12-2001

# The Judicial Process for Victims of Domestic Violence, and The Health Impact of Domestic Violence

Assembly Select Committee on Domestic Violence

# Assembly Select Committee on Domestic Violence

Rebecca Cohn, Chair



The Judicial Process for Victims of Domestic Violence
December 10, 2001
San Diego

The Health Impact of Domestic Violence
December 11, 2001
Los Angeles

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# FACTS ABOUT DOMESTIC VIOLENCE

- **Every nine seconds a woman is beaten**
- **Four women are killed by their partners every day**
- **3,000 women are killed by their partners every year**
- **81% of suicide attempts are by victims of domestic violence**
- **13% of children grow up in domestic violence households**
- **43% of domestic violence incidents are NOT reported to the police**
- **Men commit 95% of reported spousal assaults**
- **Victims leave their batterers an average of five to seven times before they are able to leave permanently**
- **Alcohol or drug use is present in a majority of domestic violence incidents**
- **Domestic violence is one of the nation's best kept secrets**

# SUMMARY REPORT
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# EXECUTIVE SUMMARY

## Introduction

Her name is not important, her story is....

With strong conviction and quiet dignity, the survivor of domestic violence takes her place at the podium. She is the only "survivor of domestic violence" willing to testify at the Assembly Select Committee on Domestic Violence. Overcome with emotion she begins her story. Sexually abused as a child she sought escape by marrying at the age of fourteen. She had five children by the time she was twenty-two years old. Her first marriage is an abusive one that she leaves when she recognizes her children are in danger, but she does not seek help. No one believed her before, why should anyone believe her now? Instead she marries again only to find herself in another abusive relationship. It is only when one of the children reveals they also are being sexually abused that she goes for help. With the past catching up the mother recognizes that only she can stop the cycle of violence for herself and her children. Fortunately the story has a happy ending. The mother seeks help in leaving an abusive relationship for the last time and becomes an amazing community advocate – a role model if you will, in helping others stop the cycle of violence.

## Mission

Compelling testimony evolved from all that participated in back-to-back hearings of the Assembly Select Committee on Domestic Violence held in San Diego and Los Angeles. What were presented were two streams of dialogue – one focused on the judicial process, the other on health care impact. The hearings serve as a catalyst to develop a strategy to encourage collaboration in sustained ways. Mapping out the strategy provides a statewide agenda for the committee whose mission is threefold:

- Increase public awareness of domestic violence;
- Encourage domestic violence awareness education in public schools, medical and nursing schools and law enforcement training;
- Advocate for necessary legislative changes that encourage collaborative efforts to end domestic violence and help victims recover.

## Hearing Summary

Four concepts best describe the shaping of policy for the committee: initiate a public awareness campaign, expand prevention through education and training, standardized data collection and improve coordination of resources and build on existing programs.

Public Awareness Campaign

Domestic violence is a public health issue. Much of the general public is unaware that each year 3,000 women are killed by their partners. The domestic violence awareness campaign could mirror strategies of the public health campaign to

inform the public about the dangers of cigarette smoking. A public awareness campaign serves to mobilize the public to be part of the solution.

Education
Teaching educators, judges and health care professionals to understand how their decisions can play a critical role in preventing domestic violence injuries and death is essential. Learning about domestic violence and how to identify, assess and intervene is a new skill set for most medical practitioners, a skill set layered onto a profession that has increasing responsibility with diminishing resources. Much like child abuse, domestic violence needs to be better incorporated into the public education arena.

Data Collection
There is no centralized bank of data information in which to access accurate domestic violence incidents and cross-reference it to create workable solutions. Data that is collected is incomplete, inaccurate and lacks coordination with other reporting agencies. Evaluation efforts are hindered by a lack of relevant data but evaluation needs to be built into any intervention. This provides a body of outcomes in which research can proceed.

Integrate Resources
Any woman will choose safety if a strong platform of resources is in place for her. The need to build on existing services and develop a collaborative, multi-agency approach is necessary to assure resources are in place. This will assure immediate referral and access to necessary healthcare, trained advocates to assist in navigating through the various systems, trained law enforcement, shelter-based programs to provide immediate security to families, resources from the Department of Child and Family Services, services of the District Attorney and City Attorney's offices and mental health services. If any of the resources falls short or is not accessible, victims fall through the cracks and won't return.

**Conclusion**

Many community problems result from the failure to implement creative solutions that have already been identified. The strategy that evolved from the hearings not only identifies creative solutions and successful collaborative efforts but also puts forth recommendations from the experts that need to be implemented. Emphasized at the hearings was that success requires a commitment to excellence and a passion to make a difference, to remove the victim's fear and instill hope in their lives.

The enclosed report contains the hearings' agendas, summary of judicial and health care barriers, along with testimonial recommendations to the committee. Also included are published reports submitted by professionals working in the domestic violence field. Of particular note is Attachment 3 reflecting an innovative model hospital-based approach to Creating a Healthcare Response and Attachment 4 on Shaping California's Health Policy for Victims of Intimate Partner Violence. The report concludes with an overview of California and national legislation pertaining to domestic violence.

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# ASSEMBLY SELECT COMMITTEE ON DOMESTIC VIOLENCE

## REBECCA COHN, CHAIR

MONDAY, DECEMBER 10, 2001
SAN DIEGO, CALIFORNIA

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# California
# Assembly Select Committee on Domestic Violence
## Rebecca Cohn, Chairwoman

The Judicial Process: Impact on Victims of Domestic Violence
Monday, December 10, 2001
10:00 a.m. - 12:00 p.m.

County Board of Supervisors Chambers
1600 Pacific Hiway
San Diego, CA

**10:00 a.m. - 10:10 a.m.** **Opening Statement and Introduction of Members**
Assemblymember Rebecca Cohn, Chair

**10:10 a.m. - 11:35 a.m.** **Speakers**

**Judicial Challenges**
*Casey Gwinn, San Diego City Attorney*, serves as the chief legal advisor and prosecutor for San Diego focusing on early intervention. The National Council of Juvenile & Family Court Judges chose his unit as a model in prosecution for the nation in the handling of domestic violence cases.

**Court Room Procedures**
*Judge Browder A. Willis, San Diego Superior Court*, will present Court Room Procedures. In your handout is a copy of the California Courts Self-Help Center website on domestic violence.

**Public Defender Representation**
*Juliana Humphrey, Chief Deputy of San Diego County Public Defenders Office* is responsible for representing the batterer in misdemeanor and felony domestic violence cases. Participates on the San Diego County Domestic Violence Council's Treatment Evaluation & Monitoring Committee to assure the quality, availability and safety of court-ordered domestic violence treatment programs for batterers.

**Family Court Representation**
*Kate Yavenditti, Senior Staff Attorney for the San Diego Volunteer Lawyer Program* heads up the family law and domestic violence unit; consults on domestic violence curriculum; is a founding member of the San Diego Domestic Violence Council.

**Law Enforcement Response**
*Lt. Jim Barker with San Diego Police Department* runs the nationally recognized Domestic Violence Unit and is the Commander of the Emergency Negotiations Team. Lt. Barker also hosted a weekly radio talk show on domestic violence and serves on numerous domestic violence councils/committees.

**Victims Services Advocacy Response**
Collette C. Galvez, *Staff Attorney for the Legal Advocacy Program for Domestic Violence Victims, YWCA*. Collette goes into the community to conduct mobile clinics for victims.

**11:35 a.m. - 11:50 a.m.** **Public Comment**

**11:50 a.m. - 12:00 p.m.** **Closing Remarks**
Assemblymember Rebecca Cohn, Chair

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## OPENING STATEMENT

- Welcome and thank you for joining us today. I would like to especially acknowledge each of our presenters for their time in preparation, their expertise and knowledge that they lend to our hearing and discussion today.

- I am pleased to introduce several colleagues interested in today's hearing on the Select Committee on Domestic Violence: Senator Dede Alpert and Assemblymembers Patricia Bates and Juan Vargas.

- Statistics on domestic violence are startling and cross every socioeconomic, religious and cultural status:

  - Each day, four women are killed by their partners;
  - Every 9 seconds a women is beaten;
  - Some 2,000 children are abused, witnesses to abuse or neglected and abandoned;
  - Domestic violence is not racially, socially, religiously or culturally motivated; domestic violence knows no bounds.

- Today we are going to address domestic violence and the judicial system head-on. I have brought experts together to develop a framework for understanding and addressing the judicial system's response to domestic violence.

- All areas of domestic violence are critical to address. Today, let's think for a moment what it must be like for victims of domestic violence to come forward. Families are faced not only with coming forward to report the crime, but also with all the ramifications coming forward brings and with the daunting court process. For some, the courts present a quagmire too difficult to navigate; for others, they feel victimized again by the courts often due to lack of resources or lack of knowledge of the judicial process.

- Our aim is not to take a shot at the judicial system – Rather today's hearing will:

  - Provide a glimpse of how the judicial system operates;
  - Look at what has been retooled in the judicial system to be more responsive to victims;
  - Present an opportunity to collaborate on innovative ways to smooth the judicial path for victims.

# SUMMARY OF TESTIMONY

**Problems Identified**

Victim Barriers

- The judicial system can be a daunting process for the victim
- The Urban Institute documented that women filing for protection orders are abused an average of 13 times in the year before they seek judicial relief, and that most women only come to court in desperation after everything else has failed to stop the abuse
- Concern over safety as many misdemeanor defendants get released from custody the same day they settle their cases
- Victims not receiving important information or not understanding what transpired in the courtroom
- Victims fear they will lose their children if they go to court

System Barriers

- Courts are expected to be appraised of violence in the family in order to render an "informed decision" when in reality they seldom receive that information or be given inaccurate information
- What works in civil court does not necessarily work in criminal court
- No two courts are the same in the handling of domestic violence cases, there is no standardization
- Courthouses have design flaws that make movement of persons in custody awkward at best and unsafe at worst
- Few designated areas for attorneys to meet privately with clients
- Volume of court cases makes understanding of plea forms, probation condition forms, and stay away orders unlikely
- Cultural differences or special needs clients can make a "simple" morning session stretch into the afternoon
- Coordination of information between family court and criminal court is deficient
- Court resources are limited
- Educational training

## WITNESSES' PROPOSED SOLUTIONS TO IMPROVE THE JUDICIAL PROCESS FOR DOMESTIC VIOLENCE CASES

1. Establish 2-3 sites – San Diego, Santa Clara and San Francisco – willing to participate in a demonstration project to identify best practices to be modeled throughout the state.

2. Create a task force to respond to courts concerns about victims safety around:
   - Guidance for judges on lifting or imposing stay-away orders and whether they should be imposed over the objection of the victims;
   - Direction on issuance of stay-away orders when defendant posts bail and a restraining order is not in place prior to the trial until an assessment of the victim's safety can be made;
   - Better coordination and communication between Family Court and Criminal Court to assure timely information. Judges feel at the mercy of making decisions based on little information rather than an informed decision because they do not have accurate, up-to-date information such as criminal history;
   - Create a prototype collaborative system connecting law enforcement with the courts.

3. Enable family court judges to issue bench/search warrants when defendant is ordered to turn over a weapon.

4. Recruit community-based court advocates whose primary responsibility is to support and assist victims in navigating through the judicial process
   - Establish a hotline for family court victims to secure advocates;
   - Funding to expand/operate domestic violence mobile clinics to assist victims with securing restraining orders, securing necessary information, navigating the process.

5. Provide funding to legislation (SB 66, Kuehl) that requires background check but was passed with no funding attached.

6. Amend Family Code Section 6228 to waive required certified copies that are being charged to victims if they waive the requirement.

7. Fund visitation/custody exchange centers to supervise and/or evaluate visitation and custody exchanges.

8. Order courts to prepare orders where party and/or victim is unrepresented.

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## REBECCA COHN, CHAIR

TUESDAY, DECEMBER 11, 2001
LOS ANGELES, CALIFORNIA

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# California
# Assembly Select Committee on Domestic Violence
## Rebecca Cohn, Chairwoman

The Health Impact of Domestic Violence
Tuesday, December 11, 2001
10:00 a.m. - 12:00 p.m.

Children's Hospital Los Angeles, Santa Anita Lecture Hall
4650 Sunset Boulevard
Los Angeles, CA

**10:00 a.m. - 10:10 a.m.** **Opening Statement and Introduction of Members**
Assemblymember Rebecca Cohn, Chair

**10:10 a.m. - 11:35 a.m.** **Speakers**

**Impact on Patients**
*Carolyn Sachs, MD, MPH, Emergency Physician at California Medical Center in Los Angeles* and Chairperson of the Domestic Violence Committee at UCLA Medical Center.

**Impact on Healthcare Delivery System**
*Robert Splawn, MD, MPH, FACEP, Medical Director for Hospital Medical Center for Emergency Services* and founder and medical director of both the Sexual Abuse Response Team and the Domestic Assault Response Team, two highly innovative programs providing victims with comprehensive medical, social and law enforcement services.

**Creating a Healthcare Response**
*Mary E. Morahan, LCSW, Director of Clinical Training and Coordinator Community Mental Health Center for the Violence Intervention Program at LAC + USC Medical Center.* Chairs the Los Angeles County Domestic Violence Council that includes all the domestic violence agencies, organizations, advocates in the county.

**Public and Professional Health Education**
*Connie Mitchell, MD, Director of Domestic Violence Education at U.C. Davis Medical Center*. Heads a multi-million dollar project to improve the healthcare response to victims of violence and recognized medical expert in intimate partner violence injuries.

**Public and Professional Health Education, continued**
*Patrick Shibuya, Assistant Superintendent for the Domestic Violence Unit for the Los Angeles City Attorney's Office*. The domestic violence unit is the oldest and largest in the United States with 37 prosecutors and specialized victim advocates. The unit is responsible for drafting legislation that created over 75 laws on the books.

*Denise Brown, founder of The Nicole Brown Charitable Foundation.*

**11:35 a.m. - 11:50 a.m.** **Public Comment**
*Survivor of domestic violence*

**11:50 a.m. - 12:00 p.m.** **Closing Remarks**
*Assemblymember Rebecca Cohn, Chair*

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## OPENING STATEMENT

- Welcome and thank you for joining us today. I'd like to especially acknowledge each of our presenters for their time in preparation, their expertise and knowledge that they lend to the second of our Southern California hearings.

- I am pleased to introduce my colleagues Assemblywomen Gloria Negrete-McLeod and Carol Liu.

- Violence-related injuries are often life threatening, frequently resulting in life-long disabilities, and certainly mental health disabilities.

- While impossible to put a price tag on the emotional pain, lost opportunities, damage that violence wreaks upon victims, families and communities, it is possible to estimate the direct medical costs associated with violence.

- About $44 million is spent annually to treat injuries caused by domestic violence, not including indirect costs such as long-term mental health care or educational services.

- Today's hearing will:

  - Explore the Health Impact of Domestic Violence on victims and providers of healthcare;
  - Provide an opportunity to look at an innovative model program that reaches beyond the hospital and clinic walls to assist healthcare professionals identify and provide positive support to reluctant victims of domestic violence;
  - Look at how some healthcare providers are addressing the root causes of violence in our communities.

- The emergency room is the most likely place to identify a domestic violence patient.

- Yet, domestic violence is underreported in the health care setting, due to a number of reasons ranging from victim reluctance, denial, intimidation, and lack of proper training for healthcare professionals to recognize, identify, treat and report suspected cases of domestic violence.

- Identifying a patient as a victim of domestic violence is only the beginning. Let's turn to our panel of experts.

# SUMMARY OF TESTIMONY

**Problems Identified**

Patient Barriers

- Some women are reluctant or unable to seek help
- Some women are literally held captive and not allowed out of the house, others may not have money or means of transportation
- Cultural, ethnic or religious background can also influence women's response to abuse and her awareness of viable options.
- Shame and humiliation at the way she is being treated or will be judged
- Fear that revelation will jeopardize her or her family's safety
- Past abuses make it more difficult for a battered woman to recognize a relationship as abusive and take steps to protect herself
- Belief that her injuries are not severe enough to mention or that she won't be believed
- Manipulation through multiple births
- Her partner may not always be abusive and this gives her hope that he will change
- Unease with the privacy protections for their medical records

Physician Barriers

- Physicians themselves are not mandated to report domestic violence incidences, only licensed healthcare facilities
- Lack of awareness to identify a domestic violence patient
- Too sensitive of an issue to raise
- Belief that identification of abuse and referral is not part of the physician's role
- Not knowing how to intervene or help even if a woman is recognized as being battered
- Concern that discussing psychosocial issues will take an overwhelming amount of time in managed care environment
- Physician's feelings of inadequacy if he/she can't fix the situation

Hospital Barriers

- Compliance with the mandate to screen and report cases has been variable
- No standardization for screening procedures
- Educational efforts are not well coordinated throughout the state; there are varied curricula in both medical and nursing schools in which core competencies cannot be identified
- There are multiple obstacles in addressing the cross-over of child and adult victimization from domestic violence abuse
- Healthcare and criminal justice services overlap when a patient is also a victim of crime
- Better coordination between hospitals and examination teams to provide forensic services for child abuse and sexual assault victims

# WITNESSES' PROPOSED SOLUTIONS TO IMPROVE THE HEALTH AND SAFETY OF VICTIMS OF DOMESTIC VIOLENCE

1. Coordinate domestic violence data collected on all inpatient admissions to hospitals in the form of a special code to identify the nature of injuries. Problem arises in that insurers reimburse domestic violence codes at a lower rate so physicians aren't coding domestic violence as such. This hampers appropriate referrals and tracking.

2. Expand domestic violence education by collaborating with Proposition 10's "Safe from the Start" tobacco tax funded program for children exposed to violence.

3. Provide funding to create electronic data base to capture:
   - Coordinate with State Library resources to assemble a county-by-county statistic on actual count of reported domestic violence cases, number of resources within each county;
   - Injury data from forensic examinations;
   - A restraining order database linked to gun sales applications;
   - Data regarding resiliency factors in both child and adult survivors of domestic violence to develop effective recovery approaches to intervene in violent families;
   - Review screening practices in substance abuse and mental health programs;
   - Review intervention strategies for mental health and substance abuse problems in batterers' treatment programs;
   - Impact of welfare to work regulations on women's access to needed services;
   - Assess how immigration policies affect survivors of domestic violence;
   - Funding to provide technical assistance to ethnic communities to collect standardized data to learn more about the context of violence in different cultures;
   - Establish reliable data to provide definitive link between domestic violence and health outcomes. Can be accomplished by collaborating with community agencies and advocacy organizations for data collection.

4. Mandate a dual response to domestic violence families by Child Protective Services and adult advocates and service agencies.

5. Secure reimbursement for forensic examinations from Victims of Crime Fund Increase funding for mental health services that address violence related conditions such as Post-Traumatic Stress Disorder.

