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Women and Domestic Violence: Programs and Tools That Improve Care for Victims

Introduction

Up to 25 percent of U.S. women have been the victims of domestic violence, which can result in immediate injury and/or chronic health problems. When victims seek medical care, clinicians often do not screen for and identify domestic violence. In fact, the U.S. Preventive Services Task Force indicates that very few research studies exist that can help guide clinicians on how to screen for domestic violence and manage care for identified victims.[1,2] Further, health care providers need to be able to refer victims to programs and counseling that will be effective in helping them end the violence in their lives. Assessing the quality and effectiveness of these programs, however, has been difficult.

This report describes training programs and tools that health care providers, social workers, and facilities and their staff can use to provide better care for victims of domestic violence. Research funded by the Agency for Healthcare Research and Quality (AHRQ) has:

- Identified gaps in research on domestic violence indicating a need to build a stronger evidence base for screening, detecting, and treating victims.
- Helped health care providers screen for and identify victims of domestic abuse.
- Created tools that help providers counsel and treat victims.
- Developed a tool that evaluates the quality of domestic violence programs.

Background

Each year in the United States, about 2 million women are physically assaulted by their intimate partners.[3,4] These assaults result in injuries that lead to over 73,000 hospitalizations and 1,500 deaths.[3,4] In addition to the physical injuries domestic violence causes, it is also a major risk factor for depression. For example, one study found that 61 percent of women diagnosed with depression had also experienced domestic violence–a rate two times that of the general population.[5] Victims of domestic violence have more physical problems, including headaches, chronic pain, sleep problems, vaginal infections, digestive problems, sexually transmitted diseases, and urinary tract infections,

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and they are more likely to rate their health as only fair or poor.[5,6]

Even though injuries and health problems are apparent and well documented, health care providers often do not ask about domestic violence or intervene on behalf of their patients who experience it.[4,7] One study found that only 6 percent of physicians ask their patients about possible domestic violence, yet 88 percent admitted that they knew they had female patients who had been abused.[8] Another study indicated that 48 percent of women supported routine screening of all women, with 86 percent stating it would make it easier to get help.[9]

Health care providers have said that they do not screen for domestic violence because they lack the necessary training, time, tools, and resources, and they do not feel they can make a difference.[4,7,8] An AHRQ-funded survey found that many primary care clinicians, nurses, physician assistants, and medical assistants lack confidence in their ability to manage and care for victims of domestic abuse.[10]

- Only 22 percent had attended any educational program on domestic violence within the previous year.[10]
- Over 25 percent of physicians and nearly 50 percent of nurses, physician assistants, and medical assistants stated that they were not at all confident in asking their patients about physical abuse.[10]
- Less than 20 percent of clinicians asked about domestic violence when treating their patients for high-risk conditions such as injuries, depression or anxiety, chronic pelvic pain, headache, and irritable bowel syndrome.[10]
- Only 23 percent of physicians, nurses, physician assistants, and medical assistants believed they had strategies that could assist victims of domestic abuse.[10]

Impact of AHRQ research

More research is needed on screening and treating domestic violence victims

In an extensive review of research literature, the U.S. Preventive Services Task Force (USPSTF)[a] did not find enough evidence to recommend for or against routine screening for domestic violence among the general population.[1,2] However, the USPSTF reinforced the necessity for health care providers to be able to identify the signs and symptoms of domestic violence, document the evidence, provide treatment for victims, and refer victims to counseling and social agencies that can provide assistance.[1,2] Essentially, the USPSTF found that:

- When domestic violence is suspected, health care providers need to conduct the appropriate history and examinations, offer treatment, document their findings, and refer the victim for counseling and support.[1,2]
- None of the research has indicated that screening patients who have no symptoms of domestic violence has reduced harm.[1,2]
- More research is needed to develop screening tools that are effective in the general population, along with programs that can improve health outcomes and reduce violence.[1,2]
- Several screening instruments have demonstrated good "internal consistency," indicating that all the items on the instrument are consistent with one another. However, the best methods to administer screening instruments in various settings have not been determined.[1,2]
- Definitions of abuse varied among the studies, which limited the ability to combine and compare studies in different settings. Refining these definitions, along with measurements of severity and the chronic occurrence of abuse, would allow development of standardized instruments and evaluation tools.[1,2]
- No research has been done to determine if there were any adverse effects of screening or interventions.[1,2]

