Towards good practices and evaluation addressing domestic violence in the health system

CAHRV Conference, 24th of september 2004
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Dear Colleagues,

1 Introduction

The input on our subject, "Towards good practices and evaluation addressing domestic violence in the health system", is based on our sociological research and experience in Switzerland. Switzerland is not one of the early innovators. Being a small country, it belongs more to those who study and adapt developments from other countries. In this respect, the findings tie in with initial common sense reactions to good practices in the health system. Our situation is probably similar in many other European countries.

• I will explore first where we stand regarding “dv and the health system“. It is our thesis that the health system has not yet become very involved in that issue and I wish to contribute some insight into possible reasons and causes for this detached position.
• My colleague will – then – focuse on processes necessary in the future to support a fruitful relationship between "dv and the health system".

2 Where do we stand with respect to dv and the health system?

2.1 Looking back 1970/80–2000 or: belated advertising for a main protagonist

I start with my first point: where do we stand with respect to dv and the health system? "Domestic violence", specifically "violence against women", has only recently become an issue that has been drawn to the attention of the health system.

[OVERHEAD 1] Regarding Switzerland, the following may be said (3 phases):
– Since the 1970s and early 1980s, the feminist movement has campaigned to break the taboo of violence against women and to establish support. Women from a wide range of professions, especially social worker, psychologists and lawyers participated in the process, but there was virtually no involvement of women doctors.
– As of the mid-1990s, a phase of co-operation emerged. Services involved with victims took the initiative to introduce intervention projects. These still have the goal of rising public awareness and of improving the institutional response to dv. The issue above all was drawn to the attention of the police and the legal system.
– Only since recently (the year 2000), also the health system has become an important actor within these intervention projects. So for example in Basle the health system is now given a special focus. This only eight years after the police.

The initiative and the resourses for the hospital study come from the outside, from the intervention project. Same with the Maternité project in Zurich – the initiative did come from the office of equal rights, not from the hospital itself.

One could say, that we are courting in a rather late moment a rather central protagonist. – There are real good reasons to comprehend the health professionals and the health system as important agents in the field of dv. The following points support this view. **[OVERHEAD 2]**

1. Health institutions are easily accessible. Woman mostly have regular contact with the health system – where as police and the legal system rather function as a last resort. Early diagnosis and preventive actions are possible.
2. Professionals respect the rule of confidentiality. This fosters confidence of the clientele and provides a favourable setting for addressing dv.
3. Health professionals are broadly acknowledged. It is standard practice to enlist help, support, and advice in health matters – this can be transferred to the field of dv.
4. If it comes to economic terms, the health system is crucial. Dv causes expenses – they are of consequence to the federal as well as to the private business budget. Health prevention and intervention reduces such expenses.

Despite the conclusion that the health system is very closely related to the problem of dv: today, the issue is clearly neglected by the health professionals.

2.2 "DV and the Health System" – Deficits and Difficulties

a) Uncertainties: jurisdiction and relevance

I give you a closer look now at some reasons for this deficit. In our studies (conducted in Zürich and Basel) on the current practice among medical and nursing staff and on their awareness of domestic violence, various uncertainties regarding dv could be identified.

The following overview summarises key points revealed in the interviews with the hospital staff: **[OVERHEAD 3]**

1. Health professionals are not aware of the frequency of dv, of what dv actually is, and furthermore, they do not know how to identify dv.
2. Health professionals mostly have received no training or further education in the field of dv.
3. Medical and nursing staff is not sure about their responsibility. What must be recognised, what action must be taken? The role of the doctors, the nursing staff and the midwives themeselves in perceiving and solving the problem is extremely unclear.
4. Dv is hardly part of the medical discourse but is rather delineated in terms of social or legal discourse. Health professionals define and understand dv not

as a medical problem but rather as a problem relevant to others – namely to welfare, police, legal, psychiatric services or specific support services. (The health system shares this reaction with other professionals. You probably haven't forgotten how long it took the police to consider themselves to have a proper duty and the authority to take action when it comes to dv. The police-force emphasised for a long time their function as mediators and interpreted it as being voluntary – the fact, that the police considers dv as a proper task of their job is only some few years old.)