6. Provide funding for increased research to learn about domestic violence from a contextual basis across age, ethnic and cultural groups.

7. Initiate a public awareness campaign by displaying billboards, bus banners, hotlines in every bathroom to promote awareness of domestic violence.

8. Mandate parenting education in batterers' treatment programs and require education for adolescents on parameters of healthy partner relationships.
9. Provide funding for:
   - Mental health services for women and children;
   - Case management requirements in caring for domestic violence families;
   - Services and intervention for children, especially those under the age of 5 who are viewed as most vulnerable to long term effects of domestic violence;
   - Programs for pregnant women in shelters and jails regarding the impact of domestic violence on children.

10. Increase physician reimbursement rates in California; introduce programs to help victims stay employed so that they can stay insured; create a "carve-out" for Medi-Cal domestic violence patients similar to the prenatal care carve out plan to ensure provision of comprehensive services.

11. Create an interdisciplinary task force, mandated by the state, to develop a model business case for healthcare domestic violence intervention.

12. Mandate Domestic Violence Coordinating Councils to adopt interdisciplinary programs and intervention on a county by county basis.

13. Create an interdisciplinary mortality review similar to the Domestic Violence Death Review Teams (Penal Code 11163.5) to conduct and identify avenues of prevention and improved intervention.

14. Tap into Victims of Crime Funding to support intervention services for domestic violence patients

ATTACHMENT 1

# DOMESTIC VIOLENCE REPORT

# BATTERER MANIPULATION AND RETALIATION IN THE COURTS: A LARGELY UNRECOGNIZED PHENOMENON SOMETIMES ENCOURAGED BY COURT PRACTICES

JOAN ZORZA

# Batterer Manipulation and Retaliation in the Courts: A Largely Unrecognized Phenomenon Sometimes Encouraged by Court Practices

by Joan Zorza

### Myths Falsely Casting Doubt on Women's Credibility

Many myths are still believed about battered women, myths which were largely created by the men who abuse them. Further compounding the confusion about battered women is the fact that many of the first academics writing about domestic violence repeated those myths, further legitimating them.

**Origins of Myths.** Before the early seventies there was virtually no study of spouse abuse. Only five short studies of the problem existed in the social and behavioral sciences when "spouse abuse" was first given a heading in the social sciences indexes in 1972. Furthermore, all of those studies incorrectly assumed that it was the wife who caused the problem by provoking her mate (Gondolf, 1985, p.4). Those first studies of battered women also assumed that wife abuse was extremely rare, so rare that the first battered women identified were believed to represent a large portion of the abused women population. Unfortunately, because the first to study the phenomena wrote about battered wives in mental hospitals, that not surprisingly included a number of battered women patients, they concluded that all battered women were mentally ill. Those studying and treating these institutionalized battered women would often ask the women's abusers what caused the women's conditions. Like most batterers, being calm, respectable and credible, in contrast to their wives (Adams, 1998, p.23), the batterers were believed. These first studies, being the only literature and "knowledge" then existing, were used inadvertently to validate many of the myths reported by the women's batterers.

In addition, we now know that many battered women consigned to mental hospitals were misdiagnosed, largely because the domestic violence and its effects were never recognized (Walker, 1994, p. 7) or misdiagnosed (Rosewater,1988, pp. 200-214). Unfortunately, this practice of inappropriate, involuntary admissions of battered women to psychiatric hospitals continues today, though far less often (Gondolf, 1998, p. 76).

However, for the batterers, who are notorious for denying or minimizing their abusive behavior and for blaming their victims for everything wrong including their own abusiveness (Adams, 1989, pp. 23-24; Gondolf, 1998, pp. 77.132-38; APA, 1996, pp. 81-82), the chance to explain their wives mental condition was an open invitation to assert misinformation. These mistruths became the basis for most of the myths about domestic violence, many of which are still believed today.

*Some abusers file actions or complaints, threaten, or actually injure witnesses, staff of battered women's shelters, the victims' attorneys, custody evaluators, or even court personnel who show sympathy for the victims. ... [C]ourts seldom punish men for such wrongful behavior.*

**Women Seldom Make False Accusations of Abuse.** One of the most pernicious of these myths, which is still widely repeated and believed, is that women frequently make false allegations of their own or a child's abuse, and are particularly likely to do so for purposes of tactical gain in divorce or custody cases. In fact, women seldom make false allegations of either domestic violence (Harrell, 1993; APA, 1996, p. 12) or child physical or sexual abuse (Thoennes, 1990, p. 161; APA, 1996, p. 12).

The Urban Institute documented that women filing for protection orders are abused an average of 13 times in the year before they seek judicial relief, and that most women only come to court in desperation after everything else has failed to stop the abuse (Harrell, 1993, p. 54). The women they studied did not come to court after minor incidents; 77% had experienced severe violence from their abusers, including being run down with a car, raped, kicked, bit, punched, beaten, choked, strangled, and/or threatened with a weapon (id, p. 55).

Similarly, child sexual abuse allegations are not common. Contrary to the myth that sexual abuse allegations are frequently made in divorce custody disputes, they are made in only 2-3% of divorce cases (Thoennes, 1990, p. 161; APA, 1996, p. 12) and in less than 10% of contested custody cases (APA, 1996, p.12). Even then, when the allegations are objectively investigated, the allegations are confirmed as often when custody is being disputed as when there is no divorce or custody case (id.; McGraw, 1992, p.58).

**Batterers Lie and Manipulate.** Men who abuse women minimize or deny their abuse or falsely blame their circumstances or others, especially their victims, for their behavior (APA, 1996, p. 82; Gondolf, 1998, p. 132; Dutton, 1995, p. 105; Barnett, 1997, p. 237; Pence, 1993, pp. 153, 158; Sonkin, 1995, p. 19). This is a polite way of saying that they lie and manipulate, in large part by projecting much of their own behavior onto their victims. When batterers feel that their authority is being threatened, they escalate their violent and terroristic tactics, often threatening to kill or seriously injure their victims (Adams, 1989, pp.

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23, 24); their children, families or loved ones (id.; Dutton, 1995, p. 105; Pence, 1993, pp. 152, 155; Barnett, 1993, p. 50); or even themselves (Adams, 1989, p. 24; Pence, 1993, p. 155; Dutton, 1994, pp. 49, 103). Batterers "who blame their female partners are likely to be even more violent than those who do not" (Barnett, 1993, p. 237). Regardless of whether or not they blame their partners for their abusive conduct, all too often batterers carry out their injurious and even homicidal threats (Pence, 1993, p. 155), particularly in response to a partner's leaving them. Indeed, the government's Bureau of Justice Statistics found that separated and divorced women, who comprise only 10% of all women, are battered fourteen times as often as women still living with their abusers and report 75% of all spousal violence (Harlow, 1991, p. 5).

*When courts are repeatedly given biased or uninformed information by "experts" ... it is likely that this misinformation will impact not only the specific case involved, but will spill over to other cases involving domestic violence. ... resulting in greater gender bias against women, allowing the abuse to escalate unchecked without proper intervention.*

**Few Therapists Trained in Domestic Violence.** Further complicating courts' understanding of the credibility and culpability of the parties is the fact that few therapists and custody evaluators have any (or sufficient) training in or understanding of domestic violence (Zorza, 1996; APA, 1996, p. 13), and few screen for it or follow up when told about it (Zorza, 1997; Gondolf, 1998, pp. 133-34). Even in psychiatric emergency rooms domestic violence is minimized or neglected, with staff seldom inquiring about it, or following up when told about abuse. At best the violence is regarded "as a secondary or tangential problem" and no referrals or interventions are typically made for the violence (Gondolf, 1988, p.134). As a result most mental health experts completely miss men's abusive behavior problems. Likewise, such mental health experts are likely to misinterpret battered women's generally maladaptive behaviors, which are normal responses to the abuse (Dutton, 1993, pp. 70-71; Gondolf, 1998, p. 81). These experts often misinterpret battered women's psychological tests to be the result of a mental illness or problem (Rosewater, 1988, pp. 200-214), most frequently "major depression, paranoid schizophrenia, dependent personality disorder, and borderline personality disorder" (Gondolf, 1998, p. 81), erroneous diagnoses likely to hurt battered women in a divorce or custody dispute.

Other mental health experts harbor false stereotypes that prevent them from looking for or recognizing family violence (APA, 1996, p. 13). These false stereotypes also cause the experts to fear getting involved, particularly if they have to report the abuse, "because they do not believe the outcome really will protect the victim, or because they fear for their own physical or psychological safety" (id.), fears which are not unrealistic (Zorza, 1998).

Batterers are adept at manipulating mental health professionals. A batterer "may appear very rational, sane and 'together.' If he does admit to abuse, he might seem regretful and contrite. He may be able to make his battering appear justified or momentary, or make it appear as part of his substance abuse or depression. Batterers, as a result, often elude identification in mental health settings, or clinicians minimize or neglect the battering that is reported or identified" (Gondolf, 1998, p. 132). "Even when batterers acknowledge their past abuse, they attempt to impress upon therapists and others that they can control any future violent and abusive behavior" even though this is most unlikely (id. at 81). Batterers will use the counseling to manipulate, only to drop out as soon as they have achieved their goal (usually return of their partner or having charges dropped), which in part explains their very high dropout rates (Gondolf, 1988, p. 87).

**Lack of Knowledge of Guardians in Domestic Violence.** Similarly, guardians ad litem and others supposed to protect the children's best interests are seldom knowledgeable about family violence (APA, 1996, p. 102). Furthermore, many of them lack adequate training in child development (id.), making it less likely they will recognize or correctly assess for signs of abuse or of having witnessed abuse.

As a result, although courts expect to be appraised of violence in the family, they seldom receive that information or, even worse, may be given inaccurate information, including being led to believe that there is no abuse. When courts are repeatedly given biased or uninformed information by "experts" who are supposed to represent the children's interests, it is likely that this misinformation will impact not only the specific case involved, but will spill over to other cases involving domestic violence. The misinformation may result in judges having further misperceptions about men's and women's credibility, resulting in greater gender bias against women, allowing the abuse to escalate unchecked without proper intervention.

### Batterer Retaliation

Not only do abusers lie, they also manipulate and use the court system to further control and discredit their victims. Batterers also retaliate; studies show that "as many as half threaten retaliatory violence" during the pendency of prosecution (Buzawa, 1996, p. 101) and 32% of batterers inflict an average of three further assaults on their partners in the first six months after their initial assaults (id., at 100). Their retaliation is not restricted to when they are criminally prosecuted. Batterers "manipulate family members, police, and social service providers to be against the battered woman and counter her story" whenever they feel threatened (id., at 77). A victim filing for divorce, custody, child support, or civil protection can be just as vulnerable to retaliation.

**Retaliation Through Manipulation of Court System.** Many abusers, upon learning that cross or counterclaims often cancel out the prior claim, bring counterclaims or contempt charges (Edleson, 1992, pp. 31, 34), often at no financial cost to themselves, but at enormous financial and emotional costs to their vic-

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tims. Abusers will also report their wives to welfare (Pence, 1993, p. 158) or file retaliatory litigation against their victims to drive them into homelessness or welfare; half of America's homeless women and children are homeless because of domestic violence (Zorza, 1991, p. 421).

**Retaliation Through Children.** Because abusers learn that they can hurt their victims most by using their children (Liss, 1993, pp. 179, 181; Pence, 1993, pp. 148-149; Dutton, 1992, p. 138), custody litigation is common, even when the abuser has never show the slightest interest in parenting. Indeed, abusive husbands and fathers are considerably more likely to fight for custody than are non-abusive men (Liss, at 181-183; APA, 1996, p. 100). It is not uncommon for a batterer (or a relative or new girlfriend, acting at his request) to falsely accuse his victim or his victim's new partner of abusing or abducting a child or of denying him access to his child. These tactics can be highly successful in redirecting the blame at the victim or getting custody of a child (Pence, 1993, pp. 152, 158). In addition, the abuser's family may support him in court, often with perjurious testimony or by filing their own suit against the victim for custody of the abuser's children.

The batterer may also force his victim to bring further litigation, e.g., abusive men are far less likely than non-abusive men to pay alimony or child support (Liss, 1993, 181; Kirkwood, 1993, p. 99). In turn, the abuser may retaliate with additional violence when the victim or the welfare system seeks alimony, child support or any property distribution from him (Kirkwood, at 98). In addition, he may use visitation to hurt or threaten the victim or the children (Liss, at 182-183), and is likely to use any court granted access to the victim (e.g., mediation, couples counseling, or shared parenting arrangements), as a further opportunity to continue his control of her.

**Retaliation Against Third Parties.** The victim and her children may not be the only victims of the abuser's retaliation. Some abusers file actions or complaints, threaten, or actually injure witnesses, staff of battered women's shelters, the victims' attorneys, custody evaluators, or even court personnel who show sympathy for the victims. Although batterers frequently falsify facts and manipulate the courts, agencies, and police for their personal advantage or to hurt their victims, courts seldom punish men for such wrongful behavior.

### Victim Blamed for Behavior Induced by Abuser

Another method used to obscure batterers' bad behavior is to focus on the dysfunctional nature of the family, based on the fact that their abused partners may also have some maladaptive behaviors. What is not considered is that the women's maladaptive behaviors often arise after the abuse begins, either as a coping mechanism to deal with the abuse and stress or through the force of their abusers. It is not uncommon for abusive men to force or entrap their female partners into substance abuse or crime or child abuse, all under threat of further violence if the women do not comply (Gondolf, 1998, p. 81; Richie, 1996). Also, the courts often blame abused mothers for actions they take to protect themselves and their children, claiming that they are alienating their children (Smith, 1997) or not fostering a good relationship between the child and the other parent (Zorza, 1992). However, even the American Psychological Association says there is no scientific basis for the theory of parental alienation syndrome (APA, 1996, p. 40).

### Victim Blamed for Abuse

Equally problematical is the courts' tendency to blame mothers for the abuse inflicted on them or their children by their past and current male partners (Edleson, 1998). This can happen because courts, police and legislatures are "unwilling to offer realistic safety and economic alternatives" to adequately protect the women and children from abusive situations (id., at 295). Although few women purposely place their children at risk, when children are injured the courts increasingly tend to charge the mothers with failure to protect or reckless endangerment, often without charging the men for the abuse they have inflicted. This practice not only unfairly blames the mothers, but also encourages abusive men to continue the abuse so that the women will lose custody of the children to the state. Often the men absolve themselves of having to pay child support by precipitating the state to take custody of their children. These men, who have seldom played any meaningful, responsible parenting role in their families (Kirkwood, 1993, pp. 54-55; Peled, 1995, p. 8), are rewarded by having their partners back full time to themselves, no longer burdened by children. Since many women will be depressed and confused after having been blamed for the harm inflicted by their abusive male partners, they may be too psychologically devastated to leave their abusers. Even if they leave, their male partners are likely to continue to increase the violence.

### What Should Be Done

It is time to abandon the myths about battered women and gender biased practices and laws. In particular, anyone in the civil or criminal justice system who assumes that women make false allegations of domestic violence or child sexual abuse for tactical gain, should be considered unfit to investigate, prosecute, act as expert, represent the children, or sit in judgment of such cases. People with this impermissible presumption are either ignorant of domestic violence or gender biased against women, in either case rendering themselves unqualified. They should be struck for cause from juries. Such bias should be seriously pursued in judicial appointments and elections, and bar associations and other screening committees should be willing to pronounce a candidate unfit who professes or acts in accordance with such beliefs.

When the abuse is directed at the battered victim's attorney or when the court appears vulnerable to the abuser's manipulation and ploys, the victim's attorney may feel drained and demoralized. The attorney may also feel vicariously abused (Zorza, 1998) solely as a result of abuse directed at the client or other people. Battered women's programs may help an attorney who is experiencing such stress. The victim's attorney nonetheless must represent the client zealously, and if this becomes impossible, the attorney may have to raise the issue with the court or help find the client another attorney. Counsel must be willing to use the court to enter orders to protect themselves; battered victims' attorneys have obtained their own protective orders against abusers.

Not punishing batterers for their falsification of evidence and manipulation of witnesses and courts subverts justice and further contributes to the cycle of violence. It rewards the wrongdoers and fails to protect the victims and their chil-

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dren. At a minimum, letting the abuser get away with such tactics reinforces the victim's powerlessness and sends the message to everyone that such behavior is permissible. A far better response is to hold the abuser accountable.

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court failed to consider his allegations of abuse by the mother. The case was again remanded to the trial court with instructions to make specific findings on all allegations of abuse and to make any changes in custody on that basis as required by statute. In **Zimmerman v. Zimmerman**, 569 N.W.2d 277 (N.D. 1997), there was evidence that both parties had committed acts of domestic violence, but the trial court found the parties' marriage "highlighted by several episodes of physical abuse" by the father against the mother, and awarded the mother sole custody. The supreme court remanded because the findings were conclusory only and did not measure the amount and extent of violence by both parents or adequately explain the court's basis for its custody award.

**One Incident of Disciplining Child Found Insufficient to Raise Presumption.** In **Dinius v. Dinius**, 564 N.W.2d 300 (N.D. 1997), the father was awarded custody of all four of the parties' children. Custody of the oldest child, a daughter, was later transferred to the mother based on the daughter's preference. Four years later the mother later moved for custody of the three younger children and alleged that the father was a perpetrator of domestic violence based on two incidents involving the oldest child that had happened six years earlier. Finding such violence, the court transferred custody to the mother. The father appealed, claiming he did not commit domestic violence, but rather was disciplining his daughter in a manner permitted by statute. The supreme court noted that parents may use "reasonable force" in disciplining children and that the legislature intended that such "reasonable force" would not constitute domestic violence. Moreover, the court found that the acts were remote in time, did not involve serious injury (although one incident left "marks on [her] arm" and "some bruises" on her head), and did not suggest a pattern of domestic violence. In addition, the court noted that a 1997 amendment to the custody statute clarified that "one incident of domestic violence which resulted in serious bodily injury or involved the use of a dangerous weapon or . . . a pattern of domestic violence within a reasonable time proximate to the proceeding" is necessary to invoke the domestic violence custody presumption. Because no further incidents of domestic violence were shown to have occurred in the seven years between the abuse and when the custody modification was tried, the court noted that "a pattern of good conduct over time could suggest a violent individual has been rehabilitated." The court reversed, instructing the trial court to deny the motion to change custody. ■

**Attachment 2**

# IMPACT OF DOMESTIC VIOLENCE ON THE HEALTHCARE DELIVERY SYSTEM

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# *"Impact of DV on the HealthCare Delivery System"*

Assembly Select Committee on Domestic Violence

Children's Hospital Los Angeles

Tuesday, December 11, 2001

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Executive Director, Family Violence and Sexual Assault Programs

California Hospital Medical Center

Chairperson Cohn, distinguished members of the panel and guests, my comments today will focus on "The Impact of Domestic Violence on the HealthCare Delivery System." I have been asked to discuss the costs of domestic violence, issues focused on data and data collection and reimbursement.

