

*Building  
Comprehensive  
Solutions to  
Domestic  
Violence*

*Publication # 6*

**A Policy and Practice  
Paper**

**Building Bridges between  
Domestic Violence Advocates  
and Health Care Providers**

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# **Building Bridges Between Domestic Violence Advocates And Health Care Providers**

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800-537-2238

and

The Family Violence Prevention Fund  
Health Resource Center on Domestic Violence  
888-RX-ABUSE

**June, 1999**

Special thanks to The Ford Foundation for its support of the National Resource Center on Domestic Violence and *Building Comprehensive Solutions to Domestic Violence*, the initiative under which these materials were produced. We also wish to acknowledge the U.S. Department of Health and Human Services for their ongoing funding of the NRC.

The ideas expressed herein are those of the author and do not necessarily represent the official position or policies of The Ford Foundation or other funders of the National Resource Center on Domestic Violence or the Family Violence Prevention Fund.

**These materials may be reprinted or adapted with proper acknowledgment.**

## *Acknowledgments*

The author is grateful to Helen Rodriguez-Trias for sharing her many insights and years of experience, as well as her commitment to strengthening working relationships between domestic violence and health care professionals.

The author is also grateful to those who read this paper and helped give it further focus and clarity: Jacquelyn Campbell, Jill Davies, Nancy Durburow, Debbie Lee, Anne Menard, and Colleen Sutkus. Special thanks go to Margaret Nelson for her help with the editing process; Susan Schechter for her vision and constant enthusiasm for this project; and my friends at the Family Violence Prevention Fund for providing me - for so many years - with the camaraderie, the resources, and the support with which to learn and grow.

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# Building Bridges Between Domestic Violence Advocates And Health Care Providers

Domestic violence advocates face new challenges in the field of health care, with growing demands to provide health care-based training, interventions, and policy initiatives. The goal of this paper is to help battered women's advocates by setting out:

- ◆ the opportunities presented by working with the health care community to strengthen advocacy and intervention on behalf of battered women;
- ◆ the possible and desirable health care responses to domestic violence; and
- ◆ practice and policy starting points and agendas for advocates within a variety of health care settings.

## **I. Health systems reform work presents opportunities for battered women's advocates.**

Advocates for battered women have influenced social and political institutions to bring about change in many areas – in the justice system's response to domestic violence; in media recognition of the prevalence, lethality and brutality of domestic violence; in improved public policies at the local, state and federal levels; in increased funding for services; and in stronger legal protections for victims.

In the United States, domestic violence is one of the most serious threats to women's health, and the domestic violence community once again has the opportunity to influence systemic change that can greatly assist battered women – and even *prevent* domestic violence. There is a growing awareness that domestic violence is a criminal justice issue *and* a public health issue. For advocates, one of the most significant social change opportunities of the decade is to articulate the concerns of battered women within the health system changes that are taking place.

Concern for women's health is growing, and the need to respond to domestic violence as a major women's health issue is being raised by mainstream policymakers and health organizations alike. As advocates working for change within the health care arena, our role is similar to other systems reform work – to expand and enhance the support and range of options available to battered women. In order to ensure *meaningful* long-term social and institutional change for battered women, advocates must seek out the help of the health care community as partners in this endeavor.

## A. Why battered women need a strengthened health care response

### ◆ Many battered women are seen in health care settings

Domestic violence victims come into frequent contact with health professionals, but physicians often treat their injuries only symptomatically. As a result, the health care community misses important opportunities for intervention, and victims continue to suffer the adverse health consequences of physical and emotional abuse.

The numbers are staggering: close to four million American women are physically abused each year in this country (Commonwealth Fund, 1993). Many battered women seek assistance in health care settings, often repeatedly (Berrios & Grady, 1991; Bowker & Maurer, 1987). The U.S. Department of Justice reports that 37% of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend or girlfriend (U.S. Department of Justice, 1997). Battering can result in physical injuries ranging from relatively minor bruising and abrasions to those requiring hospitalization or major surgical intervention (Berrios & Grady, 1991).

Emergency departments are not the only health care setting in which victims of domestic violence seek care. Twenty-eight percent of women surveyed in three university-affiliated ambulatory care internal medicine clinics had experienced domestic violence at some time in their lives, and 14% were currently experiencing abuse (Gin, Rucker, Frayne, Cygan & Hubbell, 1991). One Midwestern family practice clinic reported that 23% of women clients had been physically assaulted by their partners within the last year, and 39% had experienced physical abuse at some time in their lives (Hamberger, Saunders, & Hovey, 1992).

Obstetrical health providers also have an important role in identifying battered women. Studies indicate that 10-32% of women seeking care from prenatal health care providers have a past history of domestic abuse (Campbell, Poland, Waller, & Ager, 1992; Helton, McFarlane, & Anderson, October 1987; Parker, McFarlane, Soeken, Torres, & Campbell, 1993; Stewart & Cecutti, 1993).

Some studies suggest that pregnancy is a risk factor for battering. Studies indicate a range of incidence from 8% to 26% of pregnant women in public and private clinics (Helton, McFarlane, & Anderson, October 1987). Furthermore, battering during pregnancy jeopardizes the pregnancy. Abused women have a higher rate of miscarriage, stillbirths, premature labor, low birth weight babies, and injuries to the fetus, including fractures (Berrios & Grady, 1991; Bowker & Maurer, 1987; Bullock, McFarlane, 1989).

◆ **Battered women are seen in a variety of health contexts**

The full range of health care specialties – and disciplines – encounter battered patients. Mental health care providers see battered women for suicide attempts, anxiety, and depression (Berrios & Grady, 1991; Stark & Flitcraft, 1995). In one study, 64% of female psychiatric inpatients had experienced physical assaults, and 38% had experienced sexual assaults as adults; these were largely due to abusive relationships (Jacobson & Richardson, 1987).

Practitioners who specialize in chronic pain, such as headache or stomach disorders, also treat battered women (Domino & Haber, 1987; Drossman et al., 1990; Follingstad, Wright, Lloyd, & Sebastian, 1991). Some HIV-positive women or women with AIDS may have contracted the virus from coerced sexual activity in the context of a battering relationship (Norton, Peipert, Zierler, Lima, & Hume, 1995). Pediatricians who see abused children also see battered women because child abuse and spousal abuse frequently co-exist (Bowker & Maurer, 1987; McKibben, DeVos & Newberger, 1989; Stark Flitcraft, 1988; Walker, 1979).

◆ **Health professionals often fail to perceive that domestic violence is part of a patient's life**

Because of a lack of training on what to look for and how to ask about domestic violence, rates of non-identification of battered women remain high. In one study of 476 women seen consecutively by a family practice clinic in the Midwest, 394 agreed to be surveyed. Of these patients, 89 (22.6%) had been physically assaulted by their partners within the last year, and 153 (38.8%) had been abused during their lifetime.

However, only 6 women (1.5%) said they had ever been asked about domestic violence by their physicians (Hamberger, Saunders, & Hovey, 1992). In a study of a major metropolitan emergency department that had a protocol for domestic violence, the emergency department physician failed to obtain a psychosocial history, ask about abuse, or address the woman's safety in 92% of the domestic violence cases (Warshaw, 1989).