5. Health professionals see their main contribution as referring victims to the welfare department, specialised services or other agencies but not in medical diagnosis and intervention.
6. They sense a kind of ambivalence between ignorance, uncertainty, lack of time and over-extension, on one hand, and interest in a new, uncharted territory, on the other hand. The conversations with professionals indicated us a readiness to accept the need to involve the health system in this issue.

During our interviews the staff expressed all those aspects. I will present you 3 examples.

A midwife said, when asked if there exists anything written in the hospital concerning dv:

"As far as I know there is nothing written about dv. But when such problems arise, it is clear that you go to the social worker who is familiar with the issue. This step is established. …" (Int. 1, midwife)

A nurse explained us:

"… If problems of this kind [dv] are recognised by nursing staff or doctors, then usually the social work department is contacted. It plays every important role in our clinic. It is an unwritten rule to contact the social worker department. – [And then she ads:] It would be helpful to know what domestic violence actually is, who you can turn to and what you can do when you come across such a case." (Int. 2, nurs)

And a senior physician told us:

"… We have a ' physician's book' on the guidelines in our institution. As far as I know, it contains nothing on domestic violence. – … The question of domestic violence has been out of sight so far, we're not even familiar with it. … Obviously, this is a deficit. But how great the priority is, depends of course, on how many women patients are threatened by some form of violence. If it's two percent, it's not so urgent but if it's 50 percent it would have to be considered quite urgent." (Int. 4, senior physician)

I would like to show you now as well two statistical results from the Maternité survey in Zurich.

– **[OVERHEAD 4]** In the written questionnaires filled out by doctors, nursing staff, midwives and other staff involved with patients, 72 % said that their own

experience is insufficient to take concrete action with respect to dv. And 71 % felt that their background knowledge of dv was insufficient.

– **[OVERHEAD 5]** Conversely 85 % of physicians, 78 % of midwives, 88 % of nursing staff and 69 % of other staff involved with patients said that they did not agree that a hospital should not address dv in addition to its main tasks.

Thus – we may say – professionals clearly feel that the health system carries a responsibility for dv. However, according to their own evaluation, they lack the knowledge required to deal adequately with dv.

b) The Difficulty of Identification of Violence

I come to a next point, why dv is rather neglected: It is the difficulty of identification of the problem within the health systems context. The health professions have barely begun to address the role of dv as a possible cause of health problems. Although research studies are available (primarily from the United States), these findings on the relationship between the experience of violence and its impact on health have received very little attention in Switzerland.

What explains such reservations? We observe that dv is held to be difficult terrain. In summary, all medical studies so far indicate how hard it is to identify dv. There are no clear-cut symptoms and no simple symptom patterns that allow an unequivocal determination of specific consequences of violence. The research points out "red flags", which might indicate dv, but the situation remains complex.

I would like to ask – in this context – a few questions from our sociological point of view:

1. Are other complaints always so easy to identify? Haven't you come across cases where a heart attack was first diagnosed as back pain or a tubal pregnancy as appendicitis? Isn't making a diagnosis often a complex process full of uncertainties, which requires substantial professional knowledge, commitment and experience?
2. Would and could the complexity be reduced if more professionals in the health system took a deeper look over a greater length of time? Would the picture possibly become clearer on looking at it long enough to recognise the background, the shading, the nuances and the subtleties? (A finding from our hospital study points in this direction – it shows that those professionals who have experienced dv in their own circle or even personally are significantly more sensitive to the perception of dv among patients.)
3. Is the field awkward because the personal factor is so dominant? Dv undoubtedly relates to somatic, psychic and psychosomatic levels. Does this perhaps make practitioners of traditional organ-oriented medicine uneasy? Is there possibly even a lack of prestige associated with dv? And what about the gender-specific component?

