

Clinical Guidelines for
Assessment
and Referral for
Victims of Domestic Violence:
A Reference for
Utah Health Care Providers

2008

Utah Department of Health

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DOMESTIC VIOLENCE

Prevalence

Domestic violence (DV), also called intimate partner violence (IPV), is a serious problem plaguing the homes and health of millions of Americans. Every year, more than 1.5 million women and 834,700 men are physically assaulted and/or raped by their intimate partner.¹ An estimated 20-30 percent of women and 7 percent of men have been physically assaulted and/or raped by an intimate partner in their lifetime.² While studies show that men are also victims of domestic violence, the majority of victims are women. One study found that of those who have been physically assaulted, 92 percent were women who had been assaulted by men.² In many cases the violence does not end with debilitating physical abuse, but escalates into homicide.

The effects of domestic violence are both devastating and far-reaching and impact men, women, children, and the elderly. Domestic violence knows no limits and can be found in every socioeconomic level, race, religion, age group, and community. The total financial impact of domestic violence on communities is unknown, but the estimated cost of treatment for battered women seeking medical attention is \$1.8 billion each year.¹

Although the impact of domestic violence on the community continues to be explored, it is clear that women experiencing abuse, or who have experienced abuse, suffer physically and psychologically—beyond the actual episodes of violence. Health problems may persist even after the victim has left the abusive relationship. Abused women commonly report adverse health effects such as chronic neck or back pain, arthritis, headaches, sexually transmitted diseases including HIV/AIDS, chronic pelvic pain, chronic irritable bowel syndrome, peptic ulcers, and a combination of indigestion, diarrhea, and constipation.³ Intimate partner violence is associated with high rates of depression, substance abuse, and anxiety disorders.⁴ Such problems are often compounded by the use of alcohol and illicit drugs by the victims.⁵

Abused women are not the only victims of domestic violence who suffer negative health

effects from abuse. Both children and the elderly experience abuse, neglect, and exploitation. In approximately 60 percent of homes where IPV takes place, child abuse also occurs.⁶ Whether the child is an actual victim of physical abuse or a witness to it, children in homes where domestic violence occurs are more likely to experience post-traumatic stress disorder, chronic somatic problems, depression, and anxiety. They are also more prone to exhibit the following behaviors: violence toward peers, alcohol and drug abuse, suicide attempts, involvement in teenage prostitution, running away from home, and involvement in sexual assault crimes.^{7, 8}

Although the literature is not conclusive as to whether pregnancy increases a woman's vulnerability to domestic violence, researchers as well as victims of domestic violence identify that the child-bearing years are the years of highest risk for domestic violence to occur or intensify.^{9,10, 11}

Because of the devastating effects and prevalence of domestic violence, action must be taken to decrease the enormity of the problem and to alleviate the suffering caused by abuse. Domestic violence is not an issue that can be solved overnight or with one specific intervention: It is a complicated health problem that must be addressed through a collaborative effort involving religious leaders, law enforcement, employers, health professionals, policy makers, legal professionals, educators, advocates, and friends of the abused.¹³

Utah Data:

From 2000-2002, a current or former intimate partner perpetrated 64.2% percent of female homicides in Utah. These figures support previous reports that suggest "...violence against women is predominantly intimate partner violence".² Nearly 8,000 (4.2%) Utah women who delivered a live birth in 2000-2003 reported physical abuse by a husband or partner during the year before her most recent pregnancy or during her most recent pregnancy. The health impact of abuse on pregnant women and their offspring may be substantial. Utah women who were physically abused during pregnancy (2.7%) were more likely to receive late prenatal care, deliver a low birthweight infant, and experience postpartum depression.¹²

DOMESTIC VIOLENCE

Definitions

Domestic Violence (DV), or Intimate Partner Violence (IPV)

A pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, or was, involved in an intimate or dating relationship and are aimed at establishing control by one partner over the other.¹⁴

Physical Abuse

Any forceful, physical behavior, which may include:

1. Pushing, slapping, hitting, shoving, biting, punching, kicking, or strangulation
2. Assault with a weapon
3. Holding, tying down, or restraining
4. Leaving partner in a dangerous place
5. Refusing to obtain medical help when partner is sick or injured
6. Restricting sleep or access to food and/or water

Emotional and Psychological Abuse

Any verbal/nonverbal form of communication used to control a partner, which may include :

1. Threats of harm or suicide
2. Physical and social isolation
3. Extreme jealousy and possessiveness
4. Intimidation
5. Degradation and humiliation
6. Name-calling and constant criticism, insults, and belittlement
7. False accusations and blame
8. Ignoring, dismissing, or ridiculing needs
9. Lying, breaking promises, and destroying trust
10. Driving fast and recklessly to frighten and intimidate
11. Restricting access to financial resources such as checkbook, money, car keys, etc.

Sexual Abuse

Any form of forced sex or sexual degradation, which may include:

1. Forcing sexual behaviors when partner is particularly vulnerable (e.g., asleep, drunk, intoxicated, not fully conscious, or afraid to say no)
2. Physically hurting partner during sex or assaulting partner's genitals
3. Criticizing or calling partner sexually degrading names
4. Treating partner as a sex object
5. Making partner perform sexual acts against his/her will
6. Limiting access to contraceptives
7. Forcing partner to watch or witness sexual acts performed by others ¹⁵

I. Understanding Domestic Violence

ELDER ABUSE

Prevalence

According to the 2002 U.S. Census, the elderly, defined as persons age 65 and older, numbered 35.6 million. This represents approximately 12.3 percent of the U.S. population or one in every eight Americans. Utah has one of the fastest-growing older populations in the country. It is forecast that Utah's 65+ population will increase 165 percent by 2030.¹⁶

Federal and state statutes require that vulnerable adults, who include the elderly and mentally or physically impaired, be protected from abuse, neglect and exploitation. Utah statute includes a mandatory reporting law that requires anyone who suspects abuse, neglect or exploitation of a vulnerable adult to report it to either law enforcement or Utah Adult Protective Services (APS). APS within the Division of Aging and Adult Services, is in turn mandated to investigate allegations of abuse against any vulnerable adult.

In 2000, APS agencies nationwide received 472,813 reports of elder/adult abuse or mistreatment. Incidents of elder abuse are largely underreported to authorities. It is estimated that only one in ten cases of elder abuse is ever reported to the proper authorities. There may be a number of reasons that people fail to report suspected abuse.

Utah Data:

In 2002, Utah APS investigated 2,139 referrals of abuse of vulnerable adults. Of these, 791 were substantiated. Of the substantiated cases, 53 percent were for neglect, 32 percent for abuse and 15 percent for exploitation. Of these cases, 64 percent of the victims were female and 55 percent were over the age of 70. In most cases (67 percent), the perpetrator was a relative or family member of the victim.

Definitions

Vulnerable Adult

Accepted referrals require an adult to be at risk due to an allegation of abuse, neglect, or exploitation and contain one of the following elements:

1. A person 65 years of age or older
2. A person who is 18 years of age or older and has a mental or physical impairment that substantially affects that person's ability to:
 - Provide personal protection
 - Provide necessities such as food, shelter, clothing, or mental or other health care
 - Obtain services necessary for health, safety, or welfare
 - Carry out the activities of daily living
 - Manage his/her own resources
 - Comprehend the nature and consequences of remaining in a situation of abuse, neglect, or exploitation.

Physical Abuse:

Any forceful, physical behavior, which may include:

1. Physical injury/harm
2. Unlawful restraint
3. Sexual abuse
4. Deprivation of life-sustaining treatment

Neglect:

1. Caretaker neglect (The caretaker is failing to provide for the basic needs of the elderly or disabled person)
2. Self-neglect (The elderly or disabled is unable to provide their own basic needs)

Exploitation:

1. Financial
2. Criminal activity
3. Power of attorney/guardianship

CHILDREN WITNESSING

Prevalence

Many children live in violent homes and are witnesses to the violence. Studies indicate that at least 50 percent of female victims of domestic violence have children less than twelve years of age in the home.¹⁷ In the United States, it is estimated that three to ten million children annually witness acts of domestic violence.¹⁸

Living in violent homes not only places children at risk of being witnesses to violence, but also of being victims of violence. Studies indicate that child abuse occurs in 33% to 77% of families in which there is abuse of adults.¹⁹ In the state of Utah, witnessing domestic violence is also considered a form of child maltreatment. As such, witnessing domestic violence is the most common form of child maltreatment in Utah, accounting for 25% of confirmed cases of child abuse.²⁰

Definition

Child witness to domestic violence or intimate partner violence is defined by the Family Violence Prevention Fund as "...a term encompassing a wide range of experiences for children whose caregivers are being abused physically, sexually, or emotionally by an intimate partner. This term includes the child who actually observes his/her parents being harmed, threatened or murdered, who overhears this behavior from another part of the home or who is exposed to the short- or long-term physical or emotional aftermath of caregiver's abuse without hearing or seeing a specific aggressive act. Children exposed to intimate partner violence may see their parents' bruises or other visible injuries, or bear witness to the emotional consequences of violence such as fear or intimidation without having directly witnessed violent acts."²¹



Children who grow up in violent homes are more likely to be involved in violent relationships in their adult lives.

I. Understanding Domestic Violence

THE HEALTH CARE PROFESSIONAL'S ROLE

Health care professionals are mandated to report to a law enforcement agency regarding the facts of an injury or wound inflicted by another person by means of a weapon (Utah Health Code Chapter 26-23a-2. The Adult Abuse Statute, Utah Health Code Chapter 26-23a-1, defines “Health care provider” as any person, firm, corporation, or association which furnishes treatment or care to persons who have suffered bodily injury, and includes hospitals, clinics, podiatrists, dentists and dental hygienists, nurses, nurse practitioners, physicians and physicians’ assistants, osteopathic physicians, naturopathic practitioners, chiropractors, acupuncturists, paramedics, and emergency medical technicians).

Health care professionals have the unique opportunity and responsibility to identify victims of domestic violence and to refer and intervene on their behalf. Often health care providers are the first or only professionals to see the injuries or other medical issues of the abused, yet many victims of domestic violence move in and out of the health care system without identification or referrals.²⁵ The development and implementation of policies and procedures, reinforced by staff education, may increase the rate of identification of battered adults and their children.^{3, 26} As domestic violence recurs emergency department identification may interrupt the cycle of violence and help prevent further incidents of abuse and violence.²⁷

Health professionals have a reputation as sources of comfort and care. Generally, patients trust their providers to make suggestions that will benefit their physical and mental well being. Such a relationship can open up avenues of communication that may otherwise have remained closed. This is why it is important for health care providers to ASK about the occurrence of domestic violence in the homes of their patients. In one independent study, the

majority of women reported a willingness to reveal histories of abuse to health care professionals if asked directly by the professionals.²⁸ Victim advocates and others encourage health care professionals to take advantage of one-on-one situations with their clients to ask about violence, especially if they suspect abuse.

When health care providers fail to question patients about abuse, it is usually not because they do not care about their clients’ safety, but because of existing or perceived barriers. Such barriers include:²⁸

1. Cultural differences
2. Lack of privacy
3. Language differences
4. Lack of training on domestic violence
5. Lack of time
6. Lack of resources/referrals
7. Fear or discomfort in asking questions about domestic violence
8. Desire not to become involved in the issue with the patient

It is hoped that, despite these barriers, health care workers will make the asking of questions a routine practice and will recognize the benefits of identifying and referring domestic violence victims. Even when victims do not disclose information about the violence they are experiencing, it is empowering for the victims to know there are people who care and are willing to help when they are ready to disclose. In this small way, the simple act of asking can have a positive effect on the lives of these patients. At other times, the process of asking and intervening by health care professionals may save the life of their patient.²⁹

THE HEALTH CARE PROFESSIONAL'S ROLE

Bias

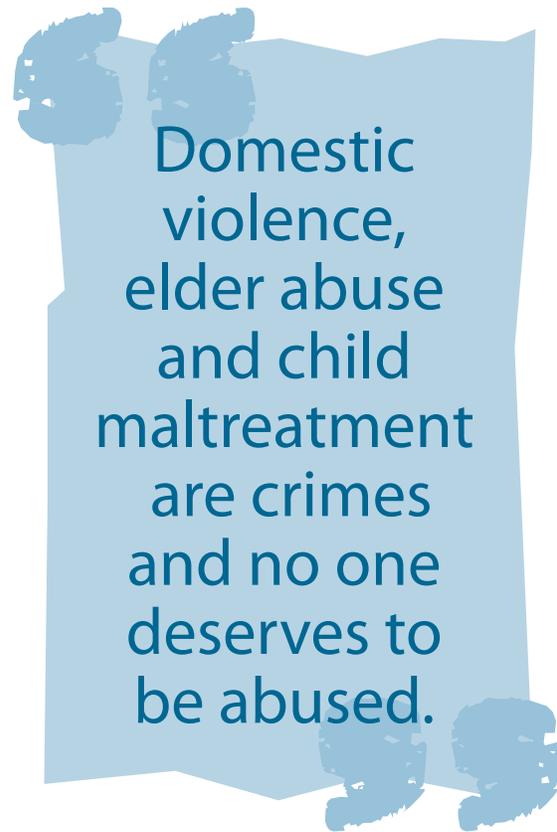
Before dealing with victims of domestic violence, it is important for the health care provider to evaluate his or her own feelings and prejudices. Victims of domestic violence have endured much – both physically and psychologically – and any indication of disbelief about the abuse may have a devastating effect on the patient's morale and confidence in divulging the truth about the violence he/she experiences.