Researchers have estimated the annual cost of domestic violence to the nation at $67 billion in labor force, child well being, housing, social services, health care, and criminal justice. (L. Laurence and R. Spalter-Roth, Measuring the Costs of DV Against

Women and the Cost-Effectiveness of Interventions: An Initial Assessment and Proposals for Further Research. Institute for Women's Policy Research, p. 2., 1996).

A National Institute of Justice Research Report estimates that economic costs of domestic violence on victim's (i.e., medical bills, property losses, reduced productivity, and non-monetary losses (fear, pain, suffering)] are $11,000 per victim with domestic crime against adults accounting for almost 15% of total crime costs (National Institute of Justice. Research Report-Victim Costs and Consequences: A New Look. Washington, DC, NIJ, February 1995).

Domestic violence has physical and emotional consequences for victims and their children. The consequences include acute injuries as well as chronic injury, chronic stress and fear, and lack of control over health care or support systems (Chalk R. and King PA editors, 1998, Health Care Interventions (Chapter 6); Violence in Families: Assessing Prevention and Treatment Programs; National Research Council and Institute of Medicine, 223-224. These consequences are manifested in a range of medical, obstetric, gynecological, and mental health problems.

**Direct** health costs to victims of DV is estimated to be in the range of 1.8 billion dollars per year (Miller ET al, 1993. Victim costs of violent crime and resulting injuries. Health Affairs, 12:186).

One large health plan showed victims of intimate partner violence against women cost approximately 92% more than a random sample of general female enrollees

(Wisner et al, 1999. Intimate Partner Violence Against Women: Do Victims Cost Health Plans More? Journal of Family Practice, 48:439-443).

High medical costs have become the impetus for insurers to use DV as an underwriting criterion to deny victims insurance coverage (Brienzaa, J. Lawmakers seek to help battered women get insurance. Trial 1996; 3 (4) 14.

**Data Collection**

Although there has been an increased push to collect data about DV at both the national and local levels, there is little consistency in the data currently collected. There are several reasons for this inconsistency which include the disparity in sources of data, types of studies conducted, and the lack of a readily agreed upon definition of domestic violence.

Most of the current data surveillance systems identifying DV focus on information obtained from the criminal justice system which include the National Incident Based Reporting system and the National Crime Victimization Survey, data on homicides, and assaults involving guns. These reporting systems provide excellent data but it's incomplete.

In 1980, the US DOJ estimated that 43% of DV incidents are never reported to the police, so these incidents never make it into surveillance systems. We need to consider additional sources of data that are reliable.

Data from healthcare sources focus on the survivor and his/her experiences. This data may provide more detailed information regarding the true impact of DV on the victim.

DV victims are high users of healthcare services. Women turn to the health care system throughout their lives for routine health maintenance; pregnancy and childbirth; illness or injury care; mental health assessment and treatment; & when accompanying children or other family members for their own health care needs. There were over 97 million visits to emergency departments alone last year. As a result, emergency departments as well as other health care settings offer a unique opportunity to do screening/data collection. These efforts should be conducted in collaboration with criminal justice system.

**Health Systems lack good data.**

Many systems lack formalized procedures and reimbursement schemes to implement and sustain published screening guidelines.

**Challenge #1: There are Barriers to Screening**

University of NC Hospital Study: 2-week periods, 119 of 595 women were screened. Barriers: 71% of those interviewed cited lack of time, 55% cited a fear of offending, 50%--feeling of powerlessness (the inability to fix it, lack of training and that ID and intervention made no real difference) 42% felt that they would lose control of the situation, because the ability to change the situation is in the hands of the victim, 39% felt that it was too close for comfort; they were reluctant to ask patients "like them" because they did not think abuse could happen to them.

Other barriers include healthcare providers dismay when they see return visits of abused patients despite their prior interventions; the failure of staff to accurately record the data; lack of support at the upper levels of administration; and lack of support by community organizations.

**Challenge #2: Medical Record Documentation**

Medical record documentation although recommended (Family Violence Prevention Fund. Preventing Domestic Violence: Clinical Guidelines on Routine Screening. San Francisco, October 1999) it is still uncommon. Accurate coding of DV is even more rare. Two reports underline the need to address coding and documentation: The US Dept of Justice estimates that nearly 4 out of 10 (37%) women seeking medical attention in emergency departments for violence-related injury are victims of DV (US DOJ. August 1997. Violence Related injuries treated in Hospital Emergency Departments. Michael R. Rand. Bureau of Justice Statistics) but an analysis of Health Care Utilization Project (HCUP) data demonstrate that only 7 in 100,000 hospitalized patients overall had a DV code entered in their medical record (Rudman, W. and Davey, D. Identifying Domestic Violence within in-patient Hospital Admissions Using Medical Records, Women and Health Volume 30. #4:1-15, 2000).

Historically, medical chart-based research has focused primarily on injuries directly caused by abuse. However, when DV is documented and coded accurately, the most common diagnosis accompanying a DV code is related either to an acute or chronic medical problem (Ibid). These include arthritis, chronic neck or back pain, migraines, stammering, visual impairment, STD's chronic pelvic pain, PUD, irritable bowel disease, and other digestive problems. Although under existing ICD classification system there is an "abuse code" with a subcategory of "spousal abuse," there is little or no reimbursement for DV without documenting an associated injury or illness.

So where to we go from here:

1. implement universal, concise, integrated screening protocols that work
2. Provide appropriate staff education and training on protocols and documentation of victims of domestic violence;
3. Provide adequate administrative and community-based resources;
4. Provide healthcare providers with a realistic expectation of the psychodynamics' of DV victims;
5. Coordinate data collection/surveillance with criminal justice system;
6. Use this data to conduct useful research; and
7. Work with legislators to positively improve reimbursement to healthcare and social service providers for DV screening and identification, assessment, intervention, and follow-up care, thereby improving health services for victims.

ATTACHMENT 3

# CREATING A HEALTHCARE RESPONSE MODEL HOSPITAL PROTOCOL

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LAC + V IOLENCE INTERVENTION PROGRAM

Center for the Vulnerable Child
Sexual Assault Center
Domestic Violence Program
Adult Protection Team

# PROGRAM BACKGROUND

The Los Angeles County (LAC) and University of Southern California (USC) Violence Intervention Program grew out of what was originally known as the Center for the Vulnerable Child (CVC). Founded in 1984 by Dr. Astrid H. Heger, the CVC is a model Child Advocacy Center for the evaluation and treatment of child abuse victims and their families. The CVC remains the largest child abuse center in California and continues to be the centerpiece of the LAC+USC Violence Intervention Program.

In 1995, the CVC expanded and was renamed the LAC+USC Violence Intervention Program (VIP). This new concept of a Family Advocacy Center was built on the success of the CVC child abuse program. Recognizing that family violence and sexual assault frequently occur in the same families, services were widened to include comprehensive medical and mental health services for sexual assault, domestic violence and more recently elder and dependent adult abuse and neglect. The heightened awareness of the impact of domestic violence on both women and children and the long-standing need for accessible victim sensitive evaluations of sexual assault cases prompted the initial growth. More recently, a partnership with Adult Protective Services, is exploring innovative ways to provide medical and mental health services to elders and dependent adults who are impacted by abuse and neglect, but have difficulty accessing appropriate services. Completion of the Family Advocacy Center will include integrated services for families and communities aimed at reducing violence in homes and neighborhoods.

Services are free of charge, available 24 hours/7 days per week and provided by expert medical and mental health professionals. All assessments are done in cooperation with social and legal services charged with the responsibility of protecting, investigating and prosecuting. When medical evaluations are combined with multidisciplinary interventions the rights of victims, their families and the accused are protected.

With a mission statement of "Intervening to protect and treat all victims of violence" the VIP provides services to over 3,000 individuals each year and is working in communities to bring prevention and early identification to each neighborhood.

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1240 North Mission Rd. T-11 Los Angeles, CA 90033 Tel: 323•226•3961 Fax: 323•226•2573

**Center for the Vulnerable Child (CVC):**

The CVC is an internationally acclaimed child abuse intervention and prevention program. It is the only program in Los Angeles County available to law enforcement, social services and parents on a 24-hour, 7-day per week basis. The philosophy of the CVC maintains that protection of the child requires thorough and accurate assessment from the very beginning, minimizing trauma to the child and the family while promoting appropriate protection decisions by social services and effective investigations by law enforcement. In addition to the around the clock medical services, the CVC provides follow-up medical and mental health services, consultations to the courts and coordinates clinic services via Telemedicine to similar programs in the San Fernando and Antelope valleys.

The CVC has been a longstanding leader in the field of child abuse. Its pioneering work in photo-documentation and research on sexual assault has established an international standard of care. More recently, the CVC developed the first of its kind Telemedicine program. This new computer system provides expert back-up for remote clinics and currently works with clinics in Southern California and Alaska, and provides consultations with Indian Health Services and national peer review.

**Sexual Assault Center:**

The Sexual Assault Center provides expert forensic evaluations of all rape victims regardless of age or gender. The goal of this program is to provide victim-sensitive evaluations away from the emergency department and without long waits for victims or law enforcement. Medical professionals with extensive training in obtaining and preserving forensic and clinical evidence conduct the evaluations. The medical professionals work in close cooperation with law enforcement and mental health advocates.

By guaranteeing that the best examinations are always provided to rape victims, the rights of the victim are protected, the legal system investigates effectively and the system is spared time and expense. Providing a victim focused evaluation from the beginning promotes cooperation from patients who then participate in important follow-up medical and mental health services.

**Domestic Violence Center:**

In 1997, an innovative hospital-based domestic violence response team was founded at the VIP. This team responds to all cases of intimate violence at all outpatient and inpatient service providers throughout the LAC+USC Medical Center and community clinics. The team is available 24 hours 7 days per week and provides much-needed support to victims and the medical staff. Team members facilitate mandated State reporting; provide access to housing, food

# DOMESTIC VIOLENCE TRIAGE PROTOCOL

## PRIMARY HEALTH CARE PROVIDER RESPONSIBILITIES

### 1. Screen for Abuse:

- All females aged 14 years and older
- If patient reports abuse and has children report to Child Abuse Hotline (1 800 540-4000) and obtain case number:
- If patient reports sexual assault follow sexual assault protocol.

### 2. When treating acute injury known or suspected to be abuse related

- Notify VIP patient advocate 323 226-6806 24 hours/7days/week
- Complete confidential domestic violence report form (located in DV reporting packet in your area)
- Call LAC+USC Safety Police Ext 3333. Request immediate response to complete DV form
- Complete referral form to VIP Community Clinic (attach to DV for,)

### 3. Distribute the complete DV Reporting form as follows.

- Original copy is placed in designated location in area for collection and mailing
- Second copy is given to patient
- Third copy goes in medical record with body map

### 4. Contact Clinical Social Worker for your area

### 5. Document in patient's medical record

- Name of batterer and relationship to patient
- Mechanism of injury
- Detailed description of patient's injuries
- Photograph injuries when appropriate
- Case number from Child Abuse hotline when appropriate
- Follow-up referrals (VIP Community Clinic; hotline; shelters

### 6. Provide patient with

- Referral to VIP Community Center 24 hour response (323 226-6806)
- LAC Domestic Violence 24-hour multi-lingual hotline (1 800-978-3600)

VIOLENCE INTERVENTION PROGRAM
DOMESTIC VIOLENCE PROGRAM
COMMUNITY CLINIC

24 HOUR/7 DAY/WEEK RESPONSE
PHONE: 323 226-6806
FAX 323 226-6348

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team for the elderly and dependent adults. Its team approach to the diagnosis and treatment of abuse and neglect at the hands of family members and caretakers provides a unique resource available to all of Los Angeles County.

The APT is located at a tertiary triage center at the LAC+USC Medical Center. Medical, social and legal services depend upon the APT to provide medical and mental health assessments and treatment for victims of elder and dependent adult abuse and neglect. Expert medical professionals provide each patient with forensic evaluations that guarantee effective protective and legal interventions. All patients are offered in-home clinical support, social services and follow-up care managed jointly by APS and the VIP.

# DOMESTIC VIOLENCE PROTOCOL

**TITLE:** Identification and Treatment of Domestic Violence Victims

**PURPOSE:** Assist all health care providers in identifying, aiding, referring and reporting victims or suspected victims of domestic violence.

**RATIONALE:** Victims of domestic violence are frequently seen in a variety of health care settings:

1. 2-12% of women presenting to the emergency department do so because of ongoing physical abuse.
2. 17% of women seeking prenatal care are being physically abused.
3. 25% of women who attempt suicide or who use psychiatric emergency services are in an abusive relationship.
4. 67-83% of HIV+ women have been victims of domestic violence.
5. Child abuse occurs in at least 50% of homes where there is ongoing spouse abuse.
6. Among battered women first identified in the medical setting, 75% will go on to suffer repeated abuse.
7. The Joint Commission for the Accreditation of Health Care Organizations has mandated compliance of standards to the care of victims of domestic violence.
8. California Law requires that patients be routinely screened for the purposes of detecting domestic violence.
9. California Law requires that injuries known or reasonably suspected to result from intimate partner abuse be reported to local law enforcement by the treating health care provider.

## CALIFORNIA LAW:

1. It is mandated that patients (ie. women) be routinely screened for the purpose of detecting domestic violence (See Appendix A; AB 890).
2. It is the responsibility of health care providers to report all patients being treated for any physical injury known or reasonably suspected to have been a result of domestic violence (See Appendix B; AB 74).

   A. The law provides immunity for good faith reporting.

B. Failure to report any injury caused by domestic violence is a criminal offense. (See Appendix B; Penal Code 11160)

**DEFINITIONS:**

1. **DOMESTIC VIOLENCE:** the infliction of or threat of physical harm (including sexual assault) against past or present adult or adolescent intimate partners. (married, cohabiting, dating, or separated relationships of heterosexuals, gays and lesbians are all included under this definition)

2. **ABUSE:** intentionally or recklessly causing or attempting to cause bodily injury. Physical and sexual assault may be accompanied by psychological abuse, verbal intimidation, destruction of property, threat to significant others, stalking, and control over victims' access to money, personal items and friends, family and children.

3. **INJURY:** any physical injury which requires any form of medical services (including examination and treatment).

**PROCEDURE:**

The following describes the process whereby victims of domestic violence may be identified, treated, receive education, emotional support and referral to appropriate community agencies.

NOTE: For information on barriers for victims and health care practitioners refer to Appendices C & D.

**SCREENING:**

NOTE: For a list of clues for detection of abuse see Appendix E.

1. All female patients 14 years and over presenting to the medical center should be screened.

2. Failure to recognize or ask about abuse legitimizes its existence and significantly increased the victim's sense of isolation and puts her at an increased risk.

3. **Screening is to be conducted in as private a setting as possible.**

   A. All persons accompanying the patient, including children, must be excluded from the area during screening.

# APPENDIX C

# BARRIERS FACING BATTERED PERSONS

# APPENDIX C

## BARRIERS FACING BATTERED PERSONS

Battered persons usually do not initiate discussions with health care practitioners concerning their abuse making it even more important for the health care provider to initiate the discussion.

This appendix contains a summary of barriers for patients who are victims when they meet with health care providers.

1. The patient may be fearful because of threats by the batterer to harm her or "hunt her down" if she leaves.

2. The batterer may have threatened to harm, kidnap or gain custody of the children if she discloses the abuse or leaves.

3. The patient's cultural, ethnic and/or religious background may discourage revealing the abuse, especially to persons outside the family.

4. The patient and/or her children may be economically dependent on the batterer.

5. The patient may believe that her children need two parents and discussing the abuse could interfere with the abusive parent's role in the family.

6. The patient may not recognize that she is in an abusive relationship.

7. The patient may believe her injuries are not serious enough to matter (ie. may deny/minimize the abuse).

8. The patient may not be aware that her physical symptoms may be related to the stress of an abusive relationship.

9. The patient may be embarrassed or humiliated about the abuse.

10. The patient may love/feel loyalty for the abuser.

11. The patient may fear the batterer will commit suicide.

12. The patient may feel guilty and/or responsible for the violence.

13. The patient may believe the batterer's promises to stop or that the behavior will change without assistance.

14. Gay men and lesbians may not want to disclose their homosexuality.

# APPENDIX D

## BARRIERS FACING HEALTH CARE PROFESSIONALS

# APPENDIX D

## BARRIERS FACING HEALTH CARE PRACTITIONERS

This appendix outlines the barriers facing health care providers as they attempt to identify domestic violence and provide an appropriate response to their patients who are victims of domestic violence.

1. There is a fear of offending patients.
2. There is an assumption about the "types of patients" who are likely to be victims (Victims and perpetrators come from all racial, ethnic and socioeconomic groups).
3. There is a sense that it is not the role of the health care provider to ask questions or intervene.
4. The health care provider may believe it's the patient's responsibility to bring up the issue of abuse.
5. The health care provider may feel there is not enough time to inquire about abuse.
6. The health care provider may fear becoming involved in a personal matter between intimates.
7. The health care provider may be unaware of, or uninformed about the scope and dynamics of domestic violence.
8. The health care provider may feel helpless given the complexity of the situation.
9. The health care provider may "blame the patient" and feel frustrated that she does not leave the relationship.
10. The health care provider may disbelieve the patient because the alleged assailant is present and seems to be very concerned and pleasant.
11. There may be ignorance of, or discomfort with the possibility of same sex domestic violence.

***Studies and experience have found that women <u>DO NOT</u> mind being asked in a non-judgmental way about whether they have been abused. This is true of both women who are abused and women who are not.**

# APPENDIX E

## CLUES/CONSIDERATIONS FOR THE HEALTH CARE PRACTITIONER

# APPENDIX E

## CLUES/CONSIDERATIONS FOR THE HEALTH CARE PROVIDER

During **ALL** patient contacts health care providers should be alert to the possibility that the patient may be a victim of domestic violence. The following clues should be noted as they may indicate that the patient may have been battered:

A. BEHAVIORAL CLUES:

1. Anxiety
2. Crying
3. Sighing
4. Nervous or inappropriate laughter or smiling
5. Defensiveness, anger
6. Overly attentive, aggressive or defensive partner.
7. Lack of eye contact or fearful eye contact

B. VERBAL CLUES:

1. Talks about "a friend" who is being abused.
2. Refers to partner's "anger" or "temper"
3. Minimizes seriousness of injury.
4. Explanation by patient inconsistent with type/extent of injury.
5. Patient responds affirmatively to questions about abuse.