Training helps providers identify and manage victims of domestic violence

Training sessions funded by AHRQ improved primary care providers' confidence in asking and treating victims of domestic violence. Providers who participated in the training increased their screening for domestic violence from 3.5 percent prior to the training program to 20.5 percent after training.[11] Upon completion of the training sessions, participants stated they:

- Felt less fear of offending patients by asking about domestic violence.
- Had less fear for their own safety.
- Asked patients more often about possible domestic violence.

[a] AHRQ supports operation of the USPSTF, which was convened by the U.S. Public Health Service to rigorously evaluate clinical research in order to assess the merits of preventive measures. The USPSTF consists of an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.

- Offered strategies to abusers to seek help.
- Provided strategies so victims could change their situation.
- Had better access to information on managing domestic violence.
- Had methods to ask abusers about domestic violence while minimizing the risk to the victims.[11]

This domestic violence training program uses a systems approach, helping health care providers working in primary care settings identify and manage domestic violence. In addition, its randomized design allows assessment of outcomes and effectiveness.[12] Specifically, one can measure changes in providers' knowledge, attitudes, and beliefs; how often they ask about domestic violence (documented); case finding; and completeness of case management.[12]

An interdisciplinary team provided training for receptionists, medical assistants, nurses, physician assistants, and physicians. The team included a nurse, an epidemiologist, primary care physicians, and personnel from treatment programs, social work, and a women's shelter, as well as a former domestic violence victim and a prosecuting attorney.

There were two 4-hour training sessions. At the first training session, participants received basic information about domestic violence, including prevalence, indications, how to get information from their patients, how patients change behaviors, documentation, and patient safety. Specifically, participants were taught how to:

- Ask direct questions.
- Acknowledge what the patient said.
- Assess the patient's safety needs.
- Refer the patient to social and mental health workers as well as community and State domestic violence agencies and hotlines.
- Document their findings in the patient's chart.
- Arrange to have the patient follow up with them.[12]

The first training session also included a discussion about abusers–those who commit domestic violence.[12] Participants learned:

- How to identify abusers by noticing injuries to the abuser's hands, problems with alcohol, depression, employment problems, stress disorders, and problems with anger and hostility.
- How to interview abusers by asking questions about what happens during disagreements with their partners and if anyone gets hurt.
- The indications of increasing risk of domestic violence, including a history of escalating violence, multiple forms of violence, threats of serious harm, increased drug and alcohol use, depression, mental illness, suicide threats or attempts, jealousy, and obsession with the victim on the part of the abuser; expressions of fear for safety from victims; separation; and divorce.
- Methods to help ensure their safety when meeting with abusers.
- What to say to the abuser: for example, this behavior is not acceptable, violence will not go away by itself, violence has harmful effects on the family, and the abuser has a responsibility to get help.
- Where to refer the abuser to get help.[12]

During the second training session, participants learned how to manage the care for victims of domestic violence. They participated in role playing, talked with a former victim of domestic violence, and received presentations from a prosecuting attorney and a community domestic violence agency.[12]

After the two half-day workshops, during the following year, newsletters were sent four times to all participants to reinforce what they had learned and were applying in practice. Additional educational sessions were held on skill improvement and community resources, and participants were told about early results of the study to encourage their efforts. Posters were placed in clinic waiting areas to allow patients to feel more comfortable about talking with providers about domestic violence. Providers also carried cue cards in their pockets to help reinforce the processes they had learned.[12]

Nine months after the training, when the intervention was fully in place, the participants were asked to rate the usefulness of 12 components of the training session, shown in Table 1.[12] Participants stated that they felt components 1-7 were significantly more important than components 8–12.[12]

An assessment tool helps providers counsel victims

The Domestic Violence Survivor Assessment (DVSA) tool helps health care providers and abused women identify issues and feelings created by domestic violence and helps guide counseling. Social workers have said that the DVSA