◆ **Battered women need health care providers who provide referrals to legal and social services**

In addition to their need for health care, battered women have a parallel need for non-medical assistance. A battered woman needs an understanding of what the criminal justice response might be within her community should she attempt to access legal

assistance. She may need help with finding temporary shelter for herself and her children, advice on how to keep herself safe should she return home, and affirmation that the abuse is not her fault and that she does not deserve to be beaten.

## **B. Why health care providers should care.**

### **◆ Health care providers can make a difference**

Health care providers are often the first, and sometimes the only, "helping" professionals that see a battered woman's injuries. Not surprisingly, a 1993 Commonwealth Fund survey found 3.9 million (7%) American women married or living with an intimate partner were physically abused, and 20.7 million (37%) were verbally or emotionally abused by their spouse or partner. However, that same survey revealed that 92% of physically abused women did not discuss these incidents with their physicians. Common sense argues that early identification of battered women, and intervention on their behalf, can help prevent injuries and save lives.

A review of the literature and anecdotal experience suggest that many battered women will talk about the abuse in their lives if they are asked about it in a direct, caring, and non-judgmental manner. According to the American Medical Association, one of "the most important contributions physicians can make to ending abuse and protecting the health of its victims is to identify and acknowledge the abuse" (Council on Ethical and Judicial Affairs, AMA, 1992). And battered women agree. Battered women in focus groups conducted by San Francisco physician Michael Rodriguez confirmed a willingness to respond if asked directly about domestic violence by a compassionate provider (Rodriguez, Quiroga, & Bauer, 1996).

### **◆ The prevention/cost-effectiveness argument**

Although it is difficult to know the true dollar cost of providing direct medical care to victims of domestic violence, it is estimated to be in the range of \$1.8 billion per year (Miller, Cohen & Wiersema, 1995). When other factors are added in – such as days of work missed; decreased productivity in the workplace due to emotional, psychiatric and medical effects of abuse; and loss of young individuals from the workforce due to early death or disability – the financial toll is even higher.

The changes taking place in the delivery and financing of health care have created a significant opening to bring to the forefront the concept of "domestic violence prevention and treatment" as a health care issue. Many health care discussions taking

place among policymakers are stressing the importance of prevention to improve health status and to reduce health care costs. These conversations present strategic opportunities to link domestic violence prevention and treatment with cost containment and the health of the community.

Domestic violence advocates also need to learn about the movement toward managed care in their states and investigate whether the issue of domestic violence is addressed in newly emerging health plans. Early involvement in these discussions will help ensure that the health concerns of battered women are integrated into any revamped managed care plan. Advocates should realize, however, that changes to the health care system are happening so rapidly that it will be necessary to deal with a system in constant transition. Continued involvement is necessary if long-lasting, institutionalized change on behalf of battered women is to be realized.

### **C. Mandate of health care providers to improve patient care**

#### **◆ Professional guidelines**

In 1993, organized medicine officially joined the effort to strengthen the health care response to domestic violence when the American Medical Association (AMA) launched its landmark "Campaign Against Family Violence." The Campaign included the formation of a "National Coalition of Physicians Against Family Violence" as well as a national domestic violence council comprised of 35 national medical specialty organizations.

In addition to these organizing efforts, professional guidelines recommending a strengthened health care response to domestic violence are emerging as well. For example, guidelines, protocols, official policy positions, and training curricula with regard to domestic violence have been developed by the AMA, the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Nurses Association, the American College of Nurse Midwives, and the Nursing Network on Violence Against Women.

#### **◆ Joint Commission guidelines**

Successful advocacy by the Philadelphia Coalition Against Domestic Violence and others led to a mandate by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) that hospitals develop protocols for the identification and

the treatment of abused women. In 1990, JCAHO (which accredits 80% of the nation's hospitals) issued domestic violence standards for the nation's emergency departments. In 1992, the standards were applied hospital-wide, and in 1997 they were further updated. These domestic violence standards require all hospital departments to have the following in place:

- **written domestic violence protocols** specifying the scope and conduct of patient care (including objective criteria for identifying and assessing possible victims of abuse, and policies and procedures that define the hospital's responsibility for collecting, retaining, and safeguarding information and evidentiary material);
- **a plan for educating staff** about domestic violence identification, treatment, and documentation; and
- **a list of private and public community agencies** that provide help for abuse victims.

The Joint Commission standards represented an important first step in defining a role for responding to domestic violence in hospital and ambulatory care settings. (Joint Commission on Accreditation of Healthcare Organizations. 1997 Hospital Standards – Possible Victims of Domestic Abuse and Neglect).

#### ◆ **State law**

In 1990, New York became the first state to require that all licensed hospitals establish protocols to identify and treat domestic violence victims and utilize community referral lists. California followed suit in 1995 with the passage of Assembly Bill 890, the first state law mandating development and implementation of protocols for all hospitals and licensed clinics to detect the presence of violence in the lives of patients. A.B. 890 also requires that all hospitals and clinics: (a) develop protocols for screening for abuse; (b) develop procedures for complete documentation of battering in the medical record; and (c) make use of domestic violence referral lists. In addition, this legislation made domestic violence coursework or training a part of the licensing and re-certification process for health care providers.

Florida and New York also require domestic violence training for re-licensure of physicians. Florida's law requires all physicians to have two hours of training in domestic violence as a condition for re-licensure.

### ◆ Professional liability

Some legal scholars argue that hospitals could conceivably be held liable for domestic violence injuries if they do not adequately screen for the root causes of injuries presented by their patients (Orloff & Chung, 1996). For example, if an injured victim of domestic violence is treated by a health care provider who does not inquire about abuse, or who accepts an unlikely explanation of the injuries, and the patient then returns to the abusive situation and sustains further injuries – or, in the worst case scenario becomes a victim of homicide at the hands of the abuser – the physician or nurse could be held liable for subsequent injuries. Consequently, it may be in the best interests of health care institutions to (a) implement routine screening to detect victimization and (b) adopt domestic violence protocols that define a comprehensive response once a battered patient is identified.

## **II. Elements of effective collaboration between domestic violence advocates and health care providers.**

### **A. Creating a framework**

Programmatic and policy responses to domestic violence should be built on a foundation of (a) accountability to the battered woman for her safety, and (b) holding the batterer responsible for his violence. The following questions should be asked when crafting program and policy solutions:

- Will this program or policy make battered women safer?
- Will this program or policy hold institutions accountable for the role they can play in preventing and responding to domestic violence?
- Will this program or policy hold individual health care providers accountable for employing attitudes and actions that are sensitive to the needs of battered women?
- Will this program or policy hold perpetrators accountable for their violence?
- Will this program or policy make all women safer?

These questions are meant to be a guide, not an exhaustive list, of some key issues that should be considered when designing clinical responses to domestic violence.

### **B. Domestic violence service providers and health care providers have separate and distinct roles and areas of expertise.**

Health systems reform work is first and foremost, and perhaps most importantly, about partnerships – gaining a better understanding of how and why health care and domestic violence professionals can and should work together to end violence against women. We can tackle these hard issues and questions together and should begin by respecting the professional expertise that each of us brings to the table. This means sharing what we know and, just as importantly, asking for help and information in areas where our knowledge base is lacking.

