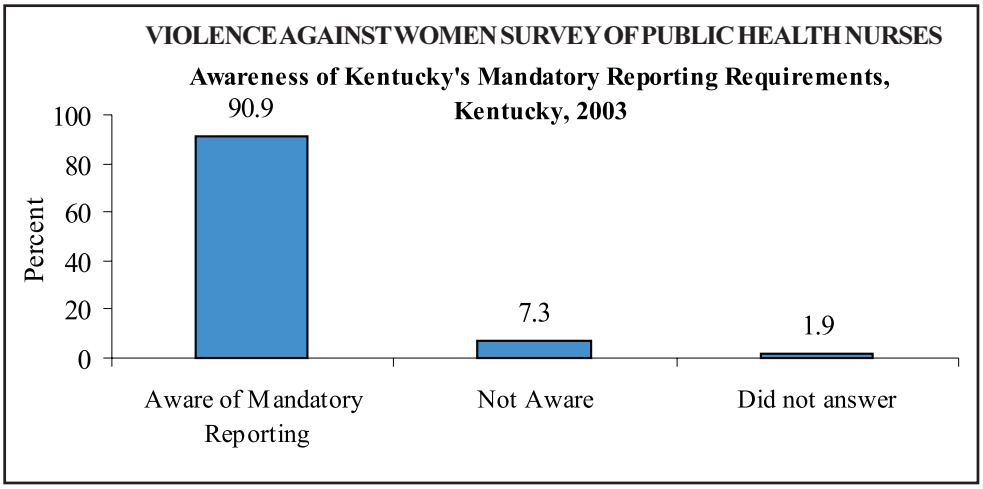
The third priority area to be identified through the survey of public health nurses focused on referrals for DV/SA. Referrals provide victims with valuable resources which can assist them immediately, such as temporary housing if a victim is in immediate danger, to more long-term services such as mental health counseling. Referrals should not be confused with mandatory reporting for spouse abuse, pursuant to KRS 209.030. Kentucky is among two states which requires mandatory reporting of spouse abuse to the Department of Community Based Services (DCBS). The majority of public health nurses (91%) are aware of this law. (See Fig. 7)

DCBS is often a valuable resource for women being victimized. There are concerns however, associated with mandatory reporting, particularly if the victim is not ready or prepared to leave the abusive spouse or if children are involved. While opinions vary on the impact of mandatory reporting on assisting victims, the majority of public health nurses (51%) felt that mandatory reporting had a positive impact on their professional practice. (Fig. 8)

Many times, a referral can be made or offered at the time of a patient's visit, providing the victim with a future source of help, when she is ready. However, public health nurses indicated several obstacles to effective referrals including lack of community resources; being too busy to refer a patient; and that the patient did not want a referral. The majority of respondents (71%) indicated that DV brochures were available in common areas of their health department. Fewer respondents (41%) indicated that material was available on SA and rape.

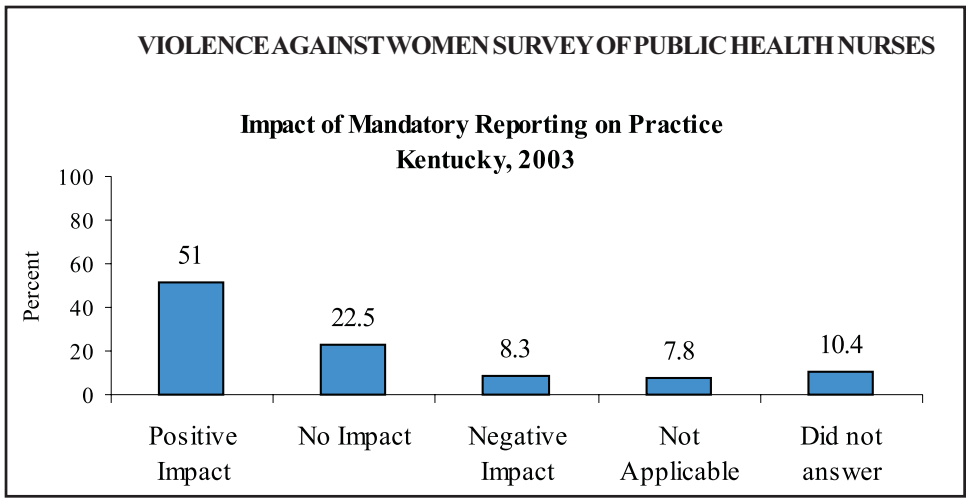
When making a referral, the majority of respondents (54%) refer their patients to DCBS. However, 14% of respondents report that the do not routinely refer their patients. Responding to the identified obstacles to referral (Fig. 9) and inconsistent referral patterns, the strategic planning team developed referral recommendations aimed at improving this important component of VAW prevention.

Fig. 7



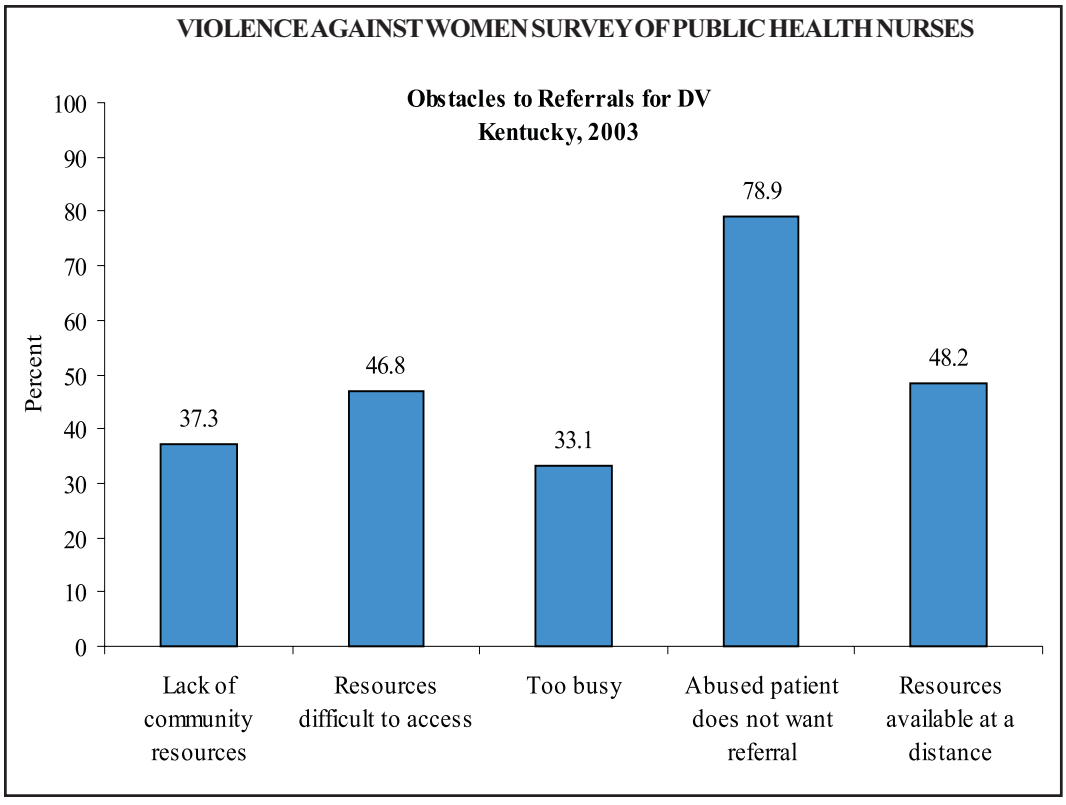
Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

Fig. 8



Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

Fig. 9



Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

Recommendations for Referral

Recommendation 1: Ensure availability of DV/SA materials in every LHD.

DV/SA program staff are encouraged to deliver or mail referral resource materials to LHDs in their area. Materials should be placed not only in common areas of the LHD, but also in exam rooms and bathrooms and should be culturally appropriate for diverse populations. DV/SA programs may choose to develop a check-list of materials to be utilized by LHDs.

Recommendation 2: Designate a staff person in each DV/SA program to be the resource material contact for LHDs.

