DOMESTIC AND SEXUAL VIOLENCE IN MINNESOTA:

Strategies for Prevention and Intervention

Five Year Objectives for Health Care and Public Health Systems

MINNESOTA MDH DEPARTMENT OF HEALTH

Injury and Violence Prevention Unit
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Introduction

This planning tool addresses the issue of domestic and sexual violence as they relate to health care and public health in Minnesota. It is a result of a year-long planning process coordinated in 2001-02 by the Injury and Violence Prevention Unit of the Minnesota Department of Health (MDH). The project was funded by a Violence Against Women Supplemental Planning Grant from the U.S. Centers for Disease Control and Prevention (CDC).

A Violence Against Women Advisory Committee (VAWAC), which was part of a larger Violence Surveillance/Planning Advisory Committee, was convened to advise MDH on this project. In addition to obtaining this committee's input and advice, MDH conducted an assessment during the first half of 2002.[1] The assessment included a literature review of health care and public health laws, policies, and best practices, both state and national, relating to domestic and sexual violence in health care and public health. It also included in-depth interviews with 56 Minnesota experts from the fields of health care, public health, and domestic and sexual violence advocacy.

Many of the individuals who were interviewed, as well as other interested and knowledgeable stakeholders, attended a planning conference in July 2002. These experts reviewed the findings of the assessment and developed, though group process, priorities for action in the coming years. Objectives for the next five years are based on their input.

The objectives and strategies in this document are ambitious, and resources are limited. Many of the strategies, however, do not require a financial investment, only a commitment to preventing and intervening in domestic and sexual violence.

An Assessment of Minnesota's Health Care and Public Health Response to Violence Against Women, September 2002. Available from the Minnesota Department of Health, (651) 281-8954.
http://www.health.state.mn.us/injury/pub/asssessvaw.pdf

The following definitions are used in this planning tool:

- Health care includes health plans, care delivery systems, medical groups or practices such as clinics and physicians' offices, and mental health programs.
- Public health includes local public health agencies as well as state health department programs.
- Sexual violence is any unwanted, non-consensual, manipulated or coerced form of sexual activity.
- Domestic violence (including dating violence) is the intentsional use of abusive tactics to create and maintain power and control over an intimate partner.

Minnesota is diverse in culture, language, and geography (rural, urban, metro). Each community and area has unique assets and needs, which may present barriers and opportunities in implementing this plan. We hope that users of this document will take those differences into account when selecting objectives and implementing strategies.

Many individuals and organizations have participated in developing this plan and are committed to its implementation. Contributors strongly encourage cooperative effort to achieve its goals on the part of government, health care providers, voluntary associations, survivors of violence and their family members, employers, policymakers, and interested citizens.

This is a planning tool for everyone in health care, public health, and victim advocacy who is concerned with prevention of and response to domestic and sexual violence. Together, we can meet the challenges and reap the rewards that this plan offers.

How To Use This Planning Tool

Those who have helped create this plan represent many aspects of the health care, public health, and victim advocacy fields. They represent cultural and geographic diversity. Many are leaders in violence prevention, both at the state and local levels.

Health care and public health systems may use this tool to:

- Conduct an organizational self-assessment,
- Incorporate the plan's objectives and strategies into organizational planning,
- Allocate resources to support the implementation of strategies, and
- Share accomplishments and lessons learned with others in Minnesota.

Policymakers in local, state and federal government, funders, and those who influence policy are encouraged to use this plan to:

- Guide the allocation of resources in assuring health and safety, and
- Advocate for the implementation of the plan and its goals.

Citizens, employers and those who interact with health systems are encouraged to use this plan to:

- Learn about prevention and intervention strategies,
- Evaluate health activities and services, and
- Promote these objectives and strategies to help make health systems more effective in addressing and preventing violence against women.

Because it is based on the collective vision and commitment of people in the field, we hope that this document will be appropriate to the work of all Minnesota health care, public health, and victim advocacy programs, and will be used to make a difference in the lives of people affected by violence.