So far the questions. – Our observation:
For practitioners who work with victims in women's shelters and advisory services, it no longer comes as a surprise that the consequences – especially in terms of health – can be extremely complex and varied, even appearing after a time gap or in phases. Intense involvement with the issue reduces uncertainty and increases the experiential learning factor.

(c) The Abbreviated Concept of Violence
A further factor responsible for a reluctance to acquire knowledge is an abbreviated concept of violence, which we observed in our two studies. To put it simply, one prototype dominates the image of dv, namely, a woman who has been beaten and injured and therefore signs into the emergency room because she needs immediate medical care for the injuries she has sustained.

Health professionals see violence primarily as acute, physical assault, manifested by obvious and recent injuries. The staff we interviewed mainly cited cases that were the consequence of acute, physical violence – these are considered relevant to health. Much less emphasis is placed on violence that is also acute (i.e. a current problem) although not predominantly physical or sexual in nature but rather primarily exercised mentally and/or socially. If a woman has been subjected over the long-term to a partner's systematic violence, then physical violence is often no longer necessary in order to assert dominance. There is still little awareness of the fact that these forms of violence are just as damaging and painful even if there is no blood or other external evidence. Even less emphasis is placed on violence, which has occurred in the past maybe years ago, whether physical, sexual, mental or social in nature, and which may be the cause of current health problems (i.e. long-term effects).

I come to my conclusion. The narrow understanding of what dv is must be extended (not only blood and emergency rooms are relevant). And the dominance of reference to acute, physical violence must be diminished (chronic complaints can also indicate dv). By extending the concept of dv it will become easier for professionals to achnowledge research findings which help to identify dv in medical settings.

So far our insight to the question where do we stand actually regarding «dv and the health system».
My colleague will give you now a look into the future.

3 Desiderata for dealing with dv in the health system

So let us turn to the question «**what is needed in the future to reach good practices in the health system?**»

No doubt, appropriate and supportive procedures – in other words, good practices in dealing with dv in the health system – have been worked out already. And they are provided in various handbooks, guidelines, standards etc. Let me – before I ask what is needed further – summarize the required actions for professionals, good practices, in a condensed form. They are:
[–> Overhead 6]

• **first: Be attentive, identify violence, address the issue**
Inquire about experiences with violence (screening)
--> because --> violence is commonplace

• **second: Thorough examination and treatment**
Pay attention to new and old injuries, chronic and vague complaints
--> because --> the effects of violence are varied

• **third: Documentation**
Keep a detailed record of clinical findings, that meets forensic demands
--> because --> violence is relevant to the penal system

• **fourth: Ascertain the need for safety and protection**
In conversation, ascertain the woman's current situation and possibilities for protection
--> because --> violence is dangerous

• **and last Referral to other services – interdisciplinary co-operation**
Provide information on other services for support and protection; cultivate co-operative interaction among institutions and interdisciplinary exchange
--> because --> violence is a concern of various institutions and fields

Although such standards readily exist, we have found that the health system is remarkably slow in addressing these concerns. Currently application is limited to specifically committed circles. Be it in Switzerland or in other European countries practices of addressing dv have not achieved any widespread or systematic application in the health professions.

One explanation may be that such guidelines are relatively new. However, this in itself does not fully explain the reluctance for innovation. I therefore would like to

draw your attention to some specific contextual preconditions for integrating dv in the health system.

We consider four contextual points as decisive for a widespread acceptance of the issue among health professionals. In order to strengthen the necessary framework for action and to provide conditions, that existing knowledge and good practices can actually sink in, greater and more concentrated attention must be directed at these four points.

a) Point 1: dv must be established as a genuine medical issue [–> OVERHEAD 7]

Physicians, nursing staff and other health staff do not actually perceive dv as a genuine medical problem and a health syndrome. The members of the health system do not realise that the attention and response of their own specific discipline and sphere of duty is required.

In future, health professions must begin to recognise their task in regard to dv as a specific task that they, and they alone, can – and therefore must – carry out. Only when this succeeds, it will be possible to create a reliable basis, – a medical context, for the systematic introduction and implementation of adequate modes of procedure.