Identify a single point of contact in DV/SA programs to coordinate with LHDs in their area on available resource materials. KASAP and KDVA are encouraged to maintain a materials inventory for use at LHDs. Updating agency policy to identify a materials contact person will improve follow-through and commitment and help ensure that LHDs have appropriate resource information available for their clients.

Recommendation 3: Increase knowledge among LHD staff and general population about DV/SA resources, in an effort to improve referrals.

DV/SA programs, DCBS, and Local Coordinating Councils on DV are encouraged to collaborate to raise awareness of, and educate LHDs and the general public on available victim services. Information on the long-term affects of DV/SA; what defines a crisis; what services are available and for how long; what services are free; and safety planning, will improve LHD's ability and initiative to refer clients to the appropriate resource.

Recommendation 4: Through training and education, dispel myths regarding DV shelters and other victim service agencies.

Inaccurate information and perceptions may affect a nurse's initiative to provide a referral for DV/SA. Ensuring that LHD nurses have a clear understanding of available victim services and what each has to offer will improve their ability to interact effectively with victims of DV/SA and further improve their comfort level when making a referral.

Recommendation 5: Raise public awareness of DV/SA referral resources, focusing on use of media outlets.

Advertising and marketing of DV/SA resources, focusing on larger media outlets, will potentially improve referrals. Strategies include creating public service announcements, submitting articles and editorials to newspapers, magazines and community newsletters, and advertising services in real estate/apartment rental booklets. All DV/SA stakeholders, particularly Local Coordinating Councils on DV, are encouraged to combine their creative ideas, staff and resources to develop effective media-related strategies.

Recommendation 6: Increase availability and funding for transportation of DV/SA victims to LHD for health care services.

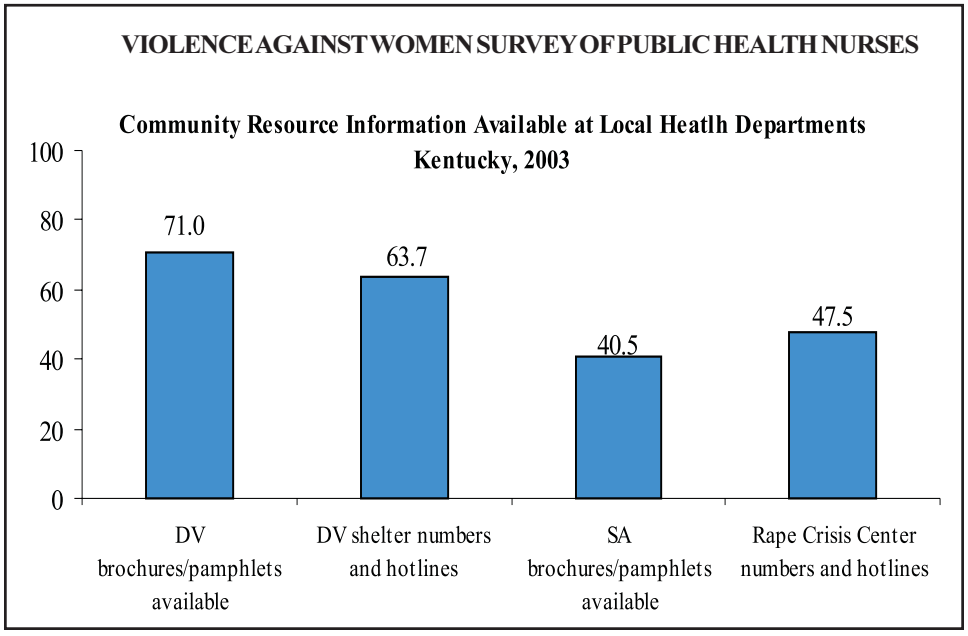
For victim service providers that do not offer in-house health care services, it can be a challenge to coordinate reliable transportation for their clients to a health care provider. One suggestion is to provide victims with a transportation voucher, enabling them to access health care services at the LHD, if necessary. Limited funding, along with geographic isolation and cultural diversity, pose potential barriers to implementing transportation assistance, however, federal and state grants may offer viable funding solutions. KDVA, KASAP, and the Governor's Office on Child Abuse and Domestic Violence Services are encouraged to research referral-based transportation vouchers and educate legislators and local officials on transportation needs of DV/SA victims. Collaboration with the Department of Transportation may generate creative strategies for funding and provide solutions for transportation needs in rural areas.

D: Priority Area #4
COMMUNITY COLLABORATION

Community collaboration was identified as the fourth priority area for public health's response to VAW. Community collaboration refers to local partnerships and alliances combining efforts for a common cause. A coordinated community response for DV and SA may include social services, law enforcement, prosecutors, victims' advocates, judges, hospitals, mental health providers, and public health agencies. Each discipline brings its own perspective and approach to the prevention and intervention of DV.

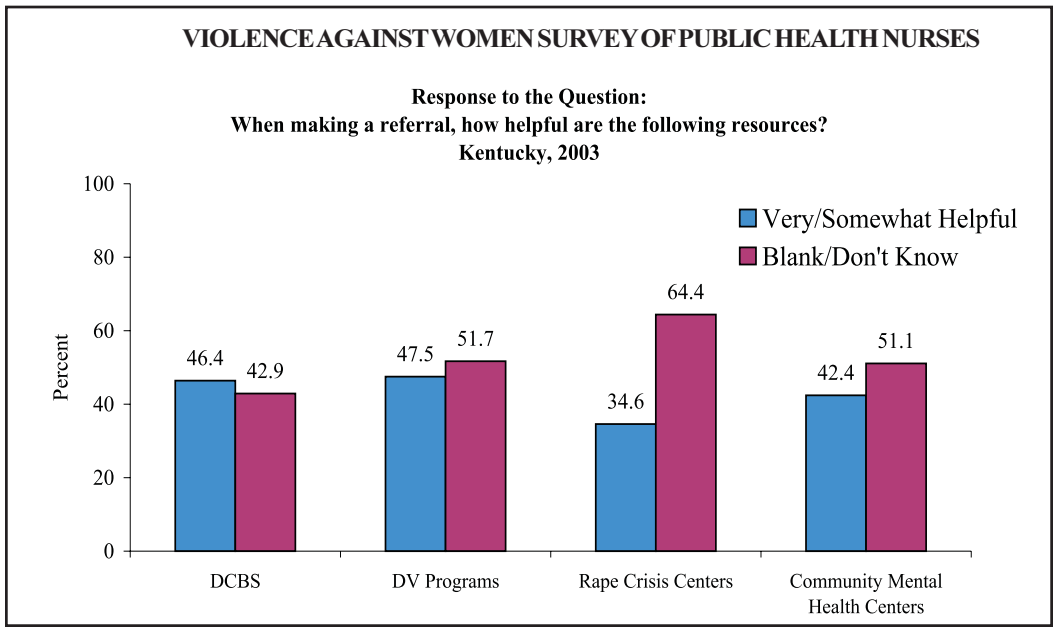
Each community is different, with varying degrees of commitment to DV and SA prevention. Many communities in Kentucky already have Local Coordinating Councils on DV, which seek to maximize community resources to improve the response to DV/SA. While some Councils are very active and organized, other communities lack a Council altogether or have a stagnant Council that is void of leadership. A key recommendation from the strategic planning meeting was to improve and support Local Coordinating Councils, elevating their influence on DV and SA in their respective communities. For those interested in improving or developing a Local Coordinating Council, please contact the Governor's Office of Child Abuse and Domestic Violence Services (502-564-2611) for information on model protocols.

Fig. 10



Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

Fig. 11



Source: 2003 Survey of Public Health Nurses, Office of Women's Physical and Mental Health, Cabinet for Health and Family Services.

Recommendations for Community Collaboration

Recommendation 1: Create/expand Local Coordinating Councils on DV.

Local Coordinating Councils on DV are multidisciplinary, community-based groups brought together to form a coordinated response to DV. All interested groups should be involved to some extent in the Local Coordinating Council, but a core group of stakeholders should be responsible for administratively managing the Council. The core group is encouraged to meet regularly, periodically inviting all interested parties to foster improved community collaboration. Creating subcommittees focusing on specific issues will utilize Council expertise. Those who should be involved in the Council include: prosecutors, social workers, DCBS, RCCs, DV programs, judges, law enforcement, LHDs, local non-profits, and hospital administrators. Attendance/involvement at meetings should be maximized by the following means:

1. Have governor and/or local judges elevate awareness of Local Coordinating Councils;
2. Set small, accomplishable goals;
3. Include all interested parties in communication loop, utilizing their expertise as needed;
4. Have online meetings;
5. Give subcommittee's time-specific, focused tasks; and
6. Rotate Council leadership.