Most battered women's advocates are not experts on health care and, conversely, most health care providers are not experts on domestic violence. We do not have to be "experts" in each other's fields to strengthen the health care response to domestic violence, but we do need to recognize and capitalize on each other's expertise.

### **C. Role of the health care provider**

The changing nature and rising costs of health care mean we need to be realistic about institutional and provider responses to domestic violence. Physicians feel increasingly overburdened by demands to see more patients in shorter time frames. We may not be able to attract health care providers to two-day trainings and cannot realistically expect multi-hour interventions. Advocates will need to listen to the realities of health care providers' lives.

Health care providers can help battered women in many ways: by screening for domestic violence; by documenting abuse in the medical record; by safeguarding evidence; by providing medical advice, referrals, and safety planning; and by showing empathy and compassion for a woman's situation and the abuse she is experiencing.

Health care professionals should provide battered patients with information about the full spectrum of interventions and options available and should support them in pursuing the options that the women think are best. We can facilitate a helping role for health care providers by training them to provide "medical advice" (a.k.a. "options counseling") that focuses on:

- inviting women to share safety concerns and needs;
- providing confidential and appropriate supportive care; and
- making well-informed and knowledgeable referrals.

It is not the role of the health care system to invoke and foster criminal justice intervention. Calling the police is not always in the best interest of a battered woman. Experience has taught some battered women to distrust the police and/or believe that law enforcement intervention will further endanger them and compromise their safety. Immigrant battered women may fear that calling the police will lead to INS involvement, and others are unwilling to use law enforcement intervention until a safety plan is in place. Each battered woman should be informed of her legal options and encouraged to make choices that meet her needs. (See IV.B. for a discussion of mandatory reporting.)

The health care providers you work with may be frustrated. For example, they might blame the local shelter for a lack of shelter beds when they are trying to make a referral for a patient that needs temporary housing. In this case, you could encourage them to advocate with shelters on behalf of increased funding for community services. Helping their patients think through alternative, non-shelter housing options is a critical component of providing an appropriate referral (e.g., friends, family, hotels, checking her into the hospital for the night, etc.)

## **D. Role which domestic violence organizations can play in the health care setting**

### **◆ Bringing domestic violence expertise to the table**

An advocate need not be a health care provider in order to offer insight into how to make health care delivery more sensitive to the needs of battered women. An advocate's job is to bring domestic violence expertise to the table. Battered women's advocates need to convey that health care is an important part of any community-wide response to domestic violence. Health care facilities will always see more battered women than almost any other community institution, yet health care providers are consistently left out of the equation in many "community-wide collaborations" on domestic violence. Making institutional and community-based change happen for battered women is certainly a formidable task. However, if we are to see real social change within our lifetimes, advocates need to be diligent about ensuring that all points of entry for battered women are strengthened.

### **◆ Helping health care providers change their definition of success**

Many health care providers are frustrated at not having the tools to fix the lives of the battered patients they see. One of the most important things a battered women's advocate can do through her work with health care providers is to help them change their definition of success.

It is counterproductive for the health care provider to define "success" as getting a battered woman into a shelter that night, or making the woman leave her batterer today. As John Fazio, chief nurse at San Francisco General Hospital, says when training his peers, "She has been dealing with domestic violence for 15 years and you've known her for 10 minutes. Who is more qualified to make a good decision for your patient – you or she?" Redefining success for a health care provider means helping them understand that what patients need most is help in making informed, autonomous decisions, with as much information and knowledge about available options as possible, and with support to gain access to help.

### **◆ Describing the health care response opportunities available**

There are many different kinds of health care-based response models available to domestic violence organizations to recommend for local use. Such models range from providing specially trained advocates who work on-site at hospital-based programs, to

providing consultation, advice, and training on an "as-needed" basis. The role that is right for your program will depend on staff resources, available funding, and the desires and needs of the health care facility with which you are working. Domestic violence programs can provide assistance in many ways, including the following:

- **Training** on the dynamics of domestic violence, law enforcement response, and community resources available – through brief introductory sessions or more extensive 1-2 day conferences
- **Case consultations**, where complicated actual domestic violence patient scenarios are summarized and presented for discussion by the attending physician and a local domestic violence professional
- Consultation on **resource materials development** and the production of multilingual materials
- **On-site counseling** of battered women
- **On-call counseling** of battered women
- Help with **health policy development** for the institution and the community
- Help with **protocol development**
- Help in developing **baseline surveys** that measure the current clinical response to domestic violence and **quality assurance mechanisms** that monitor the ongoing response

◆ **How to respond when a health care provider asks your domestic violence organization for help**

Some clinicians might not know initially what they are asking for when they call you, because they don't know what kinds of resources or help are available. Because each caller is a potential ally, take the initiative to suggest ways in which your organization can assist them. If your organization's current program load makes it impossible to take on new work, offer to make an introductory call to a domestic violence program that is in a better position to help. It is important that health care providers not be rebuffed when they initially reach out to domestic violence programs for help. Indeed, it is important to the domestic violence program to develop good working relationships with interested health care professionals.

### **III. Developing a strengthened health care response to domestic violence**

#### **A. What hospitals, clinics, and health care systems can and should be doing**

##### **◆ Gaining access – getting in the door and finding an "advocate" within the institution**

If you are interested in helping to launch a comprehensive response to domestic violence on the part of a health care institution, the first step is to find an "advocate" within the institution. Approach the health care community as you would any other community-organizing challenge. Start by generating a list of those whom you know, or those who know someone, within your local hospital or primary care clinic – any nurse, physician or administrator will do. Use those contacts to help you understand how the institution is set up, who is in charge, and whom you need to work with and talk to in order to bring about change within the institution. The key is getting your foot in the door.

##### **◆ Developing institutional commitment – who needs to be involved**

Whose job is it to care and respond to domestic violence in a health care institution? Some physicians think it is the nurse's responsibility to deal with the needs of the battered patient. Some nurses would rather call a social worker to talk to the battered patient. Not surprisingly, many social workers want to be able to call a battered women's shelter and have an advocate come to the hospital to find out what the woman wants and needs.

The reality is that everyone has a role and responsibility in responding to violence against women, particularly in a health care setting. San Francisco General Hospital designed a domestic violence training program for its inner-city trauma center that trains practically every staff person within the emergency department to understand the nature and dynamics of domestic violence and the role each can play in responding to it. Nurses, physicians, social workers, pre-hospital staff, translators, clergy, volunteers, and janitorial staff all participate in this program. Why? Because it is their belief and understanding that anyone who might come in contact with a battered woman should know how to talk to her sensitively about her concerns, situation, and options.

A good example of how this approach works occurred in a Pennsylvania hospital where a member of the janitorial staff noticed a patient crying herself to sleep every night. The janitor asked the woman why she was crying and made a domestic violence identification that everyone else missed.

### ◆ **Importance of multidisciplinary collaboration**

In order to effectively help a clinic or hospital craft a comprehensive, health care-based domestic violence response program, you must first emphasize the importance of recruiting a multidisciplinary team to design the response. Recruiting a multidisciplinary team made up of physicians, nurses, social workers, administrators, and a community domestic violence expert is essential to building support within the institution. Helping an institution understand the importance of multidisciplinary collaboration could be one of your biggest challenges.

