Domestic Violence and Women's Health

Testimony of
Marlene B. Jezierski, RN, BA in Nursing
Violence Prevention Educator, Allina Hospitals & Clinics
Minnesota

To the Senate Committee on Health, Education, Labor
And Pensions hearing on Women's Health legislation

April 25, 2002

The purpose of my testimony is to discuss why domestic violence is a health care problem and *must* have high priority in legislation dealing with women's health. In my work at Allina Hospitals and Clinics, a health care system that owns 12 hospitals and 40 clinics, I have worked as a violence prevention educator and coordinator, educating health care professionals and developing systems that support ongoing, routine and effective screening for domestic violence.

I have worked with health care professionals for more than a decade teaching them why they should ask their patients if they are being hurt by someone in their life and how they should do that. I have worked with leaders incorporating supportive infrastructure so abuse screening practices can be sustained. Working with front line providers I understand the barriers they encounter and what it takes to establish routine screening. I have heard dozens of survivor stories. I have spent countless hours with domestic abuse advocates I know from these experiences that hundreds of abuse victims can be helped. I have heard many stories from domestic abuse victims describing how their lives have been positively impacted by health care professionals' sensitivity and knowledge. I know screening and referral in the health care setting helps battered women. I believe our work has saved lives.

There are four recommendations I would like to make.

- First, to assure competent screening and intervention, health care professionals must be educated in schools and the clinical environment.
- Second, a health care "best of practice" should be established; adults and teens should be universally screened for histories of family and domestic violence.
- Third, partnerships should be developed between health care and domestic abuse advocacy services. The most preferable arrangement is provision of on-site advocacy.
- Fourth, infrastructure must be in place to maintain sustainability of abuse screening protocols. This includes measurement, leadership support, policy changes, forms revisions and clearly stated performance expectations.

When abuse screening is done properly

> During an annual physical at one of our clinics, a gynecologist screened his patient for domestic abuse. She disclosed her history of abuse by her husband. The physician's response was kind and very gentle. He said to her "You don't deserve that". A year later when she returned for her annual visit, the woman looked at him with great appreciation and said "Thank you for what you said to me when I was in here last year." Not remembering, the physician asked his patient what he had said that was so helpful. She repeated "You said 'you don't deserve that'. I want you to know that I am no longer in an abusive relationship. What you said to me that day helped me make a change".
>
> This scenario has been repeated many times in our health care settings.
> It exemplifies the value of screening all of our patients.
> Women want us to ask and to care.

Domestic violence and women's health

Domestic violence has been identified as a significant health problem by every major professional organization. The Joint Commission on Accreditation of Healthcare Organizations requires institutions it accredits to identify family violence victims.

Incidence of abuse

Research documenting the incidence of abuse includes:

- 30 to 40% of murdered women in the US are victims of intimate partner violence (IPV)
- 37% to 54% of women seen in the Emergency Department have been abused by an intimate partner at some point in their lives
- Each year over 2 million women experience intimate partner violence severe enough to cause physical injury
- At least 13-30% of all women in the US will experience one or more incidents of IPV in their lifetime
- 20% of pregnancy-associated deaths were caused by homicide
- The incidence of violence during pregnancy occurs at a rate of 4% to 8%
- 21% to 34% of women experience emotional abuse, a major factor contributing to chronic health problems

Emotional Abuse: A Survivor's Story

Response to Abuse

If he had hit me, I wouldn't think it was my fault. Instead he told me "everything" was my fault and I kept quiet to keep peace. Eventually, I guess I believed him. If he had tried to kill me, everyone would agree I needed to leave him to preserve my life, and support me when I did. Instead, he tried to kill my spirit, and I struggle alone with a sense of failure and inadequacy, questioning what have I done wrong, and why did I have to leave.

If he had been a thief, I would have been afraid of him and stayed away. Instead, he was a smooth-talking charmer whose heart was willing to take from my soul, and then tell me what I owed him. I continually search my soul and seek the Lord and His wholeness. I wonder why I allowed him to hurt me so many times before I finally realized he didn't love me, instead of wondering why he had no conscience in doing what he did to me. If he had used fists or weapons, I would have thought it was his action and his decision. But since he used words, I blame myself. I should have known. I shouldn't have allowed it. If he had been willing to listen when I tried to talk, maybe that twisted relationship could have been healed as we allowed the truth to enter. Instead, he would get angry and turn my concern into what was wrong with me, twisting it further. At first I innocently believed him. Later I got angry. Then I doubted myself. Then I was broken. When I gave up trying to have a voice, I knew I had to leave.

