DOMESTIC VIOLENCE

Medical & Social Management of Care for Victims

SUMMARY OF FINDINGS:

SURVEYS OF

EMERGENCY

DEPARTMENT AND

COMMUNITY PROVIDERS

PRINCIPAL INVESTIGATOR:
Firoozeh Vali, Ph.D.

HRET
HEALTH RESEARCH AND
EDUCATIONAL TRUST OF NEW JERSEY

SUPPORTED BY A GRANT FROM
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PREFACE

The Health Research and Educational Trust of New Jersey (HRET), a nonprofit affiliate of the New Jersey Hospital Association (NJHA), is pleased to offer the findings of the 1998 study conducted as the first phase of its project, **Domestic Violence: Medical and Social Management of Care for Victims**. Funded by the Robert Wood Johnson Foundation, the primary goal of this project is to improve access and quality of care for victims of domestic violence in New Jersey by enhancing hospitals' ability to identify and effectively refer victims to appropriate services. The project's implementation plan includes three phases: 1) survey hospital and community providers to study existing practices and assess their barriers and needs; 2) develop targeted educational interventions to help providers better identify abuse, break the cycle of violence and facilitate timely help for victims, as well as recommend new institutional practices for effective identification of victims and enhanced coordination across medical, mental and social service systems; and 3) evaluate the effectiveness of interventions.

According to the results of this study, it is evident that the current gap in identifying victims of domestic violence provides a tremendous opportunity to intervene. While there are several recommendations NJHA/HRET would suggest hospitals implement, the following four areas need immediate attention in providing care to battered women:

- Domestic violence needs to be made as the primary diagnosis for battered victims, leading to appropriate treatment and referrals;

- All providers need to be educated on an ongoing basis on domestic violence and barriers that interfere with identifying/providing appropriate care to victims;

- Hospitals should serve as a gateway to improve victims' access to hospital staff by developing a response team for on-site counseling, follow-up and linking to in-house and community resources;

- Hospitals need improved communications and stronger working relationships with community providers and should implement a care management model that will link different service systems.

HRET would like to extend its deep appreciation to the Robert Wood Johnson Foundation for funding this project. Without its support this work could not have been accomplished. The project also benefited from the invaluable advice and intellectual support of members of its advisory panel throughout the design and implementation phases. Our special thanks are extended to all of them. We would also like to acknowledge the hospital professionals who generously contributed their time and participated in the survey. We believe their individual efforts and this project as a whole can have a positive impact on the quality and effectiveness of services for victims of domestic violence, and we strongly encourage hospitals to actively participate in implementing the recommended interventions.

Gary S. Carter, FACHE
President and CEO
New Jersey Hospital Association

DOMESTIC VIOLENCE

Medical and Social Management of Care For Victims

BACKGROUND

Battering is one of the most common yet least identified health problems that women present to healthcare professionals, making domestic violence (DV) a primary healthcare and mental health issue for women. These women come from all ages, cultures, races, occupations and income levels. National statistics provided by law enforcement agencies, antiviolence groups and victims' advocacy groups indicate that every year an estimated 2 to 4 million women are battered by their partner (Lee, et. al. 1993). A woman is beaten every 6 minutes and 22 seconds in New Jersey. In 1994, the New Jersey Legislature found that thousands of persons in New Jersey are regularly beaten, tortured and often killed by spouses or cohabitants. In the last five years, cases of DV have increased 60 percent statewide with a continuing increase of 5 to 10 percent per year. There were 82,627 DV offenses reported by police in 1997, with domestic-related murders increasing 16 percent compared to 1996 (New Jersey Department of Law and Public Safety, 1997). Despite these numbers, DV is still a greatly under-reported crime both in New Jersey and nationally, leaving large numbers of underserved populations.

Although battered women are frequently seen/treated in an emergency department setting, the diagnosis of abuse is often missed. Only 4 to 5 percent of women's injuries inflicted by their partners are recognized by medical personnel as abuse (Council on Ethical and Judicial Affairs, 1992; Report on Medical Guidelines & Outcomes Research, 1998; Dearwater, et al., 1998), and physicians often fail to give any referrals or follow up for recognized abuse cases (Warshaw, 1989). The cost of failing to identify and intervene in violence is incalculable, particularly in violence by intimates, since assaults tend to be repeated over time, producing more injuries and creating more complications (Stark et al., 1981; Kurz and Stark, 1988; Margolin et al., 1988).

Recognizing DV as a societal issue, HRET initiated a project to better understand and improve the process of providing care for DV victims in hospitals and community agencies. The ultimate goal was to improve access and quality of care by objectively assessing the needs, developing targeted educational programs to equip providers with skills to better serve victims and devising/recommending new organizational practices for effective identification of victims and enhanced coordination between medical, mental and social service systems. The project was planned to be conducted in three phases: 1) collection of data from hospitals and community providers; 2) development and implementation of educational interventions based on these findings, and 3) evaluation of the effectiveness of these interventions. This report summarizes the findings of the project's first phase.