Objectives And Strategies

A. Professional education

Rationale: Through expanded professional education, we can help ensure that health care, public health, and advocacy professionals better understand the nature of domestic and sexual violence and learn about effective ways to screen for, document, and refer and support people who have experienced violence.

Objective 1:

Incorporate skill-based training about sexual and domestic violence into the core curricula of medical, dental, public health, nursing, and other appropriate schools for health professionals.

Strategies:

A. Determine the need for additional information on violence to be included in core curricula of professional training institutions.

B. Learn about the best practices in pre-service training (i.e., residency and nursing practicum programs) on these issues.

C. Provide appropriate training or refer to other resources as appropriate.

D. Ask licensing boards to require that questions about violence be included in certification exams and in continuing education requirements.

Objective 2:

Promote education of health care/public health professionals in screening/assessment, intervention, and referral for violence and in violence prevention.

Strategies:

A. Provide data and information to health policy leaders about the impact of violence on health.

B. Ensure that each organization has a protocol or process for responding appropriately when violence has been identified.

C. Assess the content and quality of education about violence that medical and public health organizations provide to their staff.

D. Conduct education efforts in screening, referral, advocacy, and patient safety, including basic information about domestic and sexual violence.

E. See that those who assess for violence have sufficient training and education to consider violence as an integral factor, equal to other health issues, in assessing the patient's health.

F. Ensure that health care providers are aware of and make referrals to appropriate community resources for victims, perpetrators, and child witnesses to violence.

G. Provide education related to issues of culture, and rural/metro location, as they relate to domestic and sexual violence, recognizing that violence affects all aspects of society.

H. Facilitate professional networks, cross-disciplinary training, and coordination among providers concerned with violence issues.

Objective 3:

Educate health care and public health professionals about the association between domestic and sexual violence and related health concerns.

Strategies:

A. Develop the capacity to address issues that occur when patients are affected both by violence and by alcohol, other drugs, or mental health issues.

B. Educate staff and share resources, information, and speakers on these issues.

C. Work with schools and the agencies that provide resources to them, to incorporate messages about the relationship of alcohol and other drug use to domestic and sexual violence.

B. Community Education

Rationale: Through expanded community education, we can work to reduce risks of domestic and sexual violence and to promote healthy, nonviolent behavior.

Objective 1:

Provide education and facilitate support for healthy intimate/dating relationships.

Strategies:

A. Work collaboratively to identify, coordinate, and enhance community resources and strategies to develop healthy relationships.

B. Develop and disseminate educational materials about healthy relationships for use in public health, health care, youth education, and other settings.

C. Create opportunities to educate and build people's skills about healthy relationships among professionals, clients, patients, and community members.

D. Model and support healthy relationships with the goal of changing community norms.

Objective 2:

Reduce risk factors for perpetration of domestic and sexual violence.

Strategies:

A. Provide appropriate interventions and support for children and youth who experience or witness violence in the home.

B. Reach out to people who are violent, or who are at risk for violence, to help them find resources and support to reduce their risk.

C. Work with organizations -- including schools, places of worship, and youth groups -- to enhance the skills of children and youth to prevent bullying and other forms of violence.

D. Promote social and environmental changes to help adults confront inappropriate behavior and actively promote nonviolent behavior.

Objective 3:

Promote peaceful parenting skills among clients and community members.

Strategies:

A. Work with existing community resources to promote and support programs that help parents raise healthy, nonviolent children.

B. Refer people to and/or conduct parenting classes.

C. Train staff to model and teach parents effective, nonviolent parenting skills and to provide support to parents.

Objective 4:

Call attention to the relationship between media violence and violent behavior.

Strategies:

A. Raise awareness within the health care and public health systems about the impact of media on human behavior, including violent behavior.

B. Promote media literacy, the critical and knowledgeable use of the media.

C. Work with others to discourage and respond to violent or inappropriate media messages.

D. Encourage media to air public service message on nonviolence.

Objective 5:

Ensure that community education is relevant to diverse cultural groups.

Strategies:

A. Learn about and educate colleagues about the cultural risks and protective factors related to domestic and sexual violence.