I'd like to illustrate the need for genuine medical and health expertise in the context of the broader network of knowledge and know-how in dealing with dv.
[–> OVERHEAD 8]

In the center of this «star-modell of knowledge and experise», we have the «general basics»: – That is knowledge about dv that all sectors must acquire. General basics include background knowledge on dv and its dynamics, dealing with the safety and protection of victims, knowledge about other institutions and interdisciplinary co-operation between institutions. The single rays of the star lead to different disciplines and professional sectors (like the police, law, victims support, intervention services, etc.). They have – each of them – specific expertise in regard to dv – professional knowledge and responsability of their own. Precisely this expertise must be established within the medical and the health context. It is vital to pay more attention to pointing out the professional, medical responsibilities and the health aspects. Primarely professional expertise – adequate medical diagnosis, identifying dv as possible cause for health troubles, appropriate medical treatment, and professional documentation – is needed. These vocational skills constitute a new contribution in the creation of a network of intervention in the field of dv – it contributes to the star.

An example from our research will demonstrate what we mean in calling for the need to establish dv as a medical and health problem. Our prevalence study in

Zürich revealed differentiated data on the health situation of the participants. One aspect was their physical status, which was examined on the basis of 14 items and summarised in an index. The questionnaire addressed such aspects as the frequency of headaches, neck ache, abdominal pain, dizziness, nausea, stomach complaints, eating disorders etc.

[–> OVERHEAD 9] The result is devastating from a medical point of view. A linear correlation is revealed. The greater the violence, the greater the physical complaints. Only 5 % percent of the women who have not experienced violence said they had manifest or frequent physical complaints, while 24.4 % of women who have been subjected to a greater amount of violence said they had manifest or frequent physical complaints. – Women who have experienced violence have far more health problems than women who have experienced less or no violence.

Further results regarding the health situation follow the same pattern. Women who have been subjected to a greater amount of violence have considered suicide four times more frequently than women who have not suffered from violence, and they have attempted suicide six times more frequently. The data on psychosomatic and mental health, and the data on their subjective assessment of health, all point in the same direction.

You are probably familiar with findings of this kind. We were, however, especially struck by the reactions of physicians and nursing personnel when we presented the results. They were extremely interested – and also extremely surprised: the point of view presented was actually new to them. And it became startlingly clear to them that they themselves, as physicians and health professionals, are called upon to act – and not simply by referring patients to other services. The findings also promoted the insight that they as professionals are not only confronted with dv when a woman appears in the emergency room with a laceration but also in many other cases when women have health problems of a different order. And even when the violence occurred several years earlier and is no longer acute.

I come to my second point of desiderata.

b) Point 2: The subject of dv must be included in undergraduate training and further education of all medical and nursing professions
Knowledge of the influence on health and the somatic consequences of dv have not yet been integrated into the educational curriculum of the health system in Switzerland. This presumably applies to other European countries as well. It is a serious and severe deficit.

If the legitimacy and professionalism of dealing with dv is to be increased in the health system, it is a central, indispensable precondition for it to become a standard

and required course in the curriculum of all health-related studies. That is the only way to ensure that dv is taken seriously and accepted as a medical concern.

c) Point 3: The structures of the health system must be taken into account
Guidelines for good practices, as I have summarized them, primarily seek to empower and support individual professionals in various health sectors. To a lesser extent, they also target projects and their institutional implementation in hospitals.

But we all know how heterogeneous the health system is – with a variety of agents and diverse interacting and sometimes conflicting hierarchical systems and interests. The health systems vary strongly from one country to another – and also on the intra-national level we frequently find substantial differences.

In the future debate these structures should be taken more into account and the whole variety of agents should be addressed in order to seek complementary alliances. We may distinct between agents on a macro, meso and a micro level:
[–> OVERHEAD 10]

Agents on the macro level are the national and regional ministries of health as well as welfare ministries, – which are, for example, responsible for controlling and regulating national health insurance. Addressing the issue of dv on this level would emphasize its legitimacy and urgency. Initial efforts made on the meso and micro levels would be reinforced if those "on top" acknowedged the subject important.