RESEARCH DESIGN AND METHODOLOGY

In this phase a series of surveys of hospital and community providers was conducted. The specific objectives were to:

- Describe the process of identification and documentation of DV cases in hospitals; determine difficulties and psychosocial/organizational obstacles clinicians face in providing coordinated care and referring victims to different service systems; and assess their unmet service and training needs to improve access and quality of care for victims;

- Describe the available community resources and services to help victims; determine difficulties and barriers community providers face in coordinating care for victims across different service systems including criminal justice, mental healthcare, social welfare, housing and transportation; and assess their unmet service and educational needs.

All acute care hospitals throughout the state were invited to participate in this project. In October 1997, 93 hospital CEOs were invited by NJHA's President to participate in this initiative. Each received a copy of the study's executive summary and a participation form. CEOs were asked to sign the form agreeing to participate and provide, via Fax, names of three professional categories in their emergency department (ED). After three follow-up contacts, 82 hospitals agreed to participate, yielding a response rate of 88 percent. Of all identified staff, 67 medical directors (physicians), 80 nurse managers and 75 social workers were interviewed face-to-face by trained nurse interviewers and the project manager, using an instrument with a number of prevalidated questions and scales. Interview questions consisted of a wide range of topics including: level of difficulty of clinicians interacting with victims, ways of identification and documentation, difficulty in referring victims, level of knowledge on topics relevant to care for domestic violence victims, their information need areas and their preference for receiving information and educational materials.

New Jersey's 21 county domestic violence coalitions that were originally proposed to be surveyed were found to be inactive or totally dissolved.[1] Instead, directors of county women shelters and domestic violence programs were surveyed. Of the 23 county programs and shelters, 18 completed a self-administered instrument, modified from the clinicians' questionnaire to tap services and challenges of community providers (78% response rate).

New Jersey hospitals and the New Jersey Coalition for Battered Women were the major collaborators in this initiative. The project was steered by a group of domestic violence experts including university faculty members, a physician and providers/administrators from state and community agencies.

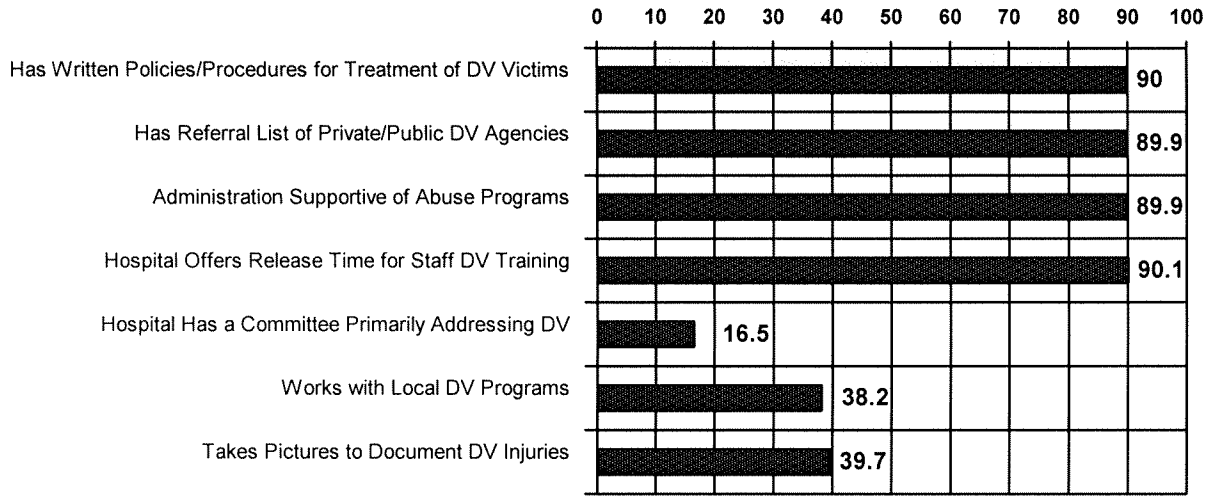
[1] New Jersey's 21 County Coalitions Confronting Domestic Violence were formed and coordinated by HRET through a Geraldine R. Dodge Foundation Grant in 1994. The common purpose of these coalitions was to reduce the incidence of domestic violence in New Jersey by improving the process of identification, treatment and referral of domestic violence victims and providing needed awareness and educational programs and linkages to different service systems. The composition of these coalitions varied across different counties. They were usually composed of a combination of the following organizations: hospitals in the county, county domestic violence programs, county Medical Society auxiliaries, The American Medical Association Alliance, The Medical Society of New Jersey, shelters, county Prosecutor's offices, New Jersey Maternal Child Health Network, Planned Parenthood groups, visiting nurse associations and various domestic violence prevention projects. The projects initiated by these coalitions, with minimal coordination, included: creating education and resource guides and domestic violence kits, developing educational programs for physicians and other hospital personnel, assisting hospitals to adopt a policy or procedure to identify and treat victims, referring victims to shelters