C. PHYSICAL SIGNS

1. Frequently seen injuries
   * Ruptured ear drums from severe slapping/head trauma
   * Facial bruising, abrasions and lacerations
   * Neck bruising from choking
   * Punch/grab bruising to the upper arms
   * Defensive posturing injuries to mid-ulnar areas
   * Whip or cordlike injuries to the neck
   * Punch or bite injuries to the breast or nipples
   * Punch injuries to the abdomen especially for pregnant women
   * Punch and kick bruising to the lateral thighs

2. Skeletal Fractures
   * Depressed skeletal fractures
   * Facial fractures (orbital & mandibular fracture common)
   * Dental fractures
   * Rib fractures (usually in various stages of healing)
   * Mid-ulnar fractures
   * Finger fractures

   **NOTE:** Be aware that a delay in treatment may be indicative of abuse.

3. Internal Injuries (Typically Caused by Blunt Trauma)
    * To spleen, liver, or intestinal system
    * Miscarriage or premature delivery
    * Punch and kick injuries to the back may cause kidney trauma or hemothorax

4. Head and Neurologic Injuries
    * Clumps of hair pulled from skull
    * Lacerations to skull
    * Intracranial bleeding from blunt blows to the head
    * Corneal abrasions and conjunctive hemorrhage (after ruling out retinal detachment which is less common)

5. Sharp Injuries
    * Cuts and incisions - tend not to enter internal cavities and are longer than they are deep
    * Stab wounds - deeper than they are long, potentially lethal

6. Gunshot Wounds

D. <u>OTHER SIGNS</u>

1. Uses health care services repeatedly, especially for psychosomatic complaints or for injury to the same site.

2. Psychosomatic/Emotional Complaints:
    * Headaches
    * Sleeping disorders
    * Anxiety/Depression
    * Suicidal attempts/gestures
    * Abdominal/Gastrointestinal complaints
    * Difficulty concentrating
    * Marital problems

3. Reluctance to speak in front of abuser.

4. Presence of child abuse within the family or a partner that is known to have abused a previous partner.

5. Presence of children who act as spies on their mother (ie. reporting all that is said to the abuser).

6. Cyclical separations, or threat to leave and reunifications of the relationship.

**NOTE:** If patient is being battered by a partner, the abuse is extremely likely to happen again. In most cases the abuse will escalate in both frequency and severity. There is <u>NOTHING</u> the patient can do to stop the violence. An apologetic partner does not mean the abuse will stop.

# APPENDIX F

## SUGGESTED QUESTIONS FOR HEALTH CARE PROVIDERS

# APPENDIX F

## SUGGESTED QUESTIONS FOR HEALTH CARE PROVIDERS

Health care providers should be prepared to ask some or all of the following questions to determine if the patient is a victim of domestic violence.

1. Do you ever feel afraid of, or threatened by your partner?

2. Has your partner ever threatened or abused you or the children?

3. Have you been hit, slapped, kicked or otherwise physically hurt you in the last year/months since I saw you?

4. Since you have been pregnant (if applicable) have you been physically or emotionally been hurt by someone?

5. Are you in a relationship in which you have been emotionally or physically abused or threatened by your partner?

6. What happens when you and your partner fight?

7. Has your partner ever destroyed your things?

8. Does your partner ever force you to engage in sex that makes you feel uncomfortable?

9. Has your partner ever prevented you from leaving the house, seeing friends or family, getting a job or continuing your education?

10. Is your partner very jealous? Does he watch your every move? Accuse you of having affairs with everyone?

## QUESTIONS/ATTITUDES NOT TO ASK/EXPRESS

1. Why don't you just leave?

2. Why don't you get some marital counseling?

3. What did you do to start the fight/cause him to hit you?

4. What could you have done to avoid or calm the situation?

5. He's a jerk, you'll find someone else soon.

***The above questions/comments assume that the victim is responsible for the beating. THE BATTERER IS RESPONSIBLE FOR CONTROLLING HIS BEHAVIOR.**

# DVY2K: A HEALTH POLICY AND RESEARCH COLLOQUIUM ON INTIMATE PARTNER VIOLENCE

# SHAPING CALIFORNIA'S HEALTH POLICY FOR VICTIMS OF INTIMATE PARTNER VIOLENCE

# THE DOMESTIC VIOLENCE HEALTH CARE INITIATIVE STRATEGIES TO IMPROVE THE HEALTH AND SAFETY OF VICTIMS OF DOMESTIC VIOLENCE

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UC Davis Medical Training Center

# DVY2K: A Health Policy and Research Colloquium

# On Intimate Partner Violence

Summation of Proceedings

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**Abstract:** The healthcare response to intimate partner violence (IPV) involves not only individual practitioners but institutional and system changes. Public policy must also support and at times promote and direct the health system's response to victims of intimate partner violence. In February of 2000, a statewide colloquium of California IPV health researchers and public policy makers was held to specifically address healthcare and public health issues regarding victims of domestic violence. The six key issues addressed were: epidemiology, outcome measures, co-morbid conditions, cultural influences, the nexus of child abuse and partner violence, and healthcare economics of care or non-care. This article summarizes the key findings and recommendations of each of the discussion groups as well as an overview of health policy considerations when addressing the needs of victims of intimate partner abuse.

**Introduction:** Intimate Partner Violence (IPV) is a major public health problem. As such there have been many recent changes in legislation and rapidly evolving research in the field that have direct impact on the public health and healthcare delivery. California, in many ways, has been a leader in trying innovative approaches to improve the healthcare response to partner violence, to integrate services and to improve safety for those who have suffered. Legislation and support for IPV Death Review Teams, funding for interdisciplinary response teams and statewide standardized training of healthcare providers are just three examples of California initiatives to improve healthcare intervention in IPV. A state colloquium of experts in public health, partner violence research and public policy was convened early in the year 2000 in the hopes of providing guidance for further progress in IPV health policy and research for the state of California. This article provides a description of the format and a summation of the proceedings.

**Planning of the Colloquium:** The lead organization, the California Medical Training Center (CMTC), is a multi-million dollar state funded state legislated project to improve the healthcare response to victims of violence and abuse particularly victims of child abuse, intimate partner abuse, elder abuse and sexual assault. CMTC is funded through the Office of Criminal Justice and Planning. The Training Center provides standardized training to healthcare providers on the identification, assessment, examination and intervention for victims of violence. CMTC also collaborates with training of law enforcement, prosecutors, judges and investigative social services regarding the physical findings, preservation of evidence and interpretation of findings. The CMTC Domestic Violence Domain had budgeted for a statewide colloquium as a

means of fostering expertise, facilitating networking of researchers and providing a cross semination of needs regarding research and health policy in the state.

The Family Violence Prevention Fund, a national non-profit organization focusing on domestic violence prevention, education and public policy reform, was a co-sponsor. The Fund is committed to strengthening the healthcare response to domestic violence and had budgeted for a statewide leadership summit so a collaborative approach was appropriate. Additional support was provided by the Department of Health Services.

An organizing committee was formed within the Bay Area Domestic Violence Research Consortium. This was a newly formed group of approximately forty researchers in the San Francisco Bay Area with an interest in partner violence. Members of the Consortium acted in an advisory capacity to formulate the basic concepts and goals for the colloquium, to identify key issues for discussion and to act as coordinators of discussion groups including invitation of key discussants and selection of relevant literature used in preparation of each discussion group.

**Goals of the DVY2K Colloquium:**

1. To assemble healthcare and public health experts, researchers, public policy makers and advocacy leadership;
2. To generate a consensus of information regarding public health issues in Intimate Partner Violence
3. To identify challenges and opportunities within each issue; and,
4. To provide specific recommendations regarding directions for public policy, funding and research efforts.

**Format:** The advisory group identified six major issues to be addressed, titled as follows:

1. Do we really understand the epidemiology of this public health problem?
2. The nexus of child abuse and DV: Coordination of care
3. Confronting co-morbidity of DV: Mental health problems and drug/alcohol abuse
4. The role of culture within the framework of prevention and intervention in intimate partner violence
5. Incentives to care: The health economics of DV, the costs of intervening and not intervening; who pays?
6. Defining outcome measures as a necessary prerequisite to evaluating intervention.

Eight to twelve panelists were invited for each issue discussion group based on their expertise with an intentional balancing of researchers, elected or state officials and healthcare providers. The panelists met all day with professionally facilitated discussion regarding current status assessment and needs analysis followed by recommendations and prioritization of future directions in research and health policy. Each discussion group had an audience of 30-50 people that also participated with questions and comments throughout the day. Each issue discussion group had a note taker and the proceedings were recorded and transcribed. A copy of a more detailed proceedings is soon to be available both in hard and electronic copies.

**Summation of the Proceedings**

The following summary provides a brief overview of the issue as presented within the discussion group followed by recommendations made by members of the group. Group participants are also listed for each issue.

1. **Do we really understand the epidemiology of this public health problem?**

(Chair: Heidi Bauer, MD, MPH; Panelists: Laura Lund, MA; Linda Baker, PhD; Judith McFarlane, RN, PhD; Billie Weiss, MPH; Connie Mitchell, MD)

Understanding the epidemiology of domestic violence is important because it will provide data that will link domestic violence with health outcomes and health interventions with health outcomes. Establishing evidence based interventions, monitoring effectiveness and providing accountability for programs and initiatives is essential in health planning around this issue. Epidemiology will also allow target populations to be identified so that prevention and intervention efforts can also be focused and maximized.

There is a growing body of literature regarding the epidemiology of intimate partner violence that is well reviewed elsewhere [1], but there are clearly some gaps in the research:

1. Lack of standardized measures
2. Inconsistent prevalence measures
3. Inconsistent risk-factor information
4. Lack of definitive link between domestic violence and health outcomes
5. Lack of information on the natural history of domestic violence; meaning without intervention

6. Lack of information about the epidemiology of injuries in IPV
7. Lack of data on sensitivity and specificity of screening in clinical practice and lack of outcomes data related to this practice/intervention
8. What interventions are currently in place in the health setting and what is their impact both in terms of benefits and unanticipated consequences?

**Recommendations**

**Research:** There were many recommendations regarding research directions. The areas of need identified as high priority included:

1. Further differentiation between patterns of abuse, severity of abuse and the effect of gender of both the victim and perpetrator and types of abuse;
2. Further data on health and IPV subgroups: the disabled, immigrants, homosexual populations, teens ;
3. Further data on how IPV relates to other forms of violence: child abuse, elder abuse, community violence ;
4. Lifetime burden of any type of abuse; nature of violence across the lifecycle;
5. Causal relationships and mechanisms that link abuse and poor health outcomes;
6. More data on relationship of IPV and socioeconomic status; how does the relationship vary according to the type of abuse or agents of control;
7. Resiliency and protective factors of IPV adult and child victims; mediators and moderators;

Increased research regarding batterers was also recommended: improved outcome measures for batterers treatment; does physical violence decrease while other

means of control increase and the health care impact both in terms of conditions and economic burden of patients who are IPV offenders.

Recommendations regarding improved methods and measures were also made such as: use of standardized definitions in healthcare research referencing those provided by the Centers for Disease Control [2], clearly differentiated epidemiologic data regarding abuse as opposed to physical violence and more longitudinal, prospective designs including multigenerational studies.

**Policy:** The group attempted to sort policy recommendations into two major categories: low effort but a potential for high impact (LE/HI) and high effort with potentially high impact (HE/HI).

While incorporating IPV questions into the National Behavioral Risk Factor Survey and the California Women's Health data was rated LE/HI, improving health information and data systems and incorporating surveillance into ongoing research and data collection was rated HE/HI. Another LE/HI strategy (although not low cost) was Community based massive public health education campaign about IPV health impacts and services. Billboards, bus banners, hotlines in every bathroom could promote awareness of IPV as a health issue for victims and children and facilitate access to services without requiring disclosure to any particular agent or professional group. Another HE/HI would be truly universal screening of all patients in a variety of clinical settings (HIV clinics, STD clinics, drug and alcohol rehabilitation programs, mental health facilities) regarding experiences with violence would contribute enormously to the prevalence data.

There were multiple suggestions regarding mandates for more collaborative research and data collection with a variety of agencies: Child Protective Services, or child abuse researchers, Adult Protective Services and elder abuse researchers; collaborations with community agencies and advocacy organizations for data collection; linkage of healthcare and criminal justice data bases; linkages with mental health, substance and alcohol abuse programs; increased representation by healthcare on county domestic violence councils and county IPV death review teams with standardized data collection for both of these community groups; IPV data collection from state trauma systems and trauma registries and mandated injury code information from all licensed hospitals.

Recommendations regarding improved funding included: greater parity in funding for the healthcare response to IPV and criminal justice response to IPV; reimbursement for forensic examinations from Victims of Crime Funding; funding to create electronic data basis to capture injury epidemiology data from forensic examinations; and increased funding for qualitative research to learn about IPV from a contextual basis across age, ethnic and cultural groups.

**2. <u>The nexus of child abuse and domestic violence: Coordination of care</u>**

(Chair: Cindy Kuelbs, MD and Debbie Lee, MA; Panelists: Michael Durfee, MD; Betsy Groves, PhD; Cathrine Koverola, PhD; Patricia Van Horn, JD, PhD; Linda Baker, MD; Laura McClosky, PhD)

Children in homes where there is physical intimate partner violence are at increased risk themselves for direct child abuse, child neglect and emotional trauma

from witnessing violence and this literature has been well reviewed elsewhere [3,4]. The safety needs of children and adults in a family must be taken into consideration and service providers recognize the need, more than ever, to collaborate investigative and advocacy responsibilities.

In the healthcare setting there are multiple obstacles in addressing the cross-over of child and adult victimization from intimate partner violence but the most pervasive are:

1. Efforts to protect the child may override the need to protect the adult victim and the duty to effectively intervene and separate the perpetrator; services and sanctions
2. The onus of responsibility for the child, the relationship, the violence and abuse seems to fall to the female IPV victim with disregard for her own vulnerabilities;
3. IPV families, regardless of how they are identified, require multiple services and expensive case management;
4. Reporting adult or child maltreatment has become more a pathway to prosecution than a means to access services; and
5. The battering partner is also a parenting father and there is great ambivalence about how to resolve this conundrum.

**Recommendations:**

**Research:** High priority research areas involved screening practices and outcomes, the role of abusive fathers with their children and improved understanding of how resiliency factors can impact long terms outcomes.

In regards to screening, more data is need regarding the sensitivity and specificity of screening for family violence in verbal children. Greater understanding of how this screening and subsequent actions, such as testifying in court, may impact the

child is important. It was emphasized that research should look at the child in the context of the family and the importance of the relationships between parents and children

Information of the role of fathers and battering fathers in child raising is needed. What are the potential benefits and harms, what impact does parenting education in batterer's treatment have, how can safety factors be instituted and relied upon for both child and adult survivors. Intergenerational research on the effect of witnessing IPV is also a high priority recommendation.

Increased data regarding resiliency factors in both child and adult survivors of IPV would be very helpful so that more targeted approaches to recovery could be instituted for violent families.

**Policy:** Policy recommendations were sorted in terms of new response and training mandates and future funding needs.

High priority recommendations for new policy mandates included: mandated dual response to IPV families by Child Protective Services (CPS) and adult advocates and service agencies; increased judicial education regarding IPV, child maltreatment and child custody cases; mandated parenting education in batterers' treatment programs; and required education for adolescents on parameters of healthy partner relationships.

The group recommended that increased funding be prioritized for: mental health services for women and children; case management requirements in caring for an IPV family; services and intervention for children, especially those under age 5 in IPV

homes, who are believed to be most vulnerable to long term effects of IPV; IPV interventions that occur at the community level and within specific cultural groups; and programs for pregnant women in shelters and jails regarding the impact of IPV on children.

Finally the group unanimously called upon the American Academy of Pediatrics to incorporate family violence in their Trauma Injury Prevention Program..

3. **Confronting co-morbidity of domestic violence: Mental health problems and drug/alcohol abuse**

(Chair: Carol Cunradi, PhD, MPH; Panelists: Jacquelyn Campbell RN, PhD; Richard Wilsnack, MD; Sharon Wilsnack, MD; Patty O'Ran, JD)

Adult Maltreatment Syndrome, the International Classification of Diseases diagnosis for intimate partner violence seems to often occur in association with other co-morbid conditions, in particular alcohol and/or drug abuse and mental health problems such as Post Traumatic Stress Disorder (PTSD) and depression. Many IPV victims in shelter situations suffer from addiction and many patients in alcohol and drug abuse treatment program suffer from partner violence. In 1997, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed guidelines for drug and alcohol abuse programs to screen for all forms of violence. The nature of the association is gradually being defined. Both IPV and substance have some long term, subtle and wide ranging effects. It is often very difficult to recover costs of intervention for any of these concerns on a short term basis. The association with partner violence and alcohol is clear for both victimization and perpetration.

**Recommendations:**

**Research:** Recommendations regarding research were organized into topical areas that lack adequate data, methodological needs, and program evaluation priorities.

Research topics included: temporal and reciprocity analysis of a history of substance abuse or mental health problem with the issues of child abuse and IPV; projectories of recovery for IPV victims with and without co-morbid conditions, sequential or in parallel intervention strategies for IPV patients with co-morbid conditions; community characteristics and their relationship to both violence and substance abuse; the batterer as a sabature of recovery efforts by the victim; relationship of substance abuse, poor nutrition and subsequent violence; association of severity of violence with severity of substance abuse; and more information about substance abuse in female perpetrated violence.

Recommendations regarding methodology in research included timesharing on research projects, population based research, real interdisciplinary research and use of specific measures regarding alcohol and drug abuse, IPV, mental and physical health.

Program evaluation should look at screening practices in substance abuse and mental health programs, the response of community and advocacy interventions in regards to substance abuse and mental health needs of their clients; intervention strategies for mental health and substance abuse problems in batterers' treatment programs; impact of welfare to work regulations on women's access to needed services, impact of mandatory reporting on women's care seeking behaviors for any health related need; and how are services coordinated and access facilitated.

**Policy:** Policy recommendations were grouped into low effort/high impact or high effort/high impact strategies.

Low effort/high impact strategies were required collaboration with IPV prevalence researchers and alcohol/substance abuse researcher ; shelter protocols for facilitating access by victims to substance abuse treatment included means for protecting the children; monitor compliance with Substance Abuse and Mental Health Services Administration guidelines; and cross training to all these disciplines regarding co-morbid conditions

High effort/high impact suggestions were: increased controls for alcohol advertisements and alcohol outlet density in neighborhoods; use the Pharmacy Partnership Project to identify pharmacies in California that provide alcohol and those that don't as was done previously with tobacco; increased accountability for violence related service programs such as Victims of Crime program; and reduced costs and increased access to programs and services addressing alcohol and substance abuse, mental health and IPV

Other recommendations were to increase funding for mental health services that address violence related conditions such as Post-Traumatic Stress Disorder and to consider mandatory reporting to public health-surveillance systems.

## 4. The role of culture within the framework of prevention and intervention in intimate partner violence

(Chair: JoAnn McAllister, PhD, Panelists: Chic Dabby, Ed; Carolina Guzman, MPH; Deana Jang, MA; Sima Shaksari; Shabha Srinivasan, Ph.D.)