When faced with the knowledge that any patient is being abused, it is important that providers understand that, even though the victims may feel responsible, the acts of violence are not their fault. The violence is the action and responsibility of the abuser. Domestic violence, elder abuse and child maltreatment are crimes and no one deserves to be abused.¹⁵

The provider should be patient and sympathetic when working with victims of domestic violence. Victims will often leave 7 to 12 times before leaving the abuser permanently.³⁰ They stay for many reasons, including but not limited to: the lethality of the situation, the love they feel for their partners, to protect their children, and socioeconomic circumstances. The provider should continue to support the victim regardless of his or her decision to leave or stay with the abuser. The provider should also continue to document any occurrences of injury.

The provider can empower victims by helping them realize that they are strong, resourceful, and clever to have gotten as far as they have under the circumstances. It is important that these compliments be honest and reasonable. The provider may want to suggest that patients keep a journal about the violence they experience. Victims will know if they would be able to do this safely.

It is natural for providers to want to present a solution to the problem; however, by empowering patients to make their own choices, the provider will be helping patients realize their potential for taking control of their own lives. It is important for the health care provider to be realistic and honest with the patient. Suggesting that patients confront abusers about their intention to leave increases the lethality of the situation.²⁹ Health care providers should inform the patient that there is risk in any decision they make.



II. Identifying, Assessing and Screening in the Health Care Setting

COMPELLING REASONS FOR ROUTINE SCREENING

Domestic violence is a health care issue. It is a significant threat to the health and well being of the victims, as well as to those who may witness domestic violence. Homicide is the leading cause of death for women in the workplace and for African-American women ages 15 to 24.³¹ It is the fourth leading cause of death for women under the age of 45.³² It is the most common cause of child maltreatment in Utah.³³

Medical professionals are often the first, and sometimes only professionals to see a victim of domestic violence. Failing to diagnose abuse increases the patient's health risk and could further harm the patient by validating their sense of entrapment.

To adhere to the American Medical Association's Principles of Medical Ethics, physicians must intercede in cases of domestic violence and elder abuse. Edmund Pellegrino and David Thomasma, bio-ethicists of the ethics council state, "The aim of medicine is to address not only the bodily assault that disease or an injury inflicts, but also the psychological, social, even spiritual dimensions of this assault. To heal is to make whole or sound, to help a person reconvene the powers of self and return, as far as possible, to his (or their) conceptions of a normal life".³⁴ The American Medical Association Policy E-2.02³⁵ has issued guidelines for detecting and treating family violence. It states:

"Due to the prevalence and medical consequences of family violence, physicians should routinely inquire about physical, sexual, and psychological abuse as part of the medical history. Physicians must also consider abuse in the differential diagnosis for a number of medical complaints, particularly when treating women.

"Physicians who are likely to have the opportunity to detect abuse in the course of their work have

an obligation to familiarize themselves with protocols for diagnosing and treating abuse and with community resources for battered women, children, and elderly persons.

"Physicians also have a duty to be aware of societal misconceptions about abuse and prevent these from affecting the diagnosis and management of abuse. Such misconceptions include the belief that abuse is a rare occurrence; that abuse does not occur in 'normal' families; that abuse is a private problem best resolved without outside interference; and that victims may be responsible for the abuse against them."

By identifying and acknowledging the abuse, the physician may be helping to end the generational cycle of violence and increase the health and welfare of the patient and their children. This simple intervention may begin a process whereby the victim may seek the necessary assistance to find safety.

The aim of medicine is to address not only the bodily assault that disease or an injury inflicts, but also the psychological, social, even spiritual dimensions of this assault.

—AMA

INDICATORS OF ABUSE

Intimidation

- Frightens with looks, actions, and gestures
- Smashes things and destroys property
- Abuses pets
- Displays weapons

Economic Abuse

- Prevents getting or keeping a job
- Gives an allowance or forces victim to ask for money
- Takes money
- Doesn't allow knowledge about or access to family income

Coercion and Threats

- Threatens harm
- Threatens to leave, commit suicide, or report victim to welfare
- Makes victim drop charges or do illegal things

Male Privilege

- Acts like the master, treats victim like a slave
- Makes all the big decisions
- Defines and enforces men's and women's roles

Uses the Children

- Makes victim feel guilty about the children and relays messages through them
- Uses visitation to harass
- Threatens to take children with charges of neglect and abuse

Emotional Abuse

- Name-calling privately or in public
- Uses put-downs to make victim feel bad
- Tries to make victim think they're crazy
- Tries to make victim feel guilty

Isolation

- Controls what victim does, who they see and talk to, what they read, and where they go
- Limits involvement in activities outside the home
- Uses jealousy as justification

Denial and Blame

- Makes light of abuse and doesn't take victim's concern seriously
- Denies abuse occurred
- Shifts responsibility for the abuse to the victim

Power and Control Wheel



II. Identifying, Assessing and Screening in the Health Care Setting

INDICATORS OF ABUSE

Recognizing Abuse

Although abusive relationships may differ in dynamics from one couple to another, research has shown that there are basic dynamics and certain (high-risk factors) indicators of abuse. Listed below are injuries or conditions that should raise suspicion of abuse:^{25, 36}

- Recent trauma history
- Injury to the head, neck, torso, breasts, abdomen, or genitals
- Bilateral or multiple injuries
- Unexplained injuries or injuries that are inconsistent with the patient's story
- Delay in seeking medical treatment
- Physical injury during pregnancy, especially on the breasts and abdomen
- Chronic pain symptoms for which no etiology is apparent
- Behavioral cues such as depression, suicide ideation, anxiety, sleep disorders, panic attacks, symptoms of post-traumatic stress disorder, and alcohol/substance abuse problems
- Overly protective, controlling partner, or a partner who refuses to leave patient
- Direct or indirect references to abuse
- Defensive wounds such as bruises/lacerations on backs of forearms, hand, etc.
- Strangulation

Victim Dynamics: 14, 37

- Often fearful of partner
- Often not allowed access to family, friends, or other support networks
- Often experiences reduced autonomy and/or, when they exercise autonomy, there are negative or abusive consequences
- Often feels guilty or wonders if he/she is to blame for his/her partner's violence
- May experience physical injuries and/or psychological problems
- Others have expressed concern about the

victim's safety

- Takes blame for the violent episode(s)

Perpetrator Dynamics: 14, 37

- Often controls access to money, property, and other shared commodities
- Often notably jealous of friends, family, co-workers, and others
- Scornful of partner's perspective
- Uses various forms of status to claim authority, knowledge, or power
- Often minimizes or explains his/her behavior, makes excuses, or becomes defensive
- Often vague about violent incidents
- May have a documented prior use of violence
- Often has defensive wounds caused by the victim (e.g., scratches or bite marks)
- Uses physical force against people or property

Research shows that children of all ages are affected by the violence in their home. It is important to note that many symptoms of violence exposure are common pediatric complaints.²²

Infants can present with

- Disrupted feeding routines
- Disrupted sleep patterns
- Failure to thrive
- Excessive screaming that the physician may diagnose as colic
- Developmental delays

Preschoolers can have

- Regression of developmental behaviors such as thumb-sucking or bed-wetting
- Become more clingy or anxious
- Decreased willingness to explore their environment and exert their independence

INDICATORS OF ABUSE

School-aged children can

- Become aggressive
- Have poor school performance
- Have behavior problems
- Have somatic complaints

Adolescents may

- Feel shame, betrayal
- Become aggressive
- Exhibit high risk behaviors, e.g., drug use, sexual promiscuity
- Run away from home
- Truancy
- Lose impulse control, which can be deadly if there are lethal weapons available

Up to 50% of children who witness assaults against their mother have clinical criteria consistent with post-traumatic stress disorder.¹⁸ Many of these children are incorrectly diagnosed with conduct disorders, mood disorders, anxiety disorders and attention deficit/hyperactivity disorder (ADHD).

However, one of the most devastating outcomes of violence exposure is the perpetuation of the cycle of violence. Children who grow up in violent homes are more likely to be involved in violent relationships in their adult lives.

Cycle of Abuse

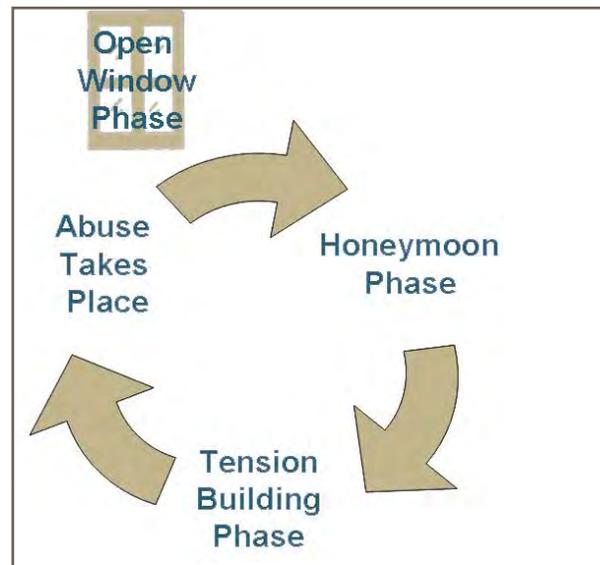
First phase: In this phase the abuser gets edgy and tense. Almost any subject, such as housework or money, may cause tension to build up. Verbal abuse, insults, and criticism increase. Shoving begins.

Second phase: Violence erupts as the abuser throws objects at his or her partner, hits, slaps, kicks, chokes, abuses him or her sexually, or uses weapons. Once the attack starts, there's little the victim can do to stop it; there generally are no witnesses.

The “open window” phase occurs just after the acute battering episode and just before the honeymoon phase. This is the time when women exhibit the most help-seeking behavior. This time offers a crucial opportunity for successful intervention in the lives of battered women and positive steps toward breaking the cycle of violence.

Third phase: The abuser apologizes and promises to change. This is known as the “honeymoon” phase. The abuser may be so charming that the victim believes that the violence will not happen again. The victim may think that the danger has passed and the relationship can be saved. From this point the cycle repeats.

Usually the abuse will continue and get worse. The longer a victim stays in an abusive relationship, the greater his or her risk of being badly hurt.



UTAH DOMESTIC VIOLENCE COUNCIL RECOMMENDATIONS

RADAR

Routinely screen female patients for abuse. Although many women who are victims of domestic violence will not volunteer any information, many will acknowledge that they are victims if asked. Intervening on behalf of battered women is an active form of preventing child abuse.

Ask direct questions. “Because violence is so common in many people’s lives and witnessing violence can have negative effects on children, we’ve begun to ask all our families about their experience with violence.” Sample questions include: “Have you ever been harmed by or felt afraid of your partner?” “Have you ever been hit, kicked, punched or otherwise hurt by your partner?” “Do you feel unsafe in your current or a previous relationship?” “Have your children witnessed anything violent or frightening in their home, school or community?”

Document your findings. Thoroughly document in the chart the patient’s description of the violence and any injuries that are present. In the case of a pediatric chart, ask the victim if it is safe to document in the child’s chart. Other ways to document in the child’s chart include abbreviations such as DV+ or RADAR+. If further information about the violence needs to be documented, then place details in a ‘restricted access’ chart. Document what information was given to the victim and the referrals made.

Assess safety of victim and children. Assess patient safety. Help the patient reduce the danger to herself and her children when the patient is discharged.

Review options and referrals. Refer the patient to specialists trained to help victims cope with all aspects of the abuse. Take time to talk about options available to the patient and the patient’s family. Give the victim written information if she feels that it is safe to do so. Call authorities (i.e. law enforcement or DCFS) if appropriate. Find safe shelter for the family if needed.

RADAR. Developed by the Massachusetts Medical Society. ©1992.



RADAR POCKET CARD

RADAR

R = ROUTINELY SCREEN WOMEN FOR ABUSE

Although many women who are victims of domestic violence will not volunteer any information, many will acknowledge that they are victims if asked. Intervening on behalf of battered women is an active form of preventing child abuse.

A = ASK DIRECT QUESTIONS

“Because violence is so common in many people’s lives and witnessing violence can have negative effects on children, we’ve begun to ask all our families about their experience with violence.” Sample questions include: “Have you ever been harmed by or felt afraid of your partner?” “Have you ever been hit, kicked, punched or otherwise hurt by your partner?” “Do you feel unsafe in your current or a previous relationship?” “Have your children witnessed anything violent or frightening in their home, school or community?” Inform patients of legal requirements.

D = DOCUMENT YOUR FINDINGS

Thoroughly document in the chart the patient’s description of the violence and any injuries that are present. In the case of a pediatric chart, ask the victim if it is safe to document in the child’s chart. Other ways to document in the child’s chart include abbreviations such as DV+ or RADAR+. If further information about the violence needs to be documented, then place details in a ‘restricted access’ chart. Document what information was given to the victim and the referrals made.

A = ASSESS SAFETY OF VICTIM AND CHILDREN

Assess patient safety. Help the patient reduce the danger to herself and her children when the patient is discharged. A safety assessment includes some of the following questions: “Are you afraid to go home? Are there guns in the home? Are you planning on leaving? Do you need access to a shelter? Can you stay with family/friends? Has the violence increased? Have there been threats of suicide/homicide? Use of drugs or alcohol? Violence toward children? ARE YOUR CHILDREN SAFE?”

R = REVIEW OPTIONS AND REFERRALS

Refer the patient to specialists trained to help victims cope with all aspects of the abuse. Take time to talk about options available to the victim and her family. Give the victim written information if she feels that it is safe to do so. Call authorities, i.e. law enforcement or DCFS, if appropriate. Find safe shelter for family if needed.

RADAR

DOMESTIC VIOLENCE (DV) GUIDE

Domestic violence is a pattern of assaultive and coercive behaviors that adults/adolescents use against their intimate partners. Children who witness domestic violence are at an increased risk for child abuse as well as behavior, emotional and psychological problems. In the State of Utah, a health care provider treating a patient for illness or injuries related to DV, must report this to law enforcement. Commission of DV in the presence of a child is considered child abuse and must be reported to law enforcement or DCFS.

