Health Care System Responses to Children Exposed to Domestic Violence

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Abstract

The health care system has only recently adopted protocols and training to enable practitioners to identify and respond to victims of domestic violence. Currently, most hospitals have domestic violence protocols in place, although training in the use of protocols is less routine. However, because the provision of health care focuses on the treatment of the individual, the well-being of the children of adult domestic violence victims has received little attention in adult health care settings. Pediatricians do not routinely receive training in domestic violence identification and do not see responding to battered mothers as within the purview of their practice. Innovative programs in children’s hospitals in Boston, Massachusetts, and San Diego, California, recognize that the safety of children is integrally tied to the safety of their mothers. These programs identify abused children whose mothers are the victims of domestic violence and provide advocacy and support that allow mothers and children to remain together in most instances. Little is known about the health impacts of teen dating violence, and opportunities for screening exist in the settings where teens receive health care. Likewise, prenatal visits provide regularized opportunities for domestic violence screening. Integrating the health care needs of mothers and children from violent households will require continued and expanded training, collaboration with community institutions, and improvements in insurance reimbursements to cover the costs of needed services.

Historically, the medical responses to child abuse and neglect and to domestic violence have been separate because different health care practitioners routinely treat adults and children. In 1962, when the medical profession first recognized child abuse as a medical problem with social welfare concerns for children, the safety of adult victims of domestic violence within the same family was not taken into account. Consequently, the management of children’s health and child abuse largely occurs without regard to the potential for domestic violence in the same family. This situation persists despite (1) research over 20 years reporting overlaps between...
child maltreatment and adult domestic violence,\(^1\) (2) reports that many children who are not abused are nevertheless adversely affected by witnessing parental domestic violence,\(^2\) and (3) recognition that adults involved in domestic violence often parent poorly.\(^3\)

This article discusses the response of the health care system (excluding the mental health system) to domestic violence, to the co-occurrence of domestic violence and child abuse, and to the effects of child witnessing of domestic violence.\(^4\) (See the article by Groves in this journal issue on mental health system response.)

**Domestic Violence Identification in Adult and Child Health Care Settings**

Both the adult and child health care systems can serve as gateways for the identification of domestic violence. Health care providers are in unique positions to screen for and identify victims, provide access to treatment and support services, document abuse, report abuse and assaults as mandated by law, and advocate for victims.

Abused women of all backgrounds are recurrent users of medical services for treatment of injuries and chronic conditions resulting from their violent relationships.\(^5\) Studies of women visiting emergency departments have found that 4% to 30% suffer from an injury inflicted by an abusive partner.\(^6\) Because abusive behavior is frequently ongoing and can vary in expression, women in violent relationships often have long medical histories with multiple visits for problems ranging from trauma to depression. They see many different care providers, routinely in primary care and mental health clinics, emergency departments, and prenatal clinics.\(^6,7\)

Health care providers attending to the needs of battered women rarely inquire about, or address the health care needs of, dependent children living in the same household despite the fact that research has found overlaps between domestic violence and child maltreatment in 30% to 60% of the families studied.\(^1,7,8\)

Pediatricians are also in positions to detect domestic violence through the identification of child abuse, as well as through routine child health examinations. Children who witness domestic violence but who are not physically abused themselves often suffer from living in a stressful, hostile environment. Routine health care visits may uncover behaviors seen in children who witness parental violence, such as running away, delinquent activities, or teen dating violence.\(^2,3\) Additionally, parents may seek help from pediatric care providers for behavior problems that can be signs of family distress.\(^3\)

Despite the opportunities for intervention provided by health care settings, most visits to health care providers end without intervention on behalf of either adult victims of domestic violence or the children who witness it. This is because women often are reluctant to reveal, and providers to ask about, the underlying abuse-related cause of the injury or illness.\(^9\) In recent years, however, and with the help of advocates, providers and institutions have undertaken more systematic efforts to identify and intervene in family violence. Through practice guidelines, education, and training, awareness of domestic violence among clinicians is increasing.