Your task – or the task of your health care ally inside the institution – is to find a nurse-friendly physician, a physician-friendly nurse, a social worker who is open to sharing his or her skills and resources, and an administrator that knows how to work as a part of a team. Each of the institutional "players" will best understand how to reach and speak to their peers. It is their responsibility to divide up the work and the response in a way that makes sense within their own institutional framework.

The next layer of hard work begins after the team has been recruited. In order to sustain the team, your role could encompass scheduling meetings, taking minutes, gathering models for resource development, providing helpful feedback and moral support, and keeping the team energized and involved.

### ◆ **Importance of involving administrators**

The importance of involving administrators in your multidisciplinary team cannot be stressed enough. Administrators have the ability to turn a programmatic initiative into a policy, which is crucial to institutionalizing the desired response. In addition, they either control or know how to access the "purse-strings" of the institution, which becomes critically important if your team wants to develop and print resource materials for the battered patient and protocols and training materials for hospital or clinic staff.

As in any organizing campaign, involving the administrator from the beginning is helpful, in hopes of their "buying-in" and feeling invested in the success of the program. Involving administrators also means you will likely design a response program that fits within the institutional confines, which will also ensure a greater level of success.

## ◆ Creating and institutionalizing the response

Battered women's advocates can help with many of the aspects of designing and implementing the health-based institutional response to domestic violence.

It is important at all stages to address the confidentiality and safety concerns of the battered woman. Abusive partners often restrict their intimate partner's access to health care in order to prevent the true nature of their injuries from being identified. Batterers may restrict their partners' access to medication, prenatal care, and regular check-ups. Batterers may also insist on accompanying their partners to the doctor's office and even into the examining room. It is not uncommon for a batterer to answer questions directed to the patient and to attempt to intimidate the patient and/or the provider. As a result, it is important to help health care providers to better understand the confidentiality and safety concerns of battered women and how they can respond appropriately to them.

### ▼ Screening

There is a wide spectrum of written and verbal screening tools available to facilitate the identification of victims of domestic violence. These include questions inserted in the *written* medical histories that patients are asked to complete during routine visits, in addition to *verbal* questions providers would ask all patients in order to detect the presence of violence in their current relationships. Some institutions use protocols that call for a simple notation on the patient's chart, intake form, medical history, or social history form. Screening notations can be printed onto charts as check-off boxes or added as stickers or via rubber stamps. Gather examples of the ways in which screening for domestic violence is taking place in various institutions and help your team determine the best approach for the health care setting in question.

Remind your team of the importance of developing and using culturally and linguistically appropriate screening tools. Don't forget that gender neutral screening can help detect same-sex battering. (Screening tools are available from the Family Violence Prevention Fund's (FVPPF) Health Resource Center on Domestic Violence. See Section VII.)

Screening questions about domestic violence should always be asked in a private room, away from the batterer and preceded by assurances that strict confidentiality will be respected: a battered woman may be reluctant to speak candidly about abuse if she thinks the batterer will find out about her disclosure.

Health care providers should also be trained to find ways to separate the patient from her partner or spouse if the latter demands to accompany the patient into the examining room. (Screening packet available from the Family Violence Prevention Fund's Health Resource Center on Domestic Violence. See Section VII.)

### ▼ **Protocols**

Protocols should be developed for all hospital departments (i.e., emergency services, pediatrics, mental health, etc.) and should include: (a) a definition of domestic violence; (b) screening questions and a clarification of who will be asking them; (c) safety assessment and planning guidelines; (d) support and intervention services for the patient; (e) legal reporting requirements (should they exist); and (f) procedures for medical record documentation and for the collection and safeguarding of evidence. Health care institutions should understand that they can call upon battered women's advocates for help when developing or updating domestic violence protocols. Specifically, they may need help accessing, developing, and understanding the following:

- Local or state domestic violence arrest and reporting laws;
- Anticipated community law enforcement response;
- Standards for documentation that local prosecutors will expect if they seek the use of a medical record for help with prosecution;
- Child protective service response;
- Full spectrum of services available from domestic violence and other organizations;
- Discharge planning; and
- Development of safety plans for use with the battered patient

### ▼ **Hospital- or clinic-based response programs**

There are myriad comprehensive, innovative, and effective programs that have been established to assist battered women in hospitals and clinics. Some are staffed by battered women's advocates and others by health care personnel. Some programs utilize "on-call" advocates that respond to patients on an as-needed basis once they have been identified as victims of domestic violence. The kinds of services provided by these programs can include advocacy, short term crisis counseling, case management, long term support, training of health care providers, and individual case consultations.

For example, the Boston-based AWAKE program at Children's Hospital provides advocacy and support to battered mothers at the same time that the hospital is responding to the needs of abused children. Comprehensive, on-site case management services for patients combined with health care provider training is provided by the WomanKind program in Minneapolis. A third example is the Medical Advocacy Project sponsored by the Women's Center and Shelter of Greater Pittsburgh. This program sponsors an apartment on the hospital grounds for domestic violence victims. It also provides a full-time, on-site advocate responsible for providing crisis intervention, safety planning, and general case management. In addition, the advocate provides domestic violence training to hospital staff. (These programs are described in the "Best Practices" manual cited in Section VII.)

### ▼ Training

The training programs that are most useful are those that are interactive, are learner-centered, and utilize role-plays that enable participants to practice screening and supportive interventions. Your program might be asked to provide speakers capable of providing "Domestic Violence 101" training on the nature and dynamics of domestic violence to local hospitals or clinics. You should also plan on making yourself available to provide training on domestic violence resources (including hotlines, safehomes, shelters, and support groups), legal assistance, child advocacy programs, job training and referral programs, supervised visitation centers, and anything else available in your community to help the battered woman.

You need to help health care providers understand what the expected law enforcement response will be if they report domestic violence or advise their battered patients to call the police. Walking a training group through a role-play that helps them feel more comfortable when screening for domestic violence is also important. More and more domestic violence professionals can speak about clinical issues as well. Provide a list of speakers and their areas of expertise to local hospitals and clinics.

Be prepared for health care providers to self-disclose – as a result of their participation in a training program – their status as current or former victims. Often, when health care providers receive training on domestic violence, it triggers their own memories or experiences with abuse. It makes sense to train Employee Assistance Program personnel and provide such programs with resource materials as well, which will enable health care providers suffering from violence to seek help.

### ▼ **Case consultation**

Community domestic violence professionals may be asked to provide case consultations for health care staff. Complicated cases are summarized and presented for discussion by staff in grand rounds or team meetings. Domestic violence consultations help other hospital or clinic staff to closely examine the right and wrong way to respond to the physical and emotional needs of a battered patient. Typically, domestic violence advocates are invited to co-present or provide guidance and information regarding how the case could have been handled differently or better.

### ▼ **Resource material development**

Health care providers may need help from you in developing culturally and linguistically appropriate resource materials for both patients and practitioners. The kinds of materials they should develop include comprehensive referral lists, domestic violence brochures, after-care or discharge instructions, victim assistance cards, safety plans, and domestic violence awareness posters.