DV+ = ANSWERED ‘YES’ TO SCREENING QUESTION(S)

Send Supportive message

“You are not alone. You are not to blame. DV is a crime.”

Assess Safety (See reverse side)

Make Referrals

Involve social worker/advocate if needed/available. Schedule follow-up appt for victim/children. Encourage victim/children to see their physician. Consider mental health referral for victim/children. Notify DCFS if meets criteria of commission of DV in the presence of a child. Notify law enforcement if appropriate. Give DV Hotline Numbers.

Follow-up

Make f/up appt for victim/children. Ask about history of violence since last visit. Ask victim/children if they have seen their physician. Ask how children are functioning at home and at school. Ensure that children are safe. Ensure victim has resource numbers and information.

DV- = ANSWERED ‘NO’ TO ALL QUESTIONS

Accept the woman’s response. Provide an open door to resources. “I am glad that you are in a safe situation. If you ever feel unsafe you can come to us for help.” Rescreen yearly or if risk factors occur.

DV ? = UNABLE TO SCREEN OR CONCERNED

If the health care provider has a concern, then redirect the question. Provide open door to resources. “I am glad that you are in a safe situation. If you ever feel unsafe you can come to us for help.” Rescreen at next visit if needed. Continue to be supportive.

DOMESTIC VIOLENCE INFORMATION

| | |
|---------------------------------------|--------------|
| National Domestic Violence Number | 800.799.SAFE |
| Utah DV Hotline Number | 800.897.LINK |
| Utah Rape Crisis Number | 888.421.1100 |
| Child Protective Services (DCFS) | 800.678.9399 |
| Adult Protective Services | 800.371.7897 |
| Salt Lake City Police | 801.799.3000 |
| Division of Safe and Healthy Families | 801.662.3600 |

©2002 RADAR Pocket Card for Pediatricians developed by The Institute for Safe Families and the PA Chapter, AAP, Philadelphia PA. www.instituteforsafefamilies.org
 RADAR acronym developed by the Mass Medical Society ©1992. Used with permission. Family Violence Prevention Fund. www.endabuse.org

RADAR. Developed by the Massachusetts Medical Society. ©1992.

24-Hour Domestic Violence Info Line
 Toll Free: (800) 897-LINK (5465)

24-hour Rape/Sexual Assault Info/Crisis Line
 Toll Free (888) 421-1100

This manual and the resources in it are available at:
www.health.utah.gov/vipp/domesticViolence/training

II. Identifying, Assessing and Screening in the Health Care Setting

DANGER REVIEW

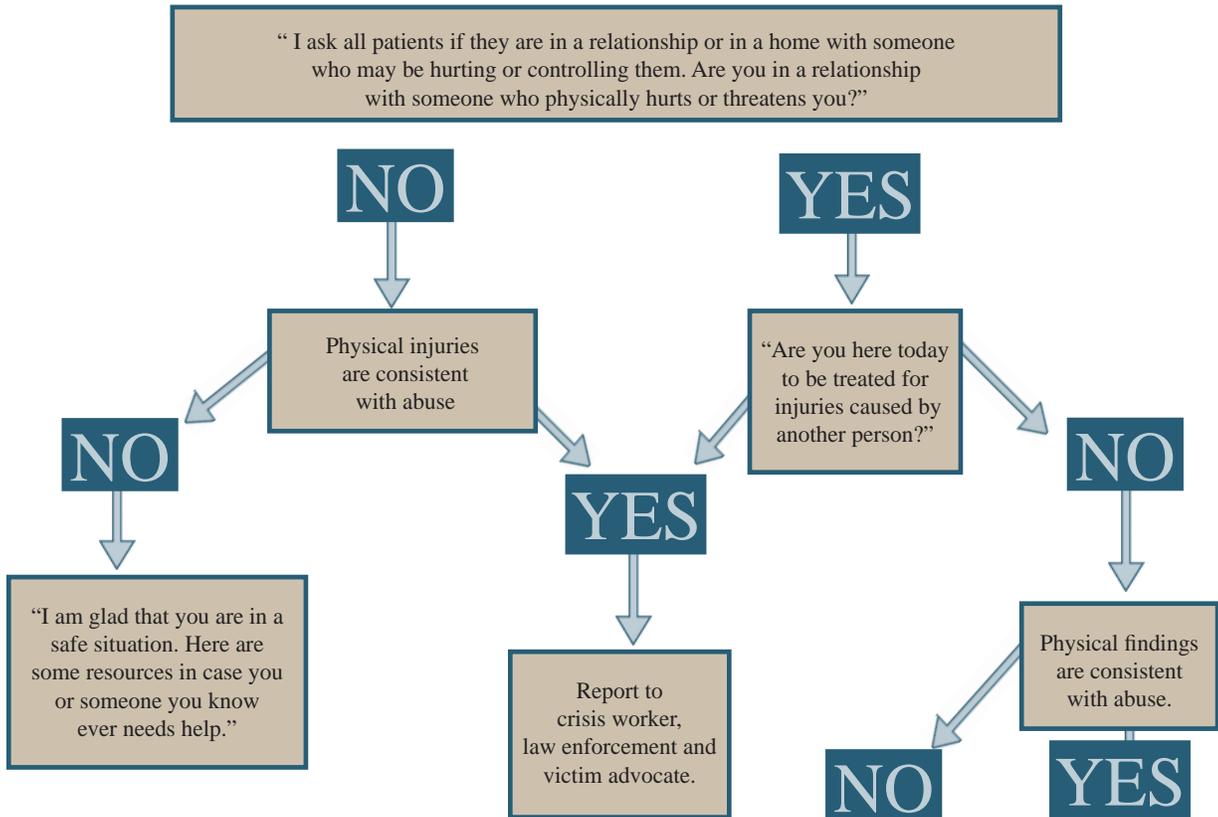
A review of safety is a difficult and uncertain task and it cannot predict if a domestic violence perpetrator will or will not seriously harm or kill his/her partner or others. The following is only a guide.

| |
|--|
| Has the perpetrator verbally threatened to kill or harm the victim, children, or others? |
| Has the perpetrator threatened to harm or kill himself/herself, or has he/she exhibited fantasies or detailed plans of suicide and/or homicide? |
| Does the perpetrator possess weapons and has he/she threatened the victim or actually used them in abusing the victim or others? |
| Has the perpetrator injured the victim, children, or others seriously enough to require medical treatment? |
| Does the perpetrator have a criminal history of violence or stalking behaviors? |
| Is the perpetrator intoxicated on a daily or weekly basis or does he/she heavily or regularly use amphetamines, heroin, or other street drugs, and/or does the perpetrator become violent when abusing substances? |
| Has the perpetrator violated a protective order in the past? |
| Has the domestic violence increased in severity and frequency over the past year? |
| Has the perpetrator forced sexual activities upon the spouse or children? |
| Has the perpetrator ever prevented the victim or children from leaving by threatening physical harm to self or others if they leave? |
| Has the victim recently separated from or terminated the relationship with the perpetrator? |
| Has the perpetrator harmed or killed family pets or threatened to do so? |
| Has the perpetrator destroyed the victim's personal property? |
| Has the perpetrator dropped out of treatment or been non-compliant in a domestic violence treatment program? |
| Does the perpetrator exhibit excessive jealousy? |

Adapted from Lethality Review by Dan Greene, LCSW and the Treatment Sub-committee of the Salt Lake Domestic Violence Advisory Committee.

II. Identifying, Assessing and Screening in the Health Care Setting

ASSESSMENT AND DECISION TREE



Documentation in Chart:

Document thoroughly in patient's chart
 If not safe to document use abbreviations (DV+, DV-, DV?)
 Place detailed information in a "restricted access" chart
 Document info given by patient and referrals that were made

Assess Safety Needs:

Are you afraid to go home? Use of drugs or alcohol?
 Do you need access to a shelter? Are there guns in the home?
 Are you planning on leaving? Threats of suicide or homicide?
 Can you stay with family/friends? Violence toward children?
 Do you want police intervention?

Send Supportive Message:

You are not alone
 You and your children do not deserve this
 Domestic violence is a crime

Referrals:

Notify social worker/advocate if needed
 Encourage follow-up appt for patient/children
 Encourage patient/children to see their physician
 Consider mental health referral for children
 Notify DCFS or law enforcement if meets criteria of commission of DV in the presence of a child

Follow-up:

Ask about history of violence since last visit
 Ask if patient/children have seen their physician
 Ask how children are functioning at home and school
 Ensure that children are safe
 Ensure patient has resource numbers and information

"I am concerned that you may not be safe in your relationship. Here are some resources. I strongly urge you to contact a victim advocate."

No one deserves to be abused. Ask the question and offer domestic violence resources to all female patients age 14 or older. Reinforce the option for the patient to return at any time for further information and available resources.

II. Identifying, Assessing and Screening in the Health Care Setting

ASSESSMENT CHECKLIST FOR VICTIMS OF DOMESTIC VIOLENCE

Interview the victim separately from the partner or other family members.

Risk Factors: (check all that apply)

- Financial problems, unemployment
- Divorce or separation (especially during pregnancy)
- Substance abuse by victim or abuser
- Victim or abuser physically abused as a child
- Overly protective or controlling abuser (refuses to leave room)
- Suicide attempts by victim or abuser
- Mental illness of victim or abuser

Signs of Physical Abuse: (check all that apply)

- Self-induced or attempted abortions; multiple therapeutic abortions
- Multiple miscarriages
- Abdominal or pelvic injuries, back or spinal injuries (not from fall or MVA)
- Injuries to face, neck, throat, chest, breasts
- Injuries during pregnancy
- Increased drug/alcohol abuse during pregnancy
- Multiple injuries in various stages of healing
- Injury inconsistent with history
- Delay in seeking medical treatment
- Minimizes frequency and seriousness of injuries
- Repeated emergency department visits
- Sexual assault by partner
- Suicide attempt
- Single car crash
- Fractures in various stages of healing
- Burn (cigarette, friction, splash, chemical)
- Head injuries
- Low self-esteem, sense of apprehension or hopelessness, depression (laughing inappropriately, crying, no eye contact, angry, defensive)

Homicidal Risk: (check all that apply)

- Presence of gun in home
- Abuser threatened to kill victim or victim believes abuser may kill him/her
- Overly jealous
- Violent behavior by abuser toward non-family members
- Use of alcohol or drugs by abuser
- Increasing severity of injuries
- Abuser has killed pets
- Abuser objectifies victim

Used with permission. Deborah Haack, Injury Prevention and Control Program, Colorado Department of Health. Reprinted from Colorado Department of Health "Suggested Protocols for Victims of Spousal or Elder Abuse."



SEPARATING THE PATIENT FROM VISITORS

The health care provider's primary concern should be for the safety of the staff and the victim. Never inquire about abuse in the presence of any person who accompanies the patient. Appearances can be deceiving. Do not assume that the person who accompanies the patient has the patient's best interest at heart.

Perpetrators of domestic violence are often very controlling and may not allow the victim to be alone for fear of disclosure. Providers should be prepared and have a plan for separating the perpetrator and the victim in a non-confrontational way that ensures the safety of the victim and the staff.

Ideas for Health Care Providers

- When possible, hang a sign in a specific area that indicates “patients only beyond this point.”
- Take advantage of the privacy of the bathroom: Go into the bathroom with the patient when a urine sample is needed, or simply use the collection of the sample as an excuse to get the patient alone.
- Assure private time with the patient during tests (e.g., x-rays, MRIs, CT scans).
- If it is safe, provide the patient with educational information and other resources. Ask the patient what would happen if her partner found the resource materials, such as phone numbers and pamphlets.
- Identify code phrases that alert staff to call for security or law enforcement (e.g., “We need A, B, or C”).

Ideas for Home Health Care Providers

- There may be an occasion when the patient is home alone. Use this opportunity to discuss abuse in the home. Keep in mind that the abuser may be someone you least expect (e.g., daughter, niece, grandchild).
- Phone the patient ahead of time to set up an appointment when the patient will be home alone (e.g., when other household members are at work, shopping, running errands).
- Use the framing questions (see page 18) to preface the reason for a private visit.
- Be creative. As a home health care provider, you often know your patients and the dynamics of their home lives.

Remember, if your patient is a “vulnerable adult” you are mandated to report all abuse, neglect, and exploitation. Your reporting rights ARE NOT limited to the existence of an injury caused by another person.

**Patients
ONLY
Beyond This
Point**

II. Identifying, Assessing and Screening in the Health Care Setting

SCREENING FOR ABUSE

Asking Questions

It is recommended that you make it a part of your routine to ask every female patient over the age of 14 about domestic violence on every visit, or any patient when there are possible signs of domestic violence. Normalize your questioning by explaining to the patient that the questions are a new personal standard or agency policy (if applicable). Most patients will not be offended if they know the questioning is policy or standard practice.

Before asking any questions regarding abuse, separate the patient from any visitors. If the mother is accompanied by children greater than 2 years of age, then separate the mother from the children so that she can be questioned in privacy. If you are unable to do this, questioning may have to wait for a safer, more private situation. Never ask accompanying family or friends to act as an interpreter when there are questionable injuries. This includes interpreting for the deaf and/or for non-English speaking patients. Always use a professional interpreter.

If one of your patients is a victim of domestic violence and is willing to discuss the problem, follow up on the issue at every visit if it is safe to do so and if he/she is willing. Respect the decision of the patient to discuss the problem or to remain silent about the issue. Victims of domestic violence will discuss the problem when they are ready. If you suspect abuse, but your patient denies being abused, you may want to pose more than one question about the issue. Document the questions asked about abuse and your client's response.

