

# Emergency Department Screening for Domestic Violence

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NEWS & OBSERVER / MEL NATHANSON

**T**o develop policies and programs to combat domestic violence, policy makers first must know who is affected and to what degree.<sup>1</sup> This article addresses one way to obtain more information on domestic violence—through health care screening, primarily in emergency departments. The article reports how emergency department screening was conducted in two programs and what steps can be taken to overcome some of the barriers to screening in the health care setting.

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## Current Data Collection Systems

Although there has been an increased effort recently to collect data about domestic violence, there is little consistency in the data being collected. One problem is that there is not an agreed-on definition of domestic violence. Studies have focused primarily on opposite-sex marital partners, but domestic violence also occurs in same-sex partnerships and between nonmarital partners (boyfriends, girlfriends, and ex-partners).

Another problem lies in the sources of data about domestic violence. Data are

ordinarily limited to information obtained from the criminal justice system.<sup>2</sup> Criminal justice sources include the National Incident Based Reporting System and the National Crime Victimization Survey, among others.<sup>3</sup> Although these sources provide excellent data, many experts question whether they accurately reflect the prevalence of domestic violence. In 1980 the U.S. Department of Justice estimated that 43 percent of domestic violence incidents are never reported to the police and so never make it into the data systems.<sup>4</sup> More recent studies estimate that only 20 percent of incidents *are* reported to the police.<sup>5</sup> Therefore, considering sources of data outside the criminal justice system is important.

Data from health care sources may give policy makers a clearer picture of the impact of domestic violence because such data focus on the victim and his or her experiences.<sup>6</sup> Emergency departments may be the most promising source of data because, of the various health

care services provided to victims of domestic violence, treatment in emergency departments appears to be particularly prevalent.<sup>7</sup>

## Screening in Health Care Settings

In an effort to find innovative ways to obtain domestic violence data from the health care community, in the mid-1990s the Centers for Disease Control and Prevention funded pilot projects in several states. The Massachusetts pilot program—Women Abuse Tracking in Clinics and Hospitals, better known as WATCH—focuses on data collection in emergency departments.<sup>8</sup> The largest program of its kind in the country, it also is one of the first to use “universal surveillance”—that is, screening for domestic violence of all females age twelve and older who come into a hospital emergency room.

Programs to screen for domestic violence in emergency departments (and public health prenatal care clinics) also have operated in North Carolina, including at the University of North Carolina (UNC) Hospitals. In the early 1990s, UNC Hospitals developed a program to screen all people age sixteen or older seeking care at the emergency room. The program, which had no internal or external funding, is no longer in place because key staff left UNC Hospitals and no other staff had the time or the mandate to take it on.<sup>9</sup> Nevertheless, the work done at UNC Hospitals as well as at WATCH is instructive about what is needed to make a program successful.

Screening of domestic violence victims in emergency departments has two distinct but closely related goals. The first, which is the focus of this article, is to document the occurrence of partner abuse and thus to create a more accurate picture of the phenomenon. The second is to offer referrals and resources to victims. Although these are different goals, one research oriented and the other care oriented, it is hard to separate them entirely. A better understanding of the incidence of domestic violence will ensure that public and private agencies dedicate sufficient resources to helping victims. But a program that only identifies victims and offers no referrals or resources misses the opportunity to help victims

break the cycle of violence. Worse, the absence of help may reinforce victims’ feelings of helplessness.

## Barriers to Screening

On the basis of available literature and interviews with program personnel at both WATCH and UNC Hospitals, emergency department screening has the potential to provide excellent data on domestic violence. The experiences of both programs, however, reveal several barriers to complete and accurate screening.