It is the agents on the macro level who decide which services will be funded and which will not be accredited. The financial burden for the health system, caused by recognised and unrecognised dv, is a powerful argument for these partners. – And their potential means of steering are manyfold: They do have influence on the educational system and the health administration, and they have the capacity to put quality standards in place and to establish certification.

On the meso-level, we have the professional associations and societies and we have the public and private hospitals, university clinics, etc.

Professional associations and societies are important agents. They are in a position to define and implement a professional approach to dv as a part of "good medicine" and "good nursing and care". This belongs to their key tasks. They also play an important role in training and further education and have the authority to establish standards and guidelines. And finally, professional associations and societies play a crucial role in the large sector of private practitionars.

Hospitals and clinics constitute the institutional setting where individual contact with victims of violence take place. It is on this institutional level that dv projects are required (– and timid first steps are being taken). With in-house guidelines and

ongoing (internal) education these institutions can perform a dual function – as innovators and as implementers.

On the micro-level we find the individual practitioners eventually. They must be empowered to perceive dv and intervene in a suitable way. Looking at the structure of all three levels, it becomes quite clear that the commitment of an individual is limited in scope. In order to guaranty a systematic and daily involvement of all the professionals in the health system, a setting is required that enables these individuals to take responsibility. And this is exactly what the agents on the meso- and macro-levels must provide.

For this reason, I it becomes clear that structural measures and co-operation are necessary on all three levels of the system. It is not a question of “either–or”, but rather of “both–and”. Within that framework the specific functions of all agents must be activated in order to enable the health system to become a full-scale partner on the question of dv.

d) Point 4: Well-aimed use must be made of evaluation and research
Evaluation and research are valuable tools to generate awareness and knowledge concerning dv and the health system – a potential that, so far, has not been used systematically. We emphasise three areas. **[–> Overhead 11]**

1. Fundamental studies that provide base knowledge: Such studies investigate and analyse the status quo of how dv is perceived and dealt with – and with what concequences for the women concerned. Knowledge of this kind is often lacking – be it on the level of national health systems, or on the institutional level of hospitals. Instead of reliable information it is rather opinions and myths that circulate. For example, people in institutions only have vague feelings and suppositions regarding the frequency of dv but there are no concrete numbers and facts available. It proves to be necessary to collect certain data locally, even if numbers are available from other countries. Knowing, for example, that the situation in one's own hospital corresponds to findings elsewhere is persuasive. Or, if findings differ, the local structure of the health system may be carefully reflected.

Another significance of investigating the status quo is, that such results may provide a solid and supportive base for launching institutional intervention projects on dv in the health system. They identify and document current practice, the standard of knowledge, but also the anxieties of the professionals. Such studies can reveal gaps and strengths. Thus institutional projects can be designed to tie in with the situation and needs of the professionals who will be responsible for implementing them on the job.

2. area concerns accompanying evaluation: New measures and changes must be scientifically accompanied – a standard that often is neclegted. Systematic findings

of formative evaluations can indicate whether changes tie in with daily practice and are moving in the desired direction. Which adjustments and improvements are necessary for success? Evaluations foster a critical, process-oriented approach – since we know, the ideal solution may not be found in the first go. Further, evaluations can provide data on the outcome. – Answering (as a ultimate test) the question whether practices in the health system actually support the well-being and safety of the women involved.

3. Thirdly, prevalence studies on dv are an important instrument. Questions on health and the consequences of violence are receiving more attention, as shown for example in representative studies in Sweden, Finland, France and Germany. This is extremely meaningful because such material is very important in communicating with the health system and should also be used for that purpose. Traditionally the health system holds empirical data and research in high esteem. The findings should therefore be used precisely in order to demonstrate the genuine medical component of dv.

Regarding the future, let it be said that research and evaluation must urgently be incorporated in the ensemble of good practices.

