

Development of the Whiteriver Indian Hospital Domestic Violence Protocol and Community Response. JoAnn Perank, Class of 1998.

Among the members of the White Mountain Apache Tribe who reside on the Fort Apache Indian Reservation in east central Arizona, injuries from assault are the most frequent type of severe injury. Nationwide among the American Indian and Alaska Natives, injury is one of the leading causes of hospitalization and mortality.¹ A previous study of assault injuries on the Fort Apache Reservation found that females accounted for 21% of the 112 reported cases. Domestic violence was the most common form of assault reported for female victims. The leading weapon used in these assaults was the use of fists or feet.² The study noted the lack of a systematic referral network to the social services or mental health programs for both the offenders and victims of assault.

In response to the need for services to victims of domestic abuse, the Whiteriver Indian Hospital approved the formation of a domestic violence prevention team (DVPT). The team focused on a multi-disciplinary team approach and addressed issues of medical care, safety concerns for victim, and cultural attitudes and beliefs about domestic abuse. Two main objectives of the DVPT were to develop a hospital-based domestic violence protocol to improve case identification and to increase referrals to the social services program. This paper describes the development and implementation of the domestic violence protocol, case identification, and increase of domestic violence cases referred to social services.

Protocol Development and Implementation

In April, 1996, the Governing Body of the Whiteriver Indian Hospital approved the project for the Domestic Violence Prevention Team. The project had several components such as the formulation of a multi-disciplinary team, developing a hospital protocol, and developing an assessment tool for defining, identifying and treating victims of domestic abuse. Other components included developing a referral system that worked closely with community resources and increasing the awareness of domestic violence as a health care issue among hospital staff and the community at large.

I began researching the existing hospital protocol for response or treatment of domestic violence victims and found that key departments such as the Emergency Department (ED), Outpatient Department Clinics A&B (OPD) and the staff physicians had their own criteria for identifying and treating victims of domestic violence. This research yielded three major issues. The first issue was a lack of uniformity in identification of domestic violence victims. Not every physician was asking patients questions about suspicious injuries and making the link to domestic violence. If a patient was seen in clinic for treatment and not identified as a suspected domestic violence victim then that patient was likely to fall through the cracks and continue undetected. Secondly, not everyone knew which department to call if they suspected domestic violence. They did not know where to make a referral for follow up services. Thirdly, incomplete and vaguely written referrals were being forwarded to social services and mental health programs. Some ED staff stated they consistently made referrals to resources for victims of domestic abuse, but we discovered that the referral effort was giving a phone number for the safe house and telling victims to call on their own.

Armed with the concerns voiced about the need for a domestic violence protocol, work began almost immediately to develop a domestic violence prevention team. This multi-disciplinary team would start work on the protocol. Social Services identified the team members to include an IHS physician, social worker, nurse and Tribal departments with representatives from Tribal Law Enforcement, Victim Advocate with the Behavioral Health Services program, Prosecution Unit and Bureau of Indian Affairs Criminal Investigator. This team would map the process to be taken when an individual is identified as a victim of domestic abuse. The value of instituting a multi-disciplinary team approach reflected the concern for victims, their children and the safety of all those involved in the volatile and uncertain environment of domestic violence.

The concept of the protocol was organized from a social services perspective for meeting the basic needs of patients living in violence. The social worker focused efforts on identifying key people in the hospital and those in the community who work in the area of domestic violence. The IHS physicians and nursing staff were in a lead position for the proposed domestic violence protocol as they are likely to have the first contact with victims. It is crucial for these individuals to be able to identify suspected victims and start the process for reporting suspected cases.

The Victim Advocate collaborated closely because she worked solely with domestic violence victims. She was the primary counselor and advocate, and provided transportation to shelters and court hearings for all victims of crime reservation-wide. She had the experience working with victims and knew what they would need from a crisis phase to resolution. She was obviously overwhelmed with her responsibilities and was struggling to keep up with a large caseload. She received most of her referrals from law enforcement.

The representatives from the White Mountain Apache Tribal (WMAT) Police Department brought to the team the law enforcement perspective. They discussed the procedures and barriers related to investigation of domestic violence cases. Their greatest barrier was that the existing Law & Order Code that had no specific provisions for domestic violence. Under the existing code, victims were required to sign the complaint bringing charges against the offender for assault. Domestic abuse cases were routinely filed under the “assault” category. The officers found that more often than not, the victim would go back the next day and drop the charges, thus continuing the cycle of abuse. The Tribal Chief of Police attended several team meetings. He became instrumental in supporting the team concept and activities to promote community awareness of domestic violence.