Of course I want to forgive him, but it's scary to even acknowledge that a person can treat someone the way he treated me. So even though I found the strength to leave, even though I've been gone for two years, I struggle daily to get free. When will I be free of all the wounds, received at the hand of someone who claimed to love me, free of the self-doubt and self-rejection? When will I see the sins as belonging to him instead of me?

Anonymous, Registered Nurse, Health Care Consultant, survivor of domestic abuse

Domestic abuse contributes to poorer health

Intimate partner violence is associated with many adverse health effects. The obvious are trauma caused by physical and sexual violence. Many additional health effects, most of which are difficult to treat, include: chest pain, sleeping/eating disorders, abdominal pain, intestinal disorders, miscarriages, substance abuse, depression, anxiety, chronic headaches, chronic pain, fatigue, fibromyalgia, sexually transmitted diseases, urinary tract infections, and post-traumatic stress disorder. Childhood sexual abuse has a significant relationship to health problems and abuse in adulthood.

Survivor Story: The Health Effects of Abuse

Would you recognize me if you met me?

Would you recognize me? I could be your sister, your daughter, your mother or your wife.

I grew up in a loving, supportive, caring family. My parents have been married for over 55 years. They taught us to care for and about one another. I became a nurse. In my professional experiences, I saw the effects of abuse on patients and their families. Now, after thirty years, I carry my own diagnoses of dysthymia which led to depression, post traumatic stress disorder, hypothyroidism, fibromyalgia and am currently undergoing a cardiac work-up. My psychotherapist and I agree that my diagnoses are the result of the myriad of abusive experiences I have endured over the past thirty years. My family and I have undergone marital and family counseling, school counseling, physical therapy and hospitalizations. My ex-husband(s) have undergone domestic abuse counseling and anger management.. My ex-husband got part of my retirement (I got none of his) and has access to health care at my employer's expense (though he never contributed). I still work full time as a health professional. Most people who meet me have no idea of what my life has been like. I now have a life free of abuse, but my diagnoses will be with me and my family until we die.

Would you recognize me if you met me? I could be, and others like me could be your sister, your daughter, your mother; or your wife.

Anonymous, Registered Nurse, Staff Educator, survivor of domestic abuse

Abuse victims not only develop poorer health, they are more likely to practice a variety of injurious and non-compliant health behaviors including: tobacco use, alcohol and/or drug use, risk-taking sexual behaviors, obesity, physical inactivity, lack of seat belt use, lack of helmet use, little or no gun safety practices, decreased self-care, and poor adherence to medication regimes for chronic illnesses

Survivor story - A success

A family practice physician was seeing a woman who had a work-related injury that simply would not improve. Because of this, he did an in-depth interview, seeking to identify underlying causative issues. The patient disclosed her history of severe emotional and physical abuse by her husband. He provided her with reassurance, support, encouragement and resources. Ten years later the patient saw this physician in a discount store, approached him and said with great appreciation how thankful she was for his insight and his support. She was no longer in an abusive relationship and attributed her current safe situation to the physician who had known how to ask and, most importantly, how to support his patient.

Health care cost

While the full extent of the cost of violence against women to individuals and to society is not fully determined, these figures are unarguably tremendous. Some facts include:

- Direct medical costs for abused women are estimated to be $1.8 billion annually
- Abuse victims have more hospitalizations, general clinic use, mental health services use and out-of-plan referrals
- Abused women have a 3.5 fold higher incidence of admission and required hospital care than non-abused women
- Medical expenses are 2.5 times higher among severely victimized women compared with non-victimized women.

On the other hand, data analysis has identified a cost-benefit value to programs that address issues of safe and peaceful lives for women. It was recently reported that the Violence Against Women Act (VAWA) saved $14.8 billion in net averted social costs.