### ▼ **Monitoring the response**

Quality assurance mechanisms (also referred to as continuous quality improvement processes) are necessary to monitor the health care providers' ongoing response to the battered women whom they see. Encourage your team to develop a baseline assessment that captures the current domestic violence response and enables you to accurately gauge both change and improvement. You can do this by surveying health care providers within the department (or institution) prior to and after they receive domestic violence training. Survey tools (see Section VII.) which have been developed by a number of domestic violence organizations can easily be adapted for use by health care institutions within your community. In addition, some institutions regularly pull patient charts to investigate whether screening is taking place routinely, whether documentation is occurring, and whether domestic violence protocols are being used.

### ▼ **Collaborating with the domestic violence community**

Collaboration is a two-way street. Health care providers need to know about the domestic violence community of which they are a part. That means knowing the battered women's programs by name, how many beds they can make available, whether or not they have a crisis-line, and the type of legal advocacy available. Your task, as an advocate, is equally important – knowing and respecting the context (i.e. the limitations and the opportunities) within which the health care provider works.

## **B. What state health departments can and should be doing**

Some state health departments are emerging as the newest allies in the effort to respond to and prevent domestic violence. The current emphasis on prevention of health care problems, the relationship of prevention to cost containment, and the attention being paid to women's health combine to present a golden opportunity to explore with health officials what a reformed health care system might mean in terms of reduction and treatment of domestic violence. However, in order to take full advantage of the opportunity to position domestic violence as the health care issue that it is, health officials need expert consultation, resource materials, training programs, and model policies and procedures that help them develop a framework for moving toward a comprehensive health care response to domestic violence on a community, state, and national level.

### **◆ How to approach state health departments**

Health departments are charged with the responsibility of protecting the health and welfare of citizens in their state. They should care about domestic violence for two very good reasons: (1) victims suffer significant health consequences as a result of domestic violence; and (2) significant savings can be realized by getting involved in domestic violence prevention efforts. Health department offices that should work on domestic violence prevention and response include those responsible for maternal and child health, women's health, injury prevention, multicultural health, immigrant health, adolescent health, and Medicaid.

### **◆ Getting ready and framing the collaboration**

Numerous resources are available as examples that describe state-of-the-art health care responses to domestic violence around the country (see below). The kinds of assistance you could offer your health departments include:

- help with understanding the landscape of domestic violence service provision within the state;
- replicable training models, service delivery models, and best practice approaches to providing comprehensive and culturally competent health care to battered patients;
- comprehensive needs assessments that identify gaps in services;
- policy initiatives that seek increased funding for efforts to strengthen the health care response to domestic violence; and
- clearly defined partnership opportunities to accomplish joint goals.

◆ **What program and policy initiatives should health departments be working on?**

The following are examples of replicable domestic violence initiatives that have been or could be sponsored by health departments. (Many of these resources are more fully described in the "Best Practices" manual cited in Section VII.)

▼ **Developing and implementing models for data collection in health care settings**

The State of Alaska's Section of Maternal, Child and Family Health conducted a statewide domestic violence training needs assessment of health care providers (see Section VII). Studies were also conducted in California and Massachusetts (by the Family Violence Prevention Fund and the Harvard Injury Control Center respectively) to gauge the emergency department response to domestic violence (see Section VII). These survey instruments could be easily adapted for use in your state to conduct an initial baseline assessment of the current health care response to domestic violence.

▼ **Facilitating domestic violence training for clinics, hospitals, private practitioners, and medical groups**

In 1993, the Alabama Department of Public Health collaborated with the Alabama Coalition Against Domestic Violence to develop and disseminate a domestic violence protocol to every hospital in the state and to offer hospital-based domestic violence training workshops and mini-conferences. In 1996, California's health department teamed up with the Family Violence Prevention Fund to develop a domestic violence training curriculum and program for the state's primary care clinics.

▼ **Underwriting materials development**

In 1989, the Colorado Department of Public Health and the Colorado Domestic Violence Coalition became the nation's first health department-state domestic violence coalition collaboration on this issue. This partnership produced a comprehensive training manual on domestic violence for health care providers and a model response protocol. Similarly, in 1984 the New York State Department of Health, in collaboration with the New York State Office for the Prevention of Domestic Violence, drafted the state's first domestic violence protocol.

▼ **Adopting policy positions on mandatory reporting, insurance discrimination, screening practices, welfare reform, and managed care mandates**

Advocates should seek alliances with health departments to further health policy initiatives that affect battered women. For example, a number of states are asking their health departments to become active in efforts to stop insurance discrimination against battered women and speak out against mandatory reporting policy proposals.

▼ **Developing and launching prevention initiatives**

In California, the Department of Health Services developed a grants program and convened an advisory committee to explore programmatic initiatives aimed at preventing domestic violence.

▼ **Convening multi-agency work groups to coordinate effort**

Many state health departments are logical co-convenors and co-coordinators of prevention and response efforts initiated by other state agencies, health associations, and domestic violence coalitions.

**C. What state medical, nursing, HMO and hospital associations can do**

There is no shortage of examples of innovative domestic violence work being done by the professional associations that represent physicians, nurses, social workers, hospitals, and HMOs.

◆ **What program and policy initiatives should they undertake?**

State domestic violence coalitions and community-based domestic violence programs can help strengthen the efforts of health associations by offering resources, assistance, and partnership opportunities. The following are examples of replicable domestic violence initiatives that have been or could be sponsored by health associations. (Many of these resources are more fully described in the "Best Practices" manual cited in Section VII.)

▼ **Developing and implementing public health-domestic violence awareness/education campaigns.**

Excellent public awareness campaigns that promote the need for health care providers to get involved in domestic violence prevention and response have been launched in Minnesota and Maryland. The Minnesota Medical Association, in collaboration with the Minnesota Coalition for Battered Women, launched a statewide public education campaign in 1992 with billboards that proclaimed, "Doctors can't cure family violence. But they can help!". The Maryland Alliance Against Family Violence, in conjunction with the state medical society, developed posters, bus placards, and a comprehensive multi-lingual training program.

▼ **Sponsoring and funding domestic violence training for various constituencies**

The Connecticut Primary Care Association and the Connecticut Domestic Violence Training Project collaborated on a training curriculum and training program for nine community health centers in underserved areas of Connecticut.

The American College of Nurse-Midwives has developed a comprehensive training manual and offers training workshops around the country to help nurse-midwifery faculty teach their students about domestic violence.

▼ **Adopting "white papers" and organizational policy positions on mandatory reporting, insurance discrimination, screening practices, welfare reform, and managed care mandates**

Numerous state and national health associations are adopting organizational policy positions on health policy issues that impact battered women. Contact the Family Violence Prevention Fund's Health Resource Center on Domestic Violence for more information (see Section VII).

▼ **Becoming active lobbyists on behalf of increased funding for battered women's services and strengthened health policy response on the local and state level**

Most health associations have active and well-respected lobbyists at the national, state, and local levels. It makes good sense for state domestic violence coalitions and community-based domestic violence programs to get to know these lobbyists and introduce them to your policy wish lists and legislative agendas.

▼ **Strengthening accreditation, licensing, and re-licensing standards through national associations**

For example, the American Nurses Association, the Emergency Nurses Association, the American Academy of Family Physicians, the American Medical Association, and the American College of Emergency Physicians have all developed recommendations or positions on behalf of education and training of health care providers in general, or members of their specialty in particular, on domestic violence. Further policy recommendations are needed regarding mandatory coursework and training on domestic violence for all health professionals, training of faculty in health professionals' schools, and continuing medical and nursing education.