4 Conclusion

So far our desiderata for the future. – An I come to the conclusion. As we have shown, dv today is a topic which still suffers from underestimation amongst the ranks of health professionals. Our concern is, to demonstrate that dv undoubtedly involves the dimension of health and thus constitutes a true medical issue. It is exactly this genuin medical dimension that has to be established on all stuctural levels, in order that the health system may take on its professional reponsability and achieve good practices.
I thank you for your attention.

Reports:

- *Gloor, D.; Meier, H. (2003):* Häusliche Gewalt als Thema des Gesundheitswesens. Aktuelle Situation und Bedarf des Personals der Klinik Maternité Inselhof Triemli für Geburtshilfe und Gynäkoloige. Untersuchung im Rahmen des Projekts «häusliche Gewalt - wahrnehmen - intervenieren». [Domestic Violence as a health topic. Current staff situation and needs of the staff at the Zurich Maternité Clinic “Inselhof Triemli”. The report is part of the integrated research-practice-project “domestic violence – identifying – intervening” (2003–2005)]. (report in german, order/information: Martha.Weingartner@bfg.stzh.ch)
- *Gloor, D.; Meier, H. (2004):* Frauen, Gesundheit und Gewalt im sozialen Nahraum. Repräsentativbefragung bei Patientinnen der Maternité Inselhof Triemli, Klinik für Geburtshilfe und Gynäkologie. [Women, health, and domestic violence. Representative survey in the Zurich maternité hospital “Inselhof Triemli” for obstetrics and gynecology.] (report in german, order: mail@soziothek.ch)
- *Gloor, D.; Meier, H. (2005; forthcoming):* Untersuchung am Universitätsspital Basel zum Thema häusliche Gewalt bei PatientInnen – die Sicht der Gesundheitsfachleute aus verschiedenen Disziplinen (Medizin, Pflege etc.). (information university hospital study: sociology@socialinsight.ch)

Developments regarding dv

1970s and early 1980s	mid-1990s	since year 2000
– feminist movement – break the taboo – establishing support	– co-operation – intervention projects – focus on police and legal system	– co-operation – intervention projects – focus also on health system

Health system - an important actor

- **Easily accessible**

  Early diagnosis, preventive action
- **Confidentiality**
  Favourable setting
- **Acknowledged**
  Help, support, advice
- **Economic factor**
  Reduction of expenses

Key points - hospital staff

- **little awareness:**
  what is dv? how to identify dv?
- **no training, no further education**
- **unclear responsability**
- ***no* medical – but social/legal discourse**
- **referrence as solution**
- **ambivalence: uncertainity – interest/readiness**

Results «hospital questionnaire»

- **72 %**
  «own experience is insufficient to take concrete action with respect to dv.»
- **71 %**
  «own background knowledge of dv is insufficient.»

Commitment to dv

- 85 % of physicians
- 78 % of midwives
- 88 % of nursing staff
- 69 % of other staff involved with patients

  – did not agree

    that a hospital should not address dv in addition to its main tasks.