Interviews with WATCH staff indicated that, of the 23 hospitals participating in the program, only 10 regularly provided reliable, usable data.<sup>10</sup> UNC Hospitals had a similar problem. During a two-week assessment of the program, 595 women came to the emergency department, but only 119 were screened.<sup>11</sup> Barriers included lack of time, insufficient administrative support, and inadequate community resources, as well as staff feelings of powerlessness and fears of offending.<sup>12</sup>

Another problem is that emergency department screening is relatively new, and there are few measurements of success. Any screening program must include, at a minimum, simple measures of success, such as increased victim identification. Once a program is operating and has met its initial measures of success, more extensive measures, such as the number of identified victims who are actually referred to resources, or the number of identified victims who make use of suggested resources, can be put in place.<sup>13</sup>

The literature on domestic violence screening by medical personnel has identified several factors depressing screening rates. In one study 71 percent of those interviewed cited lack of time, 55 percent a fear of offending, and 50 percent a feeling of powerlessness—that is, an inability to fix the problem, a lack of proper training, or a feeling that identification and intervention made no real difference. Further, 42 percent felt that they would lose control of the situation, and 39 percent felt that the situation was “too close for comfort”—that is, they were reluctant to ask about abuse inflicted on patients who were “similar to [them]” or had “similar characteristics.” One health care provider in this study

said, “I think that some physicians, and I do the same thing, if you are very busy and have lots of patients waiting, you just don’t ask a question that you know will open a Pandora’s Box. Even if the thought crosses your mind, you don’t ask.”<sup>14</sup>

The barriers identified in the literature were echoed in conversations with staff of WATCH and UNC Hospitals. Some emergency department staff did not screen for domestic violence because they did not know what to do if they identified it. Others questioned the utility of screening because they saw no “cure”: despite their intervention the victim did not leave the abusive partner and, indeed, returned to the emergency department with additional injuries.<sup>15</sup>

Another barrier to an effective screening program is incomplete record keeping. In one study, 109 patients were interviewed, but the cause of injury was identified in only 50 cases. Failure to take a complete history from the patient, and failure to note the findings in the medical chart when a complete history was taken, were the major reasons for this loss of information.<sup>16</sup>

## Possible Solutions

### Structure of the Protocol

Since the barrier to domestic violence screening most often cited by health care providers is lack of time, it is imperative to make the process as “painless” as possible by keeping the screen short and concise. Early questionnaires that were developed consisted of 19 to 30+ questions. Most hospitals encourage a short “triage time”—that is, they urge that a medical professional quickly identify a patient’s problem and decide on an appropriate course of action—so it is difficult to add more questions to the existing process.<sup>17</sup> Recognizing this limitation, researchers have developed screening tools that consist of one to four questions only. One such tool is the Personal Violence Screen (PVS), which takes an average of 20 seconds to use. It includes a basic question common in most screening instruments: “Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?” The remaining few questions focus on the victim’s perception of



his or her own safety, such as “Are you currently in a relationship in which you have felt afraid?” and “Is there a partner from a previous relationship who is making you feel unsafe now?”<sup>18</sup> Another study suggests using a question to determine if the cause of the visit to the emergency room is related to partner violence—for example, “Are you here today due to an injury or illness related to partner violence?”<sup>19</sup>

The possibility of violence may be obvious when the patient has a broken jaw or nose. However, many illnesses, including migraines, gastrointestinal disorders, and chronic pain symptoms, may be related to partner violence.<sup>20</sup> Consequently, it is important that screening protocols not rely only on staff observations of the patient. UNC Hospitals implemented a system in which triage nurses attempted to identify victims of abuse on the basis of the apparent presence of several risk factors—for example, injuries consistent with abuse; unusual markings and bruises; fearfulness of caregivers, including health professionals; withdrawn behavior; regular unscheduled emergency department use; and sleep disorders. When these nurses thought that a patient might be a victim of abuse, they questioned him or her directly. This triage screen was not effective. In an evaluation of it, all patients were asked the direct questions, regardless of whether the triage nurses suspected abuse. The evaluation revealed that the triage screen missed more than 80 percent of the cases



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that were identified through direct questions.<sup>21</sup> With a few short and direct questions, such as those on the PVS, medical personnel can begin to identify patients who have been the victims of domestic violence.