## **IV. Addressing the Health Policy Challenges Together**

Domestic violence advocates will encounter key policy questions as they initiate work with health care providers. Several of the more important policy issues are discussed below.

### **A. Routine screening for domestic violence**

#### **◆ Benefits and obstacles**

Many policymakers and advocates agree that routine screening for domestic violence is an important first step toward crafting a comprehensive health care response to domestic violence. It is clear that early recognition and intervention can significantly reduce the injuries, and perhaps even the lethality, that result from violence in the home. Therefore, many domestic violence and health care professionals are arguing that screening patients in order to detect victimization needs to become a routine part of health care delivery.

A deterrent to routine screening is a lack of training on how to ask "the question." As a result, some providers may be uncomfortable or sometimes even unwilling to ask women about the true source of injuries that the professional may suspect are domestic violence-related. Clinically speaking, domestic violence screening is no different from other routine screening conducted by health care providers to reveal, for example, unsafe sexual practices or substance abuse that could lead to contracting HIV, or unhealthy diet and/or high cholesterol that could lead to heart disease.

The Family Violence Prevention Fund's Health Resource Center on Domestic Violence has developed a one-page screening/documentation form that prompts the health care provider through all of the necessary steps of screening, assessing, and documenting domestic violence. It even includes a consent-to-be-photographed check-off box and a body map to chart and describe injuries. (To order the form, call the Health Resource Center toll-free at 888-RX-ABUSE).

#### **◆ The importance of combining screening with training, response protocols, and services**

Despite the potential benefits of screening, there can be risks and consequences to the battered patient when health care providers have not received domestic violence training. For example, an untrained health care provider could further endanger the patient by confronting a batterer or revealing knowledge of the abuse without first taking steps to ensure the patient's safety. Identifying domestic violence and then not

knowing what to say to the battered woman can further heighten her feelings of isolation and despair. Forcing inappropriate legal intervention or reporting the violence to law enforcement against her better judgment could deter the victim from seeking future health care. Screening should *always* be followed by further assessment, intervention, safety planning, documentation, and referrals.

Clearly, screening has to go hand-in-hand with domestic violence training and the use of clear and comprehensive response protocols. On-site services provided by hospital-based programs should be developed for crisis intervention and longer term case management. If on-site services are not available, support and necessary services should be sought from community-based domestic violence programs.

#### ◆ **Questions relating to screening that will need to be addressed**

A series of key questions must be answered by community domestic violence and health care experts as they attempt to implement policies calling for routine screening for domestic violence. Screening "routinely" typically means every patient is asked at every visit about violence in his or her life regardless of the purpose or nature of the visit.

##### ▼ **Who should conduct screening?**

One of the first questions that must be answered is who should conduct the screening: doctors, nurses, social workers, intake clerks, and/or on-site domestic violence advocates? There is no right answer to this question. Some institutions train all of the health care providers that come in contact with a battered woman and define a screening role for each. Other institutions ask key nurses or physicians to take on the responsibility for screening patients for domestic violence. Still other institutions ask whoever does the psychosocial history to conduct routine screening.

##### ▼ **Who should be screened for domestic violence?**

Should health care providers screen only adult women routinely at every visit, regardless of whether or not they present injuries or behavioral cues that are suggestive of domestic violence? Or should only adult women that present historic, behavioral, or physical cues that raise the index of suspicion for abuse be screened? What about men? If men aren't screened, victims of same-sex violence will likely be missed. Conversely, if men are screened, some advocates argue that batterers will present themselves as victims in order to skew and misrepresent the true nature of the abuse.

What about screening only those men who are at-risk, or present injuries that raise the health care provider's index of suspicion? Again, same-sex victims who are able to hide their injuries are likely to be lost in this equation if they feel neither invited nor welcome to discuss the abuse they are experiencing. And what about adolescent females involved in intimate relationships?

#### ▼ How often should screening take place?

You will also need to determine whether or if policies should call for screening to take place routinely or only at certain times—for example, at the patient's initial visit to her primary care physician.

#### ▼ Should screening take place across specialty?

Questions relating to screening across specialty also must be addressed. There is some general agreement that primary care providers and obstetricians and gynecologists should routinely screen for domestic violence. But what about emergency department nurses and physicians, dentists, ophthalmologists, or cardiologists?

### ◆ Different ways to create health policies that define and mandate screening

Health policy calling for routine screening is clearly a significant step in the right direction. Screening policy can be dictated at the institutional level through domestic violence response protocols or at the state level through policy recommendations developed by health departments or health associations. There is no clear consensus that legislative mandates to screen for domestic violence are the optimum response; however, a bill recently passed by the California legislature serves as an important starting point for legislative models.

Assembly Bill 890 requires all California hospitals and licensed clinics to develop and implement: (1) **protocols for screening** patients to detect the presence of violence; (2) ongoing procedures for complete **documentation** of battering in the medical record; and (3) the use of domestic violence **referral lists**. Training initiatives to teach clinicians how to screen effectively can be called for through legislation or program initiatives spearheaded by state health departments or health associations.

◆ **The screening-mandatory reporting conundrum.**

Advocates should tread cautiously around a clinical dilemma that is presented by the intersection of two health policy responses to domestic violence. In California, Assembly Bill 890 requires clinicians to screen patients routinely to detect spousal/partner abuse. A mandatory reporting law (A.B.1652/74x) signed into law prior to the emergence of the screening law requires that health care providers report to local law enforcement injuries presented to them for treatment that they suspect resulted from a domestic assault.

Some clinicians are concerned that the reporting law does not respect the confidentiality of the provider-patient relationship and might have a "chilling effect" on a battered patient's willingness to seek medical care. Therefore, *they might not want to know* if a patient has been battered, and consequently they experience ambivalence around screening patients to detect victimization. If you have both mandatory reporting and mandatory screening laws in your state, you will need to address this central issue through the training materials and training programs you conduct with local health care providers. Legislative initiatives that seek to repeal or amend mandatory reporting laws are also recommended.

◆ **Where to go for more information.**

To further your own thinking and discussions on this issue, see "Domestic Violence Screening," written by Leigh Kimberg, MD, for the Family Violence Prevention Fund. Dr. Kimberg's paper presents a defense for routine screening for domestic violence. It also presents a discussion of the benefits of routine screening and consequences of failure to screen routinely. Many of the questions raised in the above discussion are also addressed, including whom to screen, when to screen, where to screen, how to screen and who should do the screening. (To order this paper, call the Family Violence Prevention Fund's Health Resource Center on Domestic Violence toll-free at 1-888-RX-ABUSE).

**B. Mandatory reporting of domestic violence incidents to law enforcement officers**

As interest in responding to domestic violence grows, policymakers and health care professionals are looking for new and more effective health care responses to the problem. Some experts are advocating for laws that require health practitioners to report injuries due to domestic violence to the police or a specified state agency, just as they are required to

report incidents of child abuse and, in many states, elder abuse. Unfortunately, while mandatory reporting may at first sound like an appealing solution, many experts in the field see a number of problems with the adoption of such a policy.

