



OVC Bulletin

DECEMBER 2004

FAMILY VIOLENCE: AN INTERVENTION MODEL FOR DENTAL PROFESSIONALS

by Kristin Littel

Efforts to strengthen responses by health care professionals to family violence¹ have increased dramatically in recent years.² As a result, more health care providers are able to recognize the signs of abuse and assist patients who are victims. However, dental professionals appear to be the least likely of all clinicians to suspect and intervene in family violence, even though injuries to the head and neck are present in 60 percent or more of abuse cases.³ Although they may see abuse-related injuries during patient visits, dental professionals typically have not been trained to recognize the causes of these injuries or how to offer intervention and referrals to patients.

With this need in mind, the University of Minnesota's School of Dentistry and the Program Against Sexual Violence⁴ joined forces in 1997 to create a training program called *Family Violence: An Intervention Model for Dental Professionals*. The

collaboration was prompted by a patient's disclosure of partner abuse to staff at the dental school clinic.⁵ Clinic staff subsequently helped the patient access the Program Against Sexual Violence. After this incident, representatives from the two programs began discussing how to systematically prepare dental students, faculty, and practitioners to deal with patients affected by family violence. The resulting training program, funded through a grant from the U.S. Department of Justice's Office for Victims of Crime (OVC), addresses the following points:

- Ethical and legal responsibilities of dental professionals.
- Definitions and dynamics of family violence.
- The impact of abuse on victims.
- Intervention skills and techniques.
- Methods for creating a safe office environment.

Message From THE DIRECTOR

Dental professionals are in a key position to identify neglect and abuse caused by family violence and to intervene on behalf of victimized patients. However, research shows that dental professionals are the least likely of all health care providers to do so.

This bulletin discusses a University of Minnesota training program designed to address the gaps in knowledge about domestic violence that prevent many dentists and dental hygienists from taking action. The program, which can be incorporated into dental schools and continuing education curricula, educates dental professionals about the signs of abuse and neglect and teaches proactive and appropriate intervention. This training has increased the number of dental professionals who screen their patients for family violence and has helped implement proactive intervention policies in dental offices across the country.

Finally, the bulletin underscores the importance of including dental professionals on community teams that respond to family violence issues. These groups play key roles in local training, policy and procedure development, interagency agreements, and communication and collaboration.

John W. Gillis
Director

Connection Between Dentistry and Family Violence Intervention

Research indicates that most physical injuries resulting from family violence are found on the head and neck, areas that are clearly visible to the dental team during examinations.⁶ For example, dental professionals may observe physical injuries such as chipped or cracked teeth, poor dental hygiene, a broken jaw, a black eye, a broken nose, bruises on the earlobes or chin, and fingermarks on the neck, upper arms, or wrists. Multiple studies confirm that head, face, and neck injuries occur in more than one-half of child abuse cases.⁷ In cases of partner abuse, one study of 218 female domestic violence victims who were examined at a hospital emergency department found that the most common injuries were bruises (70 percent), and the most common location of injury was the face (68 percent).⁸ A similar study found that 94.4 percent of domestic violence victims had head, neck, or facial injuries,⁹ and a third study of 98 battered women found that 58 percent had injuries to the face and head.¹⁰ In elder abuse cases, the types of abuse most frequently reported included bruises and welts, broken dentures, fractured and avulsed teeth, and abrasions and lacerations.¹¹

Given that dental professionals routinely assess the head, face, and neck of patients, they are in a unique position to identify the signs of family violence.¹² In fact, these victims may seek out dental treatment for injuries related to violence. A 1998 national survey revealed that 16.7 percent of women who sought health care for rape injuries visited dentists, and 9.2 percent of women who sought care for physical assault by a partner saw a dentist.¹³ In addition, routine dental visits

Bulletin Goals

This bulletin seeks to—

- Promote training for dental professionals on their role in intervening in patient cases of family violence.
- Encourage the inclusion of dental professionals in community efforts to coordinate response to family violence.

may alert dental professionals to evidence that patients are being abused and lead to early intervention.