Health care professionals and domestic abuse: What we must do

Health care professionals must be educated

Generally, family violence curricula is incomplete; instruction time is generally minimal, the content and teaching methods vary and subject matter is not well integrated. As a result, health care professionals often enter their professional lives lacking insight into the dynamics of abusive relationships, the issues related to making change in these relationships, and the skills necessary to perform a sensitive and nonjudgmental screening and referral. ***Many have had no education in this area.*** Many institutions have incorporated abuse screening requirements without providing staff education. Lack of education is a major barrier to identification, treatment and referral. It is optimal for education to be provided by a team including someone from the health care environment and from a domestic abuse agency.

Schools of medicine and nursing should have advanced curriculum that integrates family violence content throughout. Health care professionals should receive an initial four hours of education. The entire health care team should receive education as well. Initial education should be followed with information to include child abuse, elder abuse, teen violence, cultural sensitivity, childhood sexual abuse and competency building.
It is a process, not a "one-stop-shop". Often, those who have not received adequate education have made several, sometimes dangerous, mistakes.

Inappropriate screening

> I have heard countless stories of inadequate or inappropriate screening practices. Consider these examples. A nurse poked her head around the curtain and said to the patient in an offhand, casual manner, "Oh, by the way, you aren't abused by anyone, are you?" Two different pregnant women (an advocate for a domestic abuse agency and a family physician who teaches family practice residents to screen for abuse) were screened in the hospital in the presence of their partners. Others have noted that the nurse doing the screening would introduce the subject by saying "Our hospital policy requires me to ask these questions" or "I know this isn't happening to you but I *have* to ask you: are you being hurt by

anyone at home?" Each of these examples illustrates the gross inadequacy of health care professionals' knowledge base. In these cases, because of their ineffectiveness and potential for jeopardizing the safety of the patient, it would have been better if the nurse had done no screening at all.

Universal screening

It is important that *all* patients be screened. Screening should *not* be selective. Because the health effects of domestic violence result in much more than physical injury, universal screening and interviewing should be an essential component of assessment in health care encounters. It is unrealistic for any health care professional to assume one patient is being abused and another is not. More often than not, it is impossible to tell. .

A current medical best-of-practice universally taught and practiced is routine screening for hypertension (high blood pressure). Today, blood pressures are routinely taken in most health care encounters regardless of the reason for the visit. The incidence of high blood pressure in the population is 23%. Considering the fact that the lifetime incidence of abuse of women is minimally 25% coupled by the significant effect current or past abuse has on health, routine screening is the obvious best of practice recommendation.

Survivor story - A case for universal screening

A middle-aged woman was seen in one of our urgent care clinics for a bee sting. The clinic routinely screens patients for abuse. The day following her visit, the nurses received the following fax:

"While at the urgent care clinic, one of the nurses was asking a number of probably very normal medical history questions. She also asked a question about domestic abuse. At the time, since my bee sting was totally unrelated to any domestic abuse, I responded by saying no. However that was not a totally true statement. *I am concerned about my living situation and do not feel safe.*

My husband has a violent temper and at times I am afraid for my life. He has raised both hands towards my neck as a choking gesture and says "Do you want to hear a funny sound?" He has said he'd like to whip me with a garden hose in order to "beat the meanness out of me….I am involved in a number of volunteer activities and this upsets him very much. He blows up, throws a temper tantrum, slams doors, when I mention another activity. He knew I (volunteered) before we were married and did not object then, in fact he seemed to admire the many things I am able to do. Now however, he is adamant that I retire early from my job and would like me to spend all of my time with him and him alone. I am not allowed to go to the store alone, for instance. He insists on taking me anywhere and everywhere I go.

…I am concerned and want to have this on my medical history charts in case anything does happen to me. "

This message is more than a request for documentation in the medical record. It is a cry for help. The nursing staff was able to contact this woman, provide reassurance, support and resources.

Develop partnerships with local domestic abuse agencies

A key element of success in implementation of screening programs includes developing a working relationship with a local advocacy agency and seeking ways to support advocate visits in the clinical environment. This provides a trusted resource to health care professionals as well as the best case scenarios for victims. We feel the most effective system is to support a health care advocate program where the advocate is employed by the outside agency and works within the health care environment.

