



# HEALTH ALERT

## STRENGTHENING THE HEALTH CARE SYSTEM'S RESPONSE TO DOMESTIC VIOLENCE

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### Your Words Make A Difference: Broader Implications for Screening

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*Since last summer's Health Alert interview with Leigh Kimberg, MD, "Screening for Domestic Violence Changed My Practice," the release of Preventing Domestic Violence: Clinical Guidelines on Routine Screening, and Health Cares About Domestic Violence Day, 1999, we have had a flurry of requests for more information on screening for domestic violence. Many questions arose around screening in rural areas or under difficult circumstances and on how screening should be handled when domestic violence services may not be present near the health care facility. Long time domestic violence and health care advocate, Linda Chamberlain shares her thoughts with us on these and other important issues in this edition of Health Alert.*



*Lisa James, Bridgett McClesdey,  
and Linda Chamberlain, embarking on their  
flight to train providers in  
Fort Yukon, Alaska*

### A Rural Perspective

Alaska pushes the boundaries in terms of rural communities with limited services -- the majority of Alaskan villages have no road access. Our philosophy and experience has been that it is even more important for health care providers to routinely screen for domestic violence in communities where resources for victims are limited or nonexistent. Routine assessment and intervention can plant the seed to increase awareness and education in these communities. Health care professionals are often the only service providers who have contact with a victim and the opportunity to talk with her in a safe and confidential environment.

**Your Words Make a Difference**

Through my volunteer work at a local shelter and opportunities to work with survivors, I have seen firsthand how women value the awareness, supportive statements and compassion of health care providers who are willing to talk about abuse with their patients. A woman in her early twenties with three young children taught me that just letting a victim of abuse know that you care can make a difference. She belonged to a strict religious sect from a small, isolated village and had been forced to marry a man who was extremely abusive. Her family, his family and the village as a whole refused to acknowledge or address his violence. One day, a visiting public health nurse told the young woman that she was "special and did not deserve to be treated this way."

Three years later, the woman arrived at a shelter more than 200 miles from her village. Having made the decision to leave, her village would never let her return there -- she and her children were ostracized. As she recounted the violence, entrapment, threats and isolation in her life, I asked what had helped her to recognize that she had options. She told me that it was the words of the public health nurse that had given her hope. She had carried around that message like a candle in her heart as she waited, endured and planned for a different life.

### **Is Domestic Violence Screening Worthwhile?**

Even within the context of a disease-oriented model, a good argument can be made to justify routine screening for domestic violence. Three major criteria are often used to assess whether screening for a disease is worthwhile: effectiveness, human costs and sustainability (Fowler et al, 1993). In terms of effectiveness, screening should not be undertaken unless it is known with reasonable certainty to be effective in reducing the burden of disease. Screening for domestic violence, in and of itself, has therapeutic value. Simply identifying the abuse and being supportive can make a difference in the life of a victim.

The human cost of domestic violence is great in terms of injuries, chronic health problems and quality of life while the human cost of screening is minimal in terms of time, money and opportunity. Validated screening instruments are available at no cost and take a few minutes to complete (Hoff and Rosenbaum, 1994; McFarlane J, 1993; Sherin et al, 1998). When we consider the impact of domestic violence on the physical and mental health of victims, it seems unlikely that choosing not to screen for abuse would be more efficient in terms of time management. A survey of primary care physicians revealed that time constraint was not a major concern or predictor of physicians' decision to screen for domestic violence (Chamberlain, 1996).

Sustainability means that the quality of screening must be sustained as well as continuing resources being available to support screening. Follow-up domestic violence training is needed and a variety of training modalities are available to sustain the quality of screening. The primary resource needed is the commitment to take the time to ask the questions and to be prepared to listen and help.

### **Shifting Priorities**

Social problems like domestic violence challenge us to examine what guidelines we use to justify routine screening. Surely, the magnitude of the problem and the health consequences are important considerations in deciding whether to routinely screen for domestic violence. Domestic violence is a leading cause of injuries to women (Stark and Flitcraft, 1981; McLeer et al, 1989; Abbott et al, 1995). Victims of domestic violence are more likely than non-victimized women to experience numerous chronic health problems including depression, post-traumatic stress disorder, chronic pain syndrome, gynecological problems, irritable bowel syndrome, eating disorders, and complications during pregnancy (Bostwick and Baldo, 1996; Drossman et al, 1995; Folingstad et al, 1991; Haber & Roos, 1985; Mullen et al, 1988; Schei et al, 1989; Talley et al, 1994). If our decision of which health issues to prioritize for screening is based on targeting health issues that are prevalent in our patient population and known to have a significant impact on health status, then screening for domestic violence should be at the top of the list.