Recommendation 2: Initiate memorandums of agreement (MOAs) between community partners for DV training and referral.

Formalizing relationships between community partners by initiating MOAs will help clarify roles, responsibilities and limitations of agencies working together on DV training and referral. The commitment of community partners can be programmatic in nature, not necessarily involving a fiscal commitment. While issues of liability and limited capabilities may be legitimate concerns, the MOA will eliminate any uncertainty as to what activities and deliverables are expected of each agency.

Recommendation 3: Promote community awareness of VAW through outreach to all sectors of community - from early childhood to the elderly.

Local Coordinating Councils on DV are encouraged to lead awareness efforts focusing on the following activities:

1. Re-vitalize early childhood education programs to ensure children receive age-appropriate information about violence;
2. Work with youth service providers and youth groups (i.e. Boy Scouts) in after school programs;

3. Adapt education programs to apply to other populations, such as senior citizens;
4. Provide monthly trainings for service providers;
5. Educate employers on the impact of DV/SA on the workplace;
6. Target men by discussing violence in a men's health initiative;
7. Become involved in and promote statewide activities such as DV Awareness Month in October, SA Awareness Month in March, and the SA/DV Conference in December;
8. Teach basic relationship skills, such as the difference between sex and intimacy;
9. Create and utilize public service announcements;
10. Host a service provider forum with invited media;
11. Change the perception that nothing can be done about violence and that the family must break up if violence is reported; and
12. Make VAW a policy issue.

Recommendation 4: Establish relationships with local social service providers.

DPH and DCBS are encouraged to build relationships with local social service providers including social workers, Local Coordinating Councils and Sexual Assault Response Teams (SARTs). Maintaining existing relationships is difficult when leadership changes take place, therefore time and effort must be made to ensure that these relationships are sustained over time.

Appendix A.

STATEWIDE SURVEY OF PUBLIC HEALTH NURSES' RESPONSE TO DOMESTIC VIOLENCE AND SEXUAL ASSAULT/RAPE AMONG PATIENTS RECEIVING SERVICES AT LOCAL HEALTH DEPARTMENTS

To be completed by the individual public health nurse. This survey will take approximately 10 minutes to complete.

Purpose Of The Survey

Local Health Departments often provide preventive and primary medical care to women at risk of, or experiencing domestic violence and/or sexual assault. Recognizing domestic violence and sexual assault as public health issues, we feel it is necessary to gather information on current protocol and practices among health department nurses and further assess their training, attitudes, and recommendations regarding violence against women within their respective communities.

This survey is divided into two sections: (1) Domestic Violence, and (2) Rape/Sexual Assault. We recognize that each nurse's experiences with these two issues will vary, however, we appreciate your thoughtful consideration of each question. If you are uncomfortable answering any of the questions included in this survey, feel free to skip that question. We appreciate your willingness to complete this survey.

Instructions: Please circle the number corresponding to your best answer for each question. There are no right or wrong answers; we are just interested in your honest *opinions* and *experiences.* Please remember that all of your responses will remain completely confidential.

Section 1: Domestic Violence

Definition Of Domestic Violence

For the purpose of answering these questions, domestic violence means actual or threatened physical or sexual abuse by someone with whom they have, or have had, an intimate or romantic relationship.

I. Domestic Violence Training & Awareness of Reporting Requirements

1. Have you ever received training specific to domestic violence?
   1) Yes 2) No → **SKIP TO 4**

2. Please estimate the number of hours of training you have received in the past 5 years. _____

3. What topics were included in your training? *(Please circle all that apply)*

1) Dynamics of DV	4) Confidentiality Issues	7) Referrals/Resources in Community
2) Model Protocols	5) Mental Health Issues	8) Risk Issues/Safety Planning
3) Physical Evaluation	6) Mandatory Reporting	9) Other _____

4. In what areas do you have (additional) training needs with regard to domestic violence?

1) Dynamics of DV	4) Confidentiality Issues	7) Referrals/Resources in Community
2) Model Protocols	5) Mental Health Issues	8) Risk Issues/Safety Planning
3) Physical Evaluation	6) Mandatory Reporting	9) Other _____

5. Are you aware of Kentucky's mandatory requirement that if you have reason to suspect an adult has suffered abuse, neglect or exploitation you must make a report to the Department for Community Based Services/Social Services (KRS 209.030)?
   1) Yes 2) No → **SKIP TO 7**

6. What impact does mandatory reporting have on your practice as a public health nurse?

   1) Has positive impact on my practice
   2) Has no impact on my practice
   3) Has negative impact on my practice
   4) Not applicable to my practice

II. Screening For Domestic Violence

7. In the PAST 3 MONTHS, when seeing someone for a health-related appointment, *how often* did you have reason to suspect the patient was a victim of domestic violence?

   1) Very often
   2) Fairly often
   3) Only occasionally
   4) Very rarely
   5) Never

8. There are many potential obstacles to *identifying* adult patients who have been abused. For each obstacle listed below, please indicate whether it is 1) A Major Problem, 2) A Minor Problem, 3) Not a Problem for your Local Health Department, or 8) if you Don't Know.

	Major Problem	**Minor Problem**	**Not a Problem**	**Don't Know**
Patient does not mention abuse during history taking.	1	2	3	8
Patient's primary language is not English.	1	2	3	8
Patient is under the influence of drugs or alcohol.	1	2	3	8
Patient lacks privacy (has partner or children with them).	1	2	3	8
Patient denies abuse as the cause of injury.	1	2	3	8
Patient fears repercussions of being identified as abused.	1	2	3	8
Cultural norms and customs interfere with discussion of abuse.	1	2	3	8

9. When seeing a patient for a health-related event, *how often* do you SCREEN for domestic violence?

    1) I screen every patient

    2) I frequently screen my patients

    3) I only screen when I suspect domestic violence

    4) I only screen AFTER the patient reveals there is violence in the relationship

    5) I never screen → **SKIP TO 12**

10. When screening for domestic violence, how often do you follow the Public Health Practice Guidelines?

    1) Always

    2) Often

    3) Only occasionally

    4) Never

    5) Not aware of Public Health Practice Guidelines → **SKIP TO 12**

11. How helpful do you feel the Public Health Practice Guidelines are when screening a patient for domestic violence?

    1) Very Helpful

    2) Somewhat Helpful

    3) Not very helpful

    4) Not helpful at all

12. What improvements would you suggest for *screening* and *identifying* victims of DV encountered through your Local Health Department?

III. Local Resources and Referrals

13. Which of the following public education materials do you keep in your office or other common areas of the health department? *(Please circle all that apply)*

    1) Brochures/pamphlets on domestic violence
    2) Posters on domestic violence
    3) Domestic violence shelter numbers and hotlines
    4) DCBS brochures/safety plans
    5) Brochures/pamphlets on rape and sexual assault
    6) Posters on rape/sexual assault
    7) Rape crisis center phone numbers and hotlines
    8) Discreet note cards with emergency numbers
    9) Other _____

14. There are many potential obstacles to the *referral* of adult patients who have been abused. For each obstacle listed below, please indicate whether it is 1) A Major Problem, 2) A Minor Problem, 3) Not a Problem for your Local Health Department, or 8) if you Don't Know.