Table 1. Ratings of domestic violence training sessions

Training component	Percent of participants who considered the component essential or important
1. Epidemiology (background information on incidence and dynamics of domestic violence)	66.7
2. Overview of identification and management for victims	71.3
3. Overview of identification and management for abusers	70.5
4. Discussion of legal issues	71.3
5. Confidentiality issues for domestic violence patients	68.8
6. Community resources for domestic violence	69.3
7. Researchers' resources for domestic violence	70.9
8. Patient behavior change theory	51.9
9. Role play in interview techniques	51.9
10. Videotapes of domestic violence scenarios	41.0
11. Presentation by a former victim	44.4
12. Domestic violence case discussions	41.3

Source: Thompson RS, Meyer BA, Smith-DiJulio K, et al. A training program to improve domestic violence identification and management in primary care: preliminary results. Violence Vict 1998; 13(4):395-410.

is "easy to understand, quick to complete, and provided a valuable holistic viewpoint."[13] It enabled them to see visually the various states a woman was experiencing about different issues and could help them identify areas where she was "stuck" and required counseling to be able to move forward.[13]

The DVSA instrument has been adopted as an outcome measure for counseling in two community-based and one hospital-based domestic violence counseling programs. It is also being piloted for possible adoption by a State for measuring outcomes of domestic violence counseling programs.

Researchers funded by AHRQ collaborated with the United Family Services of Central Maryland and the House of Ruth of Baltimore, Maryland, to develop and implement the DVSA in order to guide interventions and measure outcomes.[13] The instrument is based on the Transtheoretical Model of Change and Landenburger's Theory of Domestic Violence Recovery. It measures where a woman perceives herself regarding 11 issues commonly experienced by survivors of domestic violence. Five of these issues concern her relationship with the abuser:

- Triggers of abusive incidents.
- Managing partner abuse.
- Attachment to the abuser.
- Views of the relationship and options.
- Managing loyalty to norms and her own beliefs.[13]

Six of the issues concern her as an individual:

- Accessing help.
- Feelings.
- Self-identity.
- Self-efficacy: ability to be on her own.
- Mental health.
- Medical care for domestic violence injuries and stress.[13]

Based on interviews with the client, the clinician identifies the state the woman is in with regard to resolving each of the 11 issues. For example, when a woman denies and excuses the abuse (Figure 1, first column) or ignores her injuries (Figure 2, first column), she is still in a state of being committed to continuing the relationship. Once she is able to reject self-blame and realizes she cannot prevent her partner's abuse, she is considering change and begins looking at the abuse and her options (Figure 1, middle column), although she may delay getting medical care for her injuries (Figure 2, middle column). Finally, she makes the decision not to tolerate the abuse and either leaves the relationship or, if she stays, becomes mindful of the need for her partner to change and seeks medical treatment as needed (Figures 1 and 2, last column).

The complete, updated DVSA can be obtained from Jacqueline Dienemann, Visiting Professor, University of North Carolina at Charlotte, Department of Adult Health Nursing, 9201 University City Boulevard, Charlotte, NC 28223, e-mail: jadienem@uncc.edu.

A critical pathway for intimate partner violence provides guidance for patient care

Researchers who developed the DVSA instrument also created a critical pathway for intimate partner violence

Figure 1. Excerpts from the domestic violence survivor assessment form: Issues about the relationship–triggers of abusive incidents

Denies and excuses abuse. May accept blame by partner.	Rejects self-blame. Continues to make excuses to others, but realizes partner chooses to abuse.	Will not tolerate abuse. If left, avoids partner. If together, monitors partner for change.
↓	↓	↓
Committed to continuing	**Considers change: abuse and options**	**Establishes a new life - apart or together**

Source: Jacqueline Dienemann, Visiting Professor, University of North Carolina at Charlotte, Department of Adult Health Nursing, 9201 University City Boulevard, Charlote, NC 28223; e-mail: jadienem@uncc.edu or jpdien@bellsouth.net. Used with permission.