When asking questions, remember that the manner in which you ask the question is just as important as the question itself. Domestic violence is a very personal, sensitive subject and should be dealt with in a respectful, non-judgmental way. How you ask the question will depend on your patient. Some people may respond better to direct questions, while others may need a question framed in such a way that will not make them defensive. You can soften questions by framing them.

Most patients will not be offended if they know the questioning is policy or standard practice. Inform the patient of your legal requirements.

SCREENING FOR ABUSE

Framing Questions:^{36, 38}

- Relationships between adults are sometimes violent. Many women experience some kind of violence at home. What happens when you disagree at home? At any time have your verbal fights included any type of physical contact?
- I am concerned that your symptoms may have been caused by someone hurting you.
- Sometimes when others are overprotective and jealous, they react strongly and use physical force. Is this happening in your current relationship?
- You mentioned your partner loses his temper with the children. Does he lose his temper with you? Does he harm you in any way?
- Because violence is so common in many people's lives and witnessing violence can have negative effects on children, we've begun to ask all our families about their experience with violence.

Steps for Questioning Patients About Abuse

1. Ask questions in a private, face-to-face setting.

2. Frame the question: "Because violence is so common in our lives today, I have begun asking all of my patients if they are in a relationship with someone who may be hurting or controlling them."

3. Directly question the patient: "Are you in a relationship or a home where someone hurts or threatens you?"

- Are you in a relationship with a person who physically hurts or threatens you?
- Are you safe at home?
- Has your partner or anyone in your home ever hit or hurt you in any way?
- Do you ever feel afraid of your partner or anyone in your home?
- Do you feel you are in danger?
- Did someone you are in a relationship with do this?
- Has your partner ever forced you to have sex when you didn't want to?
- I am concerned because I know that if you are in a relationship where violence occurs, it is likely to get worse. How can we help you?
- I am asking because I want you to have all the resources and information available for your use.
- Have your children witnessed anything violent or frightening in your home, school, or community (neighborhood)?

Questions to Avoid:

- Are you a battered woman?
- Does your husband beat you?
- You're not being hurt by your boyfriend, are you?
- Your child isn't witnessing the abuse, is she?

DOCUMENTATION

Documenting Abusive Injuries

For medical records to provide evidence of violence and patterns of violence for legal proceedings, chart documentation must be accurate, legible, and thorough. Medical records can provide crucial evidence in support of the victim in court. Documentation should include:³⁸

- Date and time of arrival
- Name, address, and phone number of anyone accompanying the patient
- Primary complaint
- Description of injury-causing event, including patient's own statements of how the injuries occurred (direct quotes)
- Patient's statements of past battering incidents (direct quotes)
- A detailed description of the injuries, including type, number, and location, (may want to record injuries on body charts)
- Complete medical history
- Relevant social history
- Laboratory and radiological results
- Name of health care professional who provided treatment
- Documentation that the patient was asked about DV and the patient's response
- Documentation that injuries were reported to law enforcement
- Documentation of resource information given for aftercare (e.g., shelters, counseling, victim advocates, etc.)
- Consent forms for any photographs taken
- Record of non-bodily evidence of abuse, such as torn clothing or damaged jewelry
- Name of translator used, if applicable

You may want to consider establishing a way of flagging charts that contain domestic violence cases so that the information in the charts will be better protected, especially from the abuser. For example, an unlabeled, colored sticker could be used to flag staff, while the abuser would not know what the sticker represents.



Flag charts of domestic violence cases so staff better protect the information in charts, especially from the abuser.

DOMESTIC VIOLENCE SCREENING/DOCUMENTATION FORM

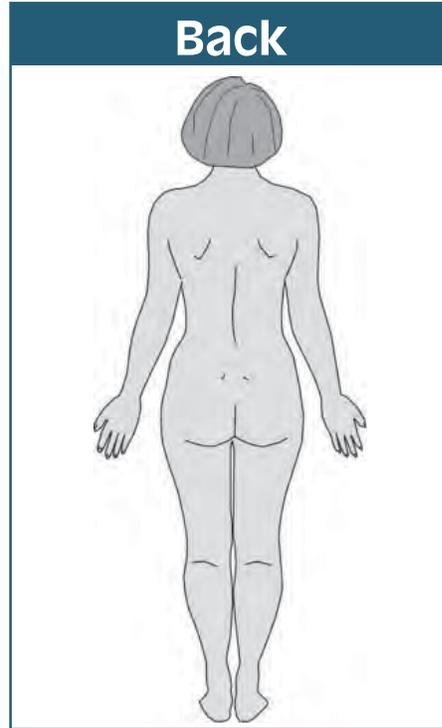
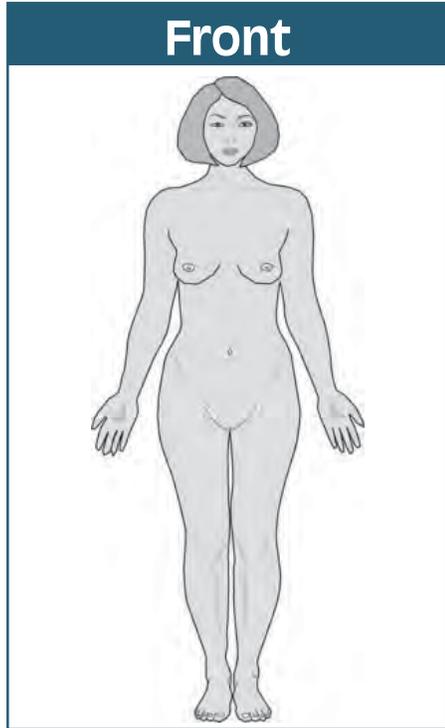
DV Screen

- DV + (positive)
- DV? (suspected)

Date _____ Patient ID# _____

Provider Name: _____

Patient Pregnant? Yes No



Assess Patient Safety

- Yes No Is abuser here now?
- Yes No Is patient afraid of partner?
- Yes No Is patient afraid to go home?
- Yes No Has physical violence increased in severity?
- Yes No Has the abuser threatened to kill?
- Yes No Is patient suicidal?
- Yes No Is there a gun in the home?
- Yes No Is there evidence of alcohol or substance abuse?
- Yes No Was safety plan discussed?

Photographs

- Yes No Consent to be photographed?
- Yes No Photographs taken? Attach photos and consent form.

Referrals

- Hotline number given
- Victim advocate referral made
- Shelter number given
- In-house referral made
- Describe: _____
- Other referral made
- Describe: _____

Reporting

- Law enforcement report made: Time _____
- Agency Name _____
- Phone # _____ Spoke w/ _____
- Child Protective Services report made
- Adult Protective Services report made

III. Reporting Requirements for Health Care Providers

REPORTING ABUSE

Reporting to Authorities

Providers are under legal obligation to report abuse (Utah Statute 26-23a-2). In Utah, providers cannot incur civil or criminal liability for reporting cases of suspected abuse. Health care professionals cannot be discharged, suspended, disciplined, or harassed for making a report.¹³

However, penalties can be pursued against providers who fail to report suspected or confirmed cases of abuse. Such consequences can include: being charged with a misdemeanor, time in jail, and both personal and corporate fines.³⁸

When possible, a provider may want to offer a patient the option to immediately report to law enforcement. This will empower a victim to take control of their own situation and provide law enforcement with more detailed information regarding the crime. Although a provider may want to record information for documentation purposes, a provider who has personal knowledge that a report has been made in compliance with Utah law is under no further obligation to make a report regarding that injury.

When reporting incidents of abuse, providers should report to the municipal or county law enforcement agency where the injury occurred. If abuse occurs in more than one jurisdiction, notify the authorities closest and report the injuries that took place in that jurisdiction. It is required that you report by telephone or by another form of spoken communication.³⁸ Again, it is important to document that the case was reported. If there are children in the home and they may have witnessed the abuse, DCFS must to be notified.

Documentation of the report should include:

- Which law enforcement agency was contacted
- What phone number was called

- When the contact was made
- Name of the law enforcement officer spoken with
- Case number assigned by the law enforcement agency

What to include in the report:

- Name and address of the injured person
- Injured person's whereabouts, if known
- Character and extent of the person's injuries
- Name, address, and phone number of the person making the report
- Information on any children who may have witnessed the incident

After the Report

After a report of abuse is made to law enforcement, the health care provider is required to inform the patient of the report, according to the Privacy Rule (HIPAA). However, if the health care provider, in the exercise of professional judgment, believes informing the individual would place the patient in greater danger, he/she is absolved of this requirement.

Health care providers should never dictate a specific course of action to the patient. In abusive relationships, the victim has always been told what to do. By offering information to patients, the provider will be giving them the tools to make choices for themselves.

The patient may, understandably, become distressed when the health care provider informs the patient of a domestic violence report. The patient may beg the provider to forgo notifying the authorities. The victim may be afraid that his/her children will be removed or that he/she will be in more danger once the police are involved. Being supportive but honest and straightforward is the best response. Explain to the patient the legal requirements of health care providers. Use this opportunity to educate the

AFTER THE REPORT

patient about domestic violence. Some important messages to convey to the patient are:

- Domestic violence is cyclical and may intensify, causing more harm to the victim.
- Abuse is not unique. According to a 2003 report released by LDS Hospital, one in ten female patients being treated in the emergency room reported being a victim of domestic violence in the previous year. Nearly 40 percent of women indicated they had been abused during their lifetime.³⁴
- Abuse is not the victim's fault and she is not responsible for the violence inflicted upon her.
- There are health risks associated with violence not only for the patient but also for his/her children. Domestic violence is a crime for which there are solutions.

It is important for the health care provider to be supportive of the patient after a report to authorities is made. The patient may be nervous, apprehensive or afraid. Some suggestions for supporting the victim after the report is made include:

- Contacting a crisis worker or social worker within your organization if one is available.
- Contacting a victim advocate on behalf of the victim.
- Providing the victim with resources and referral numbers.
- Offering to contact clergy of the victim's faith. Many hospitals have clergy on-site who may be able to offer comfort and resources to the victim.
- Discussing with the victim her level of safety and, if feasible, developing a safety plan. Brochures on safety planning are available from the Utah Domestic Violence Council at (801) 521-5544 or www.udvc.org. If there are children in the home, encourage the mother to contact their physician for appropriate referrals and care.

Many victim advocate programs have packets that contain helpful information for victims of domestic violence. However, some patients may not be willing to speak with a victim advocate. Health care agencies are encouraged to acquire similar information to distribute in the event the victim refuses a referral to a victim advocate or shelter.

These packets should include:

- A business card with the victim advocate's phone number and an after-hours crisis phone number that will automatically page the on-call advocate.
- A safety plan. Safety plan brochures may be obtained from the Utah Domestic Violence Council at (801) 521-5544 or www.udvc.org.
- Phone numbers and addresses of domestic violence shelters in the area.
- Information on protective orders and how to obtain one.
- Resource lists that provide information on emergency shelters, food, crisis nurseries, health clinics, alcohol and drug detoxification centers, legal help, support groups, and counseling options, rape recovery centers, and employment services.
- A crime victim reparation application.
- A risk and lethality assessment form.
- A victim impact statement.
- A guide to the criminal justice system (court process).

Local victim advocate programs will be helpful in obtaining this information. A list of victim advocate programs is provided in the resources portion of this manual.

III. Reporting Requirements for Health Care Providers

MANDATORY REPORTING LAWS

Health care providers are classified as mandatory reporters of abuse by the state of Utah. Mandatory reporting laws require reporting on instances of:

- Child abuse (call Child Protective Services) (800) 678-9399
- Elderly/disabled person abuse (call Adult Protective Services at (800) 371-7897)
- Any assault* (call local law enforcement or 911)

***An assault occurs when one person inflicts an injury on another person — this includes abuse. It is against the law even if an acquaintance or a loved one inflicted the injury.**

If an adult patient (excluding the elderly or disabled) presents with an injury that was inflicted by another person, “by means of a knife, gun, pistol, explosive, infernal device, or deadly weapon, or by violation of any criminal statute of this state,” the health care provider is required by law to report the injury to the authorities. It is important to note that inflicting any injury on another person with the intent of causing harm is a crime and considered a violation of the criminal statute of the state of Utah.

It is the health care provider’s responsibility to contact law enforcement if a patient presents with an injury inflicted by another person. A patient may choose to lie to a provider or to the authorities regarding the causation of the injury, but this does not absolve the provider of the requirement. It is important to document that law enforcement has been contacted.

If a patient is being treated for an injury or illness that is not related to abuse, but discloses to the provider that he or she is a victim of domestic violence, the health care provider is not required to report to the authorities. It is, however, strongly recommended that providers refer the patient to a resource for the help they need to get out of the

abusive relationship.

Any health care provider who knowingly fails to report an injury inflicted by another person can be charged with a class B misdemeanor. The Utah Health Code, which includes definition, requirements and penalties, is provided in this section.

After a report is made, health care providers are mandated by HIPAA (Health Insurance Portability and Accountability Act) to inform the patient of the report. However, health care providers are absolved of this requirement if, in their professional judgment, they believe informing the individual would place them at risk of serious harm.

Child abuse/maltreatment is a mandatory reportable crime. In the state of Utah, commission of domestic violence in the presence of a child is considered child abuse (and therefore needs to be reported to the appropriate authorities) as defined in the Utah Statutes §76-5-109.1, “... A person is guilty of child abuse if the person commits or attempts to commit criminal homicide... against a cohabitant in the presence of a child; or intentionally causes serious bodily injury to a cohabitant or uses a dangerous weapon...or other means of force likely to produce death or serious bodily injury against a cohabitant in the presence of a child...or commits an act of domestic violence in the presence of a child...”

‘In the presence of a child’ is defined as: “...in the physical presence of a child; or having knowledge that a child is present and may see or hear an act of domestic violence.’ Health care providers who are assessing a victim of domestic violence should inquire as to the presence and safety of any children who may be living in the home.