	Major Problem	**Minor Problem**	**Not a Problem**	**Don't Know**
There are no local community agencies or resources available in my area to serve battered/abused patients.	1	2	3	8
Community agencies and resources are difficult to access.	1	2	3	8
Local Health Department staff is too busy to treat anything other than physical injuries.	1	2	3	8
The abused patient does not want a referral.	1	2	3	8
Resources are available only at a distance.	1	2	3	8

15. When you confirm a patient is a victim of domestic violence, to which of the following services do you routinely refer your patient? *(Please circle all that apply)*

1) Department for Community Based Services
2) Mental health/Counseling
3) Domestic violence programs
4) Housing
5) Legal services
6) Financial Assistance
7) Other medical
8) Do not routinely refer patients

16. When you do make a referral, how helpful are the following resources to the victim?

	Very Helpful	**Somewhat Helpful**	**Not Helpful**	**Don't Know**
Department for Community Based Services	1	2	3	8
Domestic Violence Programs	1	2	3	8
Rape Crisis Centers	1	2	3	8
Community Mental Health Centers	1	2	3	8
Legal Aid	1	2	3	8
Law Enforcement/Police	1	2	3	8
Other Medical	1	2	3	8

IV. General Attitudes Regarding Domestic Violence

17. Please circle the number indicating whether you 1) Strongly Agree, 2) Somewhat Agree, 3) Somewhat Disagree, or, 4) Strongly Disagree with each of the following statements.

	Strong Agree	**Somewhat Agree**	**Somewhat Disagree**	**Strongly Disagree**
Domestic violence is not a problem in my patient population.	1	2	3	4
It is important that I make time to ask about domestic violence.	1	2	3	4
I do not have time to fully evaluate or counsel a patient who tells me she/he is a victim of domestic violence.	1	2	3	4
I am adequately trained to help a patient affected by domestic violenc.	1	2	3	4

A patient's experience with domestic violence is none of my business. It is a private issue.	1	2	3	4
I believe identifying and referring patients experiencing domestic violence is an important part of my job.	1	2	3	4
I believe I may offend a patient if I ask about domestic violence.	1	2	3	4
I only screen selected patients, especially those in lower socioeconomic situations.	1	2	3	4
A patient's health condition is often related to domestic violence.	1	2	3	4
Domestic violence is a public health issue.	1	2	3	4

Section 2: Rape and Sexual Assault

Definition of Rape and Sexual Assault:

For the purpose of answering these questions, rape and sexual assault means a sexual act without consent, by a person who is a non-intimate partner (ie., an acquaintance or stranger).

V. Screening and Referral for Rape/Sexual Assault

18. In the PAST 3 MONTHS, when seeing someone for a health-related appointment, *how often* did you have reason to suspect, or the patient disclosed, that they had experienced an unwanted sexual act or had been raped?

1) Very often

2) Fairly often

3) Only occasionally

4) Very rarely

5) Never

19. For patients being screened for sexually transmitted diseases (STDs), how often do they disclose that they have been raped?

    1) Always

    2) Often

    3) Only occasionally

    4) Very rarely

    5) Never

20. For patients being screened for STDs, how often do you ask if they have been raped?

    1) Always

    2) Often

    3 Only occasionally

    4) Very rarely

    5) Never

21. For patients being screened for HIV, how often do they disclose that they have been raped?

    1) Always

    2) Often

    3) Only occasionally

    4) Very rarely

    5) Never

22. For patients being screened for HIV, how often do you ask if they have been raped?

    1) Always

    2) Often

    3) Only occasionally

    4) Very rarely

    5) Never

23. How often do you provide information to your patients about the long-term physical and/or mental health consequences of child sexual abuse?

1) Always

2) Often

3) Only occasionally

4) Very rarely

5) Never

24. Do you know what services are available at a Rape Crisis Center?

1) Yes 2) No

25. How often do you refer patients to Rape Crisis Centers?

1) Very often

2) Fairly often

3) Only occasionally

4) Very rarely

5) Never

26. Please offer any thoughts or suggestions on improving Public Health's response to domestic violence and/or sexual assault and rape in your community.

VI. General Information

(The following information is for analytical purposes to see if practices and opinions vary by region or the extent or nature of experiences of public health nurses. This information will be reported in aggregate.)

27. In what county is the Health Department your work in located? _____County

28. How many years have you been a practicing nurse? _____ Years

29. How many years have you worked in public health? _____ Years

30. How many years have you worked in your *current* Local Health Department? _____ Years

31. What license do you hold? *(Please circle one)* 1) RN 2) LPN 3) ARNP

32. Are you a credentialed Sexual Assault Nurse Examiner (SANE)? 1) Yes 2) No

33. If so, how long have you been a credentialed SANE? _____ Years

Thank you for your taking the time to share your expertise with us!

Appendix B.

Kentucky Domestic Violence Association (KDVA)
Focus Group with Domestic Violence Shelter Directors

May 15, 2003

Participants:
Darlene Thomas, The Center for Women and Families, Louisville
Pam Johnson, The Center for Women and Families-West End Branch, Louisville
Dolores Coffman, Women's Crisis Center, Covington
Lois Valentine, LKLP Safe House, Hazard
Lisa Holmes, SpringHaven, Elizabethtown
Phyllis Konerman, Women's Crisis Center, Maysville
Melissa Kemp, YWCA Spouse Abuse Center, Lexington
Sister Mary Kay Drouin, Resurrection Home, Beattyville
Donna Overbee, D.O.V.E.S., Morehead
Mary Jo Davis, Women's Crisis Center, Covington

Facilitator:
Danielle Clore, Center for Nonprofit Leadership, University of Kentucky

Q1: What are the internal and external barriers to victim services provided by your agency?

- Lack of staff (especially for children's services)
- Lack of money to meet basic needs
- Gaps in services for single women
- Transportation
- Child care
- Housing
- Gaps in services due to new staff members' lack of knowledge
- Additional barriers for certain populations (e.g. non-English speaking)
- Costs to the agency of interpretation and translation for clients who do not speak English
- Money for medication as an external barrier, and, internally, lack of staff
- Mental health services' lack of adequate funds and training to deal with drug/alcohol abuse

- Housing—getting the victims out of shelters, they are a dumping ground, a catch-all for all types of problems in the community, but receiving little help
- Substance abuse referrals
- Major lack of public transportation
- Need continued work on philosophy; change in social attitudes on issues
- Awareness of services
- Lack of expertise in dealing with general health issues
- DCBS could be more helpful
- Stringent sex stereotype roles in rural areas, social attitudes of judicial system and law enforcement
- Level of accountability required gets in the way of service (for example, 164 reports a year must be generated, which takes up considerable time)

Q2a: How is your organization ensuring that you are effectively addressing community needs and improving your response to those needing services?

- Client satisfaction surveys
- Operating under victims' services standards that include (1) peer review, (2) data collection, (3) monitoring, and (4) director's self-evaluations
- Local coalitions, interagency councils, task forces, and collaboration with other agencies
- Multi-disciplinary teams
- Feedback from victims
- Public education

Q2b: What special or unique programs does your agency offer or what plans exist to address unmet needs?

- Leading agency for Hispanic services, working with churches in providing translation, food pantries, etc. for the growing number of migrant workers
- Collaborate with rape crisis program and health department to provide community education about available services and day treatment for substance abuse
- Trying to get grant to hire a mental health nurse and to collaborate with a psychiatrist
- Collaborate with community-based services to provide free childcare to any woman in their shelter

- Welfare to work
- Provide one of only 3 joint SA and DV programs in Kentucky
- Pet protection program by Humane Society (shots and housing for 60 days)
- Their IDA program (Individual Development Accounts) is a savings program for individuals who have jobs, but are still in poverty, with their money matched 2 to 1 upon their graduation from the program.
- Merged the SA (sexual assault) and DV (domestic violence) programs so that each staff member is trained in and responsible for both programs. They house male and female rape victims. When their new facility is complete, they will have a rape clinic on site and, hopefully, a health care clinic as well. They also have an Immigrant Advocacy program, and they provide training for all of Louisville's medical students.

Q3: What providers routinely make referrals to your agency and do you currently consult with regarding your clients?

- Court
- Law enforcement
- Hospitals/emergency rooms
- DCBS
- Mental health
- School system
- Health department
- Local doctors
- Private therapists
- Rape crisis programs
- Word of mouth and former clients
- Christian Social Services (provide clothing, rent assistance, and medication).
- Some said that the religious community rarely referred them patients, but one disagreed.

Q4: Where does your patient population typically access needed health services?

- Hospitals
- Emergency rooms

- Physicians
- Free clinics for the homeless
- Rural health services
- Health department (in more rural counties)
- Dentists

Q5: How can the health care system improve its effectiveness in identifying, screening and referring victims of sexual assault and domestic violence to appropriate agencies?

