

# MANDATORY REPORTING OF DOMESTIC VIOLENCE: *Making it Safe & Effective*

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## *Intimate Partner Violence Surveillance Project*

Kentucky Injury Prevention & Research Center @ Lexington, KY

Originally prepared and presented for [Physicians for a Violence-Free Society](#)

### Summary

Reporting responsibilities, especially mandatory reporting of domestic violence is a misunderstood, misrepresented issue, which merits full, informed consideration of its life-saving potential. Topics to be presented include: evolutionary review of domestic violence reporting philosophies, laws and practices; confidentiality/liability issues; the 22 year history of Kentucky's domestic violence protection laws, mandatory reporting and voluntary services; interfacing data bases; and current issues of controversy: vision and revision. Domestic violence interventions in coordination with child protective services, family preservation services, and welfare reform will also be addressed.

### Detailed Outline

#### I. Basic Tenets for Discussion & Debate

Consensus exists for professionals to prioritize the safety of domestic violence victims and to make all protective resources and legal remedies available to them. Yet, misconceptions and misinformation prevail about how reporting of domestic violence can facilitate these goals.

The national debate on the mandatory reporting of domestic violence began without clarification of its many definitions, and without regard for the intents and practices related to the various implementation constructs.

#### Discussion Issues

1. Clarify different definitions and intents of mandated reporting for certain persons (contagious diseases, abuse and other crime victims).
2. Assess related service practices, confidentiality and liability issues.
3. Identify key components of Kentucky's protection laws, policies and practices related to mandatory reporting and voluntary services.
4. Evaluate the merits and problems of the different models of reporting-services.

Mandatory reporting of domestic violence must be to a trained entity that offers protection, information, advocacy, autonomy, and confidentiality. These safeguards can save lives, promote healthy relationships and justice -- but **only if** laws, policies, practices, and training are developed and implemented properly.

A. Clarification of Definitions and Terms

Mandatory reporting has several different meanings and service constructs. It is important to clarify these.

'Mandates' which impact on each other must also be identified and clarified (e.g., laws that mandate reporting of domestic violence (or any injuries related to violent crime) to police, *and* which mandate arrest in domestic violence cases. These issues must be addressed in law, policy and practice.

Limited mandatory reporting: only specified professionals are obligated to report (e.g., physicians, nurses, officers, etc.).

Full mandatory reporting: ANY PERSON is obligated to report. Statute may further notice specific professionals (e.g., physicians, nurses, officers, coroners, etc.).

Privilege communications: protected, confidential communication; not subject to reporting or other disclosure mandates. Dependent on law and case law, privilege may not apply as it relates to the responsibility to report maltreatment or other matters of public concern (e.g., duty to warn, etc.).

Exemption from reporting may exist as a result of specific law or case law (e.g., attorney client relationship)

B. Discussion of Philosophy

C. Critical Questions

1. Purpose
2. Who
3. How
4. **What Happens After a Report is Made**
5. **How are Victim Safety and Confidentiality Maintained**
6. How Does the Reporting Serve to Promote Accountability (perpetrators/officials)

A few states mandate the reporting of domestic violence to some authority (e.g., police, prosecutor, and shelter). Only Kentucky requires this reporting to the state Department for Community Based Services (DCBS), a statewide, county-based victim service agency.

**In Kentucky, mandatory reporting = mandatory connecting of victims with trained community 'specialists' who offer protection, information and advocacy in a safe, confidential manner.**

II. History of “Mandatory Reporting” and Related Service Issues

III. Reporting of Domestic Violence for the Purpose of Providing Victims with Information and Enhanced Safety/Protection

All states provide child protective services to identify and protect child victims of abuse, neglect and exploitation. All states provide protective services to adult victims of maltreatment, with the majority of cases involving dependent or elderly adults.

*Several states have enacted laws that mandate the reporting of domestic violence to some ‘authority’ (e.g., law enforcement, and prosecutor). Only one state includes ‘mandatory reporting’ to the state Department for Community Based Services (DCBS) for the purpose of offering **voluntary protective services** to victims of domestic violence and their children -- Kentucky.*

Mandatory reporting of spouse and partner maltreatment within the definition of adult abuse, neglect and exploitation **can** have significant benefits to both adult and child victims as well as to the courts and service providers

1. *Can* promote early identification of vulnerable adults and children.
2. *Can* break isolation.
3. *Can* provide adult victims and their children with important information about domestic violence, safety planning, legal and community service options.
4. *Can* serve as a child abuse prevention model.
5. *Can* provide victims with *the offer of* local/state advocacy services (if necessary).
6. *Can* recognize that the adult has the right to self-determination and may accept or refuse services.
7. *Can* provide a ‘continuum of care’ for victims in coordination with other agencies and enhances effectiveness of service interventions.
8. *Can* create documentation of the maltreatment.
9. *Can* establish third party documentation that may be critical to criminal or civil legal action, if any.
10. *Can* build a centralized repository for data critical to analyzing and planning for improved adult protective services.
11. *Can* safely network with related computer files/systems for data critical to analyzing and planning for improved adult protective services.
12. *Must* be victim focused, safety driven, & provide for confidentiality & autonomy.

Reporting of spouse and partner abuse from victims themselves, by the general public and by professionals has continued to increase over the years.

DCBS data further identifies a concurrent increase in the reporting of domestic violence by professionals: law enforcement officers, physicians and other health care providers. In a recent **survey** by the **Domestic Violence Subcommittee of the Kentucky Medical Association (KMA)**:

- 59 % of physicians responding indicated that mandatory reporting needs to be in place, and
- 47 % of physicians indicated they had reported spouse abuse.

A. Mandatory Reporting “Misguided”: Flaws and Limitations of Current Research and Dissemination of Information

Safe and successful implementation of mandatory reporting of domestic violence is possible. Throughout the national debate on this issue there has existed a very obvious disparity in the writings on ‘mandatory reporting’ definitions and service constructs.

Researchers and some reform advocates have written singularly against mandated domestic violence reporting with little, if any reference, to the merits--especially the tested merits. For reasons unknown, these articles have not focused on the safe, voluntary service constructs and practices which can and have been initiated upon the receipt of same; practices which are driven by victim safety and self-determination. Without these important clarifications, informed decision-making by victims, victim service providers, community and state policy makers, and legislators, is not possible.

Given the lethal and perpetual nature of domestic violence, all parties to the debate agree, that all viable resources must be mobilized and utilized to protect adult and child victims, to stop the violence, to hold the perpetrator accountable and to promote healing of all persons (as is possible). Unfortunately, for domestic violence victims seeking safety and justice, and for service providers concerned about how best to address these complex and often high risk situations, the failure to feature and profile *safe, successful* reporting practices and voluntary services has been a disservice to everyone.

Among those critical protective resources which can be readily afforded domestic violence victims is mandated reporting which results in the offering of voluntary protective services.

**Mandated reporting, which is carefully constructed and implemented, is one of the proven viable, valuable, life saving measures. It therefore cannot be discounted simply because of ‘philosophical’ differences.**

B. Point - Counterpoint

1. Myths v. Realities of Reporting Related to the Offer of Information and Protective Services
2. Safety Issues
3. Confidentiality Issues
4. Service Issues
5. Victim Reluctance to Seek Further Assistance
6. Data and Data Base Issues

C. Flawed Arguments Against Mandatory Reporting

1. Safety of Victims Jeopardized

Mandatory reporting, in and of itself, does not jeopardize victim safety. As with any contact or intervention in domestic violence cases, HOW the intervention is handled is critical. Competency based training and comprehensive policy guidelines for mandated reporters and responders are essential.