**Domestic Violence Identification and Response Protocols**

In 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), an independent, nonprofit agency responsible for accreditation and performance evaluations of health care organizations and managed care in the United States, added guidelines for domestic abuse victim identification and response to existing care standards for victims of physical and sexual assault, child abuse, and rape.\(^10\) At the same time, professional medical organizations, such as the American Medical Association, developed and distributed guidelines for use by their members on the screening and identification of domestic violence victims.\(^4\) In addition, at least five
states have enacted laws that mandate health care institutions to develop written policies and procedures, or protocols, for domestic violence identification or that require domestic violence training for health care practitioners.\textsuperscript{11}

To conform with these mandates, many health care institutions have adopted domestic violence protocols. These protocols, at minimum, include procedures for abuse assessment, screening, identification, and victim safety planning; referrals to institutional, legal, and community resources; and requirements for evidence collection, medical record documentation, and any mandated abuse reporting. Initial implementation efforts focused on hospital emergency departments, but soon expanded to include all areas of operation within a health care organization.\textsuperscript{12}

Four model domestic violence protocols, widely distributed by the nonprofit agency the Family Violence Prevention Fund, all address children’s needs in the domestic violence assessments.\textsuperscript{13} Children in households with domestic violence are included during safety planning, and providers are instructed to ask about any possible child abuse, to follow separate child abuse identification and response protocols, and to report when required. Not all protocols are as complete as these models, however. A recent survey of a sample of emergency departments nationwide found that although nearly two-thirds (64\%) had domestic violence protocols, fewer than half (48\%) of those with protocols mentioned the possibility of associated child abuse.\textsuperscript{14}

**Protocol Training and Implementation**

Simply adopting a protocol does not mean that it will be routinely used. Training on domestic violence and in protocol use can enhance the effectiveness of protocols.\textsuperscript{15,16} Some health care institutions provide training sessions, manuals, and resource materials to physicians, nurses, medical students, and, occasionally, to all other institutional personnel. Although the training content varies, it commonly addresses the dynamics of adult domestic violence, and reviews protocol use and the role of each trainee in carrying out the protocol.

Training materials often mention the need to inquire about the safety of children during domestic violence screening—for example, by asking if children live in the household and, if so, whether they are exposed to abuse or are abused themselves. Training materials also specify the need to report any child abuse.\textsuperscript{17,18}

Despite these examples, surveys, typically of emergency department staff, suggest that such training programs are not common in health care institutions. For example, a 1993
survey of California emergency departments found that only one quarter provided training on domestic violence or protocol use. More recent data suggest that this has not changed much, with 30% of California emergency departments providing training in 1997, although 79% of California emergency departments have protocols. In the rest of the nation, 26% of emergency departments provide training, although 64% have protocols. As a result, many practitioners are inadequately prepared to use the guidance protocols provided.

Protocols and training can result in increased rates of identification of abused women. However, domestic violence training must be repeated periodically to sustain provider identification rates. Because health care providers often focus on physical symptoms and do not automatically think of domestic violence as a cause of injury and illness, the need to screen must be reinforced. Providers may also benefit from support sessions that offer an opportunity to share common experiences and barriers to identification.

A critical limitation to current domestic violence training practice is that, for the most part, it targets only health care providers who treat adults. Pediatricians receive very little training as residents, or in practice, in adult domestic violence screening and response. If health care responses to parents and children in violent households are to be integrated, future training efforts must include pediatricians and other pediatric care providers.

Addressing the Co-occurrence of Domestic Violence and Child Abuse

While it is important to assure an adult victim of domestic violence that any information revealed in the health care setting will be confidential, it is also necessary to inform her of the health care provider's legal obligation to report child abuse. As mandated reporters of suspected child abuse in every state, medical professionals reported 11% of all child abuse cases in 1996. The majority (56%) of these cases were substantiated by child protection agencies. Child abuse reporting can bring the immediate involvement of social services and/or law enforcement, result in the removal of a child from his or her parents, and put battered women at risk for further injury and/or death due to retaliation from their abusers. Therefore, it is imperative to assure a woman that her safety and the safety of her children are the priority. (See the article by Findlater and Kelly in this journal issue for further information about the child protective services system and domestic violence.)

Once child abuse is reported, individual health care providers often have very little control over events. The consequences of a report depend on the interaction among a health care institution, child protection agencies, law enforcement and the legal system, and community services for abused women and children. Health care providers can and do work to develop and foster these collaborations.

A few hospital-based family violence programs across the country use a team approach to assist both child and mother at the point of first identification of child abuse in a pediatric setting. For example, AWAKE (Advocacy for Women and Kids in Emergencies), a program based at Children's Hospital in Boston, has as its premise the belief that protecting battered mothers is important to the hospital's mission of protecting abused children. AWAKE seeks to provide comprehensive services to abused children and mothers. Abused women who accept AWAKE's services are paired with an advocate who collaborates with hospital staff and outside agencies to devise a safety plan and, whenever possible, to keep mothers and children together. Services provided include housing guidance, such as shelter referrals, court advocacy, referrals for medical and legal care, and individual counseling and support groups for women. AWAKE also provides consultation and education.
to hospital staff and the community. AWAKE provides opportunities for abused women, in seeking medical attention for their children, to access services for themselves that they might not have sought otherwise.23,24