The BIA Criminal Investigator represented law enforcement at the Federal level. If an injury is life threatening or severe in nature, then federal prosecution is pursued. The Prosecution Unit was represented by the Victim Witness Program Director. Her role was to bring to the team advocacy for victims’ rights in court hearings and proceedings. Occasionally the Tribal Prosecutor attended the meetings to clarify issues that impact both victim and offender. Additionally, the Tribal Court administrator attended several meetings to assist the team in understanding the tribal court proceedings, judgments and recommendations for domestic violence cases.

The team convened in late April, 1996 and developed an interagency domestic violence protocol. The protocol began by defining a victim as a woman or man who complained of being physically, sexually or emotionally abused by an intimate partner. The protocol also proposed the following measures to identify, treat and refer victims of domestic violence. A domestic violence assessment tool was developed for service providers to complete at the initial contact. A release-of-information form is also completed during the initial phase. The initial service provider notifies the police who then interview the victim and file a report. They also notify social services for further patient assessment and intervention. Social services continue to assess the victim’s safety and notify the Victim Advocate if emergency placement is needed.

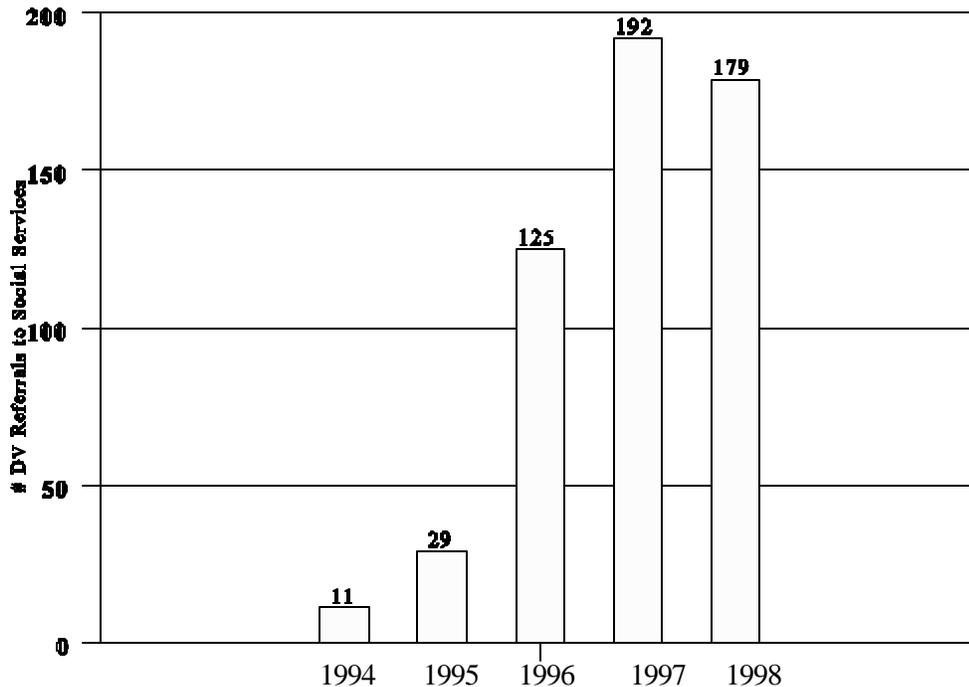
I developed a domestic violence assessment form (DVAF) that the prevention team reviewed and approved. The form has 6 components: type of abuse (physical, emotional, sexual and other); date, time and location; perpetrator’s name and relationship to the victim; physical assessment; emotional and safety assessment. The sixth component is notification of law enforcement and social services. The DVAF is a checklist and fill-in-the-blank type of form that can be completed by the attending physician, nurse or social worker. The DVAF was designed to eliminate incomplete and vague referrals. Most physicians said that writing out referrals about patient assault was time consuming. A release-of-information form to accompany the assessment form was also designed. It allowed law enforcement, prosecution and Apache Behavioral Health program to obtain patient information related to the assault. The social services staff conducted in-services training throughout the hospital to the medical and nursing staff. The primary focus of the training related to the use of the DVAF and release-of-information form. Training was extended to the WMAT Police Department. It covered the hospital protocol, the domestic violence assessment and release-of-information forms.

Protocol Evaluation

We planned to compare domestic violence referral rates to the social services department per 100 domestic violence cases treated at the hospital ED and OPD Clinics two years before the protocol (1994-1995) and two years after the protocol (1997-1998). The hospital’s data system (RPMS) was to be used to identify cases, using a case definition of female, +17 years of age, seeking treatment for injuries with E-codes E969.9 of the ICD-9. However, we found that the coding of domestic violence cases had been inconsistent. In some cases E-codes were used, but in other cases other codes were used (V-codes, N-codes) in combination with or in lieu of E-codes. Also, the ICD-9 was updated in 1997 to include a new E-code, E967.3, specific for domestic violence. With such inconsistencies in coding, medical record reviews would have to be conducted to identify domestic violence cases. Instead, a simple comparison was made of the number of domestic violence referrals received in the social services department during the 1994-1998 years. The social services log was used to identify the domestic violence referral cases and date of referral.