- More training
- Taking time to listen more
- Make it protocol - mandated from the top down
- Health departments should inform the community of all the services it provides
- One center trains U of L medical students
- Doctors should have a set of domestic violence questions that they always ask when assessing the patient
- Should be part of schooling to get degree
- Attitudes of health providers need to be changed; doctors are trained on procedure, not in dealing with emotion
- Need a holistic approach (regarding stress, depression, anxiety, for example)- instead of merely prescribing medication, health care professionals should refer a victim to a DV agency if that is a root of the problems

Q6: What services do you think the health department provides to assist victims of domestic violence and sexual assault?

- Nurse from the health department comes in 1/2 day once a week and also refers people to Cabinet for Families and Children.
- Health department has been doing trainings about home-making, personal care, etc.; training on how to care for babies and services for children; expertise in medical things, such as treating lice.
- Pap smears
- Cholesterol checks
- Mammograms
- Shots

- They advertise and get the word out well
- Reduced cost flu shots and TB testing (HD doesn't do a whole lot for them)
- Birth control

Q7: What are the consequences of mandatory reporting?

- Tracks numbers, which helps with funding
- The law was intended to serve those who cannot protect themselves and is fundamentally inappropriate for those who can protect themselves
- DCBS is not consistent from worker to worker or from county to county in the level of service they provide
- Child abuse can be discovered in subsequent interviews
- DCBS created a positive relationship
- Victims are punished
- DCBS doesn't protect elderly and/or handicapped. They do an interview, but nothing happens because of a lack of resources
- Reporting doesn't protect the victim or help them one iota
- DCBS sets up plans for the children, but sometimes has difficulity following through
- Hinders victims from seeking services
- All of one center's money was cut about 10 years ago because of mandatory reporting. Kentucky is the only state that requires everyone to report. Because of this, they get a "D" on their report card

Q8: What suggestions would you make to health care providers regarding mandatory reporting?

- Report the abuse with the victim present so as to allow victims to accept or deny services immediately. This strategy not only meets the legal requirements, but it also empowers the victim as well.
- Always inform the victim of mandatory reporting, but also inform them that they can deny services. Refer victims to local programs at that time.
- Ask your representative to change the law.
- Mandatory reporting is a dilemma because some people would never report it if it were not required, but states without mandatory reporting have fared as well as or better than Kentucky.

Appendix C.

Kentucky Association of Sexual Assault Programs
Focus Group with Rape Crisis Center Directors

Embassy Suites, Richmond Road, Lexington, Kentucky
May 9, 2003

Participants:
Susan Davisson, New Beginnings, Owensboro
Phyllis Konerman, Women's Crisis Center, Covington
Brenda Hughes, Kentucky River Community Care, Hazard
Phyllis Millspaugh, Hope Harbor, Bowling Green
Rhonda Henry, Bluegrass Rape Crisis Center, Lexington
Betty Jordan, Cumberland River Comprehensive Care, Corbin

Facilitator:
Danielle Clore, Center for Nonprofit Leadership, University of Kentucky

Q1: What are the internal and external barriers to victim services provided by your agency?

- People in the community are not always aware that rape crisis centers are there; competition for referrals with mental health providers
- Lack of money and staff, staff burnout, social attitudes about their issues (especially of law enforcement and judges), the costs of technology (with data collection not standardized)
- Poor staff development, tremendous amount of paperwork that eats away at staff's time, lack of community's awareness of the need for their services in the community
- Lack of management strength, board involvement and leadership, money, and legislative awareness/involvement. Also there is no training in colleges for professionals to deal with this issue
- Turnover and burnout, and community doesn't value or aren't aware of the unique service provided by RCCs
- All of the above, lack of community resources (in a rural area), problems with physical geographical area and the lack of transportation, and service providers in private practice who have no training at dealing with this population

Q2a: How is your organization ensuring that you are effectively addressing community needs and improving your response to those needing services?

- Adequate training

- Client satisfaction surveys, pre- and post-tests on public education, outcome measures for United Way
- Effectively reaching out within a region, with people at all levels of the organization doing different things to expand services (e.g. writing grants)
- Grievance policy, goals and objectives for programs are reviewed or monitored using data, multi-disciplinary teams tell them what services they think rape crisis centers should provide
- Survey other agencies for their impressions of what their center is doing, trying to expand their geographical scope by increasing the services provided in their 17 counties
- Multi-team approach made up of various types of information staff, different professionals-psychologists, psychiatrists, etc.

Q2b: What special or unique programs does your agency offer or what plans exist to address unmet needs?

- Want to start a college peer counseling program, expand programs they already have, offer healthy relationship classes, expand puppet program
- Pet protection program, SANE, SART, SAIC (Sexual Assault Interagency Council), GAPS (Gaining Access to Program Services), WRAP (Women's Residential Alcohol Program), DOVES (a forensic unit being set up to deal with sexual assault, domestic violence, and perpetrator evidence), Music Together (a program for children, parents, and their relationship which teaches parents another form of parenting using music, teaches children rhythm, and fosters brain development in children), PsyD, and educational program for child sexual abuse and treatment
- RAD (Rape Aggression Defense, self-defense classes for adults and children), non-offending parent therapeutic group, treatment group for adults molested as children, SANE, SART, developing more SART locations in rural areas, Hispanic outreach program, peer mentoring in high schools to teach (mostly males) about good listening skills and dangerous dating relationships, EGO (Encouraging Girls Outward, a program that can focus on at-risk population or on high-achievers to become leaders), collaboration with law enforcement to overcome the huge transportation issues in a rural area
- Full-time Hispanic outreach program, full-time African-American outreach program, programs for outreach to the elderly, males, gays/lesbians, and people with disabilities, SANE, SART, peer education in high school setting in the most eastern part of their region
- RAD, substance abuse and pregnancy
- APA-approved psychology internship, lead for Appalachian Violence Outreach Network (putting wellness coordinators in health department to identify victims of

domestic violence and sexual assault), trauma assessment program (a cutting-edge program that the psych intern conducts), collaborating with national rural law enforcement training center, co-occupy space and share services with Children's Advocacy Center, SANE, SART

Q3: What providers routinely make referrals to your agency and do you currently consult with regarding your clients?

- DCBS, homeless shelter, halfway house (Dismas charities), and some private practice mental health professionals (although not often because they don't want to lose money)
- Doctors, therapists, hospitals, former clients, alcohol/drug program people, homeless shelter, community mental health, CAC (Children's Advocacy Center), board members
- Community mental health, CAC, hospitals
- Spouse abuse shelters, guidance counselors in schools, teachers, FRYCS, law enforcement, volunteers, county and commonwealth attorneys offices/advocates, and occasionally United Way and its member agencies because they are familiar with her agency and its services
- Community center, nursing home staff
- Health department, private physicians, family & friends, schools

Q4: Where does your patient population typically access needed health services?

- Health department, private physicians, free medication at homeless shelter/hospital
- Emergency room
- Free clinic, CAC
- Planned Parenthood, Urgent Treatment Centers

Q5: How can the health care system improve its effectiveness in identifying, screening and referring victims of sexual assault and domestic violence to appropriate agencies?

- Have specific training on what to look for and give them materials to refer to like they have with teachers
- Training on how to assess for these issues in emergency rooms and doctors' offices, or health care professionals could simply ask the question and then inform the patient of the rape crisis center's services
- Have designated staff trained to provide educational services to their patients (victims) regarding available services

- Health care system could provide better pay to reduce turnover, be informed about referral information, have training on cultural diversity (to stop blaming the victim), be more proactive in referring, and be more supportive of SANE/SART and support nurses in these programs. To aid in collaboration with the health care system, the rape crisis centers could also use some training in what the health care system can and cannot do.
- Ongoing training, establishing a safe environment, having sexual assault printed materials displayed to set the tone that this is a place where you can talk about the topic

Appendix D.