Those arguing in favor of mandatory reporting suggest that it will help enhance patient safety and care through improved provider response, aid in law enforcement intervention, and improve documentation and data collection. Well-intentioned policymakers throughout the country are proposing mandatory reporting laws as a "quick-fix" to the epidemic of domestic violence and the desire of health care providers to do something about it.

These laws typically require health care providers to report injuries they believe resulted from a domestic violence assault *or* criminal act *or* deadly weapon to local law enforcement or some other specified state agency. Currently, forty states and the District of Columbia mandate reporting by health care providers in instances where the injuries appear to have been caused by a gun, knife, firearm or other "deadly weapon." At least eighteen states have laws that require a report if a patient's injuries resulted from an illegal act. At least eight laws require reports under circumstances in which the injury appears to have been intentionally inflicted. At least six states specifically address the issue of reporting where domestic violence or adult abuse is suspected (CA, CO, KY, NH, NM, and RI).

◆ **Risks of mandated reporting to law enforcement officers**

▼ **Victims may refrain from seeking critically needed health care if they do not want the police called.**

For instance, a battered woman may not go to her physician, out of fear that calling the police would endanger her and her children. Undocumented battered women are made particularly vulnerable by this law and may refrain from seeking care, fearing that a call to police will result in their deportation.

▼ **Mandatory reporting does not respect the autonomy of victims of domestic violence.**

Unlike child abuse reporting, the domestic violence victim is typically a competent adult who should be granted the right to make decisions that she believes will increase – not undermine – her safety.

▼ **Mandatory reporting interferes with provider-patient confidentiality, undermining patient candor and trust in the provider.**

The patient should have a safe place to go in the health care system where she can candidly discuss with her provider the violence she is confronting, and where she will be offered support in a private, safe, and confidential setting.

▼ **Mandatory reporting of domestic violence will likely result in biased and inconsistent reporting.**

Mandatory reports emerge at higher rates from emergency departments as opposed to primary care settings where the physician has an ongoing, personal relationship with the patient. Therefore, reporting is likely to be biased toward low-income and uninsured patients, who use emergency rooms more frequently.

▼ **It cannot be assumed that law enforcement response will increase the safety of a battered woman.**

Risks to a battered woman may be high because safety planning does not always precede the report to, and response by, local law enforcement agencies.

◆ **Where to go for more information**

For an excellent discussion of the risks posed to domestic violence victims by mandatory reporting laws, and an overview of state reporting laws from throughout the country, see "Mandatory Reporting of Domestic Violence by Health Care Providers: A Policy Paper," written by Ariella Hyman, for the Family Violence Prevention Fund. Ms. Hyman's discussion paper also sets forth policy recommendations in this area. (To order this paper, call the Family Violence Prevention Fund's Health Resource Center on Domestic Violence toll-free at 1-888-RX-ABUSE).

### **C. Insurance discrimination against battered and formerly battered women**

Some of the nation's largest insurance companies are discriminating against victims of domestic violence by denying them health, life, disability, and even homeowners insurance based solely on their status as battered or formerly battered women.

This insidious discrimination, first uncovered by the Pennsylvania Coalition Against Domestic Violence (PCADV) and the Women's Law Project in Pennsylvania, is twofold: companies are refusing to issue policies to women who have a history of domestic violence, and they are increasing the *cost* of coverage or canceling policies in response to claims submitted by battered women. Some insurance companies are arguing that battered women are willingly placing themselves at risk of injury. Others describe the current or previous abuse as a "pre-existing" condition like diabetes or heart disease.

Federal (and some state) law permits some employers to place exceptions in their group health care plans permitting them to deny coverage for injuries caused by domestic violence. This affects employees as well as their dependents.

Because of a lack of industry regulation, insurance companies vary greatly regarding the seemingly arbitrary conditions they place upon the coverage they extend to battered and formerly battered women. Some insurance companies claim they will provide life insurance to a battered women only if she agrees to leave the abusive relationship. Still another insurance company suggested that if two years and 500 miles were between a woman and her abuser, the company might consider insuring her (Family Violence Prevention Fund, 1994).

#### **◆ Current situation with regard to insurance discrimination on the state and federal level**

Since 1994, at least 31 states have taken action to prohibit insurance discrimination against victims of domestic violence either by legislation or by regulation. The types of insurance covered by the bans on discrimination include health, life, disability, and accident. (See Section VII., *Insurance Discrimination Against Victims of Domestic Violence*, updated 1997, developed by PCADV and the Women's Law Project.)

Fortunately there also appears to be strong interest on Capitol Hill in exploring ways to respond to this problem. Representatives Bernie Sanders (I-VT) and Connie Morella (R-MD) in the House, and Senators Paul Wellstone (D-MN) and Patty Murray (D-WA) in the Senate, introduced the Victims of Abuse Insurance Protection

Act to stop this blatant discrimination. These bills would put an end to the insurance industry's practice of using domestic violence as a basis for denying, limiting, or terminating coverage. Under this bill, charging higher premiums for battered women would also be illegal.

The proposed law would affect all types of insurance and also has a confidentiality provision that stops insurers from improperly using, disclosing, or transferring abuse-related information through their data networks. Federal legislation to prohibit insurance discrimination was also included in the recently introduced versions of the Violence against Women Act of 1999.

#### ◆ **Impact of insurance discrimination on battered women**

Domestic violence victims may stop seeking necessary medical treatment, counseling, legal intervention, and other forms of assistance if they learn that insurers in their community are using a history of battering to deny insurance claims or coverage. In addition, some victims may refrain from candidly discussing domestic violence as the cause of their injuries with their health care provider. And, health care providers may stop documenting abuse if they believe such documentation will put their patients at risk of losing their insurance.

#### ◆ **Institutional responses to insurance discrimination**

Some health care institutions are ambivalent about documenting domestic violence because they fear that documentation will later be used by insurance companies to deny coverage for their patients. While working for legislative change at the state level, advocates should also be working with local hospitals and clinics to raise awareness about the problem and avenues for redress. If documentation does lead to insurance discrimination, patients can file complaints with their state insurance commissioner. PCADV is available to help walk battered women through this process.

#### ◆ **Model legislation**

The Pennsylvania Coalition Against Domestic Violence and the Women's Law Project have developed model legislation to prohibit insurance discrimination against victims of domestic violence. The legislation was drafted to include all necessary elements of a law, including definitions, prohibitions, and enforcement provisions. The model was created to function as a freestanding law or as an amendment to an existing law, such as an Unfair Insurance Practices Act.

◆ **Where to go for more information**

For a copy of model legislation to prohibit insurance discrimination, a state-by-state overview of existing laws, or information about their work in this arena, call the Women's Law Project at 215-928-9801. Or, call the Pennsylvania Coalition Against Domestic Violence at 800-537-2238.

## **V. CONCLUSION**

Battered women's advocates are presented with many new opportunities *and* challenges as they embark upon efforts to strengthen the health care response to domestic violence. If you are new to this work, two of your primary challenges will be knowing where to begin and how to develop a plan of action that is both realistic and ambitious. Fortunately, excellent resources exist to guide you in this endeavor. Information about ordering the written materials referenced throughout this paper is provided in Section VII. Your colleagues in the domestic violence community who began this work also exist as an important resource.