Although abuse victims may be reluctant to disclose their experiences initially. Most victim/survivors are willing to discuss their situations when the responder is non-judgmental, respectful, protective of their safety and related need for confidentiality, and is 'helpful.'

Kentucky has practiced mandatory reporting for over 20 years. Issues of victim safety have been the guiding principle of intervention and service provision. Confidentiality issues are also highly respected within legal and policy guidelines.

If victim safety was being jeopardized by mandatory reporting and/or the related practices of DCBS, these issues would have been made public and changed in any of the various statewide task forces, fatality reviews, or legislative initiatives.

Other states, whose laws require the reporting of known or suspected domestic violence to authorities other than a voluntary protective services program, need only adhere to the same guiding principles and confidentiality protections to maintain *victim safety as the primary focus*.

2. Right to Self Determination, Respecting the Wishes of the Adult

Unlike other patients or other crime victims, the on-going coercive nature of the abusive relationship too often prohibits adult and child domestic violence victims from exercising any right to self-determination. Perpetrators effectively use intimidation, isolation and misinformation to keep their victims from disclosing, prosecuting or leaving. Mandatory reporting breaks through the isolation and can mobilize a variety of protective and legal resources for victims of domestic violence and their children.

3. Discouragement from Seeking Help

When the reporting process and the offer of information and services is handled appropriately, there is minimal discouragement from seeking help. If 'discouragement from seeking help' were a real factor for ceasing a protective remedy for domestic violence victims, law enforcement and court action would have been eliminated a long time ago.

Many ask, how it is that victims after ineffective, unjust or inhumane treatment from the 'system', ever return for assistance. Far too many do not return or are killed. And we'll never know how many never reach out - even for confidential information - after learning that another victim had sought assistance or legal protection and was killed in the process.

Domestic violence is rarely an isolated event, and without appropriate intervention, is predictably going to occur again--possibly with greater frequency or severity.

Often, the failure of responders to report and take appropriate action, dooms domestic violence victims to further maltreatment, not to mention being mislabeled as 'co-dependent' or 'co-morbid', because they are not afforded the safety planning, information and assistance they need to reduce the risk of victimization. The obstacle to safety and justice that these victims face are many and each alone is overwhelming.

4. Re-Victimization by 'System'

Unfortunately, *some* domestic violence victims who reach out for safety and justice are faced with obstacles, misinformation, bias, prejudice, apathy, ignorance, or hostility by service providers, including social workers. Given the above, professionals should not eliminate or discount the value of legal or protective remedies, but rather focus on training and accountability measures to safeguard against such inappropriate and (in some cases) illegal responses.

In Kentucky, the competency based trained social worker would be an advocate or buffer against these injustices--often in partnership with shelter staff, prosecutor-based victim advocate, and/or legal services staff.

5. Loss of Children to Abuser or Placement in Out-of-Home Care

Domestic violence is a significant factor that must be considered by a trained judge when deciding custody and visitation matters. While cases of abuse victims losing or forced to share child custody with a perpetrator exist, these authors are not aware of such cases occurring because domestic violence case was simply reported to an authority or because the victim refused to prosecute on the basis of that report. Instead, these cases must be examined for other, relevant factors (i.e., substantiated child abuse or neglect, gender bias, etc.). Mere reporting of domestic violence or failure to cooperate in prosecution is not legal grounds for removal of children.

With mandatory reporting and the offer of protective services to an abuse victim, even one who may have neglected or abused a child, a competency based trained social worker can be focusing on the provision of protection and support services with the battered parent (usually the mother) so as to create a safe and healthier environment for both parent and child.

The offending party (usually the domestic violence perpetrator) who creates the greatest physical and emotional threat to the safety and well-being of the children can be removed from the home; and rehabilitated, if indicated and where long term treatment resources are available.

Many domestic violence victims who are poor parents, can significantly improve their parenting skills when the threat of abuse is removed. If, however, after these protective and support measures are implemented, the children remain at risk, then additional protective measures must be taken in the best interest of the children (e.g., emergency custody petition in juvenile court for temporary removal). On-going services for the parent should continue to be provided with the goal of reuniting the non-offending 'victim parent' with the children while holding the perpetrator accountable.

6. Family Preservation Models Ignore or Discount Domestic Violence

Several Family Preservation models (e.g., Homebuilders) across the country (i.e., Michigan, Kentucky) have adapted their policies and practices to accommodate the unique dynamics and safety needs of domestic violence and child sexual abuse victims.

7. Professional Discretion

The argument has been made that mandatory reporting takes away from professional discretion. Yet, historically, it has been this 'professional discretion' that has resulted in inadequate or discriminatory treatment of domestic violence victims.

8. Breach of Confidentiality/ Privileged Relationships

Victim safety and wishes must be considered. Confidential protective service action and a cautious police response can be effective for domestic violence victims. The status quo before reporting was not so good that it should be preserved at the expense of further injury and possible death (Jones, 1996). Confidentiality and privilege can readily be addressed by statute and training.

9. Discrimination Against Poor and Minority Persons

Certainly, prejudice and bias are issues that require constant vigilance and redress in any domestic violence intervention (legal, protection, etc.). The documented experience in Kentucky refutes this argument.

For example, in FY '95 the race of the adult reported as a spouse abuse victim:

Caucasian	17,965
Hispanic	95
African-American	2002
Asian/Pacific Islander	72
American Indian/Alaskan	13
Biracial	10
Not reported	932

The data is representative of Kentucky's general population. More importantly, each of these numbers represents a victim who was offered information about safety planning, protection & support services, legal remedies, and other options as may be indicated.

10. High Rate of Unsubstantiated Reports

The Kentucky experience consistently demonstrates a 70% substantiation rate. The top reporting sources are law enforcement (#1), health care professionals, and self-reports. This reporting serves as the catalyst for victim support and a continuum of care, if indicated and accepted.

11. Lack of Trained Workers and Resources

This argument can be applied to the judiciary, prosecutorial system, law enforcement, health/mental health, and shelters too. Yet federal, state and local initiatives have begun to address these needs through community education, professional training, and the availability of resources. In Kentucky, the Department for Community Based Services instituted a competency based domestic violence curricula for Adult Protective Services workers for the last ten years (orientation, core, and advanced instruction). Additionally, cross training was made available for Child Protective Service workers (now a current requirement per statute).

## 12. Cost of Trained Workers and Resources

The importance of a trained workforce is well recognized. As some states move to mandatory training on domestic violence, this issue has been raised as a prohibitive cost factor. Regardless of whether or not mandatory reporting is enacted, the relevant professionals should receive training on domestic violence. All training should be competency based which enhances safety and service delivery while reducing potential liability.

## 13. High Caseloads and Ineffective Response

It is well documented that all states are experiencing high case loads in the provision of child protective services, judiciary, prosecutorial system, law enforcement, health/mental health, and shelters too. However, this does not relieve government of the responsibility to address the protection needs of these high-risk families and children. It is essential for leadership in government to prioritize the funding and related resources necessary to enhance effective intervention and prevention measures.

## 14. Unenforceable Obligation

Failure to comply with mandatory reporting requirements related to any abuse victim, crime victim or person with a reportable contagious disease can result in criminal and/or civil liability. The enforcement of same is only as good as the commitment from the legal community, regulatory agencies in the interest of public health and safety. Cases have been successfully prosecuted and litigated, although this has not happened yet in a domestic violence case.