#### **Integration of the Program into the Emergency Department's Structure**

In addition to keeping the screen short and simple, it is necessary to integrate the screening program into the structure of the emergency department and to make it adaptable to the department's changing needs and configurations. One study integrated the question “Is the patient a victim of domestic violence?” into the standard medical chart and found that the simple prompt nearly doubled the identification of domestic violence victims.<sup>22</sup> Another group of practitioners, noting that the modification of patient charts increased the identification of abuse in their emergency department, recommended that “chart modification . . . be considered by other [emergency departments] as an inexpensive and time-effi-



cient means of increasing the identification of domestic violence.”<sup>23</sup>

#### **Education**

One way to tackle the feelings of powerlessness described by medical personnel in dealing with domestic violence is increased education. There are three points at which education can occur.

**Pre-implementation education.** The first and most obvious need is for education before implementation of the screening program. Both WATCH and UNC Hospitals held pre-implementation training not only on the screening protocol but also on domestic violence in general.<sup>24</sup> Without training on domestic violence, staff members may not realize its severity and prevalence or recognize the characteristics, the injuries, and the behaviors that indicate abuse. In a questionnaire sent to dental hygienists and dentists (the face being the area most often targeted for abuse), nurses, physicians, psychologists, and social workers, on average, only 40 percent could recall any formal education on partner abuse.<sup>25</sup> To be effective, training must not only address issues that medical personnel have identified as areas of concern but also dispel myths about domestic violence, including that it happens only to certain types of people and that patients will be offended if they are asked about the issue.<sup>26</sup>

Pre-implementation training also should include presentations by representatives of local domestic violence organizations, criminal justice personnel (including hospital police if they exist), and hospital social workers. These will give medical providers a clearer picture

of the steps that may be taken if abuse is identified. Although it is not the role of medical staff to decide for the victim what to do, they can help point out available options and help the victim take the next step.<sup>27</sup> As part of this training, medical providers should be made aware of situations in which state law requires that they report abuse.<sup>28</sup>

In addition to front-line staff, staff who will be responsible for entering the information in the system's databases should participate in early training. Many hospital data systems are not set up to accommodate cause-of-injury data, so modifications to existing systems often must be made before implementation of a screening program.<sup>29</sup> All staff should be fully trained in the new system and in domestic violence.

**Ongoing education.** The experiences of groups implementing screening programs indicate that pre-implementation education is not enough to ensure a continuing high level of staff interest and participation. In a study of screening programs in the southwestern United States, researchers evaluated screening levels three months into a program and then twelve months into the program. They found, after an initial increase, a 9 percent decrease in screening.<sup>30</sup> This indicates that periodic training sessions and reinforcement of the methods and the goals of the screening protocol are necessary. WATCH, having encountered this problem, now is contracting with another agency to provide periodic training for personnel at the twenty-three hospitals participating in the program. This regular training ensures that new staff members are aware of the screening protocol, and it updates all personnel on any protocol changes. Additionally, training sessions provide an opportunity for feedback from front-line staff so that modifications to the protocol can be made as necessary.

**Early professional education.** Education on domestic violence also should be a part of the professional education of medical providers. The boards of medicine and of nursing, among others, can encourage inclusion of domestic violence education in early professional education. Such training would better equip medical personnel to recognize abuse and would provide health care educators

with an opportunity to dispel myths and stereotypes about abuse. Those interviewed for this article felt that providing medical professionals with accurate information early in their professional training would facilitate efforts to implement a screening program.<sup>31</sup>

### Administrator and Community Support

A final barrier to the success of a screening program is insufficient support inside and outside the organization. As with any program, support by the organization's senior personnel is essential to success. To build and sustain support, domestic violence education should be provided to hospital administrators as well as to front-line medical staff. Administrators may have had little training on domestic violence and may not appreciate that domestic violence is not limited by race or socioeconomic level. Consequently they may not recognize the importance of screening in the population served by their hospital.