Figure 2. Excerpts from the domestic violence survivor assessment form: Issues about the individual–medical care for domestic violence injuries and stress

Ignores stress and injuries when with others. Copes alone.	For safety, delays care and counseling/ therapy. Seeks initial treatment; lies regarding abuse.	Uses medical care and counseling/ therapy. May have ongoing health and emotional problems from domestic violence.
↓	↓	↓
Committed to continuing	**Considers change: abuse and options**	**Establishes a new life - apart or together**

Source: Jacqueline Dienemann, Visiting Professor, University of North Carolina at Charlotte, Department of Adult Health Nursing, 9201 University City Boulevard, Charlote, NC 28223; e-mail: jadienem@uncc.edu or jpdien@bellsouth.net. Used with permission.

(IPV). The critical pathway encompasses physical health, mental health, and social assessment and treatment for victims of domestic violence.[14] The IPV critical pathway has been validated using the Delphi technique of gathering feedback from experts. Further research is necessary to measure processes and barriers to implementation, as well as its reliability in improving patient outcomes.[14] The pathway for intervention on the first visit (initial disclosure of IPV) is shown in Figure 3.

A tool for hospital-based domestic violence programs helps assess quality

The Delphi Instrument for Hospital-based Domestic Violence Programs, funded by AHRQ, can be used to assess the quality of a hospital's performance in implementing a domestic violence program and can be used to create program goals, assess performance over time, and compare one program to another. Eventually, it can be linked to outcomes to determine what parts of the program create the best outcomes for victims of domestic violence. The instrument examines the physical structure of the programs, such as facilities, equipment, personnel, and organizational structure. It also examines the provider's process of care, such as chart documentation and treatment.[15]

The Delphi Instrument has had both local and international impact. It was used at the University of North Carolina (UNC) Chapel Hill Medical School to evaluate the

Figure 3. Intimate Partner Violence (IPV) Clinical Pathway: Treatment after disclosure (initial visit only)

PHYSICIANS, NURSES, SOCIAL WORKERS IMMEDIATE RESPONSE AT DISCLOSURE:

1. **Believe patient and tell patient the behavior reported is abuse.**
2. **Assure patient violence is the fault of perpetrator and not the victim.**
3. **Assure patient that there are options and offer referral to IPV Program Social Worker or other appropriate resource.**
4 **Give patient hotline number. National (1-800-799-SAFE) and Local HOTLINE telephone number.**

Activity	Initial Visit (Physician and nurse do physical and mental health assessment and treatment, Social Worker or IPV Advocate/Nurse does social assessment and treatment)
Physical Assessment and Treatment	**PRESENTING COMPLAINT** 1. Assess trauma 2. Document with body map/photos and description 3. Refer or treat as appropriate 4. Report to police if gunshot or knife wound or according to state law
Physical Assessment and Treatment	**SEXUAL TRAUMA** 1. Ask about forced or undesired sex 2. If NO: document only If YES and not IPV RAPE: examine for injuries, treat, refer, document. Discuss contraceptive options, prevent pregnancy and STDs. If YES and IPV RAPE (within last 72 hours do pelvic exam, evidence collection); examine for injuries, treat, refer, document. OFFER pregnancy test and STD/HIV test.
Physical Assessment and Treatment	**PAIN** 1. Assess site, type, severity, and duration. 2. If NO: document only. If YES: assess pain in relation to violence history and its possible influence on sign/symptoms/illnesses, especially: Neurological, GI/Abdominal, GYN, Chronic stress, Other. Document, refer and/or treat.
Psychiatric/Mental Health Assessment and Treatment	**SUBSTANCE ABUSE** 1. Screen for current substance abuse problems of patient and abuser. 2. If NO: document. If YES: inform of treatment options and refer if interested at this time. Document. 3. Reinforce that this is a separate health problem from IPV although it may be exacerbated by or exacerbate IPV.
Psychiatric/Mental Health Assessment and Treatment	**DEPRESSION** 1. Assess symptoms of depression, severity and duration and relationship to IPV history 2. Assess client's need for medication. If appropriate, prescribe psychotropic medication and/or refer for psychiatric services or counseling. 3. Using danger assessment guidelines[a] assess for: suicide/homicide potential or attempts. If YES, refer for psychiatric consult. Document. Review legal protections available for homicide prevention.