The Kentucky Domestic Violence Prosecutor's Manual ('91, '97 Revised) set forth guidelines for prosecutors to connect domestic violence victims with advocates from the Dept. for Social Services for the offer of protective services, upon request of the victim. The manual, developed by a multidisciplinary subcommittee of the Attorney General's Task Force on Domestic Violence Crime, also specified provision for enforcement of reporting obligations:

“ Prosecutors should be willing to review and accept cases for prosecution for failure to report spouse and adult abuse victims who suffered physical injury, serious physical injury or death as a result of the abuse or neglect, when evidence can be presented other community professionals were aware of the circumstances and knowingly and willfully failed to notify authorities pursuant to KRS 209.030(2).”

## 15. Collection of Data at the Expense of Victim Safety

Victim safety is and always has been paramount throughout the 20-year history of Kentucky's mandatory reporting and voluntary protective services. Still, service providers must be programmatically and fiscally accountable to the public and to funding sources.

Data collected not only documents these factors, but further serves to verify the nature and extent of domestic violence and the needs of this population. More importantly, each of these numbers represents a victim who was offered information about safety planning, protection & support services, legal remedies, and other options as may be indicated.

**Kentucky Department for Community Based Services  
Adult Protective Services Reports**

**Age of Adult Victim Reported by Type \***

<b>Spouse Abuse</b>		<b>FY '95</b>
<u>Age</u>	<u>Reports</u>	<u>Percentage</u>
29 & Under	8,916	42
30 - 39	7,659	36
40 - 49	2,813	13
50 - 59	773	4
60 - 69	286	2
70 - 79	135	1
80 - 89	55	0
90 +	71	0
Unknown	381	2
<b>Total</b>	<b>21,089</b>	<b>100</b>

\* This table reflects the age of the adult reported by type of abuse (e.g., spouse abuse). This table does not reflect partner (paramour) abuse data. An adult may have one or more types of abuse. Those sources reflecting 0% are less than .5%. Percentages: rounded to nearest whole number. **NOTE: 75% of spouse abuse reports are substantiated by DCBS.** (Division of Program Management, Systems Administration Branch, 1996)

**Kentucky Department for Community Based Services  
Adult Protective Services Reports**

**Age of Alleged Perpetrator \*  
Spouse Abuse  
FY '95**

<u>Age</u>	<u>Reports</u>	<u>Percentage</u>
29 & Under	5,495	34
30 - 39	6,130	39
40 - 49	2,586	16
50 - 59	763	5
60 - 69	292	2
70 - 79	119	1
80 - 89	31	0
90 +	3	0
Unknown	480	3
Total	15,899	100

**\* 75% of reported spouse abuse cases were substantiated by DCBS, formerly Dept. for Social Services (FY '95). Alleged perpetrators are reported when the results of the investigation are substantiated, some indication, or found & substantiated. Percentages: rounded to nearest whole number. (Division of Program Management, Systems Administration Branch, 1996. pg. 31.)**

**Kentucky Department for Social Services  
Adult Protective Services Reports**

**Case Status \*  
FY '95**

<u>Status</u>	<u>Numbers</u>	<u>Percentage</u>
Not Open - No Services Provided	23,613	55
Opened - General Services	75	0
Active DCBS Cases	140	4
Not Opened - Referrals Made/ Short Term Services Provided	2,763	39
Opened - Protective Services	185	2
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Total	26,776	100

**(Total cases reported = 42,861)**

\* Adults have the right to refuse protective services. Involuntary services may be provided only through a court order. Sources denoting 0% are less than .5%. Percentages: rounded to nearest whole number. (DSS, Division of Program Management, Systems Administration Branch, 1996). Each of these numbers represents a victim who was offered information about safety planning, protection & support services, legal remedies, and other options as may be indicated and appropriate.

#### 16. No Simple Solution

The authors are not aware of anyone, ever, having proposed mandatory reporting as “the answer” to victim safety and prevention of domestic violence. As with the development of innovative justice solutions and legal response, mandatory reporting has been presented as an additional tool for early identification of victims and opportunity for additional protection and advocacy.

#### 18. Responsibilities v. Liabilities

There are many people, including law enforcement officers and physicians, who are not aware of the statutory mandate to report or who, for whatever reason, choose not to report the maltreatment. In the majority of states criminal prosecution of non-reporters is extremely rare. It appears that, as with the non-reporting of child and adult maltreatment, prosecutors may need to be encouraged to file criminal charges in appropriate cases.

Regardless of possible criminal liability, persons who fail to report are additionally exposed to civil liability -- regardless of action taken or not taken by prosecutors. Civil tort damage actions can provide the incentive to comply with statutory mandate and recognized standard of care for domestic violence victims. Civil tort damage actions can also compensate the injured battered spouses or partners--or their survivors.

#### IV. Kentucky’s Adult Protection Law and Voluntary Services to Domestic Violence Victims: The Hidden 20 + Year Success Story

For 20 years, Kentucky has successfully implemented mandatory reporting of domestic violence to the Department for Community Based Services (DCBS, *formerly* Dept. for Social Services) for the offer of voluntary protective services. Since 1978, mandatory reporting by “all persons” has been a catalyst for early victim identification and opportunity for trained DCBS adult protection workers to offer them information about safety options, legal remedies and community resources. DCBS may also assist victims with legal advocacy, accessing shelter and other programs essential to their safety and well-being. As indicated in statute, adult victims have the right to refuse or accept any or all DCBS services.

Victim safety and autonomy are the guiding principles of DCBS adult protective service policies and practices. These are implemented carefully, cautiously, and conscientiously. Revisions have consistently been made over the years to maintain the priority of these principles through other reforms (e.g., Family Preservation Services, welfare reform, etc.).

Since 1978, over 192,000 reports of spouse/partner abuse have been received and investigated by DCBS. If victim safety, autonomy, confidentiality, or help-seeking behavior were being jeopardized, or if victims were losing custody of their children due to mandatory reporting or related DCBS practices, these issues would have been made public with recommendations for legislative change at any point during these nineteen years.

For example, in 1980 the requirement for victims to prosecute prior to receiving protective services was found to hinder the intent of the statute. It was promptly repealed.

Since the inception of the DCBS Quality Assurance Branch, no complaints of DCBS adult protective service provisions to spouse or partner abuse victims have been received (1988-96). Any such complaint would require an administrative review or administrative hearing for a valid issue.

In a 1995 statewide survey of physicians, 59% indicated that mandatory reporting does need to be in place; 47% had reported spouse abuse (Kentucky Medical Association).

Major *statewide* domestic violence related task forces, councils, fatality review committees and legislative initiatives afforded numerous opportunities to identify problems or concerns related to mandatory reporting and voluntary protective services.

- Gender Bias in the Courts ('91) Kentucky Bar Association
  - Homicide Followed by Suicide in Kentucky: 1985-1990. ('91) Centers for Disease Control
  - Attorney General's Task Force on Domestic Violence Crime ('91) Office of Attorney General Frederic J. Cowan, Kentucky
  - The Homicides of Marla Payne & Susie Septer & the Suicide of Wendell Payne. An Investigation & Recommendations for the City of Henderson, Kentucky. ('91) Office of Attorney General Frederic J. Cowan
  - Standing Committee on Gender Fairness in the Courts ('92)
  - Legislative Task Force on Domestic Violence ('94)
  - Kentucky Homicides & Suicides: '91-'93. Preliminary Findings ('94) Office of the Attorney General, Kentucky
  - Adult/Child Protection Internal/External Workgroup ('95) Cabinet for Families and Children
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- Numerous local & regional Kentucky task forces, study groups and fatality reviews are not included in this document. Their findings and recommendations are reflective of the above-referenced statewide initiatives.