Adequate support in the community also is essential to a successful screening program.<sup>32</sup> Emergency department staff must have readily available resources for patient referrals. If shelters or other agencies are not able to provide services to those identified as abused, hospital staff may conclude that screening is not worth their time and effort. Before setting up a screening protocol, an emergency department should identify and contact local community groups to act as partners in the program.

### Conclusion

Protocols for addressing domestic violence, including emergency department screening, are endorsed by most major medical associations<sup>33</sup> and are mandated by the Joint Commission on Accreditation of Healthcare Organizations.<sup>34</sup> In assessing the importance of domestic violence protocols in the health care system, public health experts have noted that "early education, supportive education, effective referral, and ongoing support and follow-up for abused women . . . could eventually reduce the prevalence of abusive injury by up to 75%."<sup>35</sup> A simple screening process in the emergency department would create an important new source of data on domestic violence,

which in combination with data from the criminal justice system and other sources would provide a clearer picture of the prevalence and the impact of domestic violence. Armed with this knowledge, policy makers would be in a better position to target programs and funding to combat the problem.

### Notes

1. "A prerequisite for the scientific study . . . of injury is acquisition of data on which to base priorities and research." Fredrick P. Rivara et al., *Cost Estimates for Statewide Reporting of Injuries by E Coding Hospital Discharge Abstract Data Base Systems*, 105 PUBLIC HEALTH REPORTS 635, 635 (1990); see also GOVERNOR'S TASK FORCE ON DOMESTIC VIOLENCE, GOVERNOR'S CRIME COMM'N, FINAL REPORT (Raleigh, N.C.: the Commission, Jan. 1999) (recommending increased collection of data on domestic violence).

2. JAMES ZEPP, JUSTICE RESEARCH AND STATISTICS ASS'N, DOMESTIC AND SEXUAL VIOLENCE DATA COLLECTION: A REPORT TO CONGRESS UNDER THE VIOLENCE AGAINST WOMEN ACT, NCJ-161405 (Washington, D.C.: JRSA, July 1996).

3. Anna E. Waller et al., *Health Related Surveillance Data on Violence against Women: State and Local Sources*, 6 VIOLENCE AGAINST WOMEN 868 (Aug. 2000).

4. Judith McFarlane et al., *Assessing for Abuse: Self-Report vs. Nurse Interview*, 8 PUBLIC HEALTH NURSING 245 (1991).

5. JEFFREY FAGAN, CRIMINALIZATION OF DOMESTIC VIOLENCE: PROMISES AND LIMITS 29 (NIJ-157641, Washington, D.C.: Nat'l Inst. of Justice, Jan. 1996).

6. Waller et al., *Health Related Surveillance Data*.

7. Estimates of the prevalence of domestic violence in emergency department populations range from 17 percent to 37 percent. MICHAEL R. RAND, BUREAU OF JUSTICE STATISTICS, VIOLENCE-RELATED INJURIES TREATED IN HOSPITAL EMERGENCY DEPARTMENTS, NCH-156921, at 2 (Washington, D.C.: BJS, Aug. 1997); Geraldine D. Greany, *Is She a Battered Woman? A Guide for Emergency Response*, 84 AMERICAN JOURNAL OF NURSING 724 (1984).

8. WATCH has three goals: (1) to create a statewide data-collection system on domestic violence that uses both new data sources and existing data sources that have been modified to obtain additional information; (2) to create an emergency department data-collection system on domestic violence; and (3) to create a blueprint of the program that can be used elsewhere. The program works with 23 randomly selected hospitals. It provides the emergency department staff with training in identification and treatment of victims of domestic violence,

as well as in documentation of the cases. At the outset of the project, personnel worked with the hospitals to change or modify their coding systems to account for the variables that needed to be reported, and staff were trained in use of these modified systems. Data now are collected monthly from the participating hospitals and incorporated into the program database. Telephone Interviews with Rahel Mathews, Data Manager, & Carter Pratt, Director, WATCH (Jan. 7 & Feb. 11, 2000, respectively).