Lack of Recognition and Intervention

Despite the likelihood that dental professionals will interact with a victim of abuse in a clinical setting, few recognize family violence as a problem their patients encounter.¹⁴ One study found that dentists ($n=247$) and dental hygienists ($n=271$)

were the least likely of all clinicians surveyed to suspect child, spouse, or elder abuse. Close to one-half of the dental professionals surveyed did not view themselves as responsible for dealing with these problems.¹⁵ In a second survey of dentists ($n=321$), 87 percent said they never screened for domestic violence, and 18 percent did not screen even when patients had visible signs of trauma on their heads or necks.¹⁶ Respondents intervened only minimally to help patients they had identified as victims.¹⁷ A third survey of dentists ($n=400$) found that 29 percent of them had suspected at least one patient to be a victim of child abuse and 14 percent had reported at least one such case.¹⁸ Only 7 percent had suspected a case of elder abuse, and slightly more than 1 percent had reported at least one such case.¹⁹ About 30 percent of respondents indicated they had suspected at least one case of spouse abuse and 3 percent had reported such a case.²⁰ Less than 1 percent of all child abuse reports nationwide are made by dental professionals even though all 50 states require dentists to report suspected cases of child abuse and neglect, and 41 states require the same of dental hygienists.²¹

Barriers to Intervention Reported by Dental Professionals

- Limited knowledge of family violence issues.
- Lack of practical experience on how to intervene.
- Misconceptions about the nature of intervention.
- Fear of litigation.
- Lack of local referral information.
- The presence of a partner or children.
- Concern about offending patients.
- Embarrassment about bringing up the topic.

Dental professionals may observe physical injuries such as chipped or cracked teeth, poor dental hygiene, a broken jaw, a black eye, a broken nose, bruises on the earlobes or chin, and fingermarks on the neck, upper arms, or wrists.

Barriers to Reporting

The results of a pretraining survey taken as part of the *Family Violence: An Intervention Model for Dental Professionals* training program revealed several reasons why dental staff do not proactively intervene in family violence.²² Key factors include limited knowledge of the issue of family violence and lack of practical experience on how to intervene effectively. Close to 60 percent of respondents had received no training on domestic violence. In another survey, 68 percent of responding dentists identified a lack of training as a barrier to screening for domestic violence.²³

Misconceptions about the nature of intervention also discourage dental professionals from getting involved.²⁴ In a study of dental attitudes and practices related to domestic violence, dentists and dental hygienists said they thought of intervention in terms of rescuing a helpless victim such as a child.²⁵ They tended to perceive adult victims of partner abuse as autonomous and having the capacity for self-defense in abusive situations.²⁶ Though spousal abuse is the most frequently suspected category of abuse noted by dental professionals, it rarely causes them to intervene.²⁷

Dental professionals also cited fear of litigation as another reason for not intervening. Approximately 28 percent of respondents in the *Family Violence: An Intervention Model for Dental Professionals* pretraining survey said they felt uncomfortable talking about family violence with patients because they feared the legal ramifications of reporting their suspicions.²⁸ Respondents indicated that a lack of referral information and knowledge about how to develop a coordinated referral network were additional reasons they did not intervene.²⁹ Other major obstacles included the presence of a partner or children, concern about offending patients, and the dentists' own embarrassment about bringing up the topic.³⁰

Critical Need for Education

The likelihood that dentists and dental hygienists will suspect or intervene in family violence appears to depend on the amount of related education they receive.³¹ Of all the clinicians sampled in one survey, dentists and dental hygienists reported the smallest proportion of education in child, spouse, and elder abuse.³² As a group, they also suspected abuse the least often. Another survey found that dentists who received domestic violence education were significantly more likely to screen for domestic violence and intervene as necessary.³³ The study's authors concluded that education on domestic violence needs to be "standardized and incorporated into dental school and continuing education curricula, thus 'normalizing' intervention with victims and making it a standard part of a dentist's professional responsibility."³⁴

Family Violence: An Intervention Model for Dental Professionals

Clearly, there is a need to better prepare dental professionals to intervene on

behalf of patients who have been abused and neglected. The University of Minnesota's *Family Violence: An Intervention Model for Dental Professionals* training program was developed for this purpose.³⁵ It includes a 6-hour curriculum, instructional videos, a training manual, a poster for office display, resource directories, and marketing materials.³⁶

The comprehensive curriculum educates dental professionals about the symptoms and patterns of abuse, methods for creating a safe environment for disclosure, appropriate interventions when abuse is suspected, and patient referrals. The curriculum, which includes overheads, slides, and a template, can be duplicated and integrated into dental school and dental hygiene programs. It can be used in two segments for training students or as an all-day seminar for practicing dental professionals.