Kentucky Domestic Violence Programs/Shelters

- Barren River Area - (800) 928-1183
  (Counties: Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson and Warren)
- Big Sandy Area - (800) 649-6605
  (Counties: Floyd, Johnson, Magoffin, Martin and Pike)
- Bluegrass Area - (800) 544-2022
  (Counties: Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrision, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott and Woodford)
- Buffalo Trace Area - (800) 928-6708
  (Counties: Bracken, Fleming, Lewis, Mason and Robertson)
- Cumberland Valley Area - (800) 755-5348
  (Counties: Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle and Whitley)
- FIVCO Area - (800) 926-2150
  (Counties: Boyd, Carter, Elliott, Greenup and Lawrence)
- Gateway Area - (800) 221-4361
  (Counties: Bath, Menifee, Montgomery, Morgan and Rowan)
- Green River Area - (800) 882-2873
  (Counties: Daviess, Hancock, Henderson, McLean, Ohio, Union and Webster)
- Kentucky River Area - (800) 928-3131
  (Counties: Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry and Wolfe)
- KIPDA Area - (877) 803-7577
  (Counties: Bullitt, Jefferson, Oldham, Shelby, Spencer and Trimble)
- Lake Cumberland Area - (800) 755-2017
  (Counties: Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor and Wayne)
- Northern Kentucky Area - (800) 928-6708
  (Counties: Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen and Pendleton)

- Pennyrile Area - (800) 766-0000
  (Counties: Caldwell, Christian, Crittendon, Hopkins, Livingston, Lyon, Muhlenburg, Todd and Trigg)
- Purchase Area - (800) 585-2686
  (Counties: Ballard, Benton, Calloway, Carlisle, Hickman, Fulton, Graves, Marshall, Mayfield, McCracken, Murray and Paducah)

Appendix E.

Kentucky Rape Crisis Centers

- District 1 (Counties: Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, Marshall, and McCracken)

  Rape Victim Services, Inc.
  P.O. Box 8506
  Paducah, KY 42002-8506
  (800) 928-7273

- District 2 (Counties: Caldwell, Christian, Crittenden, Hopkins, Livingston, Lyon, Muhlenburg, Todd and Trigg)

  Sanctuary, Inc.
  P.O. Box 1165
  Hopkinsville, KY 42241
  (800) 766-0000

- District 3 (Counties: Daviess, Hancock, Henderson, McLean, Ohio, Union and Webster)

  New Beginnings Sexual Assault Support Services
  P.O. Box 903
  Owensboro, KY 42303-0903
  (800) 226-7273

- District 4 (Counties: Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson and Warren)

  Hope Harbor
  913 Broadway
  Bowling Green, KY 42101
  (800) 347-1848

- District 5 (Counties: Breckinridge, Grayson, Hardin, Larue, Marion, Meade, Nelson and Washington)

  Advocacy & Support Center
  P.O. Box 1537
  Elizabethtown, KY 42702
  (877) 672-2124

- District 6 (Counties: Bullitt, Henry, Jefferson, Oldham, Shelby, Spender and Trimble)

  Center for Women and Families
  P.O. Box 2048
  Louisville, KY 40201-2048
  (877) 803-7577

- District 7 (Counties: Boone, Bracken, Campbell, Carroll, Fleming, Gallatin, Grant, Kenton, Lewis, Mason, Owen, Pendleton and Robertson)

  Women's Crisis Center, Inc.
  835 Madison Avenue
  Covington, KY 41011
  (800) 928-3335

- District 10 (Counties: Bath, Boyd, Carter, Elliott, Greenup, Lawrence, Menifee, Montgomery, Morgan and Rowan)

  Pathways, Inc.
  201 22nd Street
  Ashland, KY 41101
  (800) 562-8909

- District 11 (Counties: Floyd, Johnson, Magoffin, Martin and Pike)

  Mountain Comprehensive Care Center
  150 South Front Street
  Prestonsburg, KY 41653
  (800) 422-1060

- District 12 (Counties: Breathitt, Knott, Lee, Leslie, Letcher, Perry, Owsley and Wolfe)

  Kentucky River Community Care, Inc.
  465 Cedar Street
  Hazard, KY 41701
  (800) 375-7273

- District 13 (Counties: Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle and Whitley)

  Cumberland River Comprehensive Care Center, Inc.
  P.O. Box 568
  Corbin, KY 40702
  (606) 528-7010

- District 14 (Counties: Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor and Wayne)

  Adanta Regional Victim Services Program
  259 Parkers Mill Road
  Somerset, KY 42501
  (800) 633-5599

- District 15 (Counties: Anderson, Boyle, Bourbon, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott and Woodford)

  Bluegrass Rape Crisis Center, Inc.
  P.O. Box 1603
  Lexington, KY 40588
  (800) 656-4673

Appendix F.

Kentucky's District Health Departments

Adair County Center 801 Westlake Drive Columbia, KY 42728 (270) 384-2286	Boone County Health Center Clinical/Home Visiting 7505 Burlington Pike Florence, KY 41042 (859) 525-1770
Ashland-Boyd County Center 2916 Holt Street P.O. Box 4180 Ashland, KY 41105-4180 (606) 324-7181	Breckinridge County Home Health Highway 60 P.O. Box 456 Hardinsburg, KY 40143
Ashland-Boyd County Center Cannonsburg Division 1320 Wolohan Drive Ashland, KY 41105 (606) 928-0948	Butler County Center 104 North Warren Street P.O. Box 99 Morgantown, KY 42261-0099 (270) 526-3221
Ballard County Center U.S. Highway 60 P.O. Box 357 LaCenter, KY 42056 (270) 665-5432	Caldwell County Health Department 310 Hawthorne Street P.O. Box 327 Princeton, KY 42445 (270) 365-6571
Barren County Center 318 West Washington P.O. Box 1464 Glasgow, KY 42142-1464 (270) 651-8321	Calloway County Center 701 Olive Street P.O. Box 1115 Murray, KY 42071
Bath County Center 56 Treadway P.O. Box 537 Owingsville, KY 40360 (606) 674-2731	Campbell County Health Center 12 East Fifth Street Newport, KY 41071 (859) 431-1704
Bell County Center 310 Cherry Street Pineville, KY 40977 (606) 337-7046	Carlisle County Center East Court Center P.O. Box 96 Bardwell, KY 42023 (270) 628-5431
Bell County Center Branch Office 111 21st Street P.O. Box 160 Middlesboro, KY 40965 (606) 248-2862	Carroll County Center 401 Eleventh Street Carrollton, KY 41008 (502) 732-6641

Kentucky's District Health Departments

Carter County Center U.S. 60 East P.O. Box 919 Grayson, KY 41143 (606) 474-5100	Edmonson County Center 221 Mammoth Cave Road Brownsville, KY 42210 (270) 597-2194
Carter Center - West Hitchins Avenue P.O. Box 728 Olive Hill, KY 41164 (606) 286-6000	Elliott County Center Main Street P.O. Box 762 Sandy Hook, KY 4171 (606) 738-5205
Casey County Center 199 Adams Street P.O. Box 778 Liberty, KY 42539 (606) 787-6911	Fulton County Center - West 402 Troy Street Hickman, KY 42050 (270) 236-2825
Clay County Center 100 South Court Street Manchester, KY 40962 (606) 598-2425	Fulton County Center - East 350 Browder Street Fulton, KY 42041 (270) 472-1982
Clinton County Center 201 Twin Lakes Medical Center Albany, KY 42602 (606) 387-5711	Gallatin County Center 204 Franklin Street P.O. Box 315 Warsaw, KY 41095 (859) 567-2844
Crittenden County Health Department 402 Walker Street P.O. Box 392 Marion, KY 42064 (270) 965-5215	Grant County Center Clinical/Environmental 234 Barnes Road Williamstown, KY 41097 (859) 824-5074
Cumberland County Center 133 Lower River Street P.O. Box 412 Burkesville, KY 42717 (270) 864-2206	Graves County Center 100 East Lochridge Mayfield, KY 42066 (270) 247-3553
Cumberland Valley District Branch Office 316 North Hill Street London, KY 40741 (606) 864-4764	Grayson County Center 124 East White Oak Street Leitchfield, KY 42754 (270) 259-3141