Patients, both those with a history of abuse and those with no history of victimization, believe that physicians should screen for domestic violence (Friedman et al, 1992; McNutt et al, 1999). The fact that the

majority of male and female survey respondents supported routine screening for domestic violence is an important consideration for tailoring a health care system that is responsive to patients' needs and concerns.

### Screening as a Prevention Strategy

Prevention strategies are often examined within a framework of three levels of prevention (Last and Wallace, 1992). When the potential impact of domestic violence screening is assessed within this framework, the advantages of routine screening become apparent: the aim of tertiary prevention is to minimize the consequences of a disease or health event. In terms of tertiary prevention, screening victims of abuse provides the opportunity for disclosure in a safe and confidential environment. Every time a health care provider talks about domestic violence with a patient who is being victimized, they are ending the victim's isolation. Identifying the abuse, validating victims' experiences and being supportive are the cornerstones of an appropriate medical response to domestic violence. When you suspect that a patient is being abused but the patient does not disclose it, you can express your concern about her safety and let her know that she has options. Survivors have emphasized that even when they chose not to disclose their victimization, the fact that their health care provider asked about the abuse gave them a message that this person cared and would listen if they ever wanted to talk.

Screening is usually considered to be a secondary prevention strategy. The aim of secondary prevention is to detect a health risk as early as possible to reduce the prevalence of disease and disability. Early identification of an abusive relationship can help victims to escape before the violence escalates, the entrapment leads to further isolation and chronic health problems limit patient's options. At this secondary level of prevention, helping patients to understand that the abuse will only get worse and the impact that it has on their health and their children will allow them to make more informed choices. Screening for domestic violence with patients who do not have a history of abuse is an opportunity for primary prevention. The aim of primary prevention is to preserve health by removing the precipitating causes of departures from good health. Screening informs patients that domestic violence is an important health care issue and lets them know that you are a safe person to talk to if they ever experience abuse or if someone close to them is being abused. A health care provider's decision not to screen compromises the quality of care that a patient receives while contributing to the conspiracy of silence around her abuse. Focus groups with domestic violence survivors revealed that many women felt that their abuse was "unimportant or embarrassing" to health care providers who chose to focus on the standard medical treatment without trying to understand the underlying issue of abuse in their lives (Rodriguez et al., 1996).

### The Talkeetna Story

When a community acknowledges the need for domestic violence services, we often find previously undiscovered resources for victims of domestic violence. Health care providers can be the catalysts for a community identifying resources and developing a coordinated response. Approximately one hundred miles north of Anchorage, the small town of Talkeetna (population: 363) is nestled at the foot of a mountain range. The community health clinic has a small staff that serves a huge, sparsely populated area. The clinic is run by a dynamic physician's assistant, Jessica Stevens, who became concerned about the number of women coming in with symptoms of depression. She was aware of the violence in some of these women's relationships and called us to provide domestic violence training for her staff. The clinic implemented routine screening for domestic violence and was shocked by the number of disclosures, but the closest women's shelter was nearly 50 miles away. Even if a victim had access to a vehicle, she would have to leave her community and often deal with treacherous road conditions in the winter.

Jessica arranged for me to do a one-hour, call-in radio show about domestic violence. From the volunteer-staffed, public radio station located in a tiny log cabin with no running water, we started what became a series of radio programs about domestic violence. There was only one caller that first night when I spoke -- Jessica. She called in to encourage people to break the conspiracy of silence about domestic violence. People were afraid or reluctant to speak out at first. But slowly, people willing to be a resource for victims came forward. A survivor who did not want women to go through what she did came forward, then a clergyman who was concerned about the level of violence in the community.

Female elders at the senior center donated some money to help. A support group started meeting one evening a week at the clinic. Volunteers offered transportation for women who decided that they needed to leave their community to seek refuge at a women's shelter.