HIPAA Regulations⁴⁰

The Health Insurance Portability and Accountability Act (HIPAA) permits covered entities to disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence. Such disclosures can be made only to government agencies authorized by law to receive such reports, such as:

- Public health authorities
- Social service or protective services agencies
- Law enforcement authorities

HIPAA allows providers to disclose abuse that is required to be reported to comply with state law.

***Utah law allows for reporting of domestic violence to authorities without disclosure to the patient or their representatives prior to the report.**

The following is excerpted from the Health Insurance Portability and Accountability Act 42CFR Section 164.512(c).

Standard: Disclosures about victims of abuse, neglect or domestic violence.

(1) Permitted disclosures. Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

- (i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;
- (ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) Informing the individual. A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

III. Reporting Requirements for Health Care Providers

THE JOINT COMMISSION

JCAHO STANDARD PE.1.9

Possible victims of abuse are identified using criteria developed by the hospital.

Intent of PE.1.9

Victims of abuse or neglect may come to a hospital through a variety of channels. The patient may be unable or reluctant to speak of the abuse, and it may not be obvious to the casual observer. Nevertheless, hospital staff members need to know if a patient has been abused, as well as the extent and circumstances of the abuse, to give the patient appropriate care.

The hospital has objective criteria for identifying and assessing possible victims of abuse and neglect, and the criteria are used throughout the organization. Staff are to be trained in the use of these criteria. The criteria focus on observable evidence and not on allegation alone. They address at least the following situations:

- Physical assault
- Rape or other sexual molestation
- Domestic abuse
- Abuse or neglect of elders and children

When used appropriately by qualified staff members, the criteria prevent any action or question that could create false memories of abuse in the individual being assessed. Staff members are able to make appropriate referrals for victims of abuse and neglect. To help them do so, the hospital maintains a list of private and public community agencies that provide help for abuse victims. In addition, the assessment of victims of alleged or suspected abuse or neglect is conducted consistent with standard PE.8.

JCAHO STANDARD PC.3.10

Patients who may be victims of abuse or neglect are assessed (see standard RI.2.150).

Rationale for PC.3.10

Victims of abuse or neglect may come to a hospital in a variety of ways. The patient may be unable or

reluctant to speak of the abuse, and it may not be obvious to the casual observer. Staff needs to be able to identify abuse or neglect as well as the extent and circumstances of the abuse or neglect to give the patient appropriate care. Criteria for identifying and assessing victims of abuse or neglect should be used throughout the hospital. The assessment of the patient must be conducted within the context of the requirements of the law to preserve evidentiary materials and support future legal actions.

JCAHO STANDARD PE.8

Patients who are possible victims of alleged or suspected abuse or neglect have special needs relative to the assessment process.

Intent of PE.8

As part of the initial screening and assessment process, information and evidentiary material(s) may be collected that could be used in future actions as part of the legal process. The hospital has specific and unique responsibilities for safeguarding such material(s).

Policies and procedures define the hospital's responsibility for collecting, retaining, and safeguarding information and evidentiary material(s). The following are documented in the patient's medical record:

- Consents from the patient, parent, or legal guardian, or compliance with other applicable law
- Collecting and safeguarding evidentiary material released by the patient
- Legally required notification and release of information to authorities
- Referrals made to private or public community agencies for victims of abuse.

Hospital policy defines these activities and specifies who is responsible for implementing them.

Adult Abuse Statute

UTAH HEALTH CODE CHAPTER 26-23a
INJURY REPORTING BY HEALTH CARE
PROVIDERS

26-23a-1. Definitions

As used in this chapter:

- (1) “Health care provider” means any person, firm, corporation, or association which furnishes treatment or care to persons who have suffered bodily injury, and includes hospitals, clinics, podiatrists, dentists and dental hygienists, nurses, nurse practitioners, physicians and physicians’ assistants, osteopathic physicians, naturopathic practitioners, chiropractors, acupuncturists, paramedics, and emergency medical technicians.
- (2) “Injury” does not include any psychological or physical condition brought about solely through the voluntary administration of prescribed controlled substances.
- (3) “Law enforcement agency” means the municipal or county law enforcement agency:
 - (a) having jurisdiction over the location where the injury occurred; or
 - (b) if the reporting health care provider is unable to identify or contact the law enforcement agency with jurisdiction over the injury, “law enforcement agency” means the agency nearest to the location of the reporting health care provider.
- (4) “Report to a law enforcement agency” means to report, by telephone or other spoken communication, the facts known regarding an injury subject to reporting under Section 26-23a-2 to the dispatch desk or other staff person designated by the law enforcement agency to receive reports from the public.

26-23a-2. Injury reporting requirements by health care provider – Contents of report.

- (1) (a) Any health care provider who treats or cares for any person who suffers from any wound or other injury inflicted by the person’s own act or by the act of another by means of a knife, gun, pistol,

explosive, infernal device, or deadly weapon, or by violation of any criminal statute of this state, shall immediately report to a law enforcement agency the facts regarding the injury.

(b) The report shall state the name and address of the injured person, if known, the person’s whereabouts, the character and extent of the person’s injuries, and the name, address, and telephone number of the person making the report.

(2) A health care provider may not be discharged, suspended, disciplined, or harassed for making a report pursuant to this section.

(3) A person may not incur any civil or criminal liability as a result of making any report required by this section.

(4) A health care provider who has personal knowledge that the report of a wound or injury has been made in compliance with this section is under no further obligation to make a report regarding that wound or injury under this section.

26-23a-3. Penalties

Any health care provider who intentionally or knowingly violates any provision of Section 26-23a-2 is guilty of a class B misdemeanor.

76-5-III. Abuse, Neglect and Exploitation of an Elder or Disabled Adult

Abuse, neglect, or exploitation of a vulnerable adult – Penalties.

(1) As used in this section:

(a) “Abandonment” means a knowing or intentional action or inaction, including desertion, by a person or entity acting as a caretaker for a vulnerable adult that leaves the vulnerable adult without the means or ability to obtain necessary food, clothing, shelter, or medical or other health care.

(b) “Abuse” means:

(i) attempting to cause harm, intentionally or knowingly causing harm, or intentionally or knowingly placing another in fear of imminent harm;

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(ii) causing physical injury by knowing or intentional acts or omissions;

(iii) unreasonable or inappropriate use of physical restraint, medication, or isolation that causes or is likely to cause harm to a vulnerable adult that is in conflict with a physician's orders or used as an unauthorized substitute for treatment, unless that conduct furthers the health and safety of the adult; or

(iv) deprivation of life-sustaining treatment, except:

(A) as provided in Title 75, Chapter 2, Part 11, Personal Choice and Living Will Act; or

(B) when informed consent, as defined in this section, has been obtained.

(c) "Business relationship" means a relationship between two or more individuals or entities where there exists an oral or written agreement for the exchange of goods or services.

(d) "Caretaker" means any person, entity, corporation, or public institution that assumes the responsibility to provide a vulnerable adult with care, food, shelter, clothing, supervision, medical or other health care, or other necessities. "Caretaker" includes a relative by blood or marriage, a household member, a person who is employed or who provides volunteer work, or a person who contracts or is under court order to provide care.

(e) "Deception" means:

(i) a misrepresentation or concealment:

(A) of a material fact relating to services rendered, disposition of property, or use of property intended to benefit a vulnerable adult;

(B) of the terms of a contract or agreement entered into with a vulnerable adult; or

(C) relating to the existing or preexisting condition of any property involved in a contract or agreement entered into with a vulnerable adult; or

(ii) the use or employment of any misrepresentation, false pretense, or false promise in order to induce, encourage, or solicit a vulnerable adult to enter into a contract or agreement.

(f) "Elder adult" means a person 65 years of age

or older.

(g) "Endeavor" means to attempt or try.

(h) "Exploitation" means the offense described in Subsection (4).

(i) "Harm" means pain, mental anguish, emotional distress, hurt, physical or psychological damage, physical injury, suffering, or distress inflicted knowingly or intentionally.

(j) "Informed consent" means:

(i) a written expression by the person or authorized by the person, stating that the person fully understands the potential risks and benefits of the withdrawal of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health, and that the person desires that the services be withdrawn. A written expression is valid only if the person is of sound mind when the consent is given, and the consent is witnessed by at least two individuals who do not benefit from the withdrawal of services; or

(ii) consent to withdraw food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health, as permitted by court order.

(k) "Intimidation" means communication conveyed through verbal or nonverbal conduct which threatens deprivation of money, food, clothing, medicine, shelter, social interaction, supervision, health care, or companionship, or which threatens isolation or harm.

(i) "Isolation" means knowingly or intentionally preventing a vulnerable adult from having contact with another person by:

(A) preventing the vulnerable adult from receiving visitors, mail, or telephone calls, contrary to the express wishes of the vulnerable adult, including communicating to a visitor that the vulnerable adult is not present or does not want to meet with or talk to the visitor, knowing that communication to be false;

(B) physically restraining the vulnerable adult

in order to prevent the vulnerable adult from meeting with a visitor; or

(C) making false or misleading statements to the vulnerable adult in order to induce the vulnerable adult to refuse to receive communication from visitors or other family members.

(ii) The term “isolation” does not include an act intended to protect the physical or mental welfare of the vulnerable adult or an act performed pursuant to the treatment plan or instructions of a physician or other professional advisor of the vulnerable adult.

(m) “Lacks capacity to consent” means an impairment by reason of mental illness, developmental disability, organic brain disorder, physical illness or disability, chronic use of drugs, chronic intoxication, short-term memory loss, or other cause to the extent that a vulnerable adult lacks sufficient understanding of the nature or consequences of decisions concerning the adult’s person or property.

(n) “Neglect” means:

(i) failure of a caretaker to provide nutrition, clothing, shelter, supervision, personal care, or dental or other health care, or failure to provide protection from health and safety hazards or maltreatment;

(ii) failure of a caretaker to provide care to a vulnerable adult in a timely manner and with the degree of care that a reasonable person in a like position would exercise;

(iii) a pattern of conduct by a caretaker, without the vulnerable adult’s informed consent, resulting in deprivation of food, water, medication, health care, shelter, cooling, heating, or other services necessary to maintain the vulnerable adult’s well being;

(iv) intentional failure by a caretaker to carry out a prescribed treatment plan that results or could result in physical injury or physical harm; or

(v) abandonment by a caretaker.

(o) “Physical injury” includes damage to any bodily tissue caused by non-therapeutic conduct, to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the

extent that the tissue cannot be restored to a sound and healthy condition. “Physical injury” includes skin bruising, a dislocation, physical pain, illness, impairment of physical function, a pressure sore, bleeding, malnutrition, dehydration, a burn, a bone fracture, a subdural hematoma, soft tissue swelling, injury to any internal organ, or any other physical condition that imperils the health or welfare of the vulnerable adult and is not a serious physical injury as defined in this section.

(p) “Position of trust and confidence” means the position of a person who:

(i) is a parent, spouse, adult child, or other relative by blood or marriage of a vulnerable adult;

(ii) is a joint tenant or tenant in common with a vulnerable adult;

(iii) has a legal or fiduciary relationship with a vulnerable adult, including a court-appointed or voluntary guardian, trustee, attorney, or conservator; or

(iv) is a caretaker of a vulnerable adult.

(q) “Serious physical injury” means any physical injury or set of physical injuries that:

(i) seriously impairs a vulnerable adult’s health;

(ii) was caused by use of a dangerous weapon as defined in Section 76-1-601;

(iii) involves physical torture or causes serious emotional harm to a vulnerable adult; or

(iv) creates a reasonable risk of death.

(r) “Sexual exploitation” means the production, distribution, possession, or possession with the intent to distribute material or a live performance depicting a nude or partially nude vulnerable adult who lacks the capacity to consent, for the purpose of sexual arousal of any person.

(s) “Undue influence” occurs when a person uses the person’s role, relationship, or power to exploit, or knowingly assist or cause another to exploit, the trust, dependency, or fear of a vulnerable adult, or uses the person’s role, relationship, or power to gain control deceptively over the decision making of the vulnerable adult.

(t) “Vulnerable adult” means an elder adult, or an

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adult 18 years of age or older who has a mental or physical impairment which substantially affects that person's ability to:

- (i) provide personal protection;
- (ii) provide necessities such as food, shelter, clothing, or medical or other health care;
- (iii) obtain services necessary for health, safety, or welfare;
- (iv) carry out the activities of daily living;
- (v) manage the adult's own resources; or
- (vi) comprehend the nature and consequences of remaining in a situation of abuse, neglect, or exploitation.

(2) Under any circumstances likely to produce death or serious physical injury, any person, including a caretaker, who causes a vulnerable adult to suffer serious physical injury or, having the care or custody of a vulnerable adult, causes or permits that adult's person or health to be injured, or causes or permits a vulnerable adult to be placed in a situation where the adult's person or health is endangered, is guilty of the offense of aggravated abuse of a vulnerable adult as follows:

- (a) if done intentionally or knowingly, the offense is a second degree felony;
- (b) if done recklessly, the offense is third degree felony; and
- (c) if done with criminal negligence, the offense is a class A misdemeanor.

(3) Under circumstances other than those likely to produce death or serious physical injury any person, including a caretaker, who causes a vulnerable adult to suffer harm, abuse, or neglect; or, having the care or custody of a vulnerable adult, causes or permits that adult's person or health to be injured, abused, or neglected, or causes or permits a vulnerable adult to be placed in a situation where the adult's person or health is endangered, is guilty of the offense of abuse of a vulnerable adult as follows:

- (a) if done intentionally or knowingly, the offense is a class A misdemeanor;
- (b) if done recklessly, the offense is a class B misdemeanor; and

(c) if done with criminal negligence, the offense is a class C misdemeanor.