continued

Figure 3. Intimate Partner Violence (IPV) Clinical Pathway: Treatment after disclosure (initial visit only) (*continued*)

Psychiatric/Mental Health Assessment and Treatment	**PTSD/ANXIETY** 1 Assess sleep, startle, anxiety, re-experiencing of trauma (flashback), numbing. 2. If YES, refer for psychiatric consult.
Social Assessment and Treatment	**IPV SERVICES** 1. IPV counselor meets with patient. 2. Assess trauma history.
Social Assessment and Treatment	**ADDITIONAL DEMOGRAPHICS** 1. Marital status with abuser: married, separated, divorced, widow, single 2. Living with abuser: yes, no, sometimes 3. Harassment and/or stalking by abuser? 4. Children: number and ages. Custody? 5. Health insurance: none, abuser's policy, personal policy.
Social Assessment and Treatment	**INFORMATION ON CHILDREN** 1. During woman's treatment/hospitalization: children living with patient? Where are they now? How can their safety and care be assured? How support mother's custody? 2. Child trauma: ask if children demonstrating signs of trauma from observing violence (i.e., sleep problems, nightmares, aggressiveness or withdrawal, school problems). Refer if indicated.
Social Assessment and Treatment	**DANGER** 1. Use Danger Assessment guidelines[a] to assess IPV severity and extent of danger. Express concern for safety. 2. Explain police services. ASK IF VICTIM DESIRES for provider to call police. 3. Explain court ex parte/protection orders and victim's services and legal assistance options. Give resource sheet. 4. Explain mandatory legal reporting of child abuse. Inquire if children have been abused and refer if indicated.
Social Assessment and Treatment	**SAFETY PLANNING** 1. Use guidelines[b] to assess safety behaviors and plans for future.

[a]Campbell JC. Danger assessment. Web site: <http://www.son.jhmi.edu/research/cnr/homicide/da_instrument.htm>. Accessed Dec 12, 2003.

[b]McFarlane J, Parker B, Cross B. Abuse during pregnancy: a protocol for prevention and intervention, 2nd ed. March of Dimes nursing module. 2001. March of Dimes Fulfillment Center, P.O. Box 1657, Wilkes-Barre, PA 18773. Web site: <www.modimes.org>.

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domestic violence program at UNC hospitals.[16] Foyle Women's Aid and the Consultancy Mentoring Works research team, based in Northern Ireland, used the Delphi Instrument in a study to investigate care for victims of domestic violence at Altnagelvin Hospital.[17] The findings from that study led researchers to recommend the Delphi Instrument as an "excellent template . . . for any organization, agency or public body to monitor their services in respect to domestic violence."[17]

The tool measures nine different categories of performance (Figure 4). A panel of 18 experts on domestic violence (researchers, program planners, and advocates) evaluated and agreed on 37 performance measures in these nine categories that can be used to evaluate hospital-based domestic violence programs.[18] Each performance measure within a category is assigned a score[15] and the scores are added to obtain a total for the category. The raw scores for each category are then weighted and the weighted scores added to obtain a total score, with 100 being the best possible score.[15] Guidelines, instructions, and the tool itself can be found on AHRQ's Web site at <http://www.ahrq.gov/research/domesticviol/>.

Figure 4. Excerpts from the Delphi Instrument for Hospital-based Domestic Violence Programs: Categories of performance and examples of questions that measure performance