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To enhance the curriculum, two instructional videos were produced. "Clinical Implications," which is 6 minutes and 40 seconds in length, provides visual images of abuse injuries on the mouth, lip, ear, neck, and head, and corresponding descriptions of how these injuries would occur. "Healing Voices," which is 11 minutes and 18 seconds in length, discusses

Curriculum Topics

- Definitions of family violence.
- Myths and realities about family violence.
- Values clarification.
- Warning signs of abuse.
- Patterns of abuse.
- Clinical signs of abuse (video).
- Role clarification.
- Ethical and legal responsibilities.
- Intervention techniques (video).
- Development of office safety plans.
- Sharing of safety plans.
- Team intervention techniques.
- Community resources.
- Introduction to local service providers.

effective intervention strategies for dental professionals. It presents several scenarios in which abuse is suspected and shows how dental professionals can respond in a caring and responsible manner. One scenario explores how a dental team might react if abusive or threatening behavior occurs in the office.

The participant training manual includes an outline of the curriculum, research and training materials, and references. The manual also includes a sample medical and dental history form with specific family violence questions. As part of the training, participants also receive a poster to display in their dental offices. This poster was created to raise awareness that the dentist's office is a safe place to talk about abuse. Participants in the Minnesota training sessions received a state resource directory, and those attending training sessions in other states received a national resource directory.

To promote the project on a national level, every dental school in the United States, state dental association, and state

coalition on sexual assault, child abuse, and domestic violence were sent a project abstract, introductory letter, and marketing brochures. Information in the brochure was intended to be reproduced in group newsletters, as well as used to encourage dental practitioners to participate in training. In addition, an article from the September/October 1997 issue of *Northwest Dentistry* promoted the project by describing the training model.

In Minnesota, the State Board of Dentistry approved 6 hours of continuing

dental education credits for completion of the training program. The training program was successfully implemented at multiple sites in Minnesota and across the Nation from 1998 to 2000. At the University of Minnesota, the training is conducted annually for senior dental hygiene students and freshman dental students. Also, a 15-week, 50-minute course on family violence that builds on the project's curriculum was developed for dental hygiene students.

Training Highlights

The first part of *Family Violence: An Intervention Model for Dental Professionals* focuses on the basics that dental professionals should know about the abuse of children, vulnerable adults, and partners. It discusses the behavioral dynamics of family violence, myths and facts about abuse, different types of abuse and neglect, barriers to identification that may be posed by patients and dental professionals, and related clinical clues. The training then teaches dental professionals how to initiate intervention, document the situation properly, report it appropriately, identify community service providers, and establish related office protocols.

Openness Encourages Disclosure

Objectivity and a nonjudgmental attitude are essential when broaching the topic of family violence. As stated by Short, Tiedemann, and Rose (1997), "Perhaps the most important information that a dental professional can give a victim is the fact that no one deserves to be abused and that perpetrators are responsible for their own actions The simple act of assuring people in this situation that they are not to blame for the violence will often open the door for further intervention and action."

Fostering a Cohesive Community Response

The training program stresses that effective intervention requires dental professionals to see themselves as part of a community response team³⁷ that includes other health care professionals, law enforcement personnel, protection agencies, and antiviolence advocates.³⁸ Once dental professionals view themselves as part of the local intervention network, it becomes necessary to determine the best ways for them to communicate with agencies and individuals on the community response team about abuse cases and how to help victims. Likewise, community service providers need to recognize that dental professionals are likely to come into contact with victimized patients, putting dental professionals in a position to intervene on the victim's behalf. A victim's willingness to collaborate with dental professionals on abuse issues can promote early recognition of family violence and potentially prevent further abuse.