To date, no testimony or legislative proposals were presented from any of the state, local or regional reform initiatives to amend or repeal these laws and services.

The reality is that Kentucky's various task force recommendations supported enhanced awareness and enforcement of same. *In 1998, the Kentucky General Assembly strengthened the Adult Protection Act.*

V. Problems with Mandatory Reporting, Adult Protective Services Staff or Cases.

Any time there is a problem with the work or actions of a protective services staff person, such complaints are encouraged to be addressed as is appropriate to the person's supervisor. If necessary, recourse may be pursued through the administrative chain of command or, if necessary, made directly to a District level manager, Central Office staff, or to the Quality Assurance Branch of the Commissioner's Office.

VI. DCBS Adult Protection-Domestic Violence Data.

The DCBS adult and child abuse registries provide important information to workers assessing reports and active cases. Additionally the workers have security clearance to access information on active and historical domestic violence protective orders through the Kentucky State Police LINK-Domestic Violence File, and criminal history information in cooperation with the court system.

DCBS statistics can provide the data to indicate the nature and extent of adult abuse in a community, region or state. A centralized data system collects and analyzes adult and child maltreatment cases reported to DCBS.

Regular assessment and dissemination of this data assists the public and professionals responsible for responding to domestic violence victims to better understand and plan for intervention and services needed in these cases. It also generates data for research initiatives and for comparison with other statistics (e.g., court, shelter, and law enforcement) to assess if victims are being reported as required by statute.

VII. Community partnership & coordinated community response

Literature and research consistently focus on the value of coordinated community response to domestic violence as a means of increasing safety. This partnership can be exemplified through the concerted efforts of national, state, and local communities actively mobilizing their resources.

No one agency can singularly stop and prevent domestic violence. Likewise, agencies working in isolation only exacerbate the problem.

The offer of protection, information and advocacy is essential to promote the safety and well-being of domestic violence victims. Not all professionals have the time or sufficient training to fully address the often-complex needs of domestic violence victims. Everyone should be alert to domestic violence victims and prepared to offer information and safety planning. It is incumbent upon professionals to do so. Best practice is to assist these victims and then connect them with 'specialists' whose services they may or may not accept.

Shelters are life-saving services. But, not all victims go to shelters or call crisis lines for a variety of reasons. Victims who use shelters will return to the community. Many shelters are not able to accommodate every victim, particularly those with special needs (e.g., victims with older male children; elderly victims; victims with disabilities, substance abuse or mental health problems; male victims).

It is well documented that domestic violence victims utilize a variety of strategies as they try to procure safety for themselves and their children. Therefore, collaboration and partnership are essential. Reporting of domestic violence can serve as the vehicle for this protected communication.

Many shelters, law enforcement and prosecutor-based advocates, and other victim services programs practice a form of 'reporting' and 'voluntary services.' People make referrals or reports, or cases brought to their attention. These advocates attempt to make safe contact with the referred victims to offer information and services. Kentucky's DCBS responds similarly to domestic violence reports (est. 1978). Trained social workers offer victims voluntary, confidential protective services that they may accept or decline. These practices help to validate the components necessary for effective and early intervention--including the reporting of domestic violence.

Mandatory reporting, **if** enacted and implemented correctly, can offer significant benefits to victims, and to professionals who respond to the needs of this at-risk population. This is evident in the Kentucky Model.

#### VIII. Making Reporting of Domestic Violence Safe and Effective

Critical to reporting is how the law is crafted, the related training, policies and practices. Of equal importance is *how it is explained to the victim* and *what happens next*--with the victim and the report. Law and policy should specify measures that are victim focused and safety driven, and which provide for confidentiality and victim autonomy. Kentucky laws and policies address these issues.

Mandatory reporting laws must specify the:

- Protected persons
- Persons obligated to report
- Entity to receive reports and duties related to same
- Basic elements of a report (including how to safely contact victims, if known)
- Provisions for anonymous reporting and response
- Confidentiality protections (including limited, legitimate release of specified information)
- 'Good faith' protection from criminal or civil liability for reporting sources; and provisions for accountability, including penalties for failure to report.

**States that mandate reporting to police, and which mandate arrest in domestic violence cases,** must also address these issues in law, policy and practice. Take similar measures where states or municipalities mandate the reporting of other injuries or deaths (e.g., firearm injuries).

Mandatory reporting of domestic violence must be to a trained entity that offers protection, information, advocacy, autonomy, and confidentiality. These safeguards can save lives, promote healthy relationships and justice -- but **only if** laws, policies, practices, and training are developed and implemented properly.

- A. Attend to the victim/patient
  - 1. Carefully assess
  - 2. Validate
  - 3. Address concern for safety
  - 4. Express understanding of the complexity of domestic violence & the relationship issues
  - 5. Share information about domestic violence dynamics & effects (in the language of the patient)
  - 6. Assess risk/lethality & any special needs
  - 7. Offer information, support & explanation about the role of ‘community specialists’ (mandated reporting recipient)
    - a. Personal awareness of the persons & services is essential
    - b. Be aware of policies & protocols
  - 8. Clarify issues of confidentiality & importance of appropriate documentation
  - 9. Document, document, document
  - 10. Reaffirm concern for the patient’s well-being & safety.

**RADAR: A Domestic Violence Intervention**

- R** = Routinely screen female patients
- A** = Ask direct questions
- D** = Document your findings
- A** = Assess patient safety
- R** = Review options & referrals

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\*Massachusetts Medical Society, 1992

**Common Statements from Spouse/Partner Abuse Victims  
& Responses from Health Care Professionals  
that Can Encourage Self-help Behavior** =====

**Objective:** To facilitate more detailed information to be shared with domestic violence victims (e.g., safety planning, rights, protective & support services).

Patient/Victim

Health Care Professional

“I don’t think I want anyone else to know this.”

“It took a lot of courage to talk about your about situation. You are not alone. Many patients we see are facing some of the same questions and concerns that you have shared.

“Unfortunately, this is a situation that does not ‘heal’ on its own. Fortunately, we know more now about ways to reduce your safety risks and have more information on confidential support services which you may be interested in learning more about.

I have time to talk some today with you, and I want to encourage you to talk with a person who helps other people in situations similar to yours. I have referred other patients-just as I would to any other specialist- and I will answer your questions about [name/agency] information and help.

You may want to use the Power & Control Wheel as part of patient education & assessment.

Explain the possible consequences of silence, importance of safety planning, and the possible opportunities/limitations of community safety & support services.