Another innovative hospital-based program serving both battered mothers and abused children is the Family Violence Program at San Diego Children's Hospital. Initiated by the hospital’s Center for Child Protection in 1991, the program provides advocacy support for mothers and mental health services for both mothers and children. A 1995 study of the program found that the percentage of women participants reporting physical assault decreased from 88% at intake to 10% at six-month follow-up, and that 85% of the participating mothers were living with their children.25

**Domestic Violence Without Associated Child Abuse**

Even when children are not the direct victims of violence within the family, they are affected by violence against their mothers. It is therefore important that health care providers treating battered women are cognizant of the needs of children living in the same household.

**Mandatory Reporting of Domestic Violence**

In five states (California, Kentucky, New Hampshire, New Mexico, and Rhode Island), health care providers are mandated reporters of adult domestic violence.11 The laws vary by state, but the mandates generally require that any person “having reasonable cause to suspect” an adult has been abused must report the abuse to the designated authorities. In California, only health care practitioners who treat injuries resulting from domestic violence are mandated reporters.

These reporting laws are controversial in the health care community. Whereas child abuse reporting laws were enacted to protect dependent and vulnerable children from adult abusers, domestic violence reporting laws deal with adults who have a right to control their own lives and situations. Supporters of domestic violence reporting laws believe that reporting will enhance patient safety, improve the health care system response, and improve data collection.26 Opponents fear that reporting will deter battered women from getting care and put women at risk of retaliation from abusers.26 Some care providers are concerned that the breach in patient confidentiality will weaken the provider-patient relationship.27 In addition, if child witnesses are involved, domestic violence reporting could potentially lead to the involvement of child protective services with the family.

Little research exists on the effects of mandatory domestic violence reporting laws. One California study surveyed physicians about their likelihood of complying with the law and queried abused women about their perspective on the law.27 Sixty-eight percent of physicians said that if the patient had no objection, they would report domestic violence all of the time. However, if
the patient objected, only 44% of physicians would report all of the time. Most of the physicians surveyed believed that the law violates patient confidentiality (74%) and authority (67%), and discourages abused women from seeking medical care (71%). However, most physicians also thought that the law would provide useful statistics about domestic violence (80%) and would improve physician responsiveness to domestic violence (60%).

Abused women in focus groups expressed overall opposition to mandatory reporting, citing reasons such as fear of retaliation by the abuser, mistrust of the legal system, fear of family separation, and preference for confidentiality and autonomy.27 At the same time, they believed mandatory reporting could make needed police protection more easily available.

Ongoing research on the effects of these laws will answer questions about their impact on women and their children. In the interim, the National Research Council, in a recent report on family violence, recommends that states “. . . delay adopting a mandatory reporting system in the area of domestic violence until the positive and negative impacts of such a system have been rigorously examined in states in which domestic violence reports are now required by law.”28

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Pediatric Settings
When the child is the patient, but not the direct victim of abuse, recognition of family violence by child health care providers is the first step to intervention. Routine questions at well-child visits can reveal information about a mother’s relationship with her child and her partner, family conflict-resolution practices, coping strategies, and support resources.3 Specific questions about domestic violence asked routinely to all mothers in pediatric settings can give abused women additional opportunities to seek help for themselves. After identifying family violence, practitioners can work with mothers to help their children and themselves by offering concern, support, and access to protection and institutional and community services. However, inquiries about domestic violence are not routine practice in most pediatric settings.

Very little identification of adult domestic violence occurs in pediatric settings because pediatric care providers have little training and experience in identifying domestic violence.21,29–31 Most pediatric fellows in a 1997 survey believed that responding to battered mothers was not within the purview of pediatrics.18 While 98% of respondents had received training in identification of child abuse and neglect, only 30% had received training in identification of domestic violence. Furthermore, those providers in pediatric facilities who want to respond to domestic violence frequently find protocols absent, knowledgeable social workers unavailable, and community collaborations few.21

Institutional Resources
Overall, institutional resources for domestic violence response are more abundant in hospitals and emergency departments than in clinics because of large institutions’ easier access to diagnostic tools and social service support. Smaller clinics cannot often afford to do more than close follow-up and are dependent on patients returning for continuing evaluation and care. This situation speaks to the necessity of institutional and organizational collaboration in domestic violence service provision and 24-hour service availability in any geographic area.