Reporting

The training program points out the legal and ethical responsibility of dental professionals to report cases of suspected child and vulnerable adult abuse and neglect. Reporting suspected child abuse or neglect is mandatory in every state; many states also have mandatory reporting laws for cases involving suspected abuse of the elderly or persons with disabilities. The training explores general reporting procedures and appropriate agencies to contact. Trainers stress that “although making such a report can seem intimidating, it is critical for dental professionals to know that reporters who act in good faith are immune from civil liability. In fact, not making a report when abuse is suspected poses a significantly greater legal risk than filing that report.”³⁹

Intervention Basics

Do

- Assure patients of confidentiality to the extent allowed under the state's mandatory reporting laws.
- Listen to the patient.
- Respond to the patient's feelings.
- Acknowledge that disclosure is scary for the patient.
- Tell the patient that you are glad she or he told you.
- Provide the patient with options and resources.
- Document the information in the patient's chart.
- File mandatory reports.
- Schedule a followup visit.

Don't

- Joke about the violence.
- Minimize the issue or try to change the subject.
- Discuss the abuse in front of the suspected perpetrator.
- Violate confidentiality, unless it falls under the state's mandatory reporting laws.
- Give advice or dictate an appropriate response.
- Shame or blame the patient.
- Grill the patient for excessive details of the abuse.
- Lie about the legal and ethical responsibilities to report suspected abuse.

Creating a Safe Environment for Disclosure

The training also examines ways that dental offices can create a safe environment for disclosure. For example, patients may respond to nonverbal cues in the dental office, such as family violence literature or posters displayed in the waiting room or restrooms, and ask for assistance or referral options.⁴⁰ Including questions about family violence on a medical and dental history intake form also provides an opportunity for patient disclosure.⁴¹ Useful questions might include—⁴²

- Have you experienced significant injury during the past year?

- Are you now being or have you been emotionally or physically abused by a family member or someone close to you?
- Have you had an injury to your face, head, neck, or jaw?

Patients may disclose abuse during a dental examination, but dentists, dental hygienists, and other dental staff should be aware of the social and clinical cues that may suggest family violence. Examples may include missed appointments, billing problems, injuries in various stages of healing, inappropriate clothing for the season, oral damage caused by neglect or traumatic injuries that are inconsistent with a patient's explanation of how the

Participant Evaluation Results

Prior to Training

- Close to 60 percent had no training in this area.
- Only 3 percent had questions about family violence on their office intake form.
- Nearly 60 percent experienced discomfort in discussing abuse due to a lack of information.
- When family violence was suspected but not mentioned by the patient, only 31 percent felt comfortable describing intervention strategies.

After Training

- 96 percent thought providing referrals was a natural extension of their role as dental health providers.
- 85 percent believed they should report suspected abuse to the proper authorities.
- 74 percent thought family violence screening questions should be added to their intake form.
- Participants indicated significantly greater understanding of the dynamics of abuse and their legal obligation.

injuries happened, or a caregiver or partner who will not allow the patient to speak to anyone alone.

Intervention

The training stresses that suspicion alone is enough to warrant further investigation into whether abuse is occurring.⁴³ Following up requires dental professionals to ask their patients questions, listen closely to understand their issues and feelings, and offer support, information, and referrals. These discussions should occur privately, without the patient's partner, caregiver, or parent, as one of these individuals could be the abuser or may not support the victim's attempts to get help. In cases of suspected child and vulnerable adult abuse and neglect, intervention includes mandatory reporting to appropriate protection agencies. In cases of suspected partner abuse, dental professionals can help patients consider their options, such

as calling the police, talking with an advocate at a shelter, leaving the abuser, taking related brochures, or doing nothing.⁴⁴ Knowing these options, the patient can decide his or her next course of action.

The training also discusses changes to the physical environment that might help abuse victims feel more comfortable during the dental exam. For example, a victim of sexual violence may feel anxious lying back in a dental chair; therefore, minimizing the time the patient spends in this position may help him or her feel more at ease.⁴⁵ Sometimes, simply acknowledging a patient's discomfort with a particular procedure can help alleviate anxiety. For example, victims who have experienced forced oral penetration may be nervous about the use of instruments in their mouths.