(4) (a) A person commits the offense of exploitation of a vulnerable adult when the person:

(i) is in a position of trust and confidence, or has a business relationship, with the vulnerable adult or has undue influence over the vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, credit, assets, or other property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the adult's property, for the benefit of someone other than the vulnerable adult;

(ii) knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, or assists another in obtaining or using or endeavoring to obtain or use, the vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of his property for the benefit of someone other than the vulnerable adult;

(iii) unjustly or improperly uses or manages the resources of a vulnerable adult for the profit or advantage of someone other than the vulnerable adult;

(iv) unjustly or improperly uses a vulnerable adult's power of attorney or guardianship for the profit or advantage of someone other than the vulnerable adult;

(v) involves a vulnerable adult who lacks the capacity to consent in the facilitation or furtherance of any criminal activity; or

(vi) commits sexual exploitation of a vulnerable adult.

(b) A person is guilty of the offense of exploitation of a vulnerable adult as follows:

(i) if done intentionally or knowingly and the aggregate value of the resources used or the profit made is or exceeds \$5,000, the offense is a second degree felony;

(ii) if done intentionally or knowingly and the aggregate value of the resources used or the profit made is less than \$5,000 or cannot be determined, the offense is a third degree felony;

(iii) if done recklessly, the offense is a class A misdemeanor; or

(iv) if done with criminal negligence, the offense is a class B misdemeanor.

(5) It does not constitute a defense to a prosecution for any violation of this section that the accused did not know the age of the victim.

(6) An adult is not considered abused, neglected, or a vulnerable adult for the reason that the adult has chosen to rely solely upon religious, non-medical forms of healing in lieu of medical care.

76-5-111.1. Reporting requirements

(1) Any person, including but not limited to, a social worker, physician, psychologist, nurse, teacher, or employee of a private or public facility serving adults, who has reason to believe that any disabled or elder adult has been the subject of abuse, emotional or psychological abuse, neglect, or exploitation shall immediately notify the nearest peace officer, law enforcement agency, or local office of Adult Protective Services within the Department of Human Services, Division of Aging and Adult Services.

(2) Anyone who makes that report in good faith is immune from civil liability in connection with the report.

(3) (a) When the initial report is made to a peace officer or law enforcement agency, and the disabled or elder adult requires protection, the officer or agency shall immediately notify the nearest local office of Adult Protective Services and that office shall coordinate its investigation with law enforcement, and provide protection to the disabled or elder adult as necessary.

(b) When the initial report involves a resident of a long-term care facility, as defined in Section 62A-3-202, the local long-term care ombudsman within the Department of Human Services, Division of Aging

and Adult Services, shall be immediately notified. The ombudsman and the local Adult Protective Services office shall cooperate in conducting the investigation.

(c) When the initial report or investigation by an Adult Protective Services office indicates that criminal abuse, neglect, or exploitation, as defined in Section 76-5-111 has occurred, or that any other criminal offense against a disabled or elder adult has occurred, the local Adult Protective Services office shall immediately notify the local law enforcement agency. That law enforcement agency shall initiate an investigation in cooperation with the local Adult Protective Services office.

(4) A person who is required to report suspected abuse, emotional or psychological abuse, neglect, or exploitation of a disabled or elder adult under Subsection (1), and who willfully fails to do so, is guilty of a class B misdemeanor fines these activities and specifies who is responsible for implementing them.

Utah Code: Cohabitant Abuse Procedures Act

77-36-1. Definitions.

As used in this chapter:

(1) “Cohabitant” has the same meaning as in Section 30-6-1.

(2) “Domestic violence” means any criminal offense involving violence or physical harm or threat of violence or physical harm, or any attempt, conspiracy, or solicitation to commit a criminal offense involving violence or physical harm, when committed by one cohabitant against another. “Domestic violence” also means commission or attempt to commit, any of the following offenses by one cohabitant against another:

(a) aggravated assault, as described in Section 76-5-103;

(b) assault, as described in Section 76-5-102;

(c) criminal homicide, as described in Section 76-5-201;

(d) harassment, as described in Section 76-5-106;

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(e) telephone harassment, as described in Section 76-9-201;

(f) kidnaping, child kidnaping, or aggravated kidnaping, as described in Sections 76-5-301, 76-5-301.1, and 76-5-302;

(g) mayhem, as described in Section 76-5-105;

(h) sexual offenses, as described in Title 76, Chapter 5, Part 4, and Title 76, Chapter 5a;

(i) stalking, as described in Section 76-5-106.5;

(j) unlawful detention, as described in Section 76-5-304;

(k) violation of a protective order or ex parte protective order, as described in Section 76-5-108;

(l) any offense against property described in Title 76, Chapter 6, Part 1, 2, or 3;

(m) possession of a deadly weapon with intent to assault, as described in Section 76-10-507;

(n) discharge of a firearm from a vehicle, near a highway, or in the direction of any person, building, or vehicle, as described in Section 76-10-508;

(o) disorderly conduct, as defined in Section 76-9-102, if a conviction of disorderly conduct is the result of a plea agreement in which the defendant was originally charged with any of the domestic violence offenses otherwise described in this Subsection (2). Conviction of disorderly conduct as a domestic violence offense, in the manner described in this Subsection (2)(o), does not constitute a misdemeanor crime of domestic violence under 18 U.S.C. Section 921, and is exempt from the provisions of the federal Firearms Act, 18 U.S.C. Section 921 et seq.; or

(p) child abuse as described in Section 76-5-109.1.

(3) “Victim” means a cohabitant who has been subjected to domestic violence.

77-36-2.1. Duties of law enforcement officers— Notice to victims.

(1) A law enforcement officer who responds to an allegation of domestic violence shall use all reasonable means to protect the victim and prevent further violence, including

(a) taking the action that, in the officer’s discretion,

is reasonably necessary to provide for the safety of the victim and any family or household member;

(b) confiscating the weapon or weapons involved in the alleged domestic violence;

(c) making arrangements for the victim and any child to obtain emergency housing or shelter;

(d) providing protection while the victim removes essential personal effects;

(e) arrange, facilitate, or provide for the victim and any child to obtain medical treatment; and

(f) arrange, facilitate, or provide the victim with immediate and adequate notice of the rights of victims and of the remedies and services available to victims of domestic violence, in accordance with Subsection (2).

(2) (a) A law enforcement officer shall give written notice to the victim in simple language, describing the rights and remedies available under this chapter, Title 30, Chapter 6, Cohabitant Abuse Act, and Title 78, Chapter 3h, Child Protective Orders.

(b) The written notice shall also include:

(i) a statement that the forms needed in order to obtain an order for protection are available from the court clerk’s office in the judicial district where the victim resides or is temporarily domiciled;

(ii) a list of shelters, services, and resources available in the appropriate community, together with telephone numbers, to assist the victim in accessing any needed assistance; and

(iii) the information required to be provided to both parties in accordance with Subsection 77-36-2.5(7).

Utah Code: Cohabitant Abuse Act

30-6-1. Definitions.

As used in this chapter:

(1) “Abuse” means intentionally or knowingly causing or attempting to cause a cohabitant physical harm or intentionally or knowingly placing a cohabitant in reasonable fear of imminent physical harm.

(2) “Cohabitant” means an emancipated person pursuant to Section 15-2-1 or a person who is 16

years of age or older who:

- (a) is or was a spouse of the other party;
 - (b) is or was living as if a spouse of the other party;
 - (c) is related by blood or marriage to the other party;
 - (d) has one or more children in common with the other party;
 - (e) is the biological parent of the other party's unborn child; or
 - (f) resides or has resided in the same residence as the other party.
- (3) Notwithstanding Subsection (2), "cohabitant" does not include:
- (a) the relationship of natural parent, adoptive parent, or step-parent to a minor; or
 - (b) the relationship between natural, adoptive, step, or foster siblings who are under 18 years of age.
- (4) "Court clerk" means a district court clerk.
- (5) "Domestic violence" means the same as that term is defined in Section 77-36-1.
- (6) "Ex parte protective order" means an order issued without notice to the defendant in accordance with this chapter.
- (7) "Foreign protective order" means a protective order issued by another state, territory, or possession of the United States, tribal lands of the United States, the Commonwealth of Puerto Rico, or the District of Columbia which shall be given full faith and credit in Utah, if the protective order is similar to a protective order issued in compliance with Title 30, Chapter 6, Cohabitant Abuse Act, or Title 77, Chapter 36, Cohabitant Abuse Procedures Act, and includes the following requirements:
- (a) the requirements of due process were met by the issuing court, including subject matter and personal jurisdiction;
 - (b) the respondent received reasonable notice; and
 - (c) the respondent had an opportunity for a hearing regarding the protective order.

76-5-102. Assault.

- (1) Assault is:
 - (a) an attempt, with unlawful force or violence, to do bodily injury to another;
 - (b) a threat, accompanied by a show of immediate force or violence, to do bodily injury to another; or
 - (c) an act, committed with unlawful force or violence, that causes bodily injury to another or creates a substantial risk of bodily injury to another.
- (2) Assault is a class B misdemeanor.
- (3) Assault is a class A misdemeanor if:
 - (a) the person causes substantial bodily injury to another; or
 - (b) the victim is pregnant and the person has knowledge of the pregnancy.
- (4) It is not a defense against assault, that the accused caused serious bodily injury to another.

Utah Code -- Title 62A -- Chapter 04a -- Child and Family Services

62A-4a-101. Definitions.

As used in this chapter:

- (1) (a) "Abuse" means:
 - (i) actual or threatened nonaccidental physical or mental harm;
 - (ii) negligent treatment;
 - (iii) sexual exploitation; or
 - (iv) any sexual abuse.
- (b) "Abuse" does not include:
 - (i) reasonable discipline or management of a child, including withholding privileges;
 - (ii) conduct described in Section 76-2-401; or
 - (iii) the use of reasonable and necessary physical restraint or force on a child:
 - (A) in self-defense;
 - (B) in defense of others;
 - (C) to protect the child; or
 - (D) to remove a weapon in the possession of a child for any of the reasons described in Subsections (1)(b)(iii)(A) through (C).
- (2) "Adoption services" means:
 - (a) placing children for adoption;

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(b) subsidizing adoptions under Section 62A-4a-105;

(c) supervising adoption placements until the adoption is finalized by the court;

(d) conducting adoption studies;

(e) preparing adoption reports upon request of the court; and

(f) providing postadoptive placement services, upon request of a family, for the purpose of stabilizing a possible disruptive placement.

(3) “Board” means the Board of Child and Family Services established in accordance with Sections 62A-1-105, 62A-1-107, and 62A-4a-102.

(4) “Child” means, except as provided in Part 7, Interstate Compact on Placement of Children, a person under 18 years of age.

(5) “Consumer” means a person who receives services offered by the division in accordance with this chapter.

(6) “Chronic physical abuse” means repeated or patterned physical abuse.

(7) “Chronic neglect” means a repeated or patterned failure or refusal by a parent, guardian, or custodian to provide necessary care for a child’s safety, morals, or well-being.

(8) “Chronic emotional abuse” means repeated or patterned emotional abuse.

(9) “Custody,” with regard to the division, means the custody of a minor in the division as of the date of disposition.

(10) “Day-care services” means care of a child for a portion of the day which is less than 24 hours:

(a) in the child’s own home by a responsible person; or

(b) outside of the child’s home in a:

(i) day-care center;

(ii) family group home; or

(iii) family child care home.

(11) “Dependent child” or “dependency” means a child, or the condition of a child, who is homeless or without proper care through no fault of the child’s parent, guardian, or custodian.

(12) “Director” means the director of the

Division of Child and Family Services.

(13) “Division” means the Division of Child and Family Services.

(14) (a) “Domestic violence services” means:

(i) temporary shelter, treatment, and related services to persons who are victims of abuse and their dependent children; and

(ii) treatment services for domestic violence perpetrators.

(b) As used in this Subsection (14):

(i) “abuse” means the same as that term is defined in Section 30-6-1; and

(ii) “domestic violence perpetrator” means a person who is alleged to have committed, has been convicted of, or has pled guilty to an act of domestic violence as defined in Section 77-36-1.

(15) “Homemaking service” means the care of individuals in their domiciles, and help given to individual caretaker relatives to achieve improved household and family management through the services of a trained homemaker.

(16) “Minor” means, except as provided in Part 7, Interstate Compact on Placement of Children:

(a) a child; or

(b) a person:

(i) who is at least 18 years of age and younger than 21 years of age; and

(ii) for whom the division has been specifically ordered by the juvenile court to provide services.

(17) “Natural parent” means a minor’s biological or adoptive parent, and includes a minor’s noncustodial parent.

(18) (a) “Neglect” means:

(i) abandonment of a child, except as provided in Part 8, Safe Relinquishment of a Newborn Child;

(ii) subjecting a child to mistreatment or abuse;

(iii) lack of proper parental care by reason of the fault or habits of the parent, guardian, or custodian;

(iv) failure or refusal of a parent, guardian, or custodian to provide proper or necessary subsistence, education, or medical care, including surgery or psychiatric services when required, or any other care necessary for the child’s health, safety, morals, or

well-being; or

(v) a child at risk of being neglected or abused because another child in the same home is neglected or abused.

(b) The aspect of neglect relating to education, described in Subsection (18)(a)(iv), means that, after receiving notice that a child has been frequently absent from school without good cause, or that the child has failed to cooperate with school authorities in a reasonable manner, a parent or guardian fails to make a good faith effort to ensure that the child receives an appropriate education.

(c) A parent or guardian legitimately practicing religious beliefs and who, for that reason, does not provide specified medical treatment for a child, is not guilty of neglect.

(d) (i) Notwithstanding Subsection (18)(a), a health care decision made for a child by the child's parent or guardian does not constitute neglect unless the state or other party to the proceeding shows, by clear and convincing evidence, that the health care decision is not reasonable and informed.