The victim advocacy movement came out of a human rights struggle including the struggle of women to expand their sense of identity and their opportunities in this culture. There have been many positive outcomes: legislative reform, criminal justice reform and considerable public education. However, there are many who have criticized the movement as essentially a white women's movement. Analysis and interventions have suffered in that they are typically oriented towards that perspective. Furthermore, much of the understanding of victims basically comes from research on shelter populations and those who seek services. So there are considerable gaps about victims of other ethnic groups or those who survive IPV without seeking shelter or advocacy services. National data collection has also suffered from the lack of finer breakdowns by race or ethnicity.

Oftentimes, some practitioners view themselves as culturally sensitive because they accept that there are cultures that are more tolerant of men's violence. Such views are dangerously racist. Other service providers think that making small changes in the same services means they are multi-cultural but providing culturally appropriate interventions is more complicated than that.

**Recommendations:**

**Research:** The group generated a topical list of questions to direct needed research as follows:

1. What are the desired outcomes for victims of IPV in different ethnic communities and communities of color?

2. What are appropriate interventions for IPV victims in these communities:
3. How do immigration policies affect survivors of domestic violence and sexual assault?
4. What are the protective factors a culture offers? (i.e., asset mapping);
5. Why do so few men view IPV as a problem of male culture and beliefs?
6. Is there a batterer's culture?
7. How is racism linked to patriarchy?
8. How do differential arrest rates by race affect the reporting of IPV?

Two additional recommendations were to expand culture based research to include seniors, teens, rural women, homosexual relationships , and examine IPV families for multiple perpetrators particularly in cultures where there is strong patriarchy.

**Policy:** Recommendations were either targeted specific programs or agencies or were more broad considerations to be incorporated in all aspects regarding IPV intervention and prevention.

Program or agency recommendations were: disseminate standards for cultural competency from the Office of Minority Health to healthcare providers and healthcare administration; disallow the "cultural defense" as it may actually be a defense of a rigidly enforced cultural patriarchy; provide information about domestic violence through the immigration process by community advocates; include information about domestic violence to immigrants with information about other legal and human rights.

Broad considerations regarding culture and IPV policy included: increased access to linguistically appropriate services; promotion of peer advocacy in ethnic

communities and communities of color; and prohibit immigration status as a consideration when accessing health and social services regarding domestic violence;

A general consensus regarding a funding priority was to provide technical assistance to ethnic communities to collect standardized data regarding the nature of IPV in their community and to facilitate more participatory evaluation and more qualitative data so as to learn more about the context of violence in different cultures.

**5. Incentives to care: The health economics of domestic violence, the costs of intervening and not intervening; who pays?**

(Chair: Pat Salber, MD; Panelists: Frank Apgar, MD, Debbie Lee MA; Ann Hansen; Connie Mitchell, MD; Carol Ann Peterson)

There is emerging information about the cost of caring for IPV patients. Given the complex nature of the problem, the associated negative health sequela, and the effects on the health of children, IPV care must be expensive. There is little information about the impact of intervention in general and no published literature documenting the return on investment for these interventions. There is no business case for healthcare domestic violence programs.

There are multiple non-monetary incentives for healthcare providers to care for IPV patients and little to no monetary incentive. Doctors want to do the right thing for their patients as long as there are no systemic and other barriers in place. Creating an infrastructure with ease of use and feedback mechanisms is another non-monetary incentive. But ultimately, healthcare providers must be paid for performance. Additionally, purchasers of performance want to know exactly what they're paying for and how closely the service ties to the desired health outcomes.

Finally, the desire to identify and document IPV is often counterbalanced by the desire to avoid further shame or stigmatization of a patient with a label. Discrimination by insurers of any kind of indemnity policy is not legal in California, but remains a problem in many other states. The health information system relies upon diagnostic and procedure codes for all kinds of important data, not just as a means to reimbursement. By not indicating the diagnosis of IPV, progress to understanding the cost of care and obtaining more appropriate reimbursement rates, is impeded.

All of these concerns lie against a background of consumer unease with the privacy protections for their medical records, the increasing population of the uninsured, decreasing access to routine and preventive care and changing social norms about violence as a public health problem.

**Recommendations:**

**Research:** Research questions were sorted as to whether they involved access and cost of services.

Access to service issues included questions about what is the data that insurers have that have lead them to considered IPV victims high risk; how do IPV victims best get their information about IPV (television, posters, brochures, internet, word of mouth, healthcare providers); can a "Domestic Violence Specialist" within healthcare increase referral rates and streamline patient access to services; would healthcare providers increase referral rates to outside IPV service providers if there was a feedback mechanism, does documentation of IPV have unintended consequences that hinder patient access?

Cost of service questions include: would purchasers of healthcare coverage request services for IPV if they better understood the negative impact on their employee work force; what is the healthcare cost and impact of patients who are batterers; what are the healthcare utilization patterns of IPV patients; are community based services cheaper or more effective than healthcare based services; what kinds of intervention efforts are needed to improve diagnostic coding of IPV by both the provider and the health information manager?

**Policy:** Policy recommendations also sorted by the issues of access to services and cost of services.

Recommendations to improve access to services include: strict privacy protections in the healthcare system including who receives copies of bills or medical records; large scale public health education about the health impact of IPV on women and children; and age appropriate information about IPV in public education health courses.

Recommendations to address cost of care concerns are: increase physician reimbursement rates in California; support efforts to increase reimbursement ratio for "Adult Maltreatment Syndrome" due to IPV; introduce programs to help IPV victims stay employed so that they can stay insured; and create a "carve-out" for Medi-cal IPV patients similar to the prenatal care carve out plan in order to provide comprehensive services

Healthcare providers need more incentives to recognize, intervene appropriately and document accurately the issue of intimate partner violence. Without such effort, the understanding of the health care impact of IPV on patients and the industry will be

impaired. There must be support and enforcement for the AMA policy that "Adult Maltreatment Syndrome" is the primary diagnosis for injuries or illness related to IPV; clinical practice guidelines in IPV that are criterion based should be developed and disseminated; and a task force to create a model business case for healthcare domestic violence intervention should be facilitated at the state level.

## 6. Defining outcome measures as a necessary prerequisite to evaluating intervention

(Chair: Carol Huffine, PhD; Panelists: Sujata Desai, PhD; Lorena Garcia, MS; Ramani Garimella, MD, PhD; Glenda Kaufman-Kantor, PhD; Cindy Kuelbs, MD; Anna Waller, ScD;)

Every IPV program has to determine what the appropriate goals are, whether it's changes in incidence or prevalence, changes in the community level awareness, attitude change, satisfaction in safety, the reduction in child abuse, or changes in mental or physical health parameters. These goals need to be expressed in terms of discrete measurable outcomes that may be immediate, proximal or distal. In healthcare settings outcomes that are measured are usually service utilization, types of diagnoses, pregnancy outcomes, service delivery costs. Additional outcomes in IPV include: attitudes about the legitimacy of the use of violence, community level of violence data, measure of community well-being, numbers of resources within a community and many others.

Distal outcomes such as eliminating partner violence in our society, may take years before an attempt at evaluation can occur. But evaluation needs to be built into

any intervention and if they are realistic, discreet, and measurable, then the body of outcomes research will rapidly expand.

Adherence to standardized definitions and outcomes that are specific to cultural groups is important. IPV patients are an invaluable source in helping to define desired outcomes although in addition to individual change there are system and policy changes than can be measured too. Individual change can also include the healthcare or other service provider.

**Recommendations:**

**Research:** The groups identified both outcomes that need to be evaluated as well as current interventions which should be studied for outcomes on a high priority basis.

Potential outcomes measures include: changes in stalking behaviors; changes in attitudes and beliefs about IPV, changes in provider and patient satisfaction and knowledge, rates of serious female injury, rates of female homicide, work function of victims, changes in health utilization and changes in physical and psychological health status. It is further recommended that IPV patients, the consumers, help define a positive outcome and that there be increased understanding of how measures of resiliency impact outcomes. There is also very little data as to what outcomes women experience who have never had a formal intervention by healthcare, criminal justice or community agencies.

There are four major health interventions in place in California that deserve immediate outcomes analysis with attention to positive, negative and unintended consequences. What outcome data is there in California on the county Domestic Violence Coordinating Councils as far as program or system changes or new services

offered? What is the outcome of universal screening mandates in California? What is the outcome of mandated DV injury reporting in California? What is the data and recommendations that have been collected from the State's Domestic Violence Death Review Teams?

**Policy:** Policy recommendations were both specific and general.

General recommendations were to focus on more proximal outcomes; require more multi-disciplinary outcomes measures in both research and programatic interventions, encourage researchers to report effect sizes rather than statistical significance and to disseminate the Evaluation Guidebook for Projects by Martha Burt [5] to all state agencies that deal with IPV.

Specific policy recommendations are to record victim-offdender relationship data for all homicides and expand DV Death Review Teams to include serious injury review and collect data from all counties into a state standardized data base.

**Discussion:**

Public health policy refers to the set of principles guiding decision making within a government body aimed at maintaining and improving the population's state of health. Health policy in general can refer to any and all policy intended to influence health be it health determinants, public health or personal health care. Ideally a policy contains a definition of the problem being addressed, a goal statement regarding the desired state of affairs and outlines (broad or detailed) of the strategies and activities by which the goals are to be achieved. English speaking democracies have a multicentric policy system with many autonomous groups competing for influence: politicians, civil

servants, advisors and special interest groups. [6] This colloquium functioned in an ad hoc advisory fashion.

The day long format provided a rare opportunity for collegial discussion, although more specific strategies and priorities might have achieved with a two half-day approach allowing for restful reflection. There was considerable expense involved in the facilitation, recording, transcribing and editing process of six day long interactive discussion groups. The overall experience received very high praise from the invited discussants. Some suggested more colloquiums on a regional basis and a variety of additional issues were submitted for future discussion.

According to Carol Barker [7], there are 7 stages in the policymaking process: 1) issue definition, 2) setting objectives, 3) priority setting, 4) defining options, 5)options appraisal, 6)implementation and evaluation and of course a feedback loop that further defines the issue with new objectives and priorities. A framework more specific to health policy is the "Measurement Iterative Loop" by Tugwell, etal [8]. It comprises a cycle of 7 steps: 1) Determine health status using health status indicators (burden of illness, 2) Identify and assess possible causes of burden of illness (etiology or causation), 3) Assess benefit/harm ratio of potentially feasible interventions and estimate reduction of burden of illness if program successful (community effectiveness), 4) Determine relationships between costs and effects of options within and across programs (efficiency), 5) Integrate feasibility, impact and efficiency to make recommendations (synthesis and implementation), 6) Monitor using markers selected to indicate success (evaluation) and 7) Reassessment of the magnitude of burden of illness. From this colloquium a series of issues were defined and a variety of objectives

and possible options in research and policy identified. However, a major problem that surfaced in all issues groups was the lack of data regarding the health burden of IPV so that further policy assessment and implementation becomes problematic.

Policy analysis is a multidisciplinary field that relies on reviewing existing research, expert judgement and deductive modeling. [5] Health policy research is complementary to policy analysis and thus an advisory group that considers a body of research and identifies both research and policy gaps is appropriate. What is not always appropriate is research that has an eye on policy because then recognized and unrecognized bias is introduced.

The recognition of Intimate Partner Violence as a healthcare issue is a fairly new one. Treatment of physical injury and mental health consequences with or without identification of the underlying etiology has been the customary practice. Earlier identification, prevention and a more holistic approach to the spectrum of family abuse and the lifetime health burden of abuse at any age is a fairly recent phenomena in the consideration of health policy. It will require a great deal more data and analysis as policy evolves and health institutions shape their approach to providing appropriate interventions. For many in policy and research, the unknown, although at times daunting, is a prime motivator for seeking understanding and truly trying to help all those who suffer in violent families.

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**Shaping California's Health Policy for Victims of Intimate Partner Violence**

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Accepted for publication Harvard Public Policy Review, October 2001

Intimate partner violence (IPV), once thought of as a criminal and social justice issue, has been shaped over the last fifteen years as a public health issue. California is a leader in enacting new statutes and health policies that support women's health in general and intimate partner violence in particular [1]. These policies have improved identification, documentation and surveillance, law enforcement affiliations, professional education, forensic examination, community prevention efforts and funding of services for victims of violence.

## A Brief History of National IPV Health Policy

In 1985, former United States Surgeon General C. Everett Koop brought national attention to domestic violence as a public health problem[2]. National policies of major medical organizations such as the American Medical Association, the American Public Health Association, the College of Obstetricians and Gynecologists and the American Academy of Pediatrics have all strongly supported health care identification and intervention in family violence. The Joint Commission on Accreditation of Healthcare Organizations provided guidelines and standards for the improved recognition and initial intervention in domestic violence. The National Center for Injury Prevention and Control at the Centers for Disease Control (CDC) established the Family and Intimate Violence Prevention Team in 1993 [3]. In 1995, the Association of American Medical Colleges strengthened the curriculum on family violence. [4]. In 1999, the CDC published guidelines for research that defined and promoted the phrase intimate partner violence that is now dominant in the medical literature but still used interchangeably with domestic violence elsewhere[5].

Victim advocacy organizations worked throughout the 70's and 80's to strengthen the criminal justice response to perpetrators while providing support and safe havens for women and children victims of domestic violence. In the last ten years, these same organizations have promoted screening, safety planning and patient education by health practitioners. Battered women's service providers have aligned with hospitals to provide on-site advocacy services and to increase the identification and documentation of IPV patient care.

## The Health Impact of IPV

Intimate partner violence is attracting the attention of the health care system as evidence mounts about the acute and long-term health impact of IPV on adults and children and the subsequent costs to the delivery system. Clinical studies indicate that 37-54% of women patients in the out patient setting report a history of physical, sexual or emotional

abuse in their lifetime[6, 7]. The long term and acute consequences of domestic violence include injuries, increased complications in pregnancy, reproductive health problems, stress related illnesses, somatization, depression, Post Traumatic Stress Disorder, suicide, and substance abuse. [8-10]. An increase in negative health behaviors such as smoking, alcohol and drug abuse, sexual risk-taking, and overeating has also been reported. The health impact of domestic violence on children includes direct physical abuse, "caught in the crossfire" injuries, neglect and emotional trauma as witnesses to violence and abuse [11-13]. Recent studies on the long-term health effects of adverse childhood events have associated childhood exposure to domestic violence with high-risk health behaviors as adults [14-18].

Cost studies suggest this is an issue deserving of systemic and institutional attention. The cost of IPV to the healthcare system has been estimated at $857.3 million annually [19]. When direct costs to the health care system are combined with indirect costs to society, total health care costs of IPV can escalate into the billions of dollars. [20]. Other studies have found that IPV patients not only generate significant healthcare costs, but the costs of care of the IPV patient may exceed the costs of care for a comparable non-IPV patient. [21, 22].

**IPV Health Policy in California**

In 1996, the California Elected Women's Association for Education and Research published "Violence Against Women in California", a outline of public policy options regarding violence against women. In 1997, the Office of Women's Health drafted a policy report titled "Preventing Domestic Violence: A Blueprint for the 21st Century". This report identified six key goals for the state: 1) strengthen and expand domestic violence programs and resources, 2) protect children and youth from domestic violence, 3) ensure abuser accountability, 4) promote economic independence for domestic violence victims, 5) prevent domestic violence, and 6) improve state government operations relating to domestic violence.

**Identification:** In 1995, California enacted a screening law (Health and Professions Code §§1233.5, 1259.5) that required, as a condition of licensure, screening protocols and practices for California's licensed clinics and hospitals. Compliance has been variable; some hospitals electing to have a chart prompted screen for every patient interaction, others have opted for chart prompted screens for select groups of "at-risk" patients, and others have fostered healthcare screening by providing more professional education or more streamlined access to IPV services. These policy changes have been enacted with evidence that patients and experts alike believe verbal screening in a sensitive manner to be acceptable and helpful [23, 24], but without evidence that such intervention leads to improved outcomes. A recent study in California showed that higher rates of screening were associated with recent IPV education, use of IPV patient education materials and practices that screen for other health and safety risks [25]. Although institutions have been mandated to provide protocols, there is currently no screening mandate of individual licensed practitioners.

**Professional Education:** While the Business and Professions Code §2191 directs the Division of Medical Licensing to consider requiring continuing education on domestic violence for renewed, it does require proof of such training for new licensure. California medical and nursing schools are required to include domestic violence education in their curriculums and social workers must have 6 hours of domestic violence education for clinical licensure. A special fund was created to receive revenues from court-ordered batterer fines upon conviction of a misdemeanor or felony domestic violence assault. The fund supports additional professional training and education about domestic violence.

Training health care providers to better address the medical and forensic needs of victims of abuse was needed. Legislation in 1995 (Penal Code §13823.93) created a standardized training program called the California Medical Training Center (CMTC) funded through the Office of Criminal Justice Planning with a budget of $1.4 million per year. The Training Center's primary goal is to develop and deliver standardized training in the identification, forensic examination and care of victims of child abuse, domestic violence, elder abuse and sexual assault. There is no other long-term strategic training effort in the nation. The CMTC depends upon physician leadership, requires statewide consensus building and promotes interdisciplinary intervention. The CMTC has provided leadership in creating clinical guidelines and forensic standards for abuse victims. It is believed that forensic examination; documentation and presentation of testimony by trained health providers can minimize further traumatization of patient-victims and improve evidence collection thus protecting the rights of both victims and perpetrators. Current efforts include creating and updating state examination forms so they are electronically compatible, and creating a standardized evidence collection process in order to coordinate medical examiner procedures with crime lab capabilities.

**Patients as crime victims:** Healthcare and criminal justice services overlap when a patient is also a victim of a crime. In 1994, California's suspicious injury reporting law (PC §11160) was amended to provide immunity to healthcare providers who reported a patient with suspicious injuries and domestic violence was specifically listed as a reportable crime. Adding domestic violence to reportable crimes brought heightened awareness and concerns were raised about its potential benefits and risks. Healthcare providers, often in conjunction with advocacy and law enforcement, have met in several counties to address how best to comply with the law. They have developed protocols, on a county-by-county basis, that attempt to comply in a manner that is ethical, protective of patients as much as possible yet without minimizing the danger and criminal nature of the event. While survey studies [25, 26] indicate concern among healthcare providers and patients about healthcare reports to law enforcement, outcome studies of risks and benefits are needed in order to craft protocols or amend legislation appropriately.

In domestic violence prosecutions, the medical record and photo documentation of injuries have been significantly associated with increased prosecution and sentencing rates [27]. Medical forensic examiners have been used to examine, collect evidence, document and provide courtroom testimony for child abuse and sexual assault victims. Hospital based centers and examination teams provide forensic services for child abuse and sexual assault victims and some of these have been expanding services to include

victims of domestic violence and elder abuse. The cross over nature of violence, particularly family violence, is apparent to those working in the field and thus such centralization of services seems a natural progression. California has legislated standardized exam forms, protocols and practices in child abuse and sexual assault that may soon be extended to domestic violence and elder abuse.