B. Assure that important materials are available in translation and in accesible formats.

C. Support the capacity of cultural groups to build on strengths and to identify and address needs. This may include education and resources on domestic and sexual violence.

C. Coordination And Collaboration

Rationale: Through coordination and collaboration, we can improve our response to violence against women, benefiting from the combined efforts of many agencies and organizations.

Objective 1:

Utilize partnerships and collaboratives to address and prevent domestic and sexual violence.

Strategies:

A. Ensure that health care and public health perspectives and resources are included in community-based violence prevention collaboratives.

B. Build relationships between health professionals and others -- schools, law enforcement, corrections, victim services, criminal justice, community and social services, faith communities, employers and the media -- to promote coordination and shared action to address sexual and domestic violence.

Objective 2:

Promote coordinated, multidisciplinary community response teams for cases of domestic and sexual violence, with representation from health care and public health.

Strategies:

A. Identify and develop teams in each community, including victim services organizations.

B. Expand existing teams to address both domestic and sexual violence.

C. Ensure that sexual violence and domestic violence teams share membership, expertise, and best practices.

Objective 3:

Disseminate this planning document to all stakeholder groups concerned with violence prevention and with quality of health care and services.

Strategies:

A. Make use of internal and external communication vehicles, such as newsletters, presentations, websites, and interagency meetings, to engage partners with this document's objectives and strategies.

B. Publicize this document to the larger public, through news conferences and other media programs or events.

C. Develop ways to make the objectives and strategies dynamic, by communicating progress on a continuing basis with all stakeholders.

D. Quality And Consistency Of Services

Rationale: Through quality and consistency of services, we can collect data and monitor existing programs to assure that Minnesotans receive appropriate care and support to live free of violence.

Objective 1:

Utilize, describe and share best and promising practices in health care and public health in Minnesota.

Strategies:

A. Use existing research to guide organizational/agency planning, and to improve current practice (see *An Assessment of Minnesota's Health Care and Public Health Response to Violence Against Women*).

B. Evaluate health-based prevention practices in Minnesota that may be especially effective in addressing and preventing domestic and sexual violence.

C. Describe, publish and disseminate information on promising practices.

D. Inform health care and public health staff about local violence prevention and intervention resources

Objective 2:

Collect individual facility and statewide data related to domestic and sexual violence, to assure quality, to increase understanding of problems and strengths, and to identify needed system changes.

Strategies:

A. Collect and use data on domestic and sexual violence screening and health services.

B. Routinely evaluate internal compliance with practice guidelines and address any barriers to compliance.

C. Enhance the current surveillance system of hospital and emergency department-treated injury to provide meaningful, timely data.

D. Work toward developing a surveillance system for clinic data.

E. Improve the understanding of risks and the opportunities for prevention by linking available domestic and sexual violence data across systems.

F. Work to improve documentation of domestic and sexual violence through training of medical providers and medical records staff.

Objective 3:

Promote creation of and adherence to practice guidelines that recommend universal screening, identification, treatment (if appropriate), referral, and documentation of domestic and sexual violence.

Strategies:

A. Work with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), to assess and assure compliance by hospitals with the JCAHO standards to identify and assess possible victims of domestic and sexual violence.

B. Work with JCAHO to broaden their standards to include universal screening for domestic and sexual violence and to assure that hospitals apply the standard and document its effectiveness.

C. Promote the development of similar universal screening standards by other health care and public health programs and sites that are not subject to JCAHO accreditation.

D. Encourage health care sites to routinely evaluate internal compliance with practice guidelines related to domestic and sexual violence and to address identified barriers.

Objective 4:

Reduce disparities and improve services for cultural and ethnic groups and for people with disabilities.

Strategies:

A. Advocate for training of medical interpreters (in both spoken and sign languages) in issues relating to violence.

B. Advocate for adoption of professional standards for medical interpreters.

C. Provide ongoing education of health care and public health providers to develop cultural competency.

D. Recruit and train health care providers from diverse cultural groups to work with clients from their communities.

E. Assess the adequacy of services for cultural and ethnic groups, immigrants, and people with disabilities within individual organizations/agencies.