Some dental professionals may be concerned about using their limited clinical time to intervene in family violence.⁴⁶ The training emphasizes that they are not expected to be experts on this issue. In fact, referring patients to appropriate community resources is the best course of action.⁴⁷ In the vast majority of cases, an intervention need not last more than 5 to 10 minutes.⁴⁸

Impact of the Training Program⁴⁹

The critical importance of intervention training was documented by analyzing the participant evaluations (n=200) from the *Family Violence: An Intervention Model for Dental Professionals* curriculum. Results showed that the training made a significant, positive impact in teaching dental professionals how to identify and report cases of abuse. The training information about interventions and referrals for patients left dental personnel perceiving these actions as an extension of their practice. The entire training experience made the dental professionals more comfortable in discussing abuse issues with patients.⁵⁰ Training participants also shared anecdotal information with project staff that indicated participants no longer feared making mandated reports in suspected child and elder abuse cases because they knew how and what to report.⁵¹

Conclusion

Educating dental professionals about family violence increases the likelihood they will screen for abuse and appropriately intervene when necessary. Such a response can have a profound impact on the lives of patients who are victims.

To familiarize dental professionals with their role in responding to family violence, it is strongly recommended that training be integrated into dental schools and dental hygiene programs across the country. National and state dental associations can periodically include violence prevention and intervention topics on their conference agendas. Local, state, and national coalitions that address family violence can also educate community service providers about the role of dental professionals and invite dental professionals to participate in related training programs and initiatives for developing a coordinated response.

The University of Minnesota's project, *Family Violence: An Intervention Model for Dental Professionals*, is a useful training tool for increasing awareness of the complex problem of family violence and promoting a proactive response by dental professionals.

For Further Information

Contact OVC's Training and Technical Assistance Center (TTAC) if you are interested in obtaining more information about *Family Violence: An Intervention Model for Dental Professionals* or if you would like to schedule a training program.

OVC Training and Technical Assistance Center

1-866-OVC-TTAC (1-866-682-8822)
(TTY 1-866-682-8880)
Fax: 703-279-4673
Web site: www.ovcttac.org
E-mail: TTAC@ovcttac.org

For training materials or additional project information, please contact

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For copies of this bulletin and other OVC publications or information on additional victim-related resources, please contact

OVC Resource Center

P.O. Box 6000
Rockville, MD 20849-6000
1-800-851-3420 or 301-519-5500
(TTY 1-877-712-9279)
Ask OVC: <http://ovc.ncjrs.org/askovc>
Web site: www.ncjrs.org

Or order OVC publications online at <http://puborder.ncjrs.org>.

Notes

1. In this bulletin, *family violence* refers to partner abuse, spousal abuse, child abuse, and the abuse of elderly and vulnerable adults.
2. Public awareness campaigns and specialized training programs have educated health care practitioners about their roles in responding to family violence. One notable example is the Family Violence Prevention Fund's multifaceted efforts to improve health care response to domestic violence since the mid-1990s. Among other resources, they offer a popular resource manual, a companion trainer's manual, public education materials for providers and patients, and a model health care training program designed

to help health care systems create sustainable programs that help victims of domestic violence (see their Web site at <http://endabuse.org>). In addition, a growing body of literature explores injuries incurred by family violence and the possibilities for clinical intervention in these cases. Also, numerous professional health care associations have developed effective policies, offer literature, and provide continuing education opportunities and other initiatives aimed at promoting effective intervention in family violence, including the American Dental Association, the American Medical Association, the American Academy of Pediatrics, and the American Nursing Association.

3. G. Chiodo, "Dental Health Workers Assess and Manage Family Violence," faculty page on the University of Oregon Health Science Center Web site, www.ohsu.edu/sod/sod-research/chiodo.html. (Note: This Web site is no longer accessible to the public.) Accessed May 21, 2002.

4. The program is now called the Aurora Center for Advocacy and Education.

5. Electronic communication with Jamie Tiedemann, May 29, 2002.

6. V.P. Tilden, T.A. Schmidt, B.J. Limandri, G.T. Chiodo, M.J. Garland, and P.A. Loveless, 1994, "Factors That Influence Clinicians' Assessment and Management of Family Violence," *American Journal of Public Health* 84(4): 632, as cited in S. Short, J. Tiedemann, and D. Rose, 1997, "Family Violence: An Intervention Model for Dental Professionals," *Northwest Dentistry* 76(5)(September-October): 31.