9. The program was a two-tiered system in which the patient was initially identified as a possible domestic violence victim on the basis of evidence of several risk factors; the patient then was asked specific questions by medical personnel to determine if there was a history of abuse. Interview with Anna E. Waller, Research Associate Professor, Department of Emergency Medicine, UNC Hospitals, in Chapel Hill, N.C. (Jan. 1, 2000).

10. Interview with Mathews, WATCH.

11. Despite this low screening rate, four cases of suspected abuse during that two-week period were confirmed. Before the screening protocol was used, an average of only two to three cases per month was documented in the emergency department at UNC Hospitals. Anna E. Waller et al., *Development and Validation of an Emergency Department Screening and Referral Protocol for Victims of Domestic Violence*, 27 ANNALS OF EMERGENCY MEDICINE 754 (1996).

12. Nancy K. Sugg & Thomas Inui, *Primary Care Physicians' Responses to Domestic Violence*, 267 JAMA 3157 (1992); David H. Gremillion & Elizabeth P. Kanof, *Overcoming Barriers to Physician Involvement in Identifying and Referring Victims of Domestic Violence*, 27 ANNALS OF EMERGENCY MEDICINE 769 (1996); Elizabeth A. Delahunta, *Hidden Trauma: The Mostly Missed Diagnosis of Domestic Violence*, 13 AMERICAN JOURNAL OF EMERGENCY MEDICINE 74 (1995).

13. Interviews with Waller, UNC Hospitals; Pratt, WATCH. Jacquelyn C. Campbell & Nancy Chescheir, *What Works in Domestic Violence Health Interventions?* Seminar Presentation at School of Public Health, The Univ. of N.C. at Chapel Hill (Feb. 21, 2000).

14. Sugg & Inui, *Primary Care Physicians' Responses*, at 3158.

15. Interview with Waller, UNC Hospitals.

16. Robert J. Schwartz et al., *The Quantity of Cause-of-Injury Information Documented on the Medical Record: An Appeal for Injury Prevention*, 2 ACADEMIC EMERGENCY MEDICINE 98 (1995).

17. Interview with Waller, UNC Hospitals; Waller et al., *Health Related Surveillance Data*.

18. Kim M. Feldhaus et al., *Accuracy of 3 Brief Screening Questions for Detecting Partner Violence in the Emergency Department*, 227 JAMA 1357, 1358 (1997).

19. As cited in *id.* at 1358.

20. Peggy E. Goodman & Jan Capps, *Not in My Practice: A Look at Pervasive Consequences of Domestic Violence*, 58 NORTH CAROLINA MEDICAL JOURNAL 310 (1997); Mary P. Koss & Lynette Heslet, *Somatic Consequences of Violence against Women*, 1 ARCHIVES OF FAMILY MEDICINE 53 (1992); Chris Raymond, *Campaign Alerts Physicians to Identify, Assist Victims of Domestic Violence*, 261 JAMA 963 (1989); Douglas A. Drossman et al., *Sexual and Physical Abuse in Women with Functional or Organic Gastrointestinal Disorders*, 113 ANNALS OF INTERNAL MEDICINE 828 (1990).

21. Interview with Waller, UNC Hospitals. A key factor influencing which patients were screened for abuse was the time available to the medical professionals and a perception that other health issues were of greater importance. According to one study, 71 percent of physicians considered that screening for domestic violence was "not a good investment of time." Gremillion & Kanof, *Overcoming Barriers*, at 771.

22. Lenora Olson et al., *Increasing Emergency Physician Recognition of Domestic Violence*, 27 ANNALS OF EMERGENCY MEDICINE 741, 744 (1996). In a prenatal care clinic, once a formalized system had been incorporated into the clinic's charts, the detection of domestic violence increased from 6.4 percent to 14.1 percent. Deborah K. Covington et al., *Assessing for Violence during Pregnancy Using a Systematic Approach*, 1 MATERNAL AND CHILD HEALTH JOURNAL 129 (1997).