Have available culturally appropriate resources available to offer (concealable size)

# Mandatory Reporting of Domestic Violence: Kentucky Model

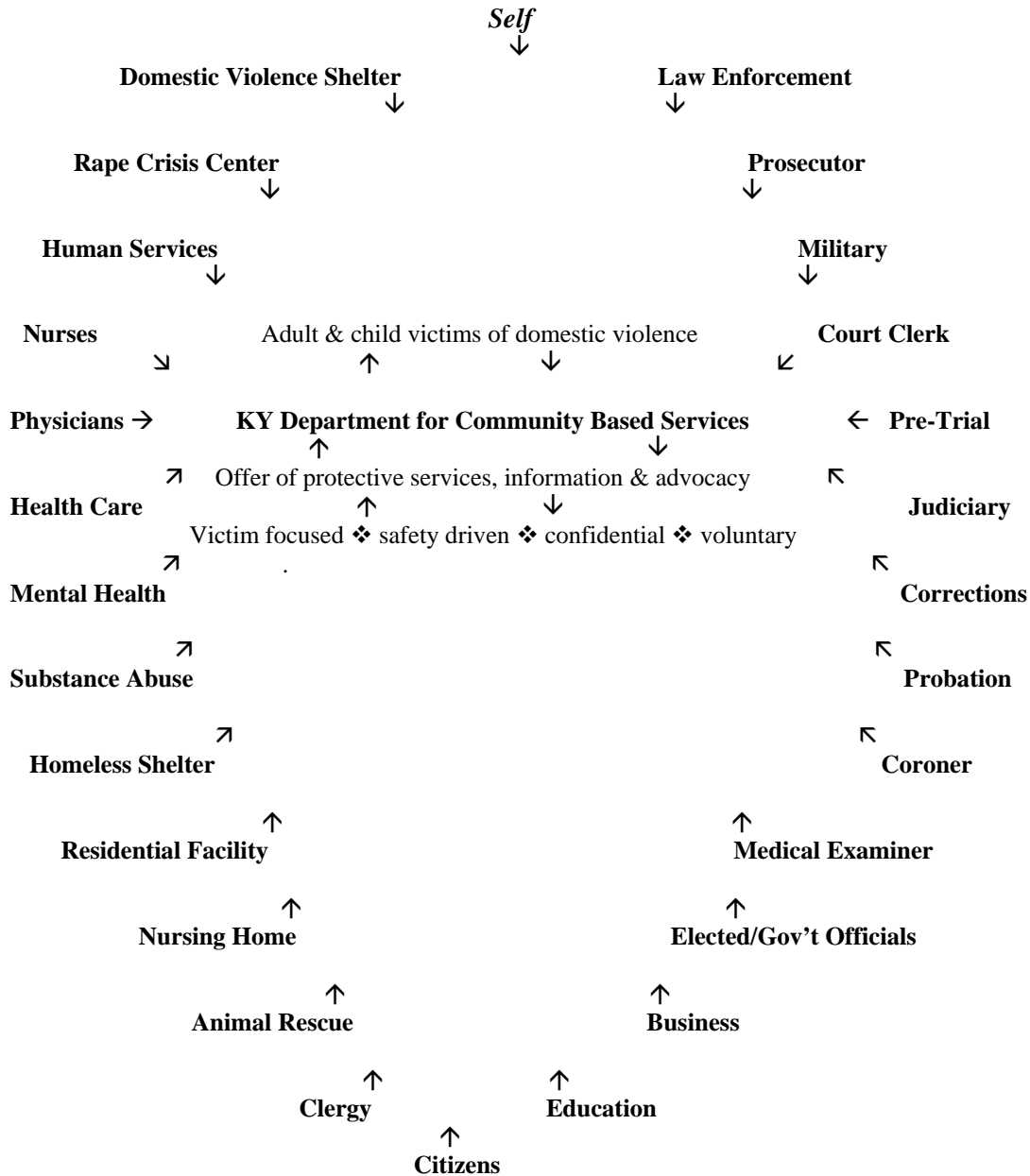
## Health and Family Service Cabinet, Department for Community Based Services

(Enact. 1978)

**Coordinated Community Response**  
Focus: Victim Safety, Confidentiality & Autonomy

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*Domestic Violence Consulting Services*  
(Lexington, KY)

**Reporting Responsibilities** =====  
**Kentucky Adult Protection Act** [KRS Chapter 209]

Health and Family Services Cabinet (HFSC),  
Department for Community Based Services (DCBS) =====

<p>The purpose in reporting known or suspected adult abuse, neglect &amp; exploitation to DCBS:</p> <ul style="list-style-type: none"><li>➤ To identify victims</li><li>➤ To offer/provide services aimed at preventing and remedying maltreatment (if indicated);</li><li>➤ To document incidents of maltreatment.</li></ul>
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**Why DCBS?** By legal mandate, DCBS adult and child protection workers have specialized roles in working with at-risk adults and children.

**Basic DCBS protection responsibilities in domestic violence cases are:**

- To respond promptly to reports of alleged maltreatment of adults and children and to determine the validity of the report;
- To assess the nature and extent of maltreatment to the alleged victim;
- To evaluate the risk of further injury to the alleged victim (for children, to determine whether the child should remain in the home while rehabilitative services are provided);
- To determine and identify the problems which may have contributed to or resulted in maltreatment;
- To offer and provide the protection and advocacy services of DCBS, if indicated;
- To make a written report of the initial findings together with a recommendation for further action, if indicated;
- To evaluate the potential for treatment and/or other services to rehabilitate or correct conditions;
- To plan a course of services and/or treatment calculated to protect, stabilize, and (if indicated) rehabilitate;
- To initiate, monitor and evaluate the plan;
- To invoke the authority of the court where indicated or requested.

***DCBS offices are located in every county.***

For purposes of adult protective services, an **adult** is considered to be:

- A person eighteen (18) years of age or older, who because of mental or physical dysfunctioning is unable to manage his own resources or carry out the activities of daily living, or protect himself from neglect, or a hazardous or abusive situation without assistance from others, and who may be in need of protective services; or
- A person, without regard to age who is the victim of abuse and neglect inflicted by a spouse.

KRS 209.020(4) (Rev. '98)

**Who is mandated to report** known or suspected spouse or partner abuse (domestic violence)?

**ANY PERSON . . . .** including but not limited to: physician, law enforcement officer, nurse, social worker, cabinet personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect or exploitation, shall report or cause reports to be made . . .

KRS 209.030(2)

See: Kentucky Domestic Violence and Abuse Act, which also mandates law enforcement officers to report any known or suspected domestic violence to DCBS [KRS 403.785(1)]; definitions [KRS 403.720]; and statutory intent of the Act [KRS 403.715].

For clarification on the **court's duty to report**, refer to **Fugate v. Fugate**, Ky. App. 896 S.W.2d 621. (April 21, 1995) and **OAG Opinion 97- 18**.

If in the course of an examination, the **coroner** suspects that an adult or child decedent may have been the victim of abuse or neglect, the coroner shall cause a report (oral or written) of this information to be made to the local DCBS -- *regardless of whether or not the coroner's findings indicate the maltreatment in any way contributed to the death of the adult or child.*

***Professionals who routinely deal with domestic violence are encouraged to get to know their local DCBS staff.*** When a patient discloses (or domestic violence is suspected), let the patient know you are familiar with the local DCBS staff who are available to assist.

Describe the voluntary services and the specialized information available through DCBS (safety planning, legal remedies, etc.). Assure the patient that the information will be kept confidential.

<b>What a report should include, if possible:</b>	KRS 209.030
<ul style="list-style-type: none"><li>➤ Name &amp; address (location) of the alleged victim, and of any person responsible for the alleged victim's care.</li><li>➤ Nature and extent of the abuse, neglect or exploitation (including information about any evidence of previous maltreatment).</li><li>➤ Identity of the alleged perpetrator, if known.</li><li>➤ Identity of the person reporting (not necessary, but helpful).</li><li>➤ Any other information which may be helpful to establish the cause of the maltreatment, to confirm the identity of the alleged perpetrator, or circumstances of the incident.</li></ul>	

**Additional information which would help DCBS, but is not necessary to effect a report:**

- current safe locations and telephone numbers where the alleged victim may be contacted (especially if different from usual residence);
- safety issues (threats of homicide or suicide, weapons, history of violence) for the victim, DCBS worker, others (e.g., officers).