7. See text and references in the American Academy of Pediatrics Policy Statement. "Oral and Dental Aspects of Child

Abuse and Neglect (RE9920): Joint Statement of the American Academy of Pediatrics and the American Academy of Pediatric Dentistry,” *Pediatrics* 104(2)(August)1999: 348–350.

8. D.C. Berrios and D. Grady, 1991, “Domestic Violence: Risk Factors and Outcomes,” *Western Journal of Medicine* 155(2)(August): 133–135.

9. A. Ochs II, M.C. Neuenschwander, and T.B. Dodson, 1996, “Are Head, Neck and Facial Injuries Markers of Domestic Violence?” *Journal of the American Dental Association* 127: 757–761. This study of 127 people at a hospital emergency department found that 75 percent had head, neck, or facial injuries. Of those patients, 23 percent were domestic violence victims.

10. M.R. Christiano, E. Pollard, B. Sturdevant, G. Benson, C. Perron, and T.T. Amatruda Jr., 1986, “Battered Women: A Concern for the Medical Profession,” *Connecticut Medicine* 50(2): 99–103, as cited in Ochs, Neuenschwander, and Dodson: 759.

11. *Family Violence: An Intervention and Training Model for Dental Professionals* (training manual), 2000, University of Minnesota: 22.

12. C. Love, B. Gerbert, N. Casper, A. Bronstone, D. Perry, and W. Bird, 2001, “Dentists’ Attitudes and Behaviors Regarding Domestic Violence,” *Journal of the American Dental Association* 132 (January): 86.

13. P. Tjaden and N. Thoennes, *Prevalence, Incidence and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey*, 1998, National Institute of Justice and

Centers for Disease Control and Prevention, Washington, DC, 1998: 6–9, as cited in Love et al.: 85.

14. Love et al.: 91.

15. Tilden et al.: 630. Clinicians sampled in the study included dental hygienists (n=271), dentists (n=247), nurses (n=236), physicians (n=218), psychologists (n=260), and social workers (n=269).

16. Love et al.: 85.

17. Ibid.

18. J.D. McDowell, D.K. Kassebaum, and G.E. Fryer Jr., 1994, “Recognizing and Reporting Domestic Violence: A Survey of Dental Practitioners,” *Special Care in Dentistry* 14(2): 49.

19. Ibid.

20. Ibid.

21. L.D. Mouden and B. Smedstad, “Reporting Child Abuse and Neglect: The Dental Hygienist’s Role,” *Dental Hygienist News*, www.dentalcare.com/soap/journals/dh_news/dhn0804/dn01n05.htm. Accessed June 8, 2002.

22. Information in this section related to the pretraining survey was drawn from J. Tiedemann and D. Rose, 2000, “Final Report, Family Violence: An Intervention Model for Dental Professionals,” (USOJ/197–GY–K030), University of Minnesota, unpublished. Approximately 278 surveys were analyzed.

23. Love et al.: 85.

24. S. Short, J. Tiedemann, and D. Rose, 1997, “Family Violence: An Intervention Model for Dental Professionals,” *Northwest Dentistry* 76(5)(September–October): 32.

25. G.T. Chiodo, V.P. Tilden, B.J. Limandri, and T.A. Schmidt, 1994, “Addressing Family Violence Among Dental Patients: Assessment and Intervention,” *Journal of the American Dental Association* 125(January): 73.

26. Ibid.

27. Tilden et al. noted that dentists and dental hygienists were most likely to suspect physical spouse abuse, followed by physical or sexual child abuse. Elder abuse was not frequently suspected.

28. After the training, respondents were 50 percent less likely to believe an intervention posed a legal risk to their practice.

29. Tiedemann and Rose, section on “Assessment of a Family Violence Intervention Model for Dental Professionals.”

30. Love et al.: 85.

31. Chiodo.

32. Tilden et al.: 630. Clinicians sampled in the study included dental hygienists, dentists, nurses, physicians, psychologists, and social workers.