Use this paper as a starting point to spark your own thinking about the kind of health care response that is possible and desirable within your own community. Think big, but remember that the plans that are most capable of sustaining long-term institutional change are those that are realistic to the context within which you are working. Finally, don't forget to think "beyond the box." There are no limits to the creative program and policy initiatives which can further fuel and strengthen advocacy and intervention on behalf of battered women within the health care arena.

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## VII. Bibliography of resource materials referenced

***Best Practices: Innovative Domestic Violence Programs in Health Care Settings, Family Violence Prevention Fund, San Francisco, CA, 1997.*** Written for health care and domestic violence professionals interested in replicating new and creative health care response programs, the Best Practices guide provides (a) concise descriptions of the most innovative training, hospital-based, community-based, and public education programs from around the country, (b) names of persons to contact for more information, and (c) ordering information for training curricula, resource materials, and patient and provider education materials. Published by the Family Violence Prevention Fund's Health Resource Center on Domestic Violence. Call 1-888-RX-ABUSE for ordering information.

***Health Resource Center on Domestic Violence.*** A project of the Family Violence Prevention Fund, the Health Resource Center on Domestic Violence serves as the nation's clearinghouse for individuals wanting to strengthen clinical and policy responses to domestic violence. Through its toll-free line – 1-888-RX-ABUSE – and trained information specialists, the Health Resource Center provides information and referral, resource materials, and technical assistance and support to callers seeking ways to develop comprehensive health care responses to domestic violence.

***Insurance Discrimination Against Victims of Domestic Violence*** (handbook). Developed by the Pennsylvania Coalition Against Domestic Violence and the Women's Law Project (updated July 1997). Call 1-800-537-2238.

**Model insurance legislation and information.** Call Women's Law Project at 1-215-928-9801.

### ■ Information Packets

The Family Violence Prevention Fund's Health Resource Center on Domestic Violence publishes free information packets that include fact sheets, referral lists, and background articles on health care and domestic violence. Subjects include the primary care, ob/gyn, and emergency department responses; model protocols; the screening of patients for domestic violence; insurance discrimination against battered and formerly battered women; nursing responses to domestic violence; responding to diversity; and mandatory reporting of domestic violence injuries. Call 1-888-RX-ABUSE for ordering information.

The "Screening Patients for Domestic Violence" information packet referenced in this paper was designed as a reference tool for practitioners already familiar with the dynamics of domestic violence. It includes sample screening questions, a screening/documentation form, and background reading.

## ■ Survey Instruments

***California Hospital Emergency Departments Response to Domestic Violence.*** A 1993 survey of California's 397 hospital-based emergency departments. Call the Family Violence Prevention Fund's Health Resource Center on Domestic Violence at 1-888-RX-ABUSE to obtain the survey instrument.

***Alaska Nurse Practitioner's Experience with Partner Abuse in Alaska.*** The State of Alaska Section of Maternal Child and Family Health conducted a statewide domestic violence training needs assessment of health care providers, including primary care physicians, nurse practitioners, public health nurses, and physician assistants. Call Linda Chamberlain at the Alaska Domestic Violence Project at 800-478-2221 to obtain the survey instrument.

***Harvard Injury Control Center's Survey on Emergency Department Response to Battered Women.*** Surveys of Massachusetts emergency department response to domestic violence were conducted in 1992 and 1996. Call Nancy Isaac at the Harvard Injury Control Center at 617-432-2123 to obtain the survey instrument.

## VIII. Glossary of terms

**Capitation.\*** A fixed amount of money paid to a health care provider based on the number of health plan members served rather than on the number of services. It is usually expressed in units of dollars per member per month and is pre-paid.

**Health Care Providers.** Typically a health care provider is synonymous with a physician. In this paper, it is meant to describe anyone who provides health care services, including physicians, nurses, physician assistants, nurse practitioners, midwives, etc.

**Health Maintenance Organization (HMO).\*** The original concept of an HMO was a prepaid health plan that provided health care to voluntarily enrolled members in return for a pre-set amount of money paid on a per-member per-month basis. The term has more recently been applied to other health care organizations with a variety of different payment mechanisms. For that reason, many prefer to use the term **Managed Care Organization** as the generic term for these organized systems of care.

**Health Departments.** Health Departments are the publicly funded and mandated organizations that protect the public's health. They exist at the county, state, and national level. State health departments typically administer special programs for prenatal, children's, women's, minority, and immigrant health; public health clinics throughout the state; and federal Medicaid programs for the state's indigent populations. They are also in charge of data collection; injury control and prevention; and other broad-based programs to improve health status, prevent illness, and reduce health care costs.

**Hospital or HMO Associations.** A professional grouping or voluntary trade association of hospitals (or HMOs) created to serve members and to lobby or advocate on behalf of their professional needs. Hospital and HMO associations typically exist at the state and national level. Some counties and regions within states also have hospital and HMO associations.

**Joint Commission for the Accreditation of Healthcare Organizations (JCAHO).** Accredits 90% of the nation's hospitals through comprehensive reviews of their policies and practice. Regularly evaluates hospitals based on their compliance with JCAHO guidelines that address all aspects of health care delivery and patient care.

**Managed Care.** The reorganization of health care delivery systems in a competitive model that seeks to control costs and improve quality. Managed care systems seek to provide a centralized system of coordinated health care for participants. Managed care systems typically emphasize the provision of primary care and de-emphasize the use of health specialists.

**Medicaid.** Medicaid is the federal program providing health care coverage for persons with low incomes. Originally a fee-for-service program, it is increasingly being organized as managed care. States may choose to allocate additional funds in order to cover more services and/or individuals.

**Medical Associations.** A professional grouping or voluntary trade association created to serve member physicians and to lobby or advocate on behalf of physicians. Medical associations typically exist at the state and national level. Some counties also have medical associations. Medical Associations exist by specialty. For example, the American College of Emergency Physicians (ACEP) represents emergency department physicians and the American College of Obstetricians and Gynecologists (ACOG) represents Ob/Gyns, while the American Medical Association (AMA) represents all of the medical specialties.

**Nursing Associations.** A professional grouping or voluntary trade association created to serve member nurses and to lobby or advocate on behalf of nurses. Nursing associations typically exist at the state and national level. Some counties also have nursing associations. Nursing Associations exist by specialty. For example, the Emergency Nurses Association (ENA) represents emergency department nurses and the American Association of Nurse Midwives (AANM) represents nurse midwives, while the American Nurses Association (ANA) represents all of the nursing specialties.

**Preferred Provider Organization (PPO).** A health plan that contracts with a limited number of independent providers at a discount from their usual fee. It usually has some type of utilization review system associated with it to discourage indiscriminate use of expensive health care services.

**Public Health.** Public health comprises the science, theory and practice of health promotion and disease prevention. It is aimed at communities and other population groups rather than individuals.

**Primary Care.** Primary care providers are most often physicians who are family practice specialists, generalists, or other non-specialty providers. They function as "gatekeepers" for patients, that is they control access to specialty services. They are responsible for identifying and treating medical problems at an early stage to prevent the occurrence of more serious illness or injury, and they oversee the provision of coordinated care.

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\* Definitions for "Capitation" and "Health Maintenance Organization" taken from "Managed Care Glossary" in *Managed Care and Domestic Violence: Challenges and Opportunities*. Prepared by Patricia R. Salber, MD, for the Family Violence Prevention Fund. November, 1997.