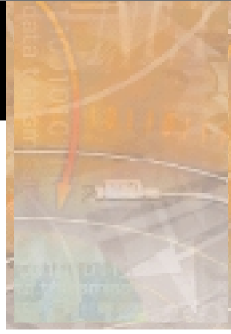

policy points

Curbing Family Violence on a National Scale

The Institute of Medicine has suggested several measures on the part of government and medical organizations to encourage treatment and prevention of family violence.

BY JEFF ATKINSON

Each year, more than 350,000 persons are treated in emergency rooms for injuries resulting from confirmed or suspected family violence. A larger number of victims of family violence are seen in other health-care settings, such as physicians' offices, dentists' offices, or nursing homes. Victims of violence include children, intimate partners, and the elderly. A nationwide study of child abuse in 1996 found that there were more than 3.1 million reports of child abuse and that more than 1 million of those were substantiated. (For more data on family violence, see "Data on Family Violence")

A report issued by the National Academy of Sciences' Institute of Medicine in September 2001 concluded that not enough is being done to educate and train medical professionals regarding family violence. Congress directed preparation of the report as part of the Health Professions Education Partnerships Act of 1998. The 300-page report, entitled, "Confronting Chronic Neglect The Education and Training of Health Professionals on Family Violence" is available on line at *http://www.nap.edu/catalog/10127.html*

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Barriers to education

A number of problems contribute to the lack of education and training about family violence. One is the attitude of physicians who may be frustrated at what they regard as an incurable condition. The report quotes one doctor: "I think we tend to look more on the technical side of medicine, things we can help, like appendicitis. Domestic violence is a big morass which we will never escape. I get a headache thinking about it. And that attitude translates into the type of care we give those patients."

A study of physicians' attitudes toward family violence included the comment that the "medical staff want to help, but feel uncomfortable doing so because they view

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the inquiry and intervention about intimate partner violence as invading their patient's personal affairs." Another physician said, "[I]f you are very busy and have lots of patients waiting, you just don't ask a question that you know is going to open a Pandora's box. Even if it crosses your mind, you don't ask."

One of the messages of the Institute of Medicine report is that family violence is a medical problem to which more resources need to be devoted. The Institute recommends that the U.S. Department of Health and Human Services establish three to five multidisciplinary education and research centers to advance scholarship and practice in family violence. The centers would focus—more than has been done in the past—on the impact of family violence and the types of training programs and curricula that would be most effective in treating family violence.

The report cites the Alzheimer's Disease Centers Program established by the National Institute on Aging as an example of how centers can be used to provide infrastructure for the development of advanced treatment and education in a specific area.

Core competencies

The Institute of Medicine identified five core competencies for health professionals related to family violence:

(1) identification, assessment, and documentation of abuse and neglect

(2) interventions to assure victim safety

(3) recognition of culture and values as factors affecting family violence

(4) understanding legal and forensics responsibilities, and

(5) prevention

The level of competency needed in each area will vary with the health professional's role.

Some specialty organizations already have taken a lead in encouraging training in issues of family violence. The American Board of Pediatrics, the American College of Obstetrics and Gynecology, and the American College of Emergency Physicians, for example, have helped develop training programs in family violence. To the extent that board certification exams include questions regarding family violence, that serves as an important incentive to provide training in the area.

Effective training techniques

The Institute of Medicine surveyed training techniques regarding family violence as well as the general field of continuing medical education and concluded that one-shot, abstract lectures are not very effective. Drawing on adult learning theory, the institute noted that physicians are most likely to learn when they perceive a significant reason to learn something and when the information presented applies to real-life situations the adults will face. Techniques that are regarded as effective include:

— *Role modeling by presenters and role playing by participants*

— *Discussion of scenes from stop-action videos*

— *Written materials to reinforce oral presentations*

— *Use of specific screening and referral protocols, some of which could be placed on pocket-size cue cards or checklists*

— *Using statistics to rebut biases that may interfere with the clinicians' judgment, and*

— *Clinical rotations with a focus on cases of abuse*

Data on Family Violence

• Each year, approximately 1.5 million women and 835,000 men are physically assaulted by an intimate partner. (1996 data)

• About 25 percent of women and 8 percent of men report having been physically assaulted at some time in their lives by a current or former spouse, cohabiting partner, or person with whom they had a dating relationship. (1996 data)

• The percentage of pregnant women experiencing intimate partner violence is between 0.9 percent and 20.1. (Review of literature)

• Women who are victims of intimate partner violence have annual health-care costs that are $1,775 more than women who are not victims of intimate partner violence. (1999 Minnesota study).

• Women in families with an annual income below $10,000 are more likely than other women to be victims of intimate violence.

• When a mother experiences intimate partner violence, the likelihood that her child will experience abuse is approximately 50 percent. (The child abuse may be from the mother's intimate partner or from the battered mother.)

• Witnessing violence is stressful and is a risk factor for long-term physical and mental problems, such as substance abuse, alcohol abuse, and intimate partner violence. ■

Source: Center for Disease Control (multiple reports).

Institutionalizing reform

To initiate or reform a program, it is important to gain the support of opinion leaders in the group, whether the leaders hold formal titles or not. At the same time, a few individuals cannot carry out the program alone. If a program to improve handling of cases of family violence is to continue in an effective way, aspects of the program

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need to be institutionalized. For example, intake forms could have specific questions about family violence and reviewers within the organization could periodically check charts to determine if the questions were being asked and if appropriate referrals were being made.

If using protocols to deal with family violence becomes one of the criteria for evaluating health-care providers, the pace of reform would increase. One basis for evaluating health-care plans is the Healthplan Employer Data and Information Set (HEDIS), which is a set of performance measures used by employers and consumers to determine the quality of health care. The National Committee for Quality Assurance (NCQA) uses HEDIS to compare managed-care plans.

Health-care researcher David Eddy said, "When NCQA published a HEDIS measure, the effect was as if every health plan in the country went on a retreat to set their clinical goals for the coming year, and all came back with the same answer." (*Health Affairs*, 17(4), 7-25 (1998)). For example, when HEDIS added a measure regarding the immunization of children, the rate of complete immunization of two-year-olds at the Group Health Cooperative increased from 63 percent to 91 percent in two years.

HEDIS does not currently measure a health plan's response to family violence, but if it did, the Institute of Medicine report said that measure "would provide a major stimulus for training efforts."

Reporting requirements

State reporting requirements also influence the level of training of health-care providers. All 50 states require that physicians and many other health-care providers report instances of child abuse or neglect. The typical state standard is that reports must be made when the health-care professional "knows" or has "reasonable grounds to suspect" abuse has occurred.

Three states (California, Colorado, and Rhode Island) require that health professionals report cases of intimate partner violence. Intimate partners include spouses, persons in dating relationships, and, by some definitions, acquaintances. Many advocates for victims of intimate violence oppose requirements that health-care providers report such violence out of concern that such mandatory reporting would interfere with the victim's autonomy and could place the victim at greater risk.

Mistreatment of elders must be reported in 43 states. (The states without reporting requirements are: Colorado, New Jersey, New York, North Dakota, Pennsylvania, South Dakota, and Wisconsin.) The events that must be reported vary from state to state, but generally include "abuse, neglect, or exploitation."

When reporting is required by the state, health-care providers usually receive training on the reporting requirements, but they might not receive training on other aspects of family violence such as assessment, intervention, and prevention.

The Institute of Medicine's goal is to promote evidence-based standards for dealing with family violence. The institute wants to establish training programs with a long "half-life"—in other words, training that the participants will remember and apply years after the initial training. ■

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