33. Love et al.: 91.

34. Ibid.

35. Only a few related educational programs, models, or publications for dental professionals were identified beyond the University of Minnesota’s *Family Violence: An Intervention Model for Dental Professionals*. The author acknowledges that other useful tools on this topic certainly may exist. Love et al. (see endnote 3) suggest that dentists follow the AVDR model when approaching patients who are battered. AVDR stands for Ask about abuse, provide Validating messages,

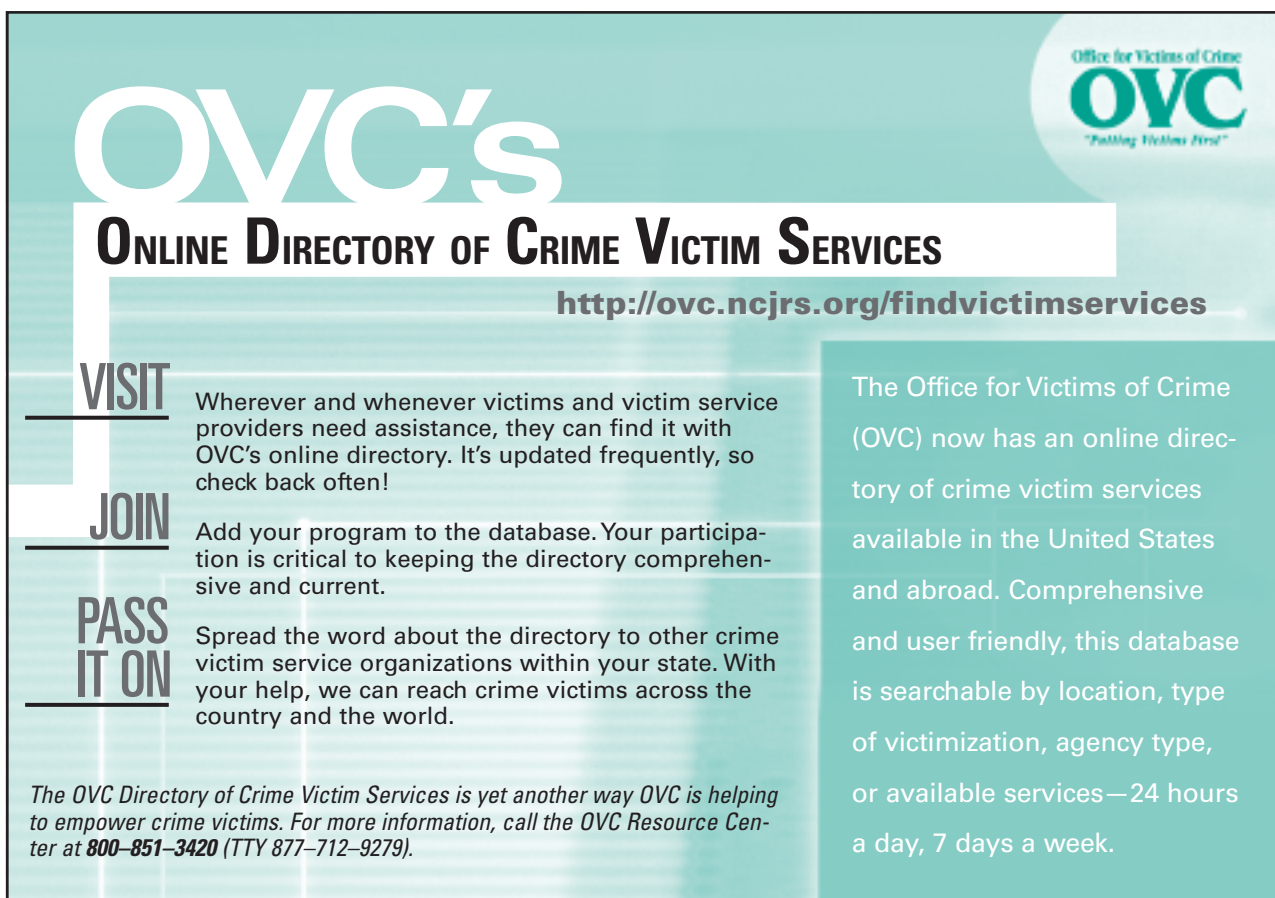
Document presenting signs, and Refer victims to domestic violence specialists. A Canadian guidebook addresses family violence issues in dental practices, educational settings, professional associations, and the community at large (see D. Denham and J. Gillespie, 1994, *Family Violence Handbook for the Dental Community*, Mental Health Division and Health Service Systems Division, Health Services Directorate, Health Canada). Another effort, called PANDA (Prevent Abuse and Neglect through Dental Awareness), has coalitions in at least 46 states, as well as Canada, Peru, and Guam, that educate dental professionals about child abuse and neglect and their responsibility to report suspected patient cases. (Information on the number of PANDA programs is available from Judy Siegel-Itzkovick, 2002, "Reading the