(ii) Nothing in Subsection (18)(d)(i) may prohibit a parent or guardian from exercising the right to obtain a second health care opinion.

(19) "Protective custody," with regard to the division, means the shelter of a child by the division from the time the child is removed from the child's home until the earlier of:

- (a) the shelter hearing; or
- (b) the child's return home.

(20) "Protective services" means expedited services that are provided:

- (a) in response to evidence of neglect, abuse, or dependency of a child;
- (b) to a cohabitant who is neglecting or abusing a child, in order to:
 - (i) help the cohabitant develop recognition of the cohabitant's duty of care and of the causes of neglect or abuse; and
 - (ii) strengthen the cohabitant's ability to provide safe and acceptable care; and
 - (c) in cases where the child's welfare is

endangered:

(i) to bring the situation to the attention of the appropriate juvenile court and law enforcement agency;

(ii) to cause a protective order to be issued for the protection of the child, when appropriate; and

(iii) to protect the child from the circumstances that endanger the child's welfare including, when appropriate:

- (A) removal from the child's home;
- (B) placement in substitute care; and
- (C) petitioning the court for termination of parental rights.

(21) "Severe neglect" means neglect that causes or threatens to cause serious harm to a child.

(22) "Shelter care" means the temporary care of a minor in a nonsecure facility.

(23) "State" means:

- (a) a state of the United States;
- (b) the District of Columbia;
- (c) the Commonwealth of Puerto Rico;
- (d) the Virgin Islands;
- (e) Guam;
- (f) the Commonwealth of the Northern Mariana Islands; or

(g) a territory or possession administered by the United States.

(24) "Severe emotional abuse" means emotional abuse that causes or threatens to cause serious harm to a child.

(25) "Severe physical abuse" means physical abuse that causes or threatens to cause serious harm to a child.

(26) "State plan" means the written description of the programs for children, youth, and family services administered by the division in accordance with federal law.

(27) "Status offense" means a violation of the law that would not be a violation but for the age of the offender.

(28) "Substantiated" or "substantiation" means a judicial finding based on a preponderance of the evidence that abuse or neglect occurred. Each

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allegation made or identified in a given case shall be considered separately in determining whether there should be a finding of substantiated.

(29) “Substitute care” means:

(a) the placement of a minor in a family home, group care facility, or other placement outside the minor’s own home, either at the request of a parent or other responsible relative, or upon court order, when it is determined that continuation of care in the minor’s own home would be contrary to the minor’s welfare;

(b) services provided for a minor awaiting placement; and

(c) the licensing and supervision of a substitute care facility.

(30) “Supported” means a finding by the division based on the evidence available at the completion of an investigation that there is a reasonable basis to conclude that abuse, neglect, or dependency occurred. Each allegation made or identified during the course of the investigation shall be considered separately in determining whether there should be a finding of supported.

(31) “Temporary custody,” with regard to the division, means the custody of a child in the division from the date of the shelter hearing until disposition.

(32) “Transportation services” means travel assistance given to an individual with escort service, if necessary, to and from community facilities and resources as part of a service plan.

(33) “Unsubstantiated” means a judicial finding that there is insufficient evidence to conclude that abuse or neglect occurred.

(34) “Unsupported” means a finding at the completion of an investigation that there is insufficient evidence to conclude that abuse, neglect, or dependency occurred. However, a finding of unsupported means also that the division worker did not conclude that the allegation was without merit.

(35) “Without merit” means a finding at the completion of an investigation by the division, or a judicial finding, that the alleged abuse, neglect, or dependency did not occur, or that the alleged

perpetrator was not responsible for the abuse, neglect, or dependency.

62A-4a-402. Definitions.

As used in this part:

(1) “A person responsible for a child’s care” means the child’s parent, guardian, or other person responsible for the child’s care, whether in the same home as the child, a relative’s home, a group, family, or center day care facility, a foster care home, or a residential institution.

(2) “Child abuse or neglect” means causing harm or threatened harm to a child’s health or welfare.

(3) “Harm or threatened harm” means damage or threatened damage to the physical or emotional health and welfare of a child through neglect or abuse, and includes but is not limited to:

(a) causing nonaccidental physical or mental injury;

(b) incest;

(c) sexual abuse;

(d) sexual exploitation;

(e) molestation; or

(f) repeated negligent treatment or maltreatment.

(4) “Incest” means having sexual intercourse with a person whom the perpetrator knows to be his or her ancestor, descendant, brother, sister, uncle, aunt, nephew, niece, or first cousin. The relationships referred to in this subsection include blood relationships of the whole or half blood without regard to legitimacy, and include relationships of parent and child by adoption, and relationships of stepparent and stepchild while the marriage creating the relationship of a stepparent and stepchild exists.

(5) “Molestation” means touching the anus or any part of the genitals of a child or otherwise taking indecent liberties with a child, or causing a child to take indecent liberties with the perpetrator or another with the intent to arouse or gratify the sexual desire of any person.

(6) “Sexual abuse” means acts or attempted acts of sexual intercourse, sodomy, or molestation directed towards a child.

(7) “Sexual exploitation of a child” means knowingly employing, using, persuading, inducing,

enticing, or coercing any child to pose in the nude for the purpose of sexual arousal of any person or for profit, or to engage in any sexual or simulated sexual conduct for the purpose of photographing, filming, recording, or displaying in any way the sexual or simulated sexual conduct, and includes displaying, distributing, possessing for the purpose of distribution, or selling material depicting a child in the nude or engaging in sexual or simulated sexual conduct.

(8) “Subject” or “subject of the report” means any person reported under this part, including, but not limited to, a child, parent, guardian, or other person responsible for a child’s care.

62A-4a-403. Reporting requirements.

(1) Except as provided in Subsection (2), when any person including persons licensed under Title 58, Chapter 67, Utah Medical Practice Act, or Title 58, Chapter 31b, Nurse Practice Act, has reason to believe that a child has been subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, or who observes a child being subjected to conditions or circumstances which would reasonably result in sexual abuse, physical abuse, or neglect, he shall immediately notify the nearest peace officer, law enforcement agency, or office of the division. On receipt of this notice, the peace officer or law enforcement agency shall immediately notify the nearest office of the division. If an initial report of child abuse or neglect is made to the division, the division shall immediately notify the appropriate local law enforcement agency. The division shall, in addition to its own investigation, comply with and lend support to investigations by law enforcement undertaken pursuant to a report made under this section.

(2) The notification requirements of Subsection (1) do not apply to a clergyman or priest, without the consent of the person making the confession, with regard to any confession made to him in his professional character in the course of discipline enjoined by the church to which he belongs, if:

(a) the confession was made directly to the

clergyman or priest by the perpetrator; and

(b) the clergyman or priest is, under canon law or church doctrine or practice, bound to maintain the confidentiality of that confession.

(3) (a) When a clergyman or priest receives information about abuse or neglect from any source other than confession of the perpetrator, he is required to give notification on the basis of that information even though he may have also received a report of abuse or neglect from the confession of the perpetrator.

(b) Exemption of notification requirements for a clergyman or priest does not exempt a clergyman or priest from any other efforts required by law to prevent further abuse or neglect by the perpetrator. 62A-4a-404. Fetal alcohol syndrome and drug dependency -- Reporting requirements.

When any person, including a licensee under the Medical Practice Act or the Nurse Practice Act, attends the birth of a child or cares for a child, and determines that the child, at the time of birth, has fetal alcohol syndrome or fetal drug dependency, he shall report that determination to the division as soon as possible.

62A-4a-405. Death of child -- Reporting requirements.

Any person who has reason to believe that a child has died as a result of child abuse or neglect shall report that fact to the local law enforcement agency, who shall report to the county attorney or district attorney as provided under Section 17-18-1 or 17-18-1.7 and to the appropriate medical examiner in accordance with Title 26, Chapter 4, Utah Medical Examiner Act. The medical examiner shall investigate and report his findings to the police, the appropriate county attorney or district attorney, the attorney general’s office, the division, and if the institution making the report is a hospital, to that hospital. Utah Code -- Title 76 -- Chapter 05 -- Offenses Against the Person

76-5-112.5. Endangerment of child or elder adult.

(1) For purposes of this section:

(a) “Chemical substance” means a substance

III. Reporting Requirements for Health Care Providers

UTAH HEALTH CODE

intended to be used as a precursor in the manufacture of a controlled substance, or any other chemical intended to be used in the manufacture of a controlled substance. Intent under this subsection may be demonstrated by the substance's use, quantity, manner of storage, or proximity to other precursors, or to manufacturing equipment.

(b) "Child" means the same as that term is defined in Subsection 76-5-109(1)(a).

(c) "Controlled substance" means the same as that term is defined in Section 58-37-2.

(d) "Drug paraphernalia" means the same as that term is defined in Section 58-37a-3.

(e) "Elder adult" means the same as that term is defined in Section 76-5-111.

(2) Unless a greater penalty is otherwise provided by law, any person who knowingly or intentionally causes or permits a child or elder adult to be exposed to, to ingest or inhale, or to have contact with a controlled substance, chemical substance, or drug paraphernalia as defined in Subsection (1), is guilty of a felony of the third degree.

(3) Unless a greater penalty is otherwise provided by law, any person who violates Subsection (2), and a child or elder adult actually suffers bodily injury, substantial bodily injury, or serious bodily injury by exposure to, ingestion of, inhalation of, or contact with a controlled substance, chemical substance, or drug paraphernalia, is guilty of a felony of the second degree unless the exposure, ingestion, inhalation, or contact results in the death of the child or elder adult, in which case the person is guilty of a felony of the first degree.

(4) (a) It is an affirmative defense to a violation of this section that the controlled substance was provided by lawful prescription for the child or elder adult, and that it was administered to the child or elder adult in accordance with the prescription instructions provided with the controlled substance.

(b) As used in this Subsection (4), "prescription" has the same definition as in Section 58-37-2.

Amended by Chapter 32, 2002 General Session 76-5-109. Child abuse.

(1) As used in this section:

(a) "Child" means a human being who is under 18 years of age.

(b) "Child abuse" means any offense described in Subsection (2) or (3), or in Section 76-5-109.1.

(c) "Physical injury" means an injury to or condition of a child which impairs the physical condition of the child, including:

(i) a bruise or other contusion of the skin;

(ii) a minor laceration or abrasion;

(iii) failure to thrive or malnutrition; or

(iv) any other condition which imperils the child's health or welfare and which is not a serious physical injury as defined in Subsection (1)(d).

(d) (i) "Serious physical injury" means any physical injury or set of injuries that:

(A) seriously impairs the child's health;

(B) involves physical torture;

(C) causes serious emotional harm to the child; or

(D) involves a substantial risk of death to the child.

(ii) "Serious physical injury" includes:

(A) fracture of any bone or bones;

(B) intracranial bleeding, swelling or contusion of the brain, whether caused by blows, shaking, or causing the child's head to impact with an object or surface;

(C) any burn, including burns inflicted by hot water, or those caused by placing a hot object upon the skin or body of the child;

(D) any injury caused by use of a dangerous weapon as defined in Section 76-1-601;

(E) any combination of two or more physical injuries inflicted by the same person, either at the same time or on different occasions;

(F) any damage to internal organs of the body;

(G) any conduct toward a child that results in severe emotional harm, severe developmental delay or retardation, or severe impairment of the child's ability to function;

(H) any injury that creates a permanent disfigurement or protracted loss or impairment of the function of a bodily member, limb, or organ;

(I) any conduct that causes a child to cease breathing, even if resuscitation is successful following the conduct; or

(J) any conduct that results in starvation or failure to thrive or malnutrition that jeopardizes the child's life.

(2) Any person who inflicts upon a child serious physical injury or, having the care or custody of such child, causes or permits another to inflict serious physical injury upon a child is guilty of an offense as follows:

(a) if done intentionally or knowingly, the offense is a felony of the second degree;

(b) if done recklessly, the offense is a felony of the third degree; or

(c) if done with criminal negligence, the offense is a class A misdemeanor.

(3) Any person who inflicts upon a child physical injury or, having the care or custody of such child, causes or permits another to inflict physical injury upon a child is guilty of an offense as follows:

(a) if done intentionally or knowingly, the offense is a class A misdemeanor;

(b) if done recklessly, the offense is a class B misdemeanor; or

(c) if done with criminal negligence, the offense is a class C misdemeanor.

(4) A parent or legal guardian who provides a child with treatment by spiritual means alone through prayer, in lieu of medical treatment, in accordance with the tenets and practices of an established church or religious denomination of which the parent or legal guardian is a member or adherent shall not, for that reason alone, be considered to have committed an offense under this section.

(5) A parent or guardian of a child does not violate this section by selecting a treatment option for the medical condition of the child, if the treatment option is one that a reasonable parent or guardian would believe to be in the best interest of the child.

(6) A person is not guilty of an offense under this section for conduct that constitutes:

(a) reasonable discipline or management of a child, including withholding privileges;

(b) conduct described in Section 76-2-401; or

(c) the use of reasonable and necessary physical restraint or force on a child:

(i) in self-defense;

(ii) in defense of others;

(iii) to protect the child; or

(iv) to remove a weapon in the possession of a child for any of the reasons described in Subsections (6)(c)(i) through (iii).

Amended by Chapter 75, 2006 General Session

76-5-109.1. Commission of domestic violence in the presence of a child.

(1) As used in this section:

(a) "Cohabitant" has the same meaning as defined in Section 30-6-1.

(b) "Domestic violence" has the same meaning as in Section 77-36-1.

(c) "In the presence of a child" means:

(i) in the physical presence of a child; or

(ii) having knowledge that a child is present and may see or hear an act of domestic violence.