23. Olson et al., *Increasing Emergency Physician Recognition*, at 745.

24. Overview of WATCH [handout, undated]; interview with Waller, UNC Hospitals.

25. Social workers and nurses had the greatest amount of education during professional development—45 percent and 43 percent respectively. Only 24 percent of physicians and 11 percent of dentists had had any training. Virginia P. Tilden et al., *Factors That Influence Clinicians' Assessment and Management of Family Violence*, 84 AMERICAN JOURNAL OF PUBLIC HEALTH 628, 630 (1994).

26. In one survey, of the 164 patients asked, 78 percent indicated that they favored regular screening, but only 7 percent remembered ever being asked. This suggests that although there may be an occasional case in which a patient is offended by the questions, the benefits of the screening outweigh the costs in this respect, and most patients understand that. Lawrence S. Friedman et al., *Inquiry about Victimization Experiences: A Survey of Patient Preferences and Physician Practices*, 152 ARCHIVES OF INTERNAL MEDICINE 1186 (1992).

27. One researcher put it well: "[T]he [physician's] referral should be made to help the victim assess her situation, and eventually make decisions." Diane Brashear, *The Role of the Physician in Identifying and Treating*

*Abused Women*, 83 INDIANA MEDICINE 574, 574 (1990).

28. In North Carolina, medical staff are required to make a report to a county social services department any time they have cause to suspect that a child is abused, neglected, or dependent, or they have reasonable cause to believe that a disabled adult needs protective services. N.C. GEN. STAT. 7B-301; 108A-102. They also are required to report to the proper law enforcement authority incidents in which a patient appears to have been injured by a gun, a knife if they believe the injury involved a criminal act, or poison. In addition, medical personnel are required to report injuries involving grave bodily harm or illness that they believe were caused by a criminal act of violence. N.C. GEN. STAT. 90-21.20. Reporting of a case of domestic violence, in and of itself, is not required. Michael Easley, *Domestic Violence*, 27 ANNALS OF EMERGENCY MEDICINE 764 (1996); Ariella Hyman & Ronald A. Chez, *Mandatory Reporting of Domestic Violence by Health Care Providers: A Misguided Approach*, 5 WOMEN'S HEALTH ISSUES 208 (1995).

29. Interviews with Waller, UNC Hospitals; Pratt, WATCH; & Mathews, WATCH.

30. William H. Wiist & Judith McFarlane, *The Effectiveness of an Abuse Assessment Protocol in Public Health Prenatal Clinics*, 89 AMERICAN JOURNAL OF PUBLIC HEALTH 1217 (1999).

31. Interviews with Waller, UNC Hospitals; Pratt, WATCH; & Sue Hoenhaus, former emergency room nurse, UNC Hospitals, in Raleigh, N.C. (Feb. 7, 2000).

32. Interviews with Waller, UNC Hospitals; Pratt, WATCH; Hoenhaus, UNC Hospitals; & Sandra Martin, Associate Professor, School of Public Health, UNC-CH, in Chapel Hill, N.C. (Jan. 13, 2000).

33. The American Medical Association, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians, among others, endorse screening. Council on Scientific Affairs, American Medical Ass'n, *Violence against Women: Relevance for Medical Practitioners*, 267 JAMA 3184 (1992); American College of Obstetricians and Gynecologists, *ACOG Technical Bulletin No. 209: Domestic Violence*, 51 INTERNATIONAL JOURNAL OF GYNECOLOGY AND OBSTETRICS 161 (1995); American College of Emergency Physicians, *Emergency Medicine and Domestic Violence*, 25 ANNALS OF EMERGENCY MEDICINE 442 (1995).

34. JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., 1996 ACCREDITATION MANUAL FOR HOSPITALS 39-50 (Oakbrooke Terrace, Ill.: JCAHO, 1995).

35. MARK L. ROSENBERG & MARY ANN FENLEY, *Violence in America: A Public Health Approach* 150 (New York: Oxford Univ. Press, 1991).