DCBS has the authority and the obligation to assure the reports meet the statutory definition of abuse, neglect, exploitation or dependency before a protection investigation is initiated. In cases where a report is not clearly within those statutory definitions, but indicates service needs, DCBS attempts to be responsive and secure appropriate services for the individual or family.

The information reported will allow DCBS to identify and safely contact the alleged victim, evaluate the problem, and respond (if indicated) quickly and appropriately. The worker needs to know as much as is possible, but all of the information cited above does not have to be answered before making a report.

**How to Report.** An oral or written report may be made to DCBS. In some cases, DCBS may request a follow-up written report.

<b><u>Where to Report</u></b>
<u>Local</u> Dept. for Community Based Services office or 24- Hour Toll-Free Reporting Hotline 1-(800)-372-7200 (In case of <i>imminent danger</i> : call local or state police)

**Residential Facility.** If the maltreatment occurred in a residential facility, including those licensed by the Cabinet for Families and Children, DCBS cooperates (as is indicated) with the Office of the Inspector General (Cabinet for Health Services), the Medicaid Fraud & Victim Abuse Unit (Office of the Attorney General), and law enforcement.

**Reporting Adult and Child Abuse from Substance Abuse Programs.** Recommended procedures for complying with state mandates to report known or suspected adult/child maltreatment which also meet federal regulations with respect to confidentiality of substance abuse programs are described in a **legal opinion** to the Cabinet for Human Resources (now *Cabinet for Health Services*), **Department for Mental Health and Mental Retardation Services, Division of Substance Abuse** (July/November, 1988), by the **Legal Action Center**, a non-profit public interest organization whose purpose is to provide legal representation and counseling to ex-offenders, former alcohol and drug abusers, and the many programs and agencies which assist in their rehabilitation. (See end of this section.)

**Exceptions to reporting: Attorney - client privileged relationship.**  
Attorneys are, however, encouraged to do so within guidelines. KRS 209.050

**Privileged Relationships.** Privileged relationships are not grounds for excluding evidence. Neither psychiatrist-victim privilege nor the husband-wife privilege shall be a ground for excluding evidence regarding the abuse, neglect, or exploitation of an adult, or the cause of such maltreatment in any judicial proceeding resulting from a report made to DCBS. KRS 209.050

**Confidentiality.** The **source of a report** of adult abuse, neglect or exploitation is kept confidential unless it is ordered released by a court order (extremely rare). Information gathered in the course of a DCBS abuse/neglect investigation is confidential (restricted release). KRS 209.140

**Sharing of Information.** Upon receipt of the report, the DCBS worker will initiate an investigation into the allegations. An appropriate law enforcement agency will be notified per statute and, *if indicated*, assistance will be requested (e.g., high-risk cases). *Victim and worker safety are paramount considerations throughout the investigation.*

***The DCBS worker may provide restricted feedback on the case -- but only to designated professionals, when indicated and consistent with statute and policy*** (persons having a legitimate interest in the case e.g., other Cabinet personnel, medical, psychological, educational or social services personnel, corrections personnel or law enforcement agencies, including the county attorney's office). KRS 209.140

**Death.** *Death of the adult and/or child does not relieve one of the responsibilities of reporting the circumstances surrounding the death* (i.e., abuse, neglect) to the Department for Community Based Services. KRS 209.030(2)

Death as a result of neglect or abuse may constitute a **homicide** within the meaning of KRS Chapter 72, the Coroner's Inquest and Medical Examiners Act. KRS 72.025(1) A coroner may order, or be required to order, an **autopsy** where reasonable grounds exist to believe the death may have occurred as a result of neglect or abuse. *If the coroner refuses to order an autopsy, the County Attorney or Commonwealth's Attorney may petition either the district or circuit court for an autopsy order.* KRS 72.445

**Immunity.** Persons reporting in good faith are immune from civil and criminal liability per law. This immunity exists with respect to reporting, and participation in any investigation or judicial proceeding resulting from the report. KRS 209.050

**Penalty.** Kentucky law sets forth a criminal penalty for failure to report adult abuse, neglect or exploitation (Class B Misdemeanor = up to 90 days in jail and/or a fine of up to \$250). Each violation constitutes a separate offense. KRS 209.990

**Civil liability** may be incurred in addition to or in lieu of criminal liability related to failure to report adult or child abuse, neglect or exploitation.

#### **After a report is made to DCBS** =====

- Cases are prioritized based on the nature of the report (e.g., type of abuse, victim age/seriousness of injury or condition);
- Contact is made with other authorities and collaterals as required by statute or policy;
- An investigation is initiated on all appropriate cases as indicated by statute and policy (usually within 24-48 hours). Where an adult (or child) may be reported to be in imminent danger, a social worker is to initiate an investigation within the hour. A police officer may be requested to investigate and/or assist.

The worker may access the state's **Law Information Network of Kentucky (LINK)-Domestic Violence File** for background and current information on **court protective orders** related to the parties. This information may also alert the DCBS worker if the respondent is believed to be armed or dangerous.

Kentucky law provides that the Health and Family Services Cabinet:

- Upon request, shall receive from any agency of the state or any other agency, institution or facility providing services to the adult/child or his family, such cooperation, assistance and information (e.g., agency records) as will enable the cabinet to fulfill its statutory responsibilities. KRS 209.030
- May enter any health facility or health service licensed by the cabinet at any reasonable time to carry out the cabinet's statutory responsibilities. KRS 209.020(5)
- Actively involved in the conduct of an abuse, neglect or exploitation investigation shall also be allowed access to the **mental and physical health records** of the adult which are in the possession of any individual, hospital, or other facility if necessary to complete the investigation mandated by law. KRS 209.020(5)

**Responsibilities of DCBS.** The Department for Community Based Services, upon receipt of a report of adult or child abuse, neglect or exploitation, shall take the following action as soon as is practical:

- Notify the appropriate law enforcement agency;
- Initiate an investigation of the complaint;
- Conduct a joint investigation, depending on the nature of the report, with local law enforcement, the Division of Licensing and Regulation, or the Attorney General's Office (Division of Medicaid Fraud and Abuse Control);
- Make a written report of the initial findings together with recommendations for further action, if indicated; and,
- Provide assessment, referral and protective services (as appropriate).

**Safety planning** for adult and child victims is paramount and is an on-going process. DCBS staff is trained to assist victims with safety planning.

Protection and support services may be provided directly by DCBS or through appropriate referrals to justice and community service agencies.

DCBS workers may also serve as advocates for clients.

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**Kentucky DCBS Services include but are not limited to:**

- safety planning
- counseling
- emergency shelter
- information on legal options & community resources
- accompaniment to court
- accessing food, housing, clothing, & other necessities; etc.

**Right to Accept or to Refuse Services.** Unlike child protective services, **adult protective services are voluntary.** The adult may accept or refuse services offered by DCBS, except in extremely rare, life-threatening situations. KRS 209.030

## **Emergency Adult Protective Services (Involuntary) =====**

Emergency protective services are available in cases where an adult lacks the capacity to consent or refuse to receive protective services in an emergency. If a question exists regarding a patient's decision-making ability (e.g., dysfunctional), contact hospital social services or the local DCBS to assess if **guardianship** or other services are indicated. In rare cases, an **adult lacks the capacity to consent receive or refuse services and may be in a life-threatening situation**. These cases almost always involve dependent or elderly adults and are frequently medical in nature.