**Programmatic interventions:** A variety of other programs and initiatives have also contributed to an improved health care response to victims of domestic violence.

- The 1994 Battered Women's Protection Act (BWPA) appropriated over $11 million annually to support battered women's shelters making access to these services easier for health care professionals.
- Women's Health Initiative, signed by then Governor Wilson included $524,000 annually for training and epidemiology of domestic violence.
- The California Insurance Code §10144.2 and the Health and Safety Code §§1374.7 and 10144.3 was revised to prohibit discrimination against domestic violence victims by life, disability or health insurers.
- Office of Victims of Crime (Government Code §13959-13969.5) defines general policy and procedures for the victims of crime restitution fund. Healthcare providers who provide medical or mental health services for victims can be reimbursed through this fund.
- Hospital discharge data is collected and tracked by the Office of Statewide Health Planning and Development. Both ICD-9 codes and E-codes for domestic violence are collected on all admitted patients and beginning in 2002 will include data from hospital emergency departments.

**Prevention:** There is little consensus about what prevention might look like beyond a few generalities. For example, there seems little doubt that effective drug and alcohol treatment would go a long way to reducing many serious and fatal intentional and non-intentional injuries. The Proposition 10 Tobacco Tax money is ear marked for early childhood intervention of children ages 0-5 and domestic violence has been designated as a priority issue. Given the negative impact of domestic violence on children, early parent education and maternal and child welfare screening practices could constitute a major prevention effort in the state. Other prevention measures include:

- A restraining order database linked to gun sales applications.
- Domestic Violence Death Review Teams (Penal Code §11163.5) to conduct an interdisciplinary mortality review and identifying avenues of prevention and improved intervention.
- Domestic Violence Coordinating Councils legislated to promote interdisciplinary programs and interventions on a county by county basis

## Future Direction

The California Medical Training Center and the Family Violence Prevention Fund co-sponsored a conference of researchers and public policy makers in 2000 called

"DVY2K" that made specific recommendations regarding IPV health policy and research needs in California. [28] California is also one of twelve states to receive grant money from the Family Violence Prevention Fund with additional support from the California Department of Health Services, to create leadership teams that promote IPV health policy change and public health education. The Leadership Team has identified six existing health intervention programs where minor policy changes could bring about major efforts to increase the early identification of IPV in adults and children.

No single health policy change will decrease the incidence or improve the health response to victims of domestic violence. A public health approach, just as has been applied to tobacco smoking or motor vehicle accidents, can be expected to have an effect in reducing domestic violence[29]. A strategic analysis of barriers and opportunities coupled with the commitment of health leadership to make incremental and persistent change can result in an overall IPV health policy shift that benefits patients and the community.

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Draft

# The Domestic Violence Health Cares Initiative

## Strategies To Improve The Health And Safety Of Victims Of Domestic Violence

California State Leadership Team
Family Violence Prevention Fund
National Standards Project

With funding from
Family Violence Prevention Fund
Conrad Hilton Foundation
California Department of Health Services, Epidemiology, Prevention, and Injury Control Division

October, 2001
Draft 3.0

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## Other National Standards Project activities

Domestic violence negatively impacts the health of individuals, families and communities. The Family Violence Prevention Fund (FVPF), a national organization promoting the improved prevention and intervention of domestic violence, has organized a major campaign called the National Standards Project focusing on health and domestic violence. The California State Leadership team is one of twelve state teams principally funded by the FVPF as part of their National Standards Project. In addition, the California Department of Health and Human Services, Epidemiology, Prevention, and Injury Control Division contributed one-third of the funding to the California team.

**The objectives of the State Leadership Team and National Standards Project are to:**

1. Craft new policies and continuous funding sources for clinical response to domestic violence;
2. Create a consensus on a standard of care for victims of domestic violence to be distributed as clinical guidelines;
3. Generate small and large scale public health campaigns to raise awareness about the negative health impact of domestic violence on adult and child victims;
4. Develop a business plan for domestic violence intervention that presents the financial argument in favor of improved health intervention;
5. Compile the strategies employed by the participating states and tribes in a new publication that highlights best practices in the field.

## Background of the Problem

The Centers for Disease Control define domestic violence using the term intimate partner violence. It is defined as physical, sexual violence or threats of physical and sexual violence, psychological/emotional abuse including coercive tactics that adults or adolescent use against current or former intimate partners [1]. The terms intimate partner violence and domestic violence are used interchangeably here.

**Prevalence:** Prior research suggests that between 960,000 to 4 million individuals are victims of intimate partner violence (IPV) each year [2-4]. Of those who are victims of IPV, 85% are women [4]. In a recent survey conducted by the Commonwealth Fund, it was estimated that approximately one-third (31%) of American women will become a victim of IPV at some point in their life [5]. Finally, while men are more likely than women to become a victim of violence are, women are 3-5 times more likely than men to victimized by an intimate partner [5-7].

Prior research on domestic violence using hospital data has generally focused on patients using emergency departments (ED) [7-13]. In 1994, it was estimated that 243,000 or 17% of all individuals who sought treatment for violent injuries in ED rooms were victims of domestic violence [7]. These studies suggest that among women, 37% of all injury related ED visits are a result of domestic violence [7]. Furthermore, it is estimated that 24% - 54% of all women seen in the ED have a lifetime history of intimate partner violence [12-14]. In the clinic setting, 5.5 % of women presenting to an ambulatory setting reported physical violence by an intimate partner within the last year [15]. Data further reports that between 20-40% of IPV victims seek repeated care for abuse [12, 16].

**Health Status of IPV Patients:** Domestic violence may be defined and has been interpreted in terms of mental health and/or physical injury ranging from bruising to broken bones to death [10, 16-19]. Women who have been abused by a partner report significantly lower self assessments of health, increased disabilities and increased chronic health conditions than non-abused women [20].

Depression, anxiety, suicide and suicide ideation have been linked to intimate partner violence. In one study 81% of women with a history of suicide attempt also reported a history of abuse [12]. Women who report any type of violence are significantly more likely than women who did not to have been diagnosed with depression or anxiety, to have depression symptoms and for women sexually assaulted by a intimate, to be currently taking medication for depression or anxiety [20]. Women who are diagnosed with persistent forms of mental illness appear to be more vulnerable to becoming victims of domestic violence [16, 21]. For example, one study found that 64% of female psychiatric patients had a history of domestic violence [22]. While not clear, data suggest a cyclical pattern in terms of mental illness and domestic violence may exist where the abuse and violence may be a consequence of mental illness, may exacerbate conditions surrounding a diagnosis of mental illness, or may create an environment where abuse can occur [4, 21].

Other health concerns that have been associated with IPV include functional gastrointestinal disorders, chronic abdominal pain [23], chronic headaches [24], and alcohol and drug addiction [25].

IPV in pregnancy results in increased morbidity and perhaps mortality. Studies suggest that women who are pregnant are at a higher risk of becoming victims of IPV [18, 26]. Between 4-16% of all women who are pregnant are battered during pregnancy [25, 27-30]; 10-32% of women seeking prenatal care have a history of domestic violence [25, 30, 31]; and 40-60% of battered women report being a victim of domestic violence during their pregnancy [18, 26]. Poor outcomes associated with IPV in pregnancy include

premature onset of labor, increased antenatal hospitalizations, and low birth weight infants. A recent study of death certificates in Maryland revealed that the primary cause of maternal mortality was homicide.

**Health Care cost of IPV:** Survey data on the cost of IPV suggest that the health care systems expends $857.3 million annually for the care of IPV patients [32]. When direct costs to the health care system are combined with indirect costs to society, total health care costs of IPV can escalate into the billions [33]. A recent study focusing on inpatient victims of IPV noted the average cost per episode of care is $8,159.81 with an average length of stay of 5.6 days [34]. This study further noted the average cost per day for IPV trauma victims is $3,592.75 [35]. A recent study comparing costs for IPV and non-IPV patients concluded that the average cost per episode of care for IPV victims is approximately $1,776.00 more than for non-IPV patients [36]. Women who experienced intimate sexual violence were more likely than other women to have had eight or more doctor visits during the past year are [20].

IPV patients not only generate significant healthcare costs for the direct and indirect consequences of the abuse, but the costs of care of the IPV patient may exceed the costs of care for a comparable non-IPV patient.

**Section I: Programmatic Actions of the SLT**

These programs are currently operational and minor protocol amendments, if adopted, could increase the recognition and intervention of domestic violence as a health problem. A common theme throughout each of the programs is the need to inform providers of the link between health risks, poor health and domestic violence; to motivate them to engage in this dialogue with their patients; to outline opportunities for intervention within that program, and to provide documentation guidelines so that they can obtain reimbursement for screening, assessment and intervention services in DV.

1. **Comprehensive Perinatal Services Program (CPSP)** is a state subsidized MediCal program. It was created in response to a study that indicated poor birth outcomes for MediCal mothers in California were related to poor prenatal care. The study demonstrated an overall cost-benefit to the state. Increased spending on prenatal care resulted in decreased costs for high-risk infant intensive care. (**Need source**) The study also indicated that the overall health of the mother affected the outcome for the baby.

   Eligible providers are required to use the state's assessment tool (Combined History Form) for all MediCal eligible pregnant women. The form currently includes ten questions (of 102) that relate to domestic violence. **(Need copy of the form)** In addition, the state reimburses for screening, assessment, intervention, referral time, and case management needs under a general "Psychosocial" billing category. There are 18 allowable units for psychosocial face-to-face visits. Units are in 15-minute intervals that can be used separately or together so there could be 18 separate visits or one 3-hour intervention. There are additional units available for high-risk clients. There are additional 16 units for health education.

   **Rationale for improved DV services:** DV services include screening and identification services as well as intervention protocols. Studies have shown that women rarely initiate the conversation about either current or past violence in their lives, but would welcome physician inquiries and would reveal, if asked, their abuse histories [20]. DV training for CPSP providers would help providers to learn a variety of screening strategies and initial intervention needs of patients. Domestic violence intervention protocols could be designed so that either psychosocial or education billing units could be employed.

2. **State Office of Family Planning (SOFP)** Family Pact Program (www.familypact.org) is a state funded program to provide reproductive health care for approximately 1.2 million non-pregnant women and who live at 200% poverty or below and do not have other insurance coverage for

reproductive health care. In addition to reproductive exams, this program reimburses for HIV screening and assessment, pregnancy counseling, teen-specific risk counseling, and birth control counseling. There are no specific protocols or directives for health risk screening. Currently, almost every county health department participates in SOFP. "Teen Smart" is a program directed specifically at health risk assessment of adolescents.

There are specific CPT codes used for reimbursement of screening, assessment and counseling and could be used to address DV as long as the chart indicated the discussion occurred within the context of overall pregnancy and STD reduction. CPT code Z97510 is a one-time use code that pays $11 for 10 minutes. Patients can return for sixteen 30 minutes follow-up visits for counseling. Counseling blocks can be lumped or accumulated and billed at the higher levels. Adolescents can receive repeat counseling sessions regarding lifestyle issues such as partner violence. These benefits have been recently extended to men of reproductive age. A copy of the CPT codes used for Family PACT office visits is included in the Appendix. **(Appendix)**

The Office of Family Planning contracts for training of providers who are required to attend a general orientation to the program. Approximately, two one-day trainings are held around the state each month. The Clinical Service Section is responsible for directing the contents of the orientation trainings. In addition, providers can receive information packets about discrete topics through regular or electronic mail systems.

**Rationale for improved DV services:** Domestic violence is associated with increased incidence of unintended pregnancy (**need source**) and pregnant teens report more partner violence than pregnant adults. (**need source**) Transmission of sexually transmitted diseases including HIV is associated with domestic violence, as victims feel intimidated or coerced to not use condoms by their partners. Women who have experienced forced sex report a younger age for first vaginal intercourse, a greater number of lifetime male sex partners and more actions of vaginal intercourse, but were less likely to have sex with condoms [37].

Protocols could be amended to include screens for domestic violence since they related to discussion regarding pregnancy and STD reduction. Practitioners would require training on DV screening, assessment and intervention.

3. **Healthy Families** is a health insurance program for low-income and children run by the Managed Risk Medical Insurance Board (MR MIB). The agency also administers a low cost insurance program for difficult to insure adults and may be extended to parents of insured children. It is

funded through SCHIP federal block grant. California invites health plans to participate and gets families to enroll by partially subsidizing the premium. There is a minimum scope of services required by states. Healthy Families is currently undergoing budget expansion and contracts will need to be clarified as to the expected scope of services.

**Rationale for improved DV services:** Expand the minimum scope of services to include screening for family violence in children and adults.

4. **Prop 10: Tobacco Tax** provides a source of funding for child development programs for children age 0 to 5 years with 80% of the money distributed at local level and 20% to the state. There is a state commission that meets monthly and establishes overall strategies and approves county plans set by each county's board of supervisors or the local Prop 10 commission. The commission has, as a priority, home health nursing for child abuse prevention. There has been a major media campaign effort to stop smoking. "School Readiness" programs have been created as an opportunity to outreach to parents and families and improve educational outcomes for young children. The money can be used for anything related to health and education of children ages 0 to 5. In fact, domestic violence is listed in the legislation. Ed Melia, MD represents Secretary Johnson on all Prop 10 issues.

   "Safe from the Start" is a Prop 10 funded program for children exposed to violence. The Attorney General's office is provided two staff to support this program. Ten forums will be held throughout the state to encourage local communities to look at children exposed to violence. On September 24th there will be a planning meeting and in March funding and evaluation strategies to be determined.

   **Rationale for Improved DV services:** Children are adversely affected when adult caretakers are abusive. In a recent review of the research children in domestic violence homes manifested more emotional and behavioral problems such as physical aggression, adjustment complications, academic problems, developmental delays, lower social competence ratings, and depressive symptoms than children in non-violent homes [38]. They are at increased risk for child physical abuse; they can become accidental victims "caught in the cross-fire"; they can be overlooked and neglected at home. Parental domestic violence in childhood has been identified as an adverse event that is associated with increased high-risk health by these children as adults [39].

   Screening parents of pre-verbal children and verbal children in the health care setting should be promoted as an important preventative measure. The School Readiness" programs should incorporate information about the

negative impact of DV on health and academic measures. The State Commission should consider and promote DV screening and intervention efforts as criteria in decision-making regarding Prop 10 programs

5. **Federally Qualified Health Centers (FQHC)** currently have mandates to provide prevention services but there is a lack of information as to what these actually are. Screening for DV could be incorporated and publicized as a preventative measure and thus comply with federal mandates. As a reimbursable benefit, it can be linked with counseling intervention.

6. **MediCal Programs:**
   a. **Local Education Agency (LEA)** is a billing option for school based health services and they can bill for case management. Partner violence education and screening, if not already included, would be particularly important for children and adolescents as patterns of intimate partner abuse often start in adolescence.

   b. **MediCal managed care Local Health Plans** have a health assessment tool that screens for child abuse and domestic violence. The tool is currently given to each client to complete and the provider addresses any problems identified.

7. **Hospital Discharge Data Collection**: Data about DV is currently collected on all inpatient admissions to California hospitals in the form of both ICD-9 codes and E codes to identify the nature of injuries. As of January 2002, the Hospital Discharge Data set should include hospital emergency rooms. More information about ICD-9 and ICD-10 is available at www.ehdp.com/epigram/.

   Since 1996, the E code for injury attributed to battering or other maltreatment by a spouse or partner. (E 967.3) has been coded for 250-300 hospitalized cases per year. But many interpret "battery or maltreatment" as only blunt face injury and would code penetrating trauma differently. California has about 150-200 intimate partner homicides per year. Most intimate partner homicides are associated with weapons and about 70% of these are firearms.

   The value of this discharge data set to track domestic violence is questionable. The care provider must identify that the nature of the injury is attributable to domestic violence and then the hospital information specialist must code the information appropriately. This data is then forwarded to the state. It is not clear if the validity of this data is being questioned and if it was, what could the State do to require hospital information specialists (HIS) to provide more reliable data. HIS would then have to evaluate if the problem is in the coding or if the problem is in the

initial documentation by the health care provider. HIS may have to train and provide feedback to the care providers so that they are better recorders of information in the medical record in regards to domestic violence and the etiology of injuries. A copy of "Coding and Documentation of Domestic Violence" is included in the appendix. **(Appendix)**

8. **Women, Infants and Children (WIC)** have video libraries that contain videos on DV. Recently a needs assessment was done regarding education needs in DV. Claudia Burnett at WIC is very interested in DV screening. WIC providers attend training each year and could provide DV education. Alabama and Alaska have protocols for DV screening for WIC.

9. **Office of Refugee Health** has brochures about DV in ten languages. It is not clear what are the leverage points for implementing DV screening.

10. **Domestic Violence Coordinating Councils:** What are they, where are they and can they be approached to increase participation of health care and to address health related issues?

**Section II: Legislative Actions of the SLT**
The following list provides suggestions for legislative actions and amendments that can help improve the health response to domestic violence patients.

1. **Death Certificates** could provide more information about maternal mortality. The CDC definition of pregnancy related mortality is one that occurs during a pregnancy or within one year after a pregnancy and is caused by pregnancy-related complications. According to the CDC, the 3 leading causes of pregnancy-related deaths in the United States are: hemorrhage, embolism, and pregnancy-included hypertension. In a recent study in Maryland, the cause of death for 247 Maryland women who died while pregnant or within a year of having been pregnant was analyzed. This study expanded the CDC definition to include accidents, homicide and suicide. The leading causes of death for pregnant or recently pregnant women was homicide and accounted for 20.2% of deaths as compared to 11.2% of deaths in non pregnant or not recently pregnant women (JAMA, Vol. 285, No. 11).

   Currently, only 17 states and New York City have a pregnancy check box or ask about pregnancy status on their death certificates. California death certificates do no record this information. **(Appendix)** The death certificate is reviewed and revised about every 10 years and was last revised in 1999.

   The National Center for Health Statistics has designed an electronic death certificate and is currently taking comments on the data sets. There may be a check box for pregnancy and maybe one for post-partum up to 12 months.

2. **DV Death Review Teams:** Another means of examining maternal mortality is through death review teams. California has passed enabling legislation for Death Review Teams for child deaths and for domestic violence related deaths but there is no appropriation to support such teams, or to support a common database for DV death review teams. SB 962 passed and provided $100,000 for funding a Death Review Coordinating Committee to create a database for fetal infant mortality reviews. Adult DV Death Review Teams also need support for creation of a common database, release of mental health records. They should also look beyond homicides to suicides and perinatal maternal deaths.