F. Work with disability advocacy organizations to develop effective ways to educate people with disabilities, their families, and health care providers about violence prevention.

G. Support the capacity of cultural groups to build on strengths and to identify and address needs. This may include education and resources on domestic and sexual violence.

H. Work to ensure confidentiality, especially in rural communities and distinct cultural groups.

Objective 5:

Define and develop the roles of public health and health care in preventing perpetration and in intervening with perpetrators of sexual and domestic violence, as well as those at risk for perpetration.

Strategies:

A. Identify community resources to address perpetration.

B. Seek and disseminate information about organizations that work with or counsel perpetrators.

C. Convene health care professionals, advocates, and perpetration experts to discuss perpetration and to discuss the role of public health and health care with patients who may be perpetrators.

E. Policy Development

Rationale: Through policy development, we can strive for greater equity and consistency in both health practices and services related to violence.

Objective 1:

Reduce cost barriers and strengthen incentives to promote health services related to domestic and sexual violence.

Strategies:

A. Assess federal, state, and local and organizational reimbursement policies and practices as they relate to violence-related screening and services.

B. Identify best practices that result in cost savings and efficiency.

C. Present findings to agencies that can create system change, and monitor the adoption of changes.

D. Monitor the cost impact of identifying victims of violence.

Objective 2:

Review recommendations from the Family Violence Prevention Fund regarding health-related state laws on sexual and domestic violence.

Strategies:

A. Evaluate the following Minnesota laws to ensure that they support victims' needs:

(1) Minnesota Statutes § 626.52: the law requiring health care providers to report firearm related injuries to law enforcement, and

(2) Minnesota Statutes § 72A.20.8(a): the law protecting victims of domestic violence from insurance discrimination.

B. Determine what Minnesota laws exist and whether changes are needed in the following:

(1) training of health care professionals on screening, identification, documentation, and referral for domestic violence,

(2) establishment of written policies to screen patients for spousal or partner abuse,

(3) coordination between health care and victim advocacy to plan for patients' safety, and

(4) requirement that health care systems allow patients to object to the release of information to law enforcement.

Objective 3:

Educate policy makers and funders on the health care impact of sexual and domestic violence.

Strategies:

A. Create first-hand opportunities for policy makers to learn about the impact of violence on people's lives, by hearing directly from victims of violence and by seeing how they are served by health care and criminal justice systems.

B. Share data with funders about the health-related costs that arise from domestic and sexual violence.

C. Advocate for increased government funding for sexual and domestic violence prevention.

F. Organizational Commitment

Rationale: Through organizational commitment, we can ensure that Minnesota's public and private health organizations and agencies maximize their ability to prevent and respond to domestic and sexual violence.

Objective 1:

Ensure that the workplace environment in health care settings is respectful and violence-free.

Strategies:

A. Recognize that staff who work with victims of violence may indirectly experience their pain and may need special support and assistance.

B. Review, provide training on, and enforce organizational policies on workplace violence and sexual harassment.

C. Promote the use of Employee Assistance Programs and other support services for employees who are personally affected by violence or are aware of violent situations.

D. Provide information to health care and public health staff about local violence prevention and intervention resources.

E. In new employee orientation and continuing education, share information about agency commitment to a violence-free and respectful environment.

F. Model appropriate behavior and use diverse communication channels to reinforce and support messages about nonviolence.

Objective 2:

Create an environment in which violence prevention is considered a high priority.

Strategies:

A Protect and increase funding for ongoing staff education and training related to sexual and domestic violence.

B. Ensure that in orientation and continuing education, all staff receive education about the impact of violence on patient/client health.

C. Allow providers sufficient time to conduct screening and follow-up with patients who are experiencing violence.

D. Dedicate time and resources to violence prevention within public and private health care, such as coordinating violence prevention programs, creating patient and staff education materials, and carrying out intervention and referral programs.

To view this document online, and to sign up as a registered supporter of these objectives, go to:
http://www.health.state.mn.us/injury/pub

By signing up, you can receive further information to promote the plan, and can connect with others who are working to prevent domestic and sexual violence in Minnesota.

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