The clinic and the regional women's shelter worked together to hire a domestic violence advocate. The process of integrating advocacy into the health care setting has not been easy -- it has been difficult to recruit someone who is willing to relocate and live on a modest income in a remote community and volunteer efforts have waned since the advocate joined the clinic staff. This small clinic has weathered each obstacle while demonstrating that routine screening can provide the foundation for a community to identify and build upon existing resources while strategizing to address unmet needs. Now the community goal is to open a domestic violence shelter.

### **A Quality of Care Issue**

Choosing not to screen for domestic violence when victim services are unavailable locally suggests a very narrow interpretation of the purpose of screening. On numerous occasions, health care providers who have participated in training and integrated screening into their practices have provided feedback to us about the insight they have gained when a patient disclosed abuse that they never had suspected. Accurate diagnosis relies on determining if domestic violence is an underlying issue. The quality of care is compromised when the potential role of domestic violence is not evaluated.

A patient's history of victimization should be taken into consideration during case management. Withholding prescriptions and limiting access to health care services are common tactics of abusers that must be taken into account when determining a treatment plan. Health care providers need to know about the current violence in a patient's life as well as any past history. Survivors of abuse may continue to have higher medical utilization for a variety of health problems for years after the abusive relationship has ended (Bergman and Brismar, 1991).

### **Redefining Success**

Perhaps some of our concern about screening for domestic violence when there are no local services available is based on a misperception of what constitutes success when intervening for domestic violence. When someone is being victimized, it is natural for us to want to remove a victim from the harm -- in other words, tell a victim to leave their abuser. In fact, domestic violence survivors have expressed concern that health care providers will take control of the situation without the women's permission rather than encouraging them to make their own decisions (Rodriguez et al, 1996; McNutt et al, 1999). Addressing domestic violence in the clinical setting does not fit neatly into a medical model. We cannot fix the problem. We need to redefine success in terms of increasing a patient's understanding of her situation, educating her about the health implications of abuse for herself and her children, informing her about resources, and most of all, enhancing her safety.

Victims of domestic violence may not go to a shelter or advocacy program even when the services are available in their community. There is no one solution for victims to end the violence in their lives, but there is one universally applicable goal-promoting safety behaviors for victims and their children. A 20-minute intervention protocol with pregnant women who were abused led to a significant increase in victims' safety behaviors during and after pregnancy (McFarlane et al, 1997). Whether or not there is a shelter or a victim chooses to use local services, an efficient and effective protocol to promote safety behaviors is an appropriate strategy to use with all victims of abuse.

When considering what options are available for victims living in communities with no shelter or advocacy program, remember that a domestic violence shelter that is hundreds of miles away from your clinical setting can still be a resource. A victim can talk with an advocate on the phone, discuss safety planning and arrange transportation if she must seek refuge outside of her community. For victims who cannot access local or regional resources, providing the toll-free National Domestic Violence Hotline (1-800-799-SAFE) can be a lifeline.

## **A Message from the Outhouse**

About a year ago, I received a phone call from a health aide who lived in a village above the arctic circle. She was the primary health care provider for her community and had participated in our train-the-trainers workshop. As a trainer, she was expected to organize two educational activities on domestic violence in her village. She had called me to withdraw as a trainer. When I asked her why, she told me that the head of the village council was a batterer. She was afraid to talk about domestic violence in her village. We brainstormed about what might be safe for her to do. She decided that she would put domestic violence posters in the public outhouses (there is no running water in the village).

Six months later I got a phone call from a woman in that village who had seen one of our posters on an outhouse door. She did not call the day that she saw the poster. She waited until she felt that it was safe and then made the call to get more information. Her call is a reminder that often doing a little can mean a lot for victims of domestic violence. Phone calls like this are how we define success—ending the isolation, making connections and letting victims know about options.

## **Start Today**

The purpose of screening for domestic violence is about much more than making referrals when abuse is disclosed and the absence of domestic violence services in your community does not negate the value of screening. Whether you practice in a resource rich city with an extensive network of victim services or you are the only clinician in a rural or isolated town, your words can make a difference in the lives of domestic violence victims. They need to know that you care and that it is OK to talk with you about the violence in their lives. In the words of Dr. Maureen Longworth, a physician in Juneau, Alaska, "It begins with me and it begins now."

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*Complete references for noted articles and/or additional articles from the FUND's Health Alert newsletter are available online at [www.fypf.org/health/](http://www.fypf.org/health/).*