**“Emergency”** refers to an adult living in conditions that present a substantial risk of death or immediate serious physical harm to him or others. The Health and Family Services Cabinet may either file a motion (Ex Parte or petition) in Circuit Court (usually) depending upon the adult's situation and degree of risk. Criteria which must be present to warrant court ordered protective services includes:

- The adult is in a state of abuse or neglect and an emergency exists;
- The adult is in need of protective services;
- The adult lacks the capacity to consent or refuse to consent to such services; and,
- No person, authorized by law or court order to give consent for the adult, is available to consent or refuse consent for protective services.

**“Lack of capacity to consent”** means a person lacks, because of physical or mental dysfunctioning, sufficient understanding or ability to make or communicate responsible decisions for himself (e.g., provisions for health care, food, clothing, shelter, etc.).

Determining an adult's capacity to consent involves assessing the adult's decision-making capabilities. Changes in the adult's pattern of thought, behavior, or self-care may be indicative of diminished mental capacity as well as the adult's overall mental status (i.e., orientation to time, place and person).

Emergency adult protection cases are usually **life-threatening**.  
'Time' is critical to allow DCBS to effectively intervene on the adult's behalf.

It is imperative for medical professionals to consult  
and cooperate with the DCBS staff.

Pertinent information and records are necessary  
for DCBS to obtain the court order for medical treatment and services.

Medical staff should follow their usual procedures for obtaining **consent** in extraordinary cases (e.g., for severely injured or incoherent persons). **Evidentiary information** most often requested by the court includes the medical records and/or testimony of the attending physician or specialist of the adult in need of emergency protective services.

*Involuntary emergency protective services* ordered by the court may include: hospitalization; medical treatment; and/or protective placement. *The court shall authorize only that intervention which is necessary to remove the “emergency” and which it finds to be the **least restrictive** of the individual's liberty and rights while consistent with the adult's welfare and safety.* KRS 209.100(2)

## **Other Reporting Responsibilities** =====

### **Specific Crime Victims / Suspicious Injury or Accident** =====

Lexington-Fayette County Code, § 14-24. **Report required by hospitals, physicians, surgeons and doctors of medicine, to the division of police of persons treated for injuries or disorders.**

When any person is brought or comes to any urban county hospital for treatment of gunshot wounds, cuts or fractures which, from the nature of same, may have been caused by the commission of a crime of violence, or the person is the victim of poisoning, misuse or abuse of drugs or narcotics, or other injuries or disorders, it shall be the duty of the hospital to immediately notify the urban county division of police of the presence of the person in the hospital and the nature of the injury or disorder.

If any person suffering from such injury or disorder thereafter dies while a patient in any urban county hospital, it shall be the duty of the hospital to immediately notify the urban county police of the death.

When any doctor shall treat a person in the urban county suffering from such injury or disorder, it shall be the duty of the doctor to immediately notify the police of the name and whereabouts of such patient, and the nature of the injury or disorder. However, when the treatment takes place in an urban county hospital, it shall be the duty of the hospital to make the report and it shall not be necessary for the doctor to make same.

When any person in the urban county who is a patient of any doctor (as described above), and who is not confined in any hospital, dies, it shall be the duty of the doctor to report the death immediately to the urban county police.

Violation of any of the provisions of this section will subject the violator to a fine (\$10-\$500), or up to six (6) months in jail, or both. (Ord. No. 214-70, § 1, 9-17-70)

## **Coroner** =====

Kentucky law requires any person, hospital or institution in possession of a body whose death occurs under certain circumstances to notify the coroner or the coroner's deputy and a law enforcement officer immediately. KRS 72.020(1) **Among** those circumstances that may require notification because of suspected abuse or neglect:

- When the death may be the result of homicide or violence;
- When the death occurs in a state mental institution or hospital and there is no medical history to explain the death; or
- When the manner of death appears to be other than natural.

**Death of an adult or child** does not relieve persons, including a coroner, of the **duty to report** known or suspected abuse or neglect to the Department for Community Based Services. If in the course of an examination, the coroner suspects that an adult or child decedent may have been the victim of abuse or neglect, the coroner shall cause a report (oral or written) of this information to be made to the local DCBS -- *regardless of whether or not the coroner's findings indicate the maltreatment in any way contributed to the death of the adult or child.* The duty to report exists even though the person may have been a resident of a long-term care facility and under the treatment of the facility's medical director or other physician.

Death as a result of neglect or abuse may constitute a **homicide** within the meaning of KRS Chapter 72, the Coroner's Inquest and Medical Examiners Act. KRS 72.025(1) A coroner may order, or be required to order, an **autopsy** where reasonable grounds exist to believe the death any have occurred in circumstances such as those listed above. *If the coroner refuses to order an autopsy, the County Attorney or Commonwealth's Attorney may petition either the district or circuit court for an autopsy order.* KRS 72.445

### **Duty to Warn** =====

Kentucky law, as other states, provides that qualified mental health professionals are mandated under KRS 202A.400 to warn any clearly or reasonably identifiable victim of threatened violence. The warning of the threat of violence should be made by the mental health professional to communicate the threat to the victim and to notify the police department closest to the patient's and to the victim's residence. The mental health professional should make reasonable efforts to seek civil commitment of the patient under KRS 202A, if indicated.

The officer should complete a report on the threatened violence and, in domestic violence related cases, notify the local Dept. for Community Based Services representative. The officer, and if indicated, the protective service worker, should make efforts to safely contact the alleged victim. All efforts to contact the victim should be noted in the record.

When contacted, the victim should be informed of the threatened violence, provide transportation to a safe location, advised of alternative safety planning strategies, informed about all available protective resources and legal remedies, and assisted to access those remedies as indicated and appropriate. Other investigative and/or protective actions should be explored with the respective supervisors of the responding officer and protective service worker. Documentation of recommendations made and actions taken on behalf of the intended victim should be noted in the record.

## Reporting from Substance Abuse Programs =====

In response to a request to the Legal Action Center for clarification regarding federal rules of confidentiality and state mandate for the **reporting of adult abuse, neglect and exploitation from substance abuse programs**, it was determined that the following six (6) procedures meet both federal and state requirements:

- Encourage the alcohol or drug abuser who is concurrently an alleged victim or perpetrator of abuse or neglect to self-report.
- Encourage the alcohol or drug abuser who is concurrently an alleged victim or perpetrator of abuse or neglect to sign a Release of Information form. This form would give written consent for the counselor to contact the Department for Community Based Services to report the suspected or known adult abuse, neglect or exploitation.
- Report the suspected or known adult abuse, neglect, or exploitation without divulging that the person is receiving alcohol or drug abuse treatment services. If the substance abuse program is a sub-component of a larger organization that provides services other than just alcohol or drug abuse, the staff person may use the name of the parent agency when making the report e.g., a general hospital or community mental health center that provides a variety of mental health services.
- Initiate the report as a private citizen rather than as a representative of a chemical dependency treatment program. The source of a report of abuse or neglect is kept confidential unless it is released by a court order. [KRS 209.140]
- Initiate the report anonymously.
- Seek a court order in compliance with federal regulations “Confidentiality of Alcohol and Drug Abuse Patient Records” (42 C.F.R. Part 2) in order to release the information regarding the suspected or known adult abuse, neglect or exploitation.”