DISTRIBUTION OF DV REFERRALS TO SOCIAL SERVICES

Whiteriver Indian Hospital Domestic Violence Protocol Study, 1994-98



Results and Discussion

The domestic violence prevention team project was seen as successful and the desired goals of protocol development, case identification and increased referrals were achieved. Social Services saw a dramatic increase in the number of domestic violence case referrals from 11 cases in 1994 to 179 cases in 1998. (Figure). However, the increase in referrals could be related to several other factors such as increased public awareness about domestic violence. The White Mountain Apache Police have stepped up their investigations of domestic violence. The ED staff reported a higher priority by the police department in responding to domestic violence cases. Another factor perhaps contributing the greatest to the increase in referrals is the added 24-hour coverage of the Social Services Department. This 24-hour coverage started in July, 1997, and affords hospital departments to call on social workers to respond to suspected cases of domestic violence. The implementation of the domestic violence hospital protocol established criteria for the identification of domestic violence victims. The protocol enables hospital providers to follow a system when reporting a suspected case, ensuring the victim is referred to appropriate community resources for safety precautions. Three months into the use of the protocol we found that the physicians, ED and OPD Clinics were using the domestic violence protocol as there was a significant rise in the reporting of violence against women and male victims. The physicians were using the domestic violence assessment form frequently and forwarding the completed form to social services for continued intervention. We also started seeing an increase of self-reported cases of domestic violence. Victims were coming in to report domestic violence in their home or concerns for relatives living in domestic abuse.

The White Mountain Apache Tribe sought funding from the Stop Violence Against Women grant (STOP), Community policing to Combat Domestic Violence grant (COPS) and the Encourage Arrest Policies (EAP). The STOP grant started in late 1996. It provided law enforcement training for identification of domestic violence and sexual assault cases, provisions for community education, and development of a data collection protocol and a victim services program. The COPS and EAP grants started the following year. Tribal programs benefiting from these grants were the Police Department, the Prosecution Unit and the Apache Behavioral Health Services (ABHS). The WMAT Police Department hired two officers, one as the victim/witness advocate to track complaints and interview victims of domestic abuse, the other to patrol in the community. The ABHS hired a clinician to counsel victims and offenders. The Prosecution Unit hired a prosecutor for domestic violence cases.

Conclusion:

The domestic violence prevention project became a community effort largely due to the active participation of the domestic violence prevention team. The Tribe passed a section for domestic violence under the Tribal Law and

Order Code with provisions for mandatory arrest, civil orders for protection, increased sentences for offenders, and mandatory counseling. Community response was positive until loved ones and relatives were charged with domestic violence. Within 30 days, the Domestic Violence Code came under attack with two main community complaints: (1) "It's a good idea generally, but not for my family." (2) "What good is all this going to do in the long run—it's not worth all the trouble it causes and will make things worse, not better." The Tribal Council remained supportive, threatening to change the codes if programs supported by domestic violence grants failed to make their programs work.

Issues surrounding the code are not likely to subside anytime soon. We cannot change current attitudes about domestic violence overnight, but we can continue to recognize that domestic violence is against the law. Domestic violence is against the traditional values of respect and surviving as a nation. To be effective in efforts to combat domestic violence in your community, keep in mind the following: (a) If you make up your mind that you will help to decrease domestic violence in your community, you will be able to do it. One person can make a difference. (b) It is very difficult to achieve great change working alone. There are other people in your community who want to eliminate domestic violence. Find them, work together and support each other's efforts. (c) Be persistent. Sometimes you will succeed, other times your efforts seem fruitless. Do not give up when experiencing failures. (d) Develop and use a plan. When you define and work toward specific objectives, you will be able to see progress.³

Summary

Domestic violence has traditionally been viewed as a problem for law enforcement. If someone was being assaulted, we called the police and had the perpetrator arrested. There was little recognition given to the cycle of abuse which is difficult to understand and even more difficult to break through. Perhaps violence has been in our native homes for so long that it seemed traditional and therefore tolerated.

The White Mountain Apache Tribe has realized that domestic violence reaches far beyond the victims and perpetrators. We now acknowledge facts about abusive marriages and abusive relationships. We acknowledge that there are significant safety concerns for victims of domestic violence and concerns for the welfare of children living in violent homes. The multi-disciplinary team approach brings awareness to address domestic violence from the health care community, law enforcement, the tribal judicial system, the tribal government and the White Mountain Apache people.

References:

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