Performance category	Example of measure	Scoring (points)
1. Hospital policies and procedures	Are there official, written hospital policies regarding the assessment and treatment of victims of domestic violence?	No (0) Yes (1)
2. Hospital physical environment	Are there posters and/or brochures related to domestic violence on public display in the hospital? If yes, list total number of locations (up to 35).	No (0) Yes (1-35)
3. Hospital cultural environment	In the last 3 years, has there been a formal (written) assessment of the hospital staff's knowledge and attitude about domestic violence? If yes, which groups have been assessed?	No (0) Yes (7)
	a) nursing staff …	
4. Training of providers	Has a formal training plan been developed for the institution?	No (0) Yes (10)
5. Screening and safety assessment	Is a standardized safety assessment performed and discussed with victims who screen positive for domestic violence?	No (0) Yes (27)
6. Documentation	Does the hospital use a standardized documentation instrument to record known or suspected cases of domestic violence? If yes, does the form include:	No (0) Yes (10)
	a) information on the results of domestic violence screening? …	
7. Intervention services	Is there a standard intervention checklist for staff to use/refer to when victims are identified?	No (0) Yes (14)
8. Evaluation activities	Is there any measurement of client satisfaction and/or community satisfaction with the domestic violence program?	No (0) Yes (19)
9. Collaboration	Does the hospital collaborate with local domestic violence programs? If yes, which types of collaboration apply:	No (0) Yes (10)
	a) collaboration with training? …	

Source: Agency for Healthcare Research and Quality. Delphi Instrument for Hospital-based Domestic Violence Programs. AHRQ Web site: <http://www.ahrq.gov/research/domesticviol/dvtool.htm>. Accessed Oct 16, 2002.

Ongoing research

AHRQ continues to fund studies that investigate domestic violence and its effects:

Treatment Outcomes for Abused Women in Public Clinics; University of Texas Health Science Center, Houston, Grant No. R01 HS11079. This project is designing, implementing, and testing the effectiveness of nurse case management and group education for black, Hispanic, and white abused women attending two inner-city primary care clinics. The clinics are part of a county-wide clinic and hospital system for low-income people. In addition, the researchers are evaluating the impact of the interventions on the health, functional status, and medical use of children of abused women.

Outcomes for Intimate Partner Violence: Patient and Provider Perspectives; University of California, San Francisco, Grant No. R01 HS11104. This study focuses on 125 Hispanic women at high risk for intimate partner violence who have low incomes and are receiving prenatal care from the public sector. The specific aim of this project is to determine the health care outcomes these women prefer from intimate partner violence interventions.

A Randomized Controlled Trial of Computer Screening for Domestic Violence; University of Chicago, Grant No. R01 HS11096. This project is evaluating the effectiveness of a computerized assessment tool to help clinicians in emergency departments identify potential victims of domestic violence and recommend specific strategies for management. The study includes women who come to the emergency departments of two hospitals, one in the inner city and the other in the suburbs.

The Cost and Benefits of Intervening: Battered Women's Mental and Physical Health Over Time; Harvard School of Public Health, Boston, MA, Grant No. R01 HS11088. This project is comparing seven existing domestic violence interventions in different hospital settings. Findings from this study will offer new information on the effectiveness and cost effectiveness of different hospital-based interventions.

Cost Effectiveness of Domestic Violence Interventions; Montefiore Medical Center, Bronx, NY, Grant No. K08 HS11297. This project is investigating the effectiveness of domestic violence interventions, defining outcome measures, and developing a method for a cost-benefit analysis. The study will provide essential timely information to guide the medical community on how best to develop domestic violence interventions and investigate the cost effectiveness of domestic violence interventions in primary care.

Long-Term Health Care Effects of Domestic Violence; Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle, WA, Grant No. R01 HS10909. This study is assessing the impact of domestic violence over an 11-year period on the health care cost and utilization of adult women and their children. For the women, the study is assessing the effects of domestic violence on health status and high-risk behaviors, such as excessive drinking. Investigators are also estimating the prevalence of domestic violence among men and the elderly of both sexes. Overall, investigators are determining the effect of domestic violence on physical and mental health status, social functioning, and health risk profiles and estimating the prevalence of domestic violence by type, duration, and frequency among women, men, and the elderly.

Conclusion

AHRQ-funded research has helped to identify gaps in the research on domestic violence and areas where better tools and programs are needed to help health care providers identify and treat victims of domestic violence. Researchers supported by AHRQ have developed training programs and critical treatment pathways for clinicians and their staff, instruments to help counsel victims, and a method for hospital providers to assess the quality of their services. The Agency continues to fund research in an effort to further reduce violence and improve health outcomes.

For more information

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