Kentucky's District Health Departments

Green County Center 220 Industrial Park P.O. Box 177 Greensburg, KY 42743 (270) 932-4341	Hickman County Center 370 South Washington Street Clinton, KY 42031 (270) 653-6110
Hancock County Center 175 Harrison Street P.O. Box 275 Hawesville, KY 42348 (270) 927-8803	Jackson County Center Highway 421 South P.O. Box 250 McKee, KY 40447 (606) 287-8421
Hardin County Center 580-C Westport Road Elizabethtown, KY 42701 (270) 765-6196	Kenton County - Dressman Health Center 634 Scott Street Covington, KY 41011 (859) 431-3345
Harlan County Center 402 East Clover Street Harlan, KY 40831 (606) 573-4820	Kenton County Health Education Center 2388 Grandview Drive Covington, KY 41017-1633 (859) 578-7660
Harlan County Center Tri-Cities Branch Office 200 Church Street P.O. Box 790 Lynch, KY 40855 (606) 848-2244	Knott County Center 880 West Main Street P.O. Box 530 Hindman, KY 41822 (606) 785-3144
Harrison County Center 416 East Pleasant Street Cynthiana, KY 41031 (859) 234-2842	Larue County Center 215 East Main Street Hodgenville, KY 42748 (270) 358-3844
Hart County Center 505 Fairground Road P.O. Box 65 Munfordville, KY 42765 (270) 524-2511	Larue County Home Health 60 Shawnee Drive Hodgenville, KY 42748 (270) 358-3155
Henderson County Center 472 Klutey Park Plaza Henderson, KY 42420 (270) 826-3951	Lawrence County Center 1080 Meadowbrook Lane Route #2 Louisa, KY 41230 (606) 638-4389
Henry County Center 125 North Property Road P.O. Box 449 New Castle, KY 40050 (502) 845-2882	Lee County Health Center 57 Main Street Beattyville, KY 41311

Kentucky's District Health Departments

Lee County Health Center Center Street P.O. Box 587 Beattyville, KY 41311 (606) 464-2492	McCracken County Center 916 Kentucky Avenue P.O. Box 2597 Paducah, KY 42002-2597 (270) 444-9631
Leslie County Center 78 Maple Street P.O. Box 787 Hyden, KY 41748 (606) 672-2393	McCreary County Center South Fork Center P.O. Box 208 Whitley City, KY 42653 (606) 376-2412
Leslie County Health Center 100 Hurts Creek Shopping Center Highway 80 Hyden, KY 41749 (606) 672-7175	McLean County Center 310 West Seventh Street Calhoun, KY 42327 (270) 273-3062
Letcher County Center 6 Broadway Street Whitesburg, KY 41858 (606) 633-2948	Meade County Center 520 Fairway Drive Brandenburg, KY 40108 (270) 422-3988
Livingston County Health Department 124 State Street P.O. Box 218 Smithland, KY 42081 (270) 928-2193	Menifee County Center U.S. 460 East P.O. Box 106 Frenchburg, KY 40322 (606) 768-2151
Logan County Center 151 South Franklin Street Russellville, KY 42276 (270) 726-8341	Metcalfe County Center 615 West Stockton Street P.O. Box 30 Edmonton, KY 42129 (270) 432-3214
Lyon County Health Department 211 Fairview Avenue P.O. Box 96 Eddyville, KY 42038 (270) 388-9763	Morgan County Center 493 Riverside Drive West Liberty, KY 41472 (606) 743-3744
Marion County Center 516 North Spalding Lebanon, KY 40033 (270) 692-3393	Nelson County Center 325 South Third Street Bardstown, KY 40004 (502) 348-3222
Mason County Center 120 West Third Street P.O. Box 266 Maysville, KY 41056 (606) 564-9447	Nicholas County Center 2320 Concrete Road Carlisle, KY 40311 (859) 289-2188

Kentucky's District Health Departments

North Central District Home Health 124 Court Street P.O. Box 358 New Castle, KY 40050 (502) 845-2761	Pulaski County Center 45 Roberts Street Somerset, KY 42503 (606) 679-4416
Ohio County Center 1336 Clay Street Hartford, KY 42347 (270) 298-3663	Radcliff Clinic Health Center 1463 North Wilson Road Radcliff, KY 40160 (270) 352-2526
Owen County Center 1005 Highway 22 East Owenton, KY 40359 (502) 484-5736	Robertson County Center 107 McDowell Street P.O. Box 72 Mt. Olivet, KY 41064 (606) 724-5222
Owensboro - Daviess County Center 1600 Breckinridge Owensboro, KY 42302 (270) 686-7744	Rockcastle County Center 120 Richmond Street P.O. Box 840 Mt. Vernon, KY 40456 (606) 256-2242
Owsley County Center Highway 28 P.O. Box 220 Booneville, KY 41314 (606) 593-5181	Rowan County Center 555 West Sun Street Morehead, KY 40351 (606) 784-8954
Owsley County Health Center North Court Square Booneville, KY 41314 (606) 593-7082	Russell County Center 69 Herriford Curve Road P.O. Box 378 Jamestown, KY 42629 (270) 343-2181
Pendleton County Center Route #1, Box 208 Falmouth, KY 41040 (859) 654-6985	Scott County Center 198 East Washington Street Georgetown, KY 40324 (502) 863-3971
Perry County Health Center 239 Lovern Street Hazard, KY 41701 (606) 436-2196	Shelby County Center 419 Washington Street Shelbyville, KY 40065 (502) 633-1231
Perry County Pre-Natal Health Center 200 Medical Center Drive Suite 3-D Hazard, KY 41701	Simpson County Center 1131 South College Street Franklin, KY 42134 (270) 586-8261

Kentucky's District Health Departments

Spencer County Center 88 Spears Drive Taylorsville, KY 40071 (502) 477-8146	Washington County Center 302 East Main Street Springfield, KY 40069 (859) 336-3980
Taylor County Center 407 East First Street Campbellsville, KY 42718 (270) 465-4191	Wayne County Center 533 Albany Road Monticello, KY 42633-1085 (606) 348-9349
Trigg County Health Department 196 Main Street P.O. Box 191 Cadiz, KY 42211 (270) 522-8121	Webster County Center 80 Clayton Avenue P.O. Box 109 Dixon, KY 42409 (270) 639-9315
Trimble County Center 138 Miller Lane P.O. Box 250 Bedford, KY 40006 (502) 225-7701	Wolfe County Center Highway 15 West P.O. Box 98 Campton, KY 41301 (606) 668-3185
Union County Center 218 West McElroy P.O. Box 88 Morganfield, KY 42437 (270) 389-1230	Wolfe County Health Center 555 Old Highway 15 West Campton, KY 41301 (606) 668-3333
Warren County Center Primary Care Center P.O. Box 1157 Bowling Green, KY 42102-1157 (270) 781-2490	

Kentucky's Independent Health Departments

Allen County Health Department 207 East Locust P.O. Box 129 Scottsville, KY 42164 (270) 237-4423	Clark County Health Department 400 Professional Avenue Winchester, KY 40391 (859) 744-4482
Anderson County Health Department 208 South Main Street Lawrenceburg, KY 40342 (502) 839-4551	Estill County Health Department 365 River Drive, P.O. Box 115 Irvine, KY 40336 (606) 723-5181
Bourbon County Health Department 341 East Main Street Paris, KY 40361 (859) 987-1915	Fleming County Health Department Rural Route #4, Box 288-H Windsor Court Square Flemingsburg, KY 41041 (606) 845-6511
Boyle County Health Department 448 South Third Street P.O. Box 398 Danville, KY 40423-0398 (859) 236-2053	Floyd County Health Department 144 North Front Avenue Prestonsburg, KY 41653 (606) 886-2788
Bracken County Health Department 429 Frankfort Street P.O. Box 117 Brooksville, KY 41004 (606) 735-2157	Franklin County Health Department 100 Glenns Creek Road Frankfort, KY 40601 (502) 564-7647
Breathitt County Health Department 359 Broadway P.O. Box 730 Jackson, KY 41339 (606) 666-5274	Garrard County Health Department 89 Farra Drive Lancaster, KY 40444 (859) 792-2153
Breckinridge County Health Department 2nd & Courthouse Square P.O. Box 456 Hardinsburg, KY 40143 (270) 756-5121	Greenup County Health Department U.S. 23 P.O. Box 377 Greenup, KY 41144 (606) 473-9838
Bullitt County Health Department 181 Lees Valley Road P.O. box 278 Shepherdsville, KY 40165 (502) 543-2415	Hopkins County Health Department 412 North Kentucky Avenue P.O. Box 1266 Madisonville, KY 42431 (270) 821-5242
Christian County Health Department 1700 Canton Street P.O. Box 647 Hopkinsville, KY 42240 (270) 887-4160	Jefferson County Health Department 400 East Gray Street P.O. Box 1704 Louisville, KY 40202 (502) 574-6530