Provider Attitudes
Education, training, and facility deficits create provider-related barriers to an adequate medical response to domestic violence. Both pediatric and adult care providers believe that domestic violence counseling takes too much time.21 This attitude is reinforced by inadequate institutional domestic violence services, and by public and private insurance reimbursement systems that undervalue or even refuse payment for the counseling services needed for domestic violence victims.
Moreover, traditional medical training encourages doctors, in particular, to believe that they can “fix” any situation. Consequently, the inability of providers routinely to resolve domestic violence situations in a way that protects their patients from harm can bring on feelings of powerlessness and helplessness, making them reluctant to approach such an emotion-filled topic with patients.32

Other Child-Centered Opportunities for Domestic Violence Identification

Adolescent Health Care Settings
Since the early 1980s, research has documented that relationship violence of a type similar to adult domestic violence is present among high-school-age teenagers.33 In these studies, the lifetime prevalence rate of physical violence in teen relationships is 20%,26 similar to the rates among adult women.6 A survey of eighth-graders found that 9% of female and male victims of relationship violence had received emergency department treatment for injuries resulting from the violence.34

Many adults mark adolescence as the start of their own experiences with partner violence.35,36 Yet, no systematic dating violence screening exists for adolescents in the settings in which they receive health care, such as pediatric, school-based, teen, and family-planning clinics. Little is known about the types of services adolescents in violent relationships require, the extent of nonfatal injuries they suffer because of abuse, and the extent to which they interact with health care professionals due to these injuries. Many adolescents accept aggression and violence in relationships as normal.37 Research is needed to determine if intervention at this age can work to prevent violence continuing in adulthood. (For information on domestic violence prevention programs for adolescents, see the article by Wolfe and Jaffe in this journal issue.)

Prenatal Care
Prevalence estimates of domestic violence during pregnancy range from 0.9% to 20.1% depending on study methodology, with most studies reporting a prevalence between 3.9% and 8.3%.36 Although the rates of violence to pregnant women are no higher than among women generally, neither does pregnancy seem to afford any special protection from violence. A recent literature review of domestic violence and adverse pregnancy outcomes found no outcome consistently associated with violence during pregnancy.39

Because prenatal care requires an ongoing relationship with the health care system, pregnancy presents regular opportunities for screening and identification of domestic violence. Additionally, women younger than 30 years old are both at greater risk for abuse than older women,40 and also are more likely to be pregnant.

Screening targeted to pregnant adolescents presents an important opportunity for domestic violence intervention. Most adolescent pregnancies are unwanted or mistimed.42 Women with unwanted pregnancies are at greater risk for experiencing physical
violence in relationships than women with intended pregnancies.42

**Conclusion**
The medical care system has become more responsive to family violence in recent years. However, maintaining this progress will require constant effort through continued care provider education and training with institution and community collaborations, the integration of pediatric health services provision, review of mandatory domestic violence reporting laws, improvements in insurance reimbursement policies to cover adequate domestic violence intervention on behalf of both mothers and children, and recognition of adolescent dating violence intervention as a possible means of reducing future adult domestic violence.

Work on this paper was supported by The California Wellness Foundation, and the University of California, San Francisco, Department of Surgery at San Francisco General Hospital. The author thanks Avis Logan, Robert Mackersie, Elizabeth McLoughlin, and Pamela Pham for their support and assistance.


13. Family Violence Prevention Fund. Domestic violence protocols: An information packet for health care providers. San Francisco: FVPF, 1997. Founded in 1980, the Family Violence Prevention Fund (FVPF) is a national nonprofit organization that focuses on domestic violence prevention, education, and public policy reform. The FVPF's Health Resource Center on Domestic Violence provides support to those interested in developing a comprehensive health care response to domestic violence in all health care settings. The protocols in the FVPF materials, developed in response to JCAHO standards, include the Carondelet Health Network protocol from St. Mary's Hospital in Tucson, AZ; the Greater Cincinnati Domestic Violence Initiative Protocol from University Hospital, Cincinnati, OH; the San Francisco Domestic Violence Health Care Protocol developed by the FVPF for use in the greater San Francisco, CA, area; and the protocol from WomanKind at Fairview Health Services in Minneapolis, MN. Each of these domestic violence protocols utilizes unique community resources, but nevertheless can serve as models for other communities.


39. Petersen, R., Gazmararian, J.A., Spitz, A.M., et al. Violence and adverse pregnancy outcomes: A review of the literature and directions for future research. American Journal of Preventive Medicine (1997) 13:366–72. However, this was attributed to the methodologic limitations of the extant literature and a resulting incomparability of findings. For example, some studies reviewed did not control for other factors, like smoking, that can result in adverse pregnancy outcomes. The authors of the review recommended continued research in the area.