Signs," *Israel Magazine on the Web*, January, www.mfa.gov.il/mfa/go.asp?MFAH01890.) PANDA coalitions typically offer short training sessions for dental staff in their states. In Missouri, the site of the first PANDA coalition, cases of suspected abuse and neglect reported by dentists increased by 160 percent within the program's first year. Other coalitions have reported similar or greater increases in reporting. ("Detecting Child Abuse and Neglect at your Local Dental Office," October 25, 2001, press release, CareFirst Web site, www.carefirst.com/media/NewsReleasesDetails/proct252001.htm. Accessed June 8, 2002.)

36. Information on products and accomplishments in this section was drawn from the University of Minnesota project's final report, first drafts of this bulletin,

actual project materials (curriculum, video boxes, etc.), and communications with project investigators.

37. This team can be a formal or informal network of agencies and individuals in a community that works in partnership to offer assistance in cases of family violence and provide education and training on the topic. Although team composition may vary by jurisdiction, a number of core services are essential to a family violence response, including victim advocacy and services with emergency shelter and housing; social services; health care services; and civil and criminal justice intervention. These services may be provided by domestic violence housing and advocacy programs; sexual assault crisis centers; child advocacy programs; programs that advocate for vulnerable adults; child and



OVC's
ONLINE DIRECTORY OF CRIME VICTIM SERVICES
<http://ovc.ncjrs.org/findvictimservices>

VISIT Wherever and whenever victims and victim service providers need assistance, they can find it with OVC's online directory. It's updated frequently, so check back often!

JOIN Add your program to the database. Your participation is critical to keeping the directory comprehensive and current.

PASS IT ON Spread the word about the directory to other crime victim service organizations within your state. With your help, we can reach crime victims across the country and the world.

The Office for Victims of Crime (OVC) now has an online directory of crime victim services available in the United States and abroad. Comprehensive and user friendly, this database is searchable by location, type of victimization, agency type, or available services—24 hours a day, 7 days a week.

The OVC Directory of Crime Victim Services is yet another way OVC is helping to empower crime victims. For more information, call the OVC Resource Center at 800-851-3420 (TTY 877-712-9279).

adult protection, child support and enforcement, foster care, public assistance, and victim compensation offices; law enforcement agencies, prosecution offices, and legal clinics; medical, dental, mental, and public health organizations and practitioners; and school staff. Other agencies that may be part of a response to family violence include organizations that serve underserved populations and civic, faith-based, neighborhood, and youth groups.

38. Short, Tiedemann, and Rose: 33.

39. Ibid.

40. Ibid.

41. Ibid.

42. J. Tiedemann, D. Rose, and S. Short, n.d., "Family Violence: An Intervention Model for Dental Professionals," early unpublished draft: 8.

43. Short, Tiedemann, and Rose: 34.

44. Ibid.: 35.

45. Ibid.

46. Ibid.

47. Ibid.

48. Ibid.

49. Information for this section was drawn from Tiedemann and Rose: 16–17.

50. Tiedemann and Rose: 16.

51. Communications with Jamie Tiedemann, May 29, 2002.

About the Author

Kristin Littel is an independent consultant who provides technical assistance on violence against women issues, including information gathering, writing, editing, and meeting planning and facilitation. She was a victim advocate for many years, including acting as an executive director of a sexual assault crisis center, a coordinator of a sexual assault unit, and a sexual assault and domestic violence victim advocate and support group facilitator. She was involved in state sexual assault coalition work as a crisis center representative and executive board member. Since 1996, Littel has consulted with the Office for Victims of Crime, the Office on Violence Against Women, the STOP Violence Against Women Grants Technical Assistance Project of the Pennsylvania Coalition Against Domestic Violence, the U.S. State Department's Bureau of International Information Programs, the Center for Effective Public Policy, the Finance Project, and the Rappahannock Council Against Sexual Assault. She also served as a writer for the Center for Sex Offender Management and Washington Crime News Services.

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