3. **Privacy in Medical Records:** Federal and State regulation regarding privacy are very important regarding domestic violence. Peter Sawires of the Family Violence Prevention Fund has reviewed the HIPAA Privacy Act and identified the issues that most directly impact domestic violence patients. **(Appendix)** There is a California Senate Privacy Committee,

chaired by Steve Peace, which would be willing to review the teams' recommendations regarding California regulations in this regard.

4. **Batterer's Fines** are a source of funding for DV health interventions. About 1/3 of the money stays in the county to support the restraining order registry. About 2/3 goes into a general fund half of which supports training and education efforts at EPIC. Half is returned to the jurisdiction from which it came. Alex Kelter provided a summary of batterer's fines collected by county **(Appendix)** that was created by researchers at Sonoma State University. There is marked variability in fines collected by county. Some counties have increased collections by 264% while others have decreased by as much as 87%. There is no information on total fines levied by county.

5. **Victims of Crime Funding** is legislated through Section 13900 of the Government Code. This funding program was administered under the State Board of Control but is now called the California Victim Compensation and Government Claims Board. Emergency awards are available to victims of crime for loss of income, emergency medical treatment, and funeral expenses. In addition, victims of domestic violence can use money for relocation expenses and for installing or increasing residential security. The emergency award application requires: identifying information, description of nature and circumstances of the crime, date of crime report, and description of expenses incurred. Additional assistance can be provided for mental health counseling including peer counseling services, job retraining or residence refitting should the victim become disabled because of the crime, and can also pay for attorney's fees. Recently, Section 13974.5 was added by Senator Burton to fund a Trauma Recovery Center at the University of California, San Francisco. This Center will provide services to meet both psychosocial and health needs for patients who have been assaulted by a stranger, by an intimate partner and by rape. The Center will be funded for $1 million dollars each year through January 1, 2005 with an evaluation of effectiveness to be done by 2004. Depending on the evaluation, there may be other centers funded.

   Victims of Crime Funding is supported through victim restitution fine set at the discretion of the court and commensurate with the seriousness of the offense. A defendant's inability to pay is not considered compelling and extraordinary reason not to impose a restitution fine. These fines are deposited in the Restitution Fund in the State Treasury. It has been reported that there may be more than $90 million in unaccessed funds.

   Victims of Crime Funding could support the intervention services for domestic violence patients but the application requirements may be a major barrier. The requirement for victim cooperation with prosecution

appears to be a barrier. Also, application is made through the DA's office and this may be a barrier.

6. **Mandatory Reporting** remains a controversial issue as the risks and benefits are still not well understood. There are concerns that victims may not be seeking medical care in order to avoid law enforcement involvement. Fears about batterer retaliation also exist. Health Care compliance is variable. Law enforcement response varies by jurisdiction. The underlying issue continues to be the potential for harm in not involving law enforcement when a victim presents to health care with injuries related to physical abuse versus the potential for harm in involving law enforcement that may increase a patient's risk in other ways.

7. **VOCA and VAWA Funding:** Task forces exist for each funding source and they are organized by OCJP.

8. **DV Forensic Exam Protocols:** SB 502 (Ortiz) has been passed and sent to the governor. It authorizes OCJP to create a standardized forensic exam form and protocol for victims of elder abuse and domestic violence. The rationale behind such an approach is that collection of historical and physical evidence should be thorough and comprehensive and a standardized approach has proved helpful for victims of child abuse and sexual assault.

## Section III: Public Health Education

Health education needs for both the public and health professionals are an on going need. The SLT intends to outline directions regarding both public health education and professional training needs, framing the issue, identifying additional funding needs and recognizing current efforts.

1. **Health Impact of DV** needs to be an essential message distributed to health care providers, managers, organizations and patients. A 30-minute PowerPoint presentation is being developed and distributed to Members of the State Leadership Team and the health care representatives on every DVCC in the state. The hope is that this message can be delivered in a variety of venues.

2. **Harm Reduction Model for DV intervention** appears to be a model that may be applicable to domestic violence patients and if so, could be a model that is promoted for intervention programs. The Harm Reduction Model is based on the following premises:
   a. It is counterproductive to think to end the health risk behavior as the only goal;
   b. Change is a stepwise process;
   c. Any movement in the direction of reduced risk is positive;
   d. Risk prevention practices are highly individualized;
   e. Work to strengthen individual capacity is essential;
   f. The goal is the improved well being of an individual and community.

   This model has been helpful in efforts to reduce the morbidity and mortality of HIV, substance abuse and gun violence. However, many have difficulty with this model because they prefer to dichotomize choices and responses. A model that emphasizes a series of small steps is conceptually ambiguous for some. Some advocates worry that a Harm Reduction Model communicates that the goal is to decrease the violence while their message has been any partner violence is unacceptable. These concepts do not appear incompatible. While harm reduction is helpful in thinking about efforts to reduce risk for individual victims, zero tolerance should remain the community standard in order to support aggressive prevention and intervention efforts for perpetrators.

3. **California Clinics Collaborative Kit** is a collection of materials that have been assembled by Rebecca Whiteman at the FVPF for distribution to California Clinics to help with clinic intervention in DV. The kit includes a variety of tools that are oriented towards immediate and practical application: camera-ready posters, chart prompts, basic education booklet for providers, screening tools, pregnancy wheels and patient education materials. Distribution is anticipated in September and could be available for other clinics and hospitals upon request.

4. **Health Cares about DV Day** planning is underway. It is the intention of the State Leadership Team to meet with Assemblywoman Thomson in August and then to have a briefing of some sort with the State Senate and Assembly regarding the health impact of DV. The FVPF has distributed an idea packet that includes buttons, sample op-ed pieces, media suggestions, sample safety cards, a consumer letter to health care providers, an email script, newsletter scripts and a CD ROM with camera-ready art. In addition, there is a nomination sheet for a health care provider that has contributed to the effort to improve the health care response to victims of DV.

   Elli Fairclough and Lisa James have drafted an Assembly Concurrent Resolution No. 99 **(Appendix)** that recognizes DV as a public health problem that requires a vigorous response. The resolution further encourages health care providers to get training and gives two resources, the FVPF and the CMTC. This resolution will be introduced by Assemblywoman Thomson in September and District Alerts will be sent out about October 10th Health Cares about DV Day. Since the legislature is not in session in October, a legislative briefing is being planned for January or February 2002.

5. **Legislative Briefing:** A legislative briefing will be held next January or February on SLT and the Health Impact of DV. A copy of CalCASA's briefing materials used recently that includes their publication, "A Vision to End Sexual Assault" can be used as a model. Taffy Rau of CEWAR to coordinate the briefing. The message needs to be developed. There should be a quick presentation and handouts of recommendations and laws. Essentially, the program would include: key message, barriers and solutions, review materials and follow-up survey to see what more is needed. A staff briefing could precede the legislative briefing in November or December. A copy of the summary or proceedings from "DVY2K: A colloquium of healthcare, health policy and researchers in DV" could be included in addition to the SLT team report.

6. **Clinical Guidelines** for health care professionals regarding DV identification, assessment and intervention are being developed by the CMTC. The guidelines have been in development for over one year as part of the mandate of the CMTC. They are in the final phases of development and graphic design and anticipate completion by November of this year.
7. **Media Efforts To Promote DV As A Health Issue** will be described here as they are identified. California Endowment provided a grant for a media campaign that includes a series of full spread newspaper ads. In July, the ad featured health care professionals who spoke about the need for

regular screening and discussion of DV with their patients. The ad was sponsored by the Sexual Assault and Domestic Violence Center of Yolo County and appeared in the Daily Drat on Monday, July 16, 2001 and sponsored by Women Escaping a Violent Environment (WEAVE) and appeared in the Sacramento Bee that same day. **(Appendix)**

8. **Victims With Disabilities Training:** The CMTC coordinated with the Office of Disabled Persons to draft a curriculum about disabled persons as crime victims.

9. **San Mateo County Health Department DV Training:** The County has been working on protocols for screening and intervention of DV. Training will occur at the County Hospital, 12 primary care clinics, public health department, Aging and Adult Services, Mental Health Services and Environmental Health. They are anticipating a training for trainers and then short trainings for clerical and support staff and then ½ day for direct service providers. They are working with the CMTC on the project.

10. **Walk the Walk for DV:** Could every county DVCC sponsor a 5K walk for DV that would emphasize the interdisciplinary intervention including criminal justice, health care and community/advocacy services? Would take almost a yearlong effort but might be great education/pr event. Perhaps it could be health-sponsored event to bring attention to the public health issue and negative health impact of DV on individuals, families and communities. Maybe a "doing our piece for peace" project.

11. **Health and DV Conferences:**
    a. Yolo County Family Violence Prevention Council "Health Care Perspectives on Domestic Violence", April 12, 2002
    b. Second Annual National Conference on Women's Health, Anaheim, March 1-3, 2002
    c. Family Violence Prevention Fund National Conference on Health and DV, October 2002, Atlanta, Georgia

## Section IV: Other National Standards Project Activities

1. The Joint Commission on the Accreditation of Hospitals and Healthcare Organizations (JCAHO) is strengthening its standards and monitors on screening and intervention in domestic violence. There may be a training of surveyors at the FVPF national conference.
2. The National Business Coalition on Health that comprises major purchasers of health care is considering adding domestic violence questions as part of their request of health insurers.

3. The DV Screening and Services Act is being reintroduced at the federal level. It will provide for Medicaid screening and intervention services.
4. The State-by-State Legislative Report Card was released at the end of August 2001. Even though California received the most points, they can receive no grade higher than A because the mandatory reporting law gets negative points by the FVPF criteria.
5. Model healthcare legislation has been drafted and distributed to all the State Leadership Teams.
6. Multiple sub-committees meeting to discuss clinical guidelines, the business case for DV and others.
7. National Meeting in November 2001 in Midwest. Two members of each team to attend.

Draft

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ATTACHMENT 5

# AMERICAN MEDICAL ASSOCIATION DIAGNOSTIC AND TREATMENT GUIDELINES ON DOMESTIC VIOLENCE

# AMERICAN MEDICAL ASSOCIATION DIAGNOSTIC AND TREATMENT GUIDELINES ON DOMESTIC VIOLENCE

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These guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. These guidelines reflect the views of scientific experts and reports in the scientific literature as of March 1992.

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## INTRODUCTION

Physical and sexual violence against women is a public health problem that has reached epidemic proportions. An estimated 8-12 million women in the United States are at risk of being abused by their current or former intimate partners. This violence causes serious physical, psychological, and social sequelae for these women and their families.

Domestic violence, also known as partner-abuse, spouse-abuse, or battering, is one facet of the larger problem of family violence. Family violence occurs among persons within family or other intimate relationships, and includes child abuse and elder abuse as well as domestic violence. Family violence usually results from the abuse of power or the domination and victimization of a physically less powerful person by a physically more powerful person.

Until the mid-1970s, assaults against wives were considered misdemeanors in most states, even when an identical assault against a stranger would have been considered a felony. The current consensus among state and federal policy makers is:

- Domestic violence is a crime
- Safety for victims of domestic violence and their children must be a priority
- Changes in traditional services, including medical care, are needed to meet the needs of abused women

Most states have improved the legal remedies available to battered women, and a number of state health departments have developed protocols for health care providers. Since January 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has required that all accredited hospitals implement policies and procedures in their emergency departments and ambulatory care facilities for identifying, treating, and referring victims of abuse. The standards require educational programs for hospital staff in domestic violence, as well as elder abuse, child abuse, and sexual assault.

Because a physician may be the first nonfamily member to whom an abused woman turns for help, he or she has a unique opportunity and responsibility to intervene. Battered women often present with repeated injuries, medical complaints, and mental health problems, all of which result from living in an abusive relationship. Physicians in all practice settings routinely see the consequences of violence and abuse, but often fail to acknowledge their violent etiologies. By recognizing and treating the effects of domestic violence, and by providing referrals for shelter, counseling and advocacy, physicians can help battered women regain control of their lives.

These guidelines are intended to:

- Familiarize you with the magnitude of the problem
- Describe how to identify abuse and violence through routine screening and recognition of clinical presentations

- Help you assess the impact of abuse and violence on your patients' health and well-being
- Provide examples of how to ask questions in ways that can elicit meaningful responses and help women to explore their options and take action
- Provide information on appropriate resources for referral and address frequently encountered obstacles
- Familiarize you with the legal aspects of medical care, including reporting requirements

## FACTS ABOUT DOMESTIC VIOLENCE

Domestic violence is characterized as a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation. These behaviors are perpetrated by someone who is or was involved in an intimate relationship with the victim. Although some women are successful in escaping a violent relationship after the first assault, most abuse is recurrent and escalates in both frequency and severity. In addition, a woman's independence may be compromised by her partner's need to dominate her and control many aspects of her life: He may restrict her access to food, clothing, money, friends, transportation, health care, social services or employment.

Research has failed to demonstrate a psychological or cultural profile of battered women. However, certain groups of women appear to be at somewhat higher risk for abuse: women who are single, separated, or divorced (or are planning a separation or divorce); women between the ages of 17 and 28; women who abuse alcohol or other drugs--or whose partners do; women who are pregnant; or women whose partners are excessively jealous or possessive. Children raised in violent homes may be at increased risk for perpetrating or experiencing violence in adulthood, but not all abusive partners or abused women were exposed to family violence while growing up.

Domestic violence cuts across all racial, ethnic, religious, educational, and socioeconomic lines. However, physicians should be aware that a woman's family background, as well as her cultural and religious beliefs may influence her perceptions of abuse. In addition, her socioeconomic status influences her access to medical care. Women of higher socioeconomic status are more likely to seek care in private practice settings, while low-income women are more likely to go to clinics and emergency departments.

Conservative studies indicate that two million women per year are assaulted by their partners, and national experts agree that the true incidence of partner violence is probably at least twice that figure.

- Nearly one quarter of women in the United States--more than 12 million--will be abused by a current or former partner some time during their lives.
- 47% of husbands who beat their wives do so three or more times a year.
- According to FBI statistics, 30% of women who were murdered in 1990 were killed by husbands or boyfriends. It is estimated that 52% of female murder victims were killed by a current partner or ex-husband.
- 14% of ever-married women report being raped by their current or former husbands, and rape is a significant or major form of abuse in 54% of violent marriages.

Clinical studies underscore the prevalence of domestic violence and its relationship to continued or repeated trauma and consequent medical and psychiatric problems. More than half of all nonfatal assaults result in injury, and 10% of the victims require hospitalization or emergency medical treatment. Seventy-five percent of battered women first identified in a medical setting will go on to suffer repeated abuse. According to various studies, battered women may account for:

- 22% to 35% of women seeking care for any reason in emergency departments, the majority of whom are seen by medical or other non-trauma services
- 19% to 30% of injured women seen in emergency departments
- 14% of women seen in ambulatory-care internal medicine clinics (28% have been battered at some time)
- 25% of women who attempt suicide
- 25% of women utilizing a psychiatric emergency service
- 23% of pregnant women seeking prenatal care
- 45% to 59% of mothers of abused children
- 58% of women over 30 years old who have been raped

Most research has focused on women who have been battered by male partners, and, in fact, women are more likely than men to be seriously injured by their partners. However, the terms spouse-abuse and partner-abuse reflect an awareness that men also can be abused in intimate relationships. The extent to which findings about battered women can be applied to men who are abused by women, or to the underrecognized problem of violence within gay and lesbian relationships, is not known. In clinical practice, these issues also must be addressed in a sensitive and nonjudgmental manner.

## FORMS OF ABUSE

Domestic violence is an ongoing, debilitating experience of physical, psychological and/or sexual abuse in the home, associated with increased isolation from the outside world and limited personal freedom and accessibility to resources. Whenever a woman is placed in physical danger or controlled by the threat or use of physical force, she has been abused. The risk for abuse is greatest when a woman is separated from supportive networks.

Physical abuse is usually recurrent and escalates in both frequency and severity. It may include the following:

- Pushing, shoving, slapping, punching, kicking, choking
- Assault with a weapon
- Holding, tying down, or restraining her
- Leaving her in a dangerous place
- Refusing to help when she is sick or injured

Emotional or psychological abuse may precede or accompany physical violence, as a means of controlling through fear and degradation. It may include the following:

- Threats of harm
- Physical and social isolation
- Extreme jealousy and possessiveness

- Deprivation
- Intimidation
- Degradation and humiliation
- Calling her names and constantly criticizing, insulting and belittling her
- False accusations, blaming her for everything
- Ignoring, dismissing, or ridiculing her needs
- Lying, breaking promises, destroying trust
- Driving fast and recklessly to frighten and intimidate her

Sexual abuse in violent relationships is often the most difficult aspect of abuse for women to discuss. It may include any form of forced sex or sexual degradation, such as:

- Trying to make her perform sexual acts against her will
- Pursuing sexual activity when she is not fully conscious or is not asked or is afraid to say no
- Hurting her physically during sex or assaulting her genitals, including use of objects or weapons intravaginally, orally, or anally
- Coercing her to have sex without protection against pregnancy or sexually transmissible diseases
- Criticizing her and calling her sexually degrading names

## INTERVIEWING PROCESS

Domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify routine screening of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. Because some women may not initially recognize themselves as "battered," the physician should routinely ask all women direct, specific questions about abuse. Such questions may be included in the social history, past medical history, review of systems, or history of present illness, as appropriate.

Although women may not bring up the subject of abuse on their own, many will discuss it when asked simple, direct questions in a nonjudgmental way and in a confidential setting. The patient should be interviewed alone, without her partner present. The physician should make an opening supportive statement, such as: "Because abuse and violence are so common in women's lives, I've begun to ask about it routinely." Even if she does not respond at the time, the fact that a provider is concerned and believes that battering is a possibility will make an impression. The physician's concern about abuse validates her feelings and reinforces her capacity to seek help when she feels ready and able to do so.

Routine questions about violence not only identify women who are currently being abused but also serve to assess the safety of women who have been battered in the past and to heighten the awareness of those who have not been in abusive relationships. Routine assessment is particularly important for women who have left a violent relationship; leaving an abusive partner or finalizing a divorce may increase her risk for abuse. The physician should provide appropriate follow-up during legal proceedings, and assess the woman's need for emergency shelter or other resources.

A medical encounter may provide the only opportunity to stop the cycle of violence before more serious injuries occur, and intervention begins by gathering information. Providing the

woman with a different kind of experience--one in which she is respected and taken seriously; one that lets her know she doesn't deserve to be abused; one that offers the possibility of support and safety, and one that encourages her own choices and decision-making is, in itself, therapeutic and an important step. Questions about domestic violence should be asked in the physician's own words and in a nonjudgmental way. Here are some examples of recommended questions:

- Are you in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?
- Are you (have you ever been) in a relationship in which you felt you were treated badly? In what ways?
- Has your partner ever destroyed things that you cared about?
- Has your partner ever threatened or abused your children?
- Has your partner ever forced you to have sex when you didn't want to? Does he ever force you to engage in sex that makes you feel uncomfortable?
- We all fight at home. What happens when you and your partner fight or disagree?
- Do you ever feel afraid of your partner?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
- You mentioned that your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?
- Do you have guns in your home? Has your partner ever threatened to use them when he was angry?