“As the federal government ruled and procedures reflect, reports of suspected or known adult abuse can be made but only information that would not identify the patient as receiving alcohol or drug abuse treatment can be disclosed absent the patient’s written consent, a proper court order under Subpart E of the regulations, or a qualified services organization agreement. Thus, absent one of the three forms of authorization listed above, an agency that does work in addition to substance abuse could report under its official name as long as no information about substance abuse or treatment is revealed. Organizations doing only substance abuse work would have to report anonymously since even revealing the name of the program would disclose the nature of the treatment.”

The Legal Action Center opinion also set forth suggestions regarding:

“Perpetrators and Self Reporting: Counselors may want to advise perpetrators of abuse to consult a lawyer before they self report or sign a consent form to allow a program to report abuse.”

“Consent Forms: Particular attention should be paid to the contents of the consent form. The federal regulations require that disclosures made pursuant to a consent form must be limited to information that is necessary to accomplish the need or purpose of the disclosure. [Sect. 2.13(a)] Since the “fact” of adult abuse is the only information necessary to accomplish the need to make the mandated report, the consent form signed by the patient should specify that the information to be disclosed by the treatment program is limited to reporting the abuse. Thus, if the representatives of the Department for Community Based Services want to meet with a treatment counselor or request additional information from a program, the client should sign a second consent form permitting this additional communication.”

“Investigative Access to Records: The Kentucky Adult Protection Act [KRS 209.030(5)] authorized any representative of the DCBS as part of their responsibilities under this statute to enter any health facility or health service licensed by the Cabinet as well as allows access to the mental and physical health records of the adult which are in the possession of any individual, hospital, or other facility. To the extent that provision would mandate disclosures by substance abuse programs covered under the federal confidentiality laws, the federal law overrides that requirement. In that situation, the DCBS would need a consent form, court order under Subpart E of the federal regulations, or qualified services organization agreement before obtaining access to such information.”

“Confidentiality and Family Members: On this issue there exists a difference of opinion between the Legal Action Center and representatives in the Counsel’s Office of the Public Health Division of Health and Human Services. In the opinion of the Legal Action Center, the federal confidentiality laws do protect a spouse or family member who reaches out first for assistance. Therefore, when programs are treating co-dependent spouses or family member, it is the advice of the Legal Action Center that in complying with the mandatory reporting requirements of Kentucky’s child or adult abuse laws, programs should proceed as they do in reporting child or adult abuse committed by the drug abuser him-or-herself.”

“It is the position of representatives in the Counsel’s Office of the Public Health Division of Health and Human Services that the non-drug abusing family member who presents him-or-herself for services is not covered by the regulations. Under their interpretation of the regulations, counselors would not be required to comply with the regulations when reporting child or adult abuse when a non-drug abusing family member is involved.”

“Summarizing this issue, the Legal Action Center’s advice was, to treat the co-dependents and family members so as not to involve any risk, as protected under the regulations. This procedure of treating these patients as protected and following the regulations when reporting child or adult abuse would be the safer course.”

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*The opinions cited above were received by the **Cabinet for Human Resources, Department for Mental Health and Mental Retardation Services, Division of Substance Abuse** (July/November, 1988), from the **Legal Action Center**, a non-profit public interest organization whose purpose is to provide legal representation and counseling to ex-offenders, former alcohol and drug abusers, and the many programs and agencies which assist in their rehabilitation.*

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**Special thanks:**

**Kathy W. Frederich, M.S.**  
Associate Director  
Families and Children Training Project  
Eastern Kentucky University  
Richmond, Kentucky



**Common Statements from Spouse/Partner Abuse Victims  
& Responses from Health Care Professionals  
that Can Encourage Self-help Behavior** =====

**Objective:** To decrease the verbal minimization of battering & encourage expression of feelings.

Patient/Victim

Health Care Professional

“I was *just* pushed down. It wasn’t a big deal. I wasn’t *really* beaten up.”

“It sounds as if you were lucky you didn’t hit your head on something when you were pushed down. It must have frightened you.”

“I’ve *only* been hit a couple of times in all the years we’ve known each other. He has a terrible temper.”

“Frequently, when you are hit once, it will happen again. Has this person threatened you or thrown objects? Does this person try to control your life, such as how much money you have, where you go or with whom you can talk? This must be difficult for you. How do you cope?”

[You may want to use the Power & Control Wheel as part of patient education/assessment. Explain the possible consequences of silence, safety planning, and the possible opportunities for safety & support services.]

“I can’t believe it happened. I do my best. I must have done something to deserve it.”

“It is not your fault. It could happen to anyone. And you must not blame yourself. The most important thing now is that you remain safe.”

“I was hurt for 5 years. I finally left my partner, but sometimes I still feel afraid.”

“Having been through an abusive relationship, it’s hard to believe it’s over. Sometimes those who have been through what you have find it helpful to talk about their feelings.

I have time to talk some today with you, and I want to encourage you to talk with a person who helps other people in situations similar to yours. I have referred other patients and will answer your questions about [name/agency] information and help.

**Objective:** To demonstrate universality of the problem and to increase awareness of safety and health options.

Patient/Victim

“I’ve been through this-on & off-for all years we’ve known each other. I’ve tried to leave *many* times before. It’s no use. Sometime I feel like killing myself.”

“Nobody cares if I get hit. I am afraid to call or talk to the police.”

Health Care Professional

“You seem to feel trapped and your feelings sound quite strong. I’m concerned about your safety [& safety of your children]. Many people have been in similar situations and have survived through changes—even after a long history of unsuccessful attempts to deal with what was happening to them.

It helps for us to carefully examine what is going on-how it started, how it has changed over time, and what it happening now. We will not be able to take care of everything today, but we will start with a careful ‘examination’ and development of a practical safety plan—then schedule a follow-up visit.”

“I care if you get hurt. We will treat your injuries today and develop a safety plan that builds on the safety measures you have been taking.

What has been happening to you is a crime? Most officers so take your situation very seriously and can talk with you about the importance of documenting your injuries. We can call them from here and you can talk with them in the safety of this office.

Arrest is a possibility, so we will also talk with a person who will be available to you-an advocate from [shelter/agency] through this process. [Name] can help more with safety planning, answer questions, assist with shelter and other services you may choose to contact.

**Objective:** To dispel myths & misinformation about domestic violence.

<u>Patient/Victim</u>	<u>Health Care Professional</u>
“A man is suppose to be in charge. He can’t help it. He only hits me and the kids if we do something wrong.”	“Making a mistake doesn’t justify hurting someone. Unfortunately, many people try to use that as an excuse to control and abuse. Now we know that’s not true, it’s unhealthy, and it can eventually be deadly.  Couples can have clearly defined roles—but hurting a partner is not ever acceptable. We have learned a lot about ways to help patients and their families when these behaviors occur. Help me to know more about what is going on . . .

**Objective:** To increase ability to recognize signs of escalating danger.

<u>Patient/Victim</u>	<u>Health Care Professional</u>
“The children are frightened. I’m afraid that they are going to get hurt, too.”	“Your situation sounds frightening. You are obviously concerned about your children. I am concerned for <i>your</i> safety <i>and</i> for the children’s safety.  Let’s examine what has been happening to you and the children, how it has been changing, any special ‘signs’ or ‘statements’ where