Infrastructure and support of leadership

Successfully sustained screening practices require a supportive infrastructure. This can include skill-based teaching of screening in employee orientation, evaluating competence and measurements of program compliance and effectiveness. Policies and procedures must be in place to support screening. *Most importantly, without the support of leaders, even the most excellent education and screening programs will encounter sustainability challenges.*

Health care settings should be made "safe places" to disclose

Creating a safe place includes having an aware, sensitive staff; educational and community resource information easily available to patients i.e. posters and brochures, and domestic abuse advocates available to see their patients.

Universal screening at Allina Hospitals & Clinics

The process

In 1996, Allina Health System (now Allina Hospitals & Clinics) announced a system-wide focus on violence prevention. Over $1,300,000 was given in violence-prevention research, education and community violence prevention grants. A portion of the grant funds included implementing domestic abuse screening and advocacy referral in Allina's 12 hospitals, over ½ of their 40 clinics and in their obstetric home visiting service. Several educational tools were utilized extensively throughout the system. These include a core curriculum, teaching video and patient educational materials.

The impact

We have identified a clear and positive relationship between education of health care providers and identification of abuse victims and subsequent referrals to advocates. One example is United Hospital and a nearby clinic, United Family Practice Center, in St. Paul. They also budgeted funding for on-site advocacy services. Prior to education, an occasional victim was identified, one or two a month at the most. After a mandatory education provided to employees beginning with the clinic, Emergency Department and the Birth Center, there was a sharp rise in referrals. These referrals rose steadily and now that the universal screening is implemented hospital-wide have leveled off at 100 per quarter for the last ten quarters. Since the education occurred in 1996, nearly 2000 abuse victims received services from the on-site advocacy service. No one would have received any on-site services prior 1996. Most would not have been identified as abuse victims. Mercy and Unity Hospitals in the suburban Minneapolis area experienced a significant rise in referrals after a major launching of screening and education in 1995-6. Throughout ensuing years through 1999, referrals consistently averaged around 100 per

quarter. During that time the hospitals budget supported on-site advocacy. In the last two years, program changes, decreased leadership support and budget cuts at these two hospitals have resulted in elimination of education funding, support for on-site advocacy and a decrease in leadership support As a result, the referral rate decreased by nearly 50%. Some leaders have now identified this as a problem and are working on solutions.

By making patient educational materials available to the public, literally thousands of community members have been provided with basic information educating them about unhealthy, violent relationships and telling them how to get help. It is not uncommon that half of the community does not know how to access domestic violence services.

Another significant benefit is creation of culture changes within the work place. Creating a "safe place" provides support not only to our patients but to our employees. Respondents to a 1996 health questionnaire mailed to new members by Medica, an insurance provider for Allina, revealed that 22% of them answered yes to the question "Have you ever been hit, kicked, pushed, or otherwise hurt or mistreated by someone important to you?" In cultures of "safe places" employees who are being hurt feel supported and encouraged to seek help.

Survivor Story - Standing beside you

> "A few months ago, my husband broke one of my fingers. I came in to the emergency department for treatment and told them I fell. I was so hurt and confused that someone I loved could treat me so horribly. I was too embarrassed to tell them what really happened. Quite a few of my coworkers jokingly asked, 'What happened to your finger? You and your husband been fighting?' I wanted to say, yes, can you help me? But just like my coworkers, I couldn't believe that I, an emergency nurse who sees abused women, helps abused women…could *be* an abused woman."
>
> Andrea M., pseudonym, "Standing Beside You", Journal of Emergency Nursing, April 1998

Research is needed to establish a basis for practice. However, unless professionals are well educated on the subject, have supportive policies in place, have an ongoing evaluation of their program and have leadership support, assessment and intervention will be ineffective at best and potentially dangerous at worst.

<u>We believe what we are doing can save lives</u>

Survivor story – no one asked

> A survivor of domestic abuse shared her health care experience with me. She had sustained a serious head injury when her husband repeatedly smashed her head into the cement of their driveway. In desperate fear for her life, she went to a local Emergency Department to have her injuries evaluated. She disclosed her feelings about what she wanted from the health care professionals in that hospital. "I thought I was dying. I felt as though I was floating above my body. If someone had asked me if I was being hurt by someone in my life, *I would have spilled my guts. But no one asked me.* And I went back home with my abuser."