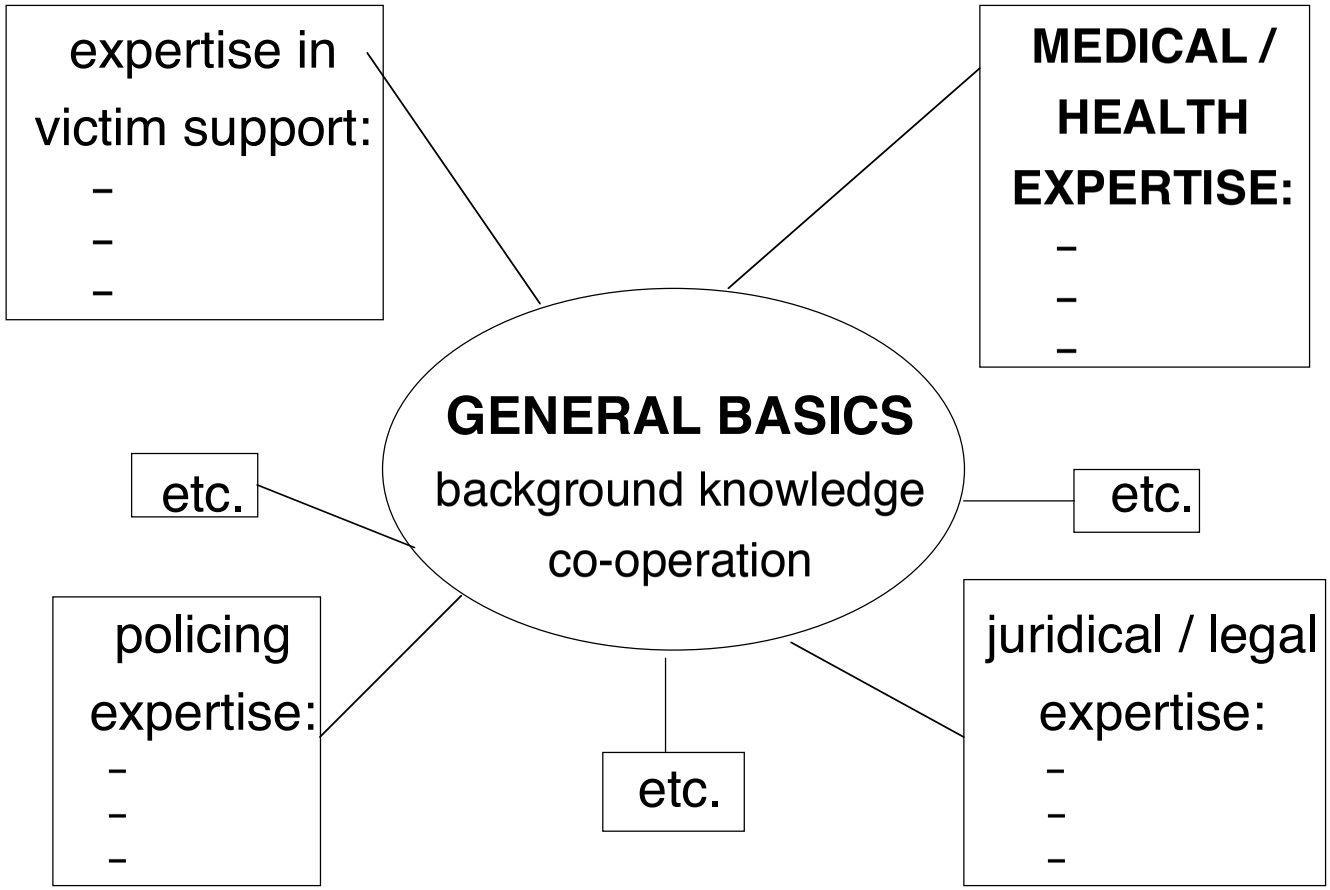
Good practices

- Be attentive, identify violence, address the issue
- Thourough examination and treatment
- Documentation
- Ascertain the need for safety and protection
- Referral to other services – co-operation

Four desiderata

- to establish dv as a genuine medical issue
- to include dv in training and further education in all health professions
- to take the structures of the health system into account
- to use evaluation and research

General basics AND professional expertise needed („star modell“)



Physical health and domestic violence

			amount	**/ extent**	**of dom.**	**violence**
		ø	no	slighter	bigger	severe
Com-plaints:	no/little	31,8%	48,6%	38,2%	27,4%	17,0%
	partly	54,8%	46,4%	53,2%	59,5%	58,6%
	frequent	13,4%	**5,0%**	8,6%	13,1%	**24,4%**
		100,0%	100,0%	100,0%	100,0%	100,0%
		N = 1753	N = 362	N = 476	N = 420	N = 495

Agents in the health system

Macro level	- Ministries - public health - health authorities - politics
Meso level	- profess. associations, societies - public/private hospitals, university clinics
Micro level	- individual practitioners, professionals

Evaluation and research

Fundamental studies	- knowledge and data on the status quo
Accompanying evaluation	- formative evaluations, process - outcome evaluations, data on outcome and effects
Prevalence studies	- overview and background