Kentucky's Independent Health Departments

Jessamine County Health Department 215 East Maple Street Nicholasville, KY 40356-1203 (859) 885-4149	Marshall County Health Department 307 East Twelfth Street Benton, KY 42025 (270) 527-5824
Johnson County Health Department 630 James S. Trimble Boulevard Paintsville, KY 41240 (606) 789-2590	Martin County Health Department Main Street P.O. Box 346 Inez, KY 41224 (606) 298-7752
Knox County Health Department Liberty Street P.O. Box 1689 Barbourville, KY 40906-0897 (606) 546-3486	Mercer County Health Department 900 North College Street Harrodsburg, KY 40330 (859) 734-4522
Laurel County Health Department 310 West Third Street London, KY 40741 (606) 864-5187	Monroe County Health Department 452 East Fourth Street P.O. Box 247 Tompkinsville, KY 42167 (270) 487-6782
Lexington-Fayette County Health Dept. 650 Newtown Pike Lexington, KY 40508 (859) 252-2371	Montgomery County Health Department 117 Civic Center Mt. Sterling, KY 40353 (859) 498-3808
Lewis County Health Department 905 Fairlane Drive P.O. Box 219 Vanceburg, KY 41179 (606) 796-2632	Muhlenberg County Health Department 105 Legion Drive P.O. Box 148 Central City, KY 42330 (270) 754-3200
Lincoln County Health Department 44 Health Way P.O. Box 165 Stanford, KY 40484 (606) 365-3106	Oldham County Health Department 700 West Jefferson Street LaGrange, KY 40031 (502) 222-3516
Madison County Health Department P.O. Box 1208 Richmond, KY 40476-1208 (859) 623-7312	Pike County Health Department 119 River Drive Pikeville, KY 41501 (606) 437-5500
Magoffin County Health Department 723 Parkway Drive Salyersville, KY 41465 (606) 349-6212	Powell County Health Department 376 North Main Street P.O. Box 460 Stanton, KY 40380 (606) 663-4360

Kentucky's Independent Health Departments

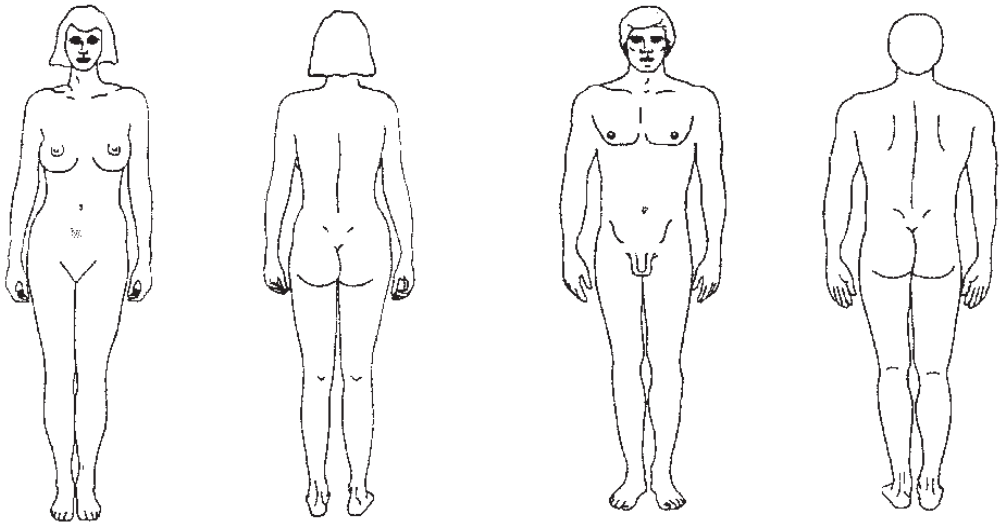
Todd County Health Department 205 McReynolds P.O. box 305 Elkton, KY 42220 (270) 265-2362	Whitely County Health Department Prenatal Clinic Baptist Regional Medical Center 2 Trillium Way, Suite 210 Corbin, KY 40701 (606) 523-8670
Whitley County Health Department 114 North Second Street Williamsburg, KY 40769 (606) 549-3380	Woodford County Health Department 229 North Main Street Versailles, KY 40383 (859) 873-4541
Whitely County Health Department Corbin Branch Cumberland Falls Highway U.S. 25 West, Junction 727 P.O. Box 1221 Corbin, KY 40701 (606) 528-5613	

Appendix G.

DOMESTIC VIOLENCE SCREENING/DOCUMENTATION FORM

DV screen
❑ DV+ (Positive)
❑ DV? (Suspected)

Date _____ Patient ID# _____
Patient Name _____
Provider Name _____
Patient Pregnant? ❑ Yes ❑ No



ASSESS PATIENT SAFETY

❑ Yes ❑ No Is abuser here now?
❑ Yes ❑ No Is patient afraid of their partner?
❑ Yes ❑ No Is patient afraid to go home?
❑ Yes ❑ No Has physical violence increased in severity?
❑ Yes ❑ No Has partner physically abused children?
❑ Yes ❑ No Threats of homicide?
By whom: _____
❑ Yes ❑ No Threats of suicide?
By whom: _____
❑ Yes ❑ No Is there a gun in the home?
❑ Yes ❑ No Alcohol or substance abuse?
❑ Yes ❑ No Was safety plan discussed?

REFERRALS

❑ Hotline number given
❑ Legal referral made
❑ Shelter number given
❑ In-house referral made
Describe: _____
❑ Other referral made
Describe: _____

REPORTING

❑ Law enforcement report made
❑ Child Protective Services report made
❑ Adult Protective Services report made

PHOTOGRAPHS

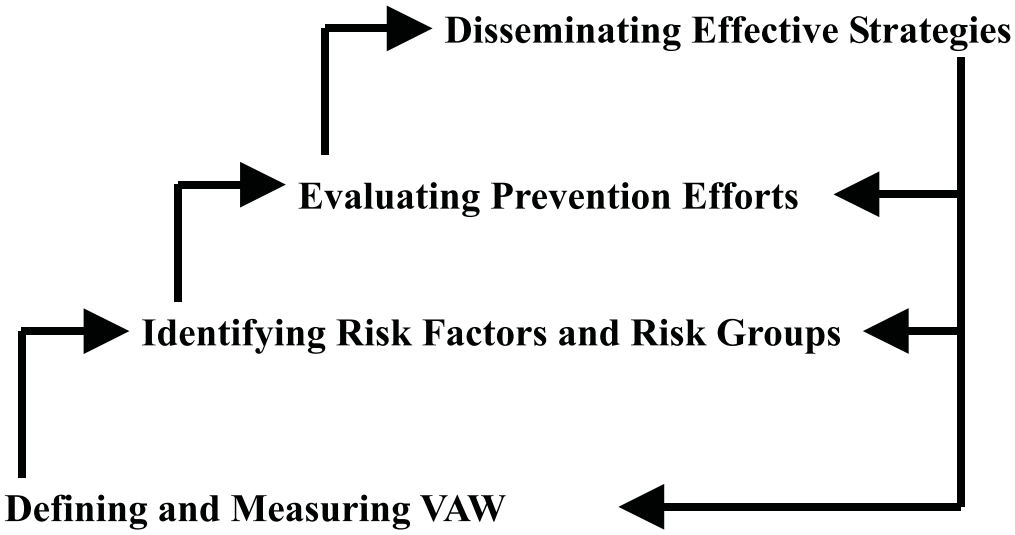
❑ Yes ❑ No Consent to be photographed?
❑ Yes ❑ No Photographs taken?

Attach photographs and consent form

Developed by the Family Violence Prevention Fund and Educational Programs Associates, Inc.

Appendix H.

Public Health Model For VAW Prevention



SOURCE: Salzman LE, Green YT, Marks JS, Thacker SB. Violence Against Women as a Public Health Issue, Comments from the CDC. American Journal of Preventive Medicine 2000; 19(4).