(2) A person is guilty of child abuse if the person:

(a) commits or attempts to commit criminal homicide, as defined in Section 76-5-201, against a cohabitant in the presence of a child; or

(b) intentionally causes serious bodily injury to a cohabitant or uses a dangerous weapon, as defined in Section 76-1-601, or other means or force likely to produce death or serious bodily injury against a cohabitant, in the presence of a child; or

(c) under circumstances not amounting to a violation of Subsection (2)(a) or (b), commits an act of domestic violence in the presence of a child.

(3) (a) A person who violates Subsection (2)(a) or (b) is guilty of a third degree felony.

(b) A person who violates Subsection (2)(c) is guilty of a class B misdemeanor.

(4) A charge under this section is separate and distinct from, and is in addition to, a charge of domestic violence where the victim is the cohabitant. Either or both charges may be filed by the prosecutor.

Amended by Chapter 81, 2002 General Session

SUMMARY OF RESOURCES

Resources

After identifying and documenting abuse, health care professionals should provide a referral to a local domestic violence shelter or victim advocate program. As a medical professional caring for domestic violence patients, it may not be necessary to be aware of every resource available. However, it is recommended you refer your patients to at least one resource for further assistance. Victim advocate programs and domestic violence shelters have a wealth of helpful information for those living with domestic violence. It is important to provide victims with a means to access help. Some resources are listed below:

- A 24-hour-a-day, domestic violence information line is available. The number is **(800) 897-LINK**. The line is staffed by caring professionals who are knowledgeable about local shelters and advocate programs.
- A Web site containing information and referral numbers is available at **www.informationandreferral.org**.
- A 24-hour-a-day, rape and sexual assault information and crisis line is available. Call **(888) 421-1100** from anywhere in the state of Utah to reach programs in your area.
- This section contains contact information for community resources available for each geographic area of the state of Utah.
- Shelters are accessible 24 hours a day for information, victim advocacy, or housing for victims of abuse.

Victim Advocate Programs

Health care providers are strongly encouraged to contact a victim advocate as soon as a report is made. Victim advocates are trained to support victims and help them through the process of making a report. They also assist domestic violence victims and their families with finding social service resources in the community such as temporary shelter, medical assistance, childcare, transportation,

and employment/education counseling. Often, victim advocates will respond to the hospital immediately. The goal of a victim advocate is to give the victim options, emotional support, and education on domestic violence, in addition to providing resources to help them take the steps necessary to become independent, functioning individuals. Advocate programs address the immediate needs of victims of crime by responding to hospitals, helping victims through the judicial system, and providing emotional support. Their knowledge of court processes, the preparation of safety plans and updated information on arraignments, pre-trials, and hearings are also key services. Victim advocate programs help victims fill out forms for Crime Victim Reparations, protective orders, and other documents that may be related to the case.

Shelters

The goal of domestic violence shelters is to provide all victims of domestic violence with resources and options to help them break the cycle of violence. These shelters provide short-term emergency shelter and support services for victims and their children at no cost to the victim. Shelters provide clothing, food, and other needed items. Most shelters provide crisis counseling, weekly support groups, individual counseling, and referrals to other agencies in their communities. Shelters also provide crisis counseling and supportive services to non-shelter clients.

Shelters/safe houses are available to victims of domestic violence 24 hours a day, seven days a week. When referring a victim to a shelter, remember that shelter staff prefer to speak to the victims personally prior to their arrival.

Tools from this Manual

The tools found in this document can be downloaded at www.health.utah.gov/vipp/domesticViolence/training.html.

STATEWIDE COMMUNITY RESOURCES

Victim Advocate Programs

For more information or an updated list call toll free: **(800) 897-LINK (5465)**

Beaver County

Beaver County Sheriff's Office
Victim Advocate Program
2160 South 600 West
Beaver, UT 84713
(435) 438-6494

Box Elder County

Your Community in Unity
Box Elder County
P.O. Box 756
Brigham City, UT 84302
877-723-5600

Box Elder County Attorney's Office

9 West Forest Suite 310
Brigham City, UT 84302
(435) 734-3369

Cache County

Cache County Victim Services
11 West 100 North, Suite C
Logan, UT 84321
(435) 755-1860

Carbon County

Carbon County Sheriff's Office
Victim/Witness Assistance
240 West Main
Price, UT 84501
(435) 636-3250 Or
(435) 636-3251

Daggett County

Refer to Uintah County

Davis County

Davis County Attorney's Office
Victim of Crime Assistance
800 West State Street
Farmington, UT 84025
(801) 451-4300

Layton City Attorney's Office

Victim Services
437 North Wasatch Drive
Layton, UT 84041
(801) 336-3590
(801) 336-3599

Duchesne County

Duchesne County Attorney's Office
Office
Victim Advocate Program
255 South State Street
Roosevelt, UT 84066
(435) 722-0828

Emery County

Refer to Carbon County

Garfield County

Refer to Iron County

Grand County

Grand County Attorney's Office
Victim Advocate Program
125 East Center Street
Moab, UT 84532
(435) 259-1326

Iron County

Iron County Attorney's Office
Victim Services
82 North 100 East, Suite 201
Cedar City, UT 84721
(435) 865-5318

Juab County

Juab County Attorney's Office
Victim/Witness Program
160 No. Main
Nephi, UT 84648
(435) 623-3460

Kane County

Kane County Sheriff's Office
Victim Services
76 North Main Street
Kanab, Utah 84741
(435) 644-4989

Millard County

Millard County Attorney's Office
Victim Advocate Program
765 South Highway 99, Suite 3
Fillmore, UT 84631
(435) 743-6522

Morgan County

Refer to Box Elder County

Piute County

Refer to Sevier County

Rich County

Refer to Cache County

Continue...

STATEWIDE COMMUNITY RESOURCES

Victim Advocate Programs Statewide

Salt Lake County

Draper City Police Dept.
Victim Advocate Program
1020 East Pioneer Road
Draper, Utah 84020
(801) 576-6355

Midvale City Police Dept.
Victim Advocate Program
7912 South Main Street
Midvale, UT 84047
(801) 256-2505
(801) 256-2506

Murray City Police Dept.
Victim Advocate Program
5025 South State Street
Murray, UT 84107
(801) 284-4203
(801) 284-4201

Salt Lake City Police Dept.
Victim Resource Center
327 East 200 South
Salt Lake City, UT 84111
(801) 799-3756
(801) 580-7969

Salt Lake County Sheriff's Office
Victim Advocate Program
3365 South 900 West
Salt Lake City, UT 84119
(801) 743-5860
(801) 743-5861

Sandy City Police Dept.
Victim Advocate Program
10000 South Centennial Parkway
Sandy, UT 84070
(801) 568-7283
(801) 568-6059

South Jordan Police Dept.
Victim Advocate Program
11175 South Redwood Rd.
South Jordan, UT 84095
(801) 254-4708, Ext. 216

South Salt Lake Police Dept.
Victim Advocate Program
2835 South Main
South Salt Lake, UT 84115
(801) 412-3660
(801) 412-3661
(801) 412-3662
(801) 412-3663 (Spanish)

Taylorsville Police Department
Victim Advocate Program
2600 West Taylorsville Blvd
Taylorsville, UT 84118
(801) 955-2067

West Jordan Public Safety Dept.
Victim Advocate Program
8070 South 1700 West
West Jordan, UT 84088
(801) 566-6511

West Valley City Attorney's Office
Victim Advocate Program
3375 South Market Street
West Valley, UT 84119
(801) 963-3223

San Juan County

San Juan County Sheriff's Office
Victim Advocate Program
P.O. Box 788
Monticello, UT 84535
(435) 587-2237 or
(435) 459-1819

Sanpete County

Refer to Sevier County

Sevier County

New Horizons Crisis Center
Richfield, UT 84701
800-343-6302

Summit County

Summit County Attorney's Office
Victim Assistance Program
6300 North Silver Creek Rd.
Park City, UT 84098
(435) 615-3850

Tooele County

Tooele Police Dept.
Victim Advocate Program
323 North Main Street
(435) 843-1645
(800) 833-5575

Pathways
Tooele County Shelter
(435) 843-1645 or
(800) 833-5515

Uintah County

Vernal Police Dept.
Victim Advocate Program
437 East Main Street
Vernal, UT 84078
(435) 789-4250

Utah County

Alpine/Highland Police Dept
Victim Advocate Program
20 North Main
Alpine, UT 84004
(801) 756-9800

STATEWIDE COMMUNITY RESOURCES

Victim Advocate Programs Statewide

Utah County Continue

American Fork Police Dept.
Victim Advocate Program
98 North Center Street
American Fork, UT 84003
(801) 763-3020

Lehi City
Victim Advocate Program
580 West State Street
Lehi, UT 84043
(801) 766-5800
Orem Dept. of Public Safety
Victim Assistance Program
95 East Center
Orem, UT 84057
(801) 229-7126
(801) 229-7127 (Spanish)
(801) 229-7128

Pleasant Grove Police Dept.
87 North 100 East
Pleasant Grove, UT 84062
(801) 785-3506

Provo City Police Dept.
Victim Advocate Program
351 West Center Street
Provo, UT 84603
(801) 852-6375
(801) 852-6280
(801) 852-6244 (Spanish)

South Utah County
Victim Advocate Program
439 West Utah Ave.
Payson, UT 84651
(801) 465-5224

Springville Police Dept.
Victim Advocate Program
45 South Main
Springville, UT 84663
(801) 489-9421

Utah County Sheriff's Office
Victim Assistance Program
51 So. University Ave Suite 105
Provo, UT 84660
(801) 851-8364
(801) 789-6708 (Spanish)

Wasatch County

Wasatch County Attorney's
Office
Victim Assistance Program
55 South 500 East
Heber, UT 84032
(435) 657-3300

Washington County

D.O.V.E. Center
P.O. Box 2972
St. George, UT 84771
(435) 628-0458

St. George Police Dept.
Victim Services
265 North 200 East
St. George, UT 84770
(435) 628-2408

Wayne County

Refer to Sevier County

Weber County

Weber County Sheriff's Office
Victim Advocate Program
2380 Washington Blvd., #G11
Ogden, UT 84401
(801) 399-8065

Weber County Attorney's Office
Victim Assistance Program
2380 Washington Blvd, Suite 230
Ogden, UT 84401
(801) 399-8377

Other Agencies

Department of Corrections
Victim Services Program
(801) 545-5899

Federal Victim/Witness Program
(800) 949-9451

FBI
Victim Services
(801) 579-1400

Utah State Board of Pardons
Victim Assistance Program
(801) 261-6464

IV. Resources and Referral

STATEWIDE COMMUNITY RESOURCES

Domestic Violence Shelters Statewide

BOX ELDER COUNTY

Your Community in Unity
Brigham City
(435) 723-5600
(866) 206-0379

CACHE COUNTY

Community Abuse Prevention
Services Agency, Logan
(435) 753-2500

CARBON COUNTY

Colleen Quigley Women's Center
Price
(435) 636-2375
(435) 637-6589

DAVIS COUNTY

Safe Harbor, Kaysville
(801) 444-3191
(801) 444-9161

GRAND COUNTY

Seekhaven, Moab
(4350) 259-2229

IRON COUNTY

Canyon Creek Women's Crisis
Center, Cedar City
(435) 867-9411
(435) 865-7443

SALT LAKE COUNTY

YWCA Women in Jeopardy
Salt Lake City
(801) 537-8600

South Valley Sanctuary
West Jordan
(801) 255-1095

SAN JUAN COUNTY

Gentle Ironhawk Shelter
Blanding
(435) 896-9294
(800) 377-5500

SEVIER COUNTY

New Horizons Crisis Shelter
Richfield
(435) 896-9294
(866) 206-0379

SUMMIT COUNTY

Peace House, Park City
(435) 647-9161

TOOELE COUNTY

Pathways, Tooele
(801) 518-2310
(800) 833-5515

UINTAH COUNTY

Women's Crisis Shelter, Vernal
(435) 781-2264

UTAH COUNTY

Center for Women and Children
in Crisis, Provo
(801) 374-9351
(801) 377-5500

WASHINGTON COUNTY

D.O.V.E. Center
(435) 628-0458
(435) 528-0458

The statewide domestic violence hotline number is 1-800-897-LINK (5465).

This list was obtained from the Utah Domestic Violence Council and last updated 02/2007.

COMMUNITY RESOURCES

Utah Rape Crisis Programs

Statewide, toll free

(888) 421-1100

Brigham City

Serves Box Elder County
Your Community In Unity
(YCU) (435) 723-5600

Cedar City

Serves Iron, Beaver, Kane, and
Garfield Counties
Canyon Creek Women's Crisis
Center
(435) 867-6149

Davis

Serves Davis County
Safeharbor
(801) 444-9161

Logan

Serves Cache and Rich Counties
Community Abuse Prevention
Services Agency
(435) 753-2500

Moab

Serves San Juan, Emery, and
Grand Counties
Seekhaven
(435) 259-2229

Ogden

Serves Weber and Morgan
Counties
Your Community Connection
(YCC)
(801) 392-7273

Park City

Serves Summit County
Summit County Victim
Advocate Program
(435) 615-3850

Provo

Serves Utah, Wasatch, Carbon,
and Juab Counties
Center For Women and Children
in Crisis, Sexual Assault Services
(801) 356-2511

Richfield

Serves Sevier, Wayne, Piute,
Millard, and Sanpete Counties
New Horizons Crisis Center
(435) 896-9294

St. George

Serves Washington County
D.O.V.E. Center
(435) 628-0458

Salt Lake City

Serves Salt Lake, Tooele
Rape Recovery Center
(801) 467-7273

Vernal

Serves Uintah, Daggett, and
Duchesne Counties
Vernal Victim Advocacy
(435) 789-4250

The 24-hour statewide rape crisis line number is 1-888-421-1100.

This list was obtained from the Utah Department of Health and last updated 03/2007.

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