## DIAGNOSIS AND CLINICAL FINDINGS

Injury: Episodes of physical assault characterize abusive relationships. Physicians should consider the possibility of assault when the woman's explanation of how an injury occurred does not seem plausible or when there has been a delay in seeking medical care. Common types of injury include:

- Contusions, abrasions, and minor lacerations, as well as fractures or sprains
- Injuries to the head, neck, chest, breasts, and abdomen
- Injuries during pregnancy
- Multiple sites of injury
- Repeated or chronic injuries

Medical findings: The stress of living in an ongoing abusive relationship may cause any of the following:

- Chronic pain, psychogenic pain, or pain due to diffuse trauma without visible evidence
- Physical symptoms related to stress, chronic post-traumatic stress disorder, other anxiety disorders, or depression. Examples are:
  - Sleep and appetite disturbances
  - Fatigue, decreased concentration, sexual dysfunction
  - Chronic headaches
  - Abdominal and gastrointestinal complaints
  - Palpitations, dizziness, paresthesias, dyspnea

  - Atypical chest pain
- Gynecologic problems, frequent vaginal and urinary tract infections, dyspareunia, pelvic pain
- Frequent use of prescribed minor tranquilizers or pain medications
- Frequent visits with vague complaints or symptoms without evidence of physiologic abnormality

Many practitioners have noted that chronic illnesses such as asthma, seizure disorders, diabetes, arthritis, hypertension, and heart disease may be exacerbated or poorly controlled in women who are being abused.

Sexual coercion and assault are common expressions of domestic violence. Assessment for sexual abuse and rape should be addressed in the sexual or social history taken during routine primary care visits, in discussions of birth control and safer sexual practices and in evaluations during gynecologic and obstetric visits.

Pregnancy: Because of the risk to the mother and fetus, assessment for abuse should be incorporated into routine prenatal and postpartum care. Presentations include:

- Injuries, particularly to the breasts, abdomen, and genital area, or unexplained pain.
- Substance abuse, poor nutrition, depression, and late or sporadic access to prenatal care
- "Spontaneous" abortions, miscarriages, and premature labor

Mental Health/Psychiatric Symptoms: Assessment for domestic violence should be included as a routine part of psychiatric intakes and evaluations. The stress of domestic violence may aggravate comorbid psychiatric disorders. Psychiatric symptoms of abuse include the following:

- Feelings of isolation and inability to cope
- Suicide attempts or gestures
- Depression
- Panic attacks and other anxiety symptoms
- Alcohol or drug abuse
- Post-traumatic stress reactions and/or disorder

Routine assessment of domestic violence in the patient's family is important for both men and women in alcohol and drug rehabilitation programs. Nearly 75% of all wives of alcoholics have been threatened, and 45% have been assaulted by their addicted partners.

Control in a Relationship: An abusive partner's use of control within a violent relationship may result in:

- Limited access to routine and/or emergency medical care
- Noncompliance with treatment regimens
- Not being allowed to obtain or take medication
- Missed appointments
- Lack of independent transportation, access to finances, ability to communicate by phone
- Failure to use condoms or other contraceptive methods

- Not being told by a partner that he is infected with HIV or other sexually transmissible diseases

Behavioral Signs: Battered women exhibit a variety of responses to the stress of ongoing abuse; such patients may appear frightened, ashamed, evasive or embarrassed. A battered woman may believe she deserves the abuse because the abuser tells her so, and she may take responsibility for his violence to maintain some sense of control over her situation. Other findings may include the following:

- Partner accompanies patient, insists on staying close, and answers all questions directed to her
- Reluctance of a patient to speak or disagree in front of her partner
- Intense irrational jealousy or possessiveness expressed by partner or reported by patient
- Denial or minimization of violence by partner or by patient
- Exaggerated sense of personal responsibility for the relationship, including self-blame for her partner's violence

## INTERVENTIONS

### Important Considerations

Once abuse is recognized, a number of interventions are possible, but even if a woman is not ready to leave the relationship or take other action, the physician's recognition and validation of her situation is important. Silence, disregard, or disinterest convey tacit approval or acceptance of domestic violence. In contrast, recognition, acknowledgment, and concern confirm the seriousness of the problem and the need to solve it. Optimal care for the woman in an abusive relationship also depends on the physician's working knowledge of community resources that can provide safety, advocacy, and support.

The injury or complaint that precipitated the health care encounter requires evaluation and appropriate treatment. In addition, the physician should ask about the patient's use of pain, sleeping, or antianxiety agents. Psychiatric problems, including severe depression, panic disorder, suicidal tendencies or substance abuse, may hinder the battered woman's ability to assess her situation or take appropriate action. When serious psychiatric conditions are present, an appropriate treatment plan includes psychiatric evaluation and treatment. On the other hand, emotional, behavioral, and cognitive symptoms of abuse can be misinterpreted as psychiatric in origin. Physicians must make sure that the mental health professional to whom they refer the patient is sensitive to these issues.

Alcohol or drugs may be used to rationalize violent behavior. Perpetrators and family members may insist that substance abuse is the problem. Evidence indicates that while substance abuse and violent behavior frequently coexist, the violent behavior will not end unless interventions address the violence as well as the addiction. Similarly, mental illness is rarely the cause of domestic violence, although mental illness in a batterer can lead to loss of control and increased frequency and severity of violence. Treating the mental illness alone will not end the violence. Both issues must be addressed.

Couples' counseling or family intervention is generally contraindicated in the presence of domestic violence. Attempts to implement family therapy in the presence of ongoing violence may increase the risk of serious harm. The first concern must be for the safety of the woman and her children.

Often women are not the only victims at home: Child abuse has been reported to occur in 33% to 54% of families where adult domestic violence occurs. In situations when children are also being abused, coordinated liaisons between advocates for victims of domestic violence and child protective service agents should be used to insure the safety of both the mother and her children. Otherwise, the reporting and investigation of alleged child abuse may increase the mother's risk of abuse.

**Patient Safety**

It is imperative that the physician inquire about a battered woman's safety before she leaves the medical setting. The severity of current or past injury is not an accurate predictor of future violence, and many women minimize the danger they face. After assessing the situation, plans for the woman's safety should be discussed before she leaves the physician's office. Various options should be considered:

- Does she have friends and family with whom she can stay?
- Does she want immediate access to a shelter?
  - -- If none is available, can she be admitted to the hospital?
  - -- If she doesn't need immediate access to a shelter, give her written information about shelters and other resources if it is safe to do so.
- Does she need immediate medical or psychiatric intervention?
- Does she want immediate access to counseling to help her deal with the stress caused by the abuse?
- Does she want to return to her partner, with a follow-up appointment at a later date?
- Does she need referrals to local domestic violence organizations?

Information and Resources

If the patient feels it is safe to do so, provide her with written information (including phone numbers) on legal options, local counseling and crisis intervention services, shelters, and community resources. In addition, educational materials on domestic violence in waiting areas and examination rooms may help patients identify violence as a personal health problem.

National organizations on domestic violence and many local and state battered women's programs have information available for use in physician offices. The National Domestic Violence hot line (800-333-SAFE) is a 24-hour resource to help women find local shelters. Counselors speak Spanish as well as English. The National Woman Abuse Prevention Center (202-857-0216) publishes fact sheets on domestic violence, a quarterly newsletter, and a series of brochures. Some of the material is translated into Spanish and Polish. The American College of Obstetricians and Gynecologists (202-863-2518) publishes "The Abused Woman," a publication for patients. The Family Violence Prevention Fund (415-821-4555) provides direct services to victims and develops public policy and training programs.

Local domestic violence shelters and statewide domestic violence programs are frequently listed in the phone book. They can help with housing, information about legal rights, welfare applications, and counseling (including peer groups and counseling for children). They may have brochures for distribution to women patients that address issues and list local resources. Many programs offer these services without charge.

## BARRIERS TO IDENTIFICATION

### Patient Barriers

Many women are reluctant or unable to seek help. Some are literally held captive and not allowed out of the house. Others may not have money or means of transportation. If they do come to a physician's office, they may have to leave before they are seen, rather than risk further abuse for "getting home late." Childhood experiences of physical or sexual abuse, or witnessing domestic violence, may make it more difficult for a battered woman to recognize a relationship as abusive and to take steps to protect herself. Cultural, ethnic or religious background may also influence a woman's response to abuse and her awareness of viable options. Other reasons for not mentioning abuse include:

- Fear that revelation will jeopardize her safety
- Shame and humiliation at the way she is being treated
- Thinking she deserved the abuse and is not deserving of help
- Feeling protective of her partner. He may be her sole source of love and affection when he is not abusive and may provide the financial support for her and her children.
- Lack of awareness that her physical symptoms are caused by the stress of living in an abusive relationship
- Belief that her injuries are not severe enough to mention

Because the experience of abuse is so degrading and humiliating, a woman may be reluctant to discuss it with someone who may not take her seriously, who may discount her experience, who may perceive her as deserving the abuse, or blame her for staying with her abuser. She may fear that reporting the abuse will jeopardize her safety and destroy her means of support; she may stay in the relationship hoping that the situation will get better. Her partner may not always be abusive and this gives her hope that he will change.

### Physician Barriers

Until recently, physicians rarely addressed issues of abuse and violence, even when the signs or symptoms were present. There are many reasons why physicians may avoid asking about abuse and why it may seem difficult to do so initially. Among these are:

- Lack of awareness of the prevalence, means of identification, or severity of the problem and lack of recognition of the social and psychological costs of abuse
- Thinking it is not a physician's place to intervene, or that the woman must have provoked the abuse
- Believing identification of abuse and referral for services is not part of the physician's role

- Not knowing how to intervene or help even if a woman is recognized as being battered
- "Blaming the patient" and feeling frustrated or angry if the woman doesn't leave her partner (she becomes the problem for being noncompliant with the physician's timetable)
- Disbelief because the alleged assailant is present and seems very concerned and pleasant
- Concern that discussing psychosocial issues will take an overwhelming amount of time
- Difficulty dealing with the feelings evoked by listening to a woman describe what has been done to her. The physician may feel helpless or inadequate if he or she can't "do something" to "fix" the situation.

## DOCUMENTATION

Thorough, well-documented medical records are essential for preventing further abuse. Furthermore, they provide concrete evidence of violence and abuse and may prove to be crucial to the outcome of any legal case. If the medical record and testimony at trial are in conflict, the medical record may be considered more credible. Records should be kept in a precise, professional manner and should include the following:

- Chief complaint and description of the abusive event, using the patient's own words whenever possible rather than the physician's assessment. "'My husband hit me with a bat'" is preferable to "Patient has been abused."
- Complete medical history
- Relevant social history
- A detailed description of the injuries, including type, number, size, location, resolution, possible causes, and explanations given. Where applicable, the location and nature of the injuries should be recorded on a body chart or drawing.
- An opinion on whether the injuries were adequately explained
- Results of all pertinent laboratory and other diagnostic procedures
- Color photographs and imaging studies, if applicable
- If the police are called, the name of the investigating officer and any actions taken

In addition to complete written records, photographs are particularly valuable as evidence. The physician should ask the patient for permission to take photographs. Imaging studies also may be useful. State laws that apply to the taking of photographs usually apply to x-rays as well.

- When possible, take photographs before medical treatment is given
- Use color film, along with a color standard
- Photograph from different angles, full body and close-up
- Hold up a coin, ruler, or other object to illustrate the size of an injury
- Include the patient's face in at least one picture
- Take at least two pictures of every major trauma area
- Mark photographs precisely as soon as possible with the patient's name, location of injury, and names of the photographer and others present

For medical records to be admissible in court the doctor should be prepared to testify:

- That the records were made during the "regular course of business" at the time of the examination or interview
- That the records were made in accordance with routinely followed procedures
- That the records have been properly si. ed and their access limite. o professional staff

## LEGAL DEVELOPMENTS

### Protection of Victims

Today every state has some form of legisla'ion designed to offer protection to victims of domestic violence. Some states have placed additional duties on police, requiring them to make arrests in certain cases, accompany women to their homes to collect children and belongings, and inform them of their legal rights. However, despite the increased interest in domestic violence and the enhanced availability of legal remedies, compliance with or enforcement of the laws on the part of some physicians, police, prosecutors, government agencies, and courts is often less than ideal. Physicians need to be aware of state laws and of the services available in their community for abuse victims.

The legal remedies available to battered women vary from state to state and these laws are changing rapidly. Advocacy programs often can explain to women the legal options that are available, and can help them access the legal system. The most common civil action in domestic violence cases is a protective order, injunction, or restraining order, which is a court order that directs the batterer to stop abusing the victim. In some states, the court may have the authority to order a batterer to leave a shared residence, receive counseling, make support payments, pay medical bills, or take other action. Depending on the jurisdiction, police may also be required to arrest abusers who violate protective orders. In any event, a woman's safety must be continually reassessed since a protective order does not guarantee it.

Criminal actions against batterers may include prosecution for assault, battery, aggravated assault or battery, harassment, intimidation, or attempted murder. Historically, abused women often have been unable to pursue such charges against their spouses, and even today they may encounter police who are reluctant to take action, prosecutors who downgrade charges, and courts that are not receptive to such claims. Some states have adopted specific provisions that criminalize domestic abuse, but the lack of explicit laws does not necessarily mean that criminal prosecution is unavailable.

### State Reporting Requirements

Few states have explicit mandatory reporting laws for domestic abuse, and it is not clear that mandatory reporting would best ensure the safety of competent adult victims or connect them with needed resources. However, virtually all states have some type of statute that requires physicians to report to law enforcement officials certain injuries that appear to have resulted from a criminal act. Disclosure of a diagnosis of abuse to partners or any third party and reporting to authorities should be done only with the abused woman's knowledge and consent.

In addition, in most areas, there are no government agencies to coordinate case management and put victims in contact with needed services for domestic violence. Thus, physicians need

to be aware of local resources to make appropriate referrals and to advocate for expanded resources. In any case, physicians should emphasize that they will remain available to help in the future and should provide the patient with a list of available resources. The physician should document the diagnosis, the information conveyed and any pamphlets or materials given to the patient, as well as the patient's decision on whether or not to allow the physician to take further action such as notifying the police.

### Testimony

Medical evidence is not required in every judicial undertaking, such as divorce or custody hearings. If court evidence becomes necessary, a well-documented medical record may reduce the time a physician is required to spend in judicial proceedings. It may be possible to place the physician "on call" for court, so that he or she need appear only when it is time to testify.

The physician may be called to testify about the contents of the record or statements made. This function is distinct from the use of the physician as an expert. The physician may be requested to give expert medical testimony and perhaps to give an opinion on whether the explanation given is consistent with the injury. With regard to such testimony, the following guidelines should be followed:

- Insist on pre-trial preparation by the attorney presenting you as a witness
- Know the facts of the case well
- If testifying as an expert witness, propose questions for the attorney to ask
- Brief the attorney on questions to ask the opposing expert
- Listen to the question asked and answer only that question
- If a question is not understood, ask that it be repeated
- Do not volunteer information
- Explain when a one-word answer is not enough
- Calmly correct an attorney who misstates prior testimony

## RISK MANAGEMENT

### Duty to the Victim

Most physicians will encounter cases of domestic abuse in their practices. Physicians must be aware of their obligations in these cases, as well as their potential liability for failing to diagnose and/or report domestic abuse. In general, doing what is medically best or most appropriate is good risk management. If an injured woman is treated by a physician who does not inquire about abuse or who accepts an unlikely explanation of the injuries and she then returns to the abusive situation and sustains further injuries, the physician could be held liable for those subsequent injuries.

The duty to the victim may arise from the special relationship between doctor and patient or from the courts' interpretations of reporting laws. The argument would be that other physicians, under the same circumstances, would have diagnosed inflicted trauma and taken appropriate management steps that would have prevented the subsequent harm.

Thus, physicians must be willing to ask all women patients about abuse, and should know how to diagnose it. Failure to conduct the interview and examination apart from the suspected victim's spouse or partner may interfere with an accurate diagnosis. Physicians also should be aware of certain "red flags" that can signal particularly dangerous situations for the woman: stalking behavior by the abuser; substance abuse by the abuser; and threatened suicide by the abuser (increased risk for a murder/suicide).

In states that have enacted mandatory reporting statutes, a physician's failure to report could give rise to liability, but since reporting laws rarely explicitly give victims such a right to sue, courts must determine whether their state's statutes implicitly contain that right. Criminal reporting statutes usually are enacted to inform the police of the occurrence of crimes rather than to protect victims of violence. In contrast, child abuse reporting statutes are usually enacted with the clear purpose of protecting abused children, and some courts have allowed abused children to sue physicians who violate a reporting statute. If a state has a specific domestic violence reporting statute, courts may be more likely to allow a suit against a physician who failed to report the abuse.

### Duty To Warn

Many states recognize a legal duty that physicians have toward third parties who might be harmed by their patients. In those states, if a physician is aware of a patient's intent to harm a third party, such as the patient's spouse or partner, the physician may have a legal duty to breach the patient's confidence and to warn the third party of the impending danger. Physicians, especially therapists, should know the law where they practice.

### Medical Malpractice Lawsuits

Even after taking all possible measures to handle cases correctly, physicians may still become defendants in medical malpractice suits. These physicians should:

- Not panic
- Not discuss the case with anyone until they have spoken with their attorney
- Contact their malpractice insurance carriers
- Record the circumstances involved in the serving of a summons
- Have thorough documentation

## TRENDS IN TREATMENT AND PREVENTION

Living in an abusive relationship takes a tremendous toll on a woman's physical and psychological well-being. As physicians begin to routinely ask about abuse, they may feel overwhelmed by the prevalence of this problem and by the amount of pain some women experience in their intimate relationships. While maintaining doctor-patient confidentiality, it is important for physicians to discuss with supportive colleagues or others how best to respond to such encounters.

All physicians should begin to respond to the JCAHO requirements of recognition, crisis intervention and referral. Some will play a more active role by developing innovative programs, advocating for increased funding for services and for violence prevention programs, and by educating students, community groups and other physicians. There is

much work to be done, but there is a great potential for improving patients' lives, especially when physicians team up with other professionals and work through local community services.

Several recent trends will improve awareness and outreach in the area of domestic violence. These include: hospital-based intervention programs that link with community groups and provide ongoing support and advocacy; community-based training projects to educate physicians and other health care providers; new residency requirements and additions to medical school curricula that train physicians to recognize violence and abuse; and the addition of assessment of abuse into existing community outreach programs for women. The AMA is working to assist physicians in their efforts to reduce violence and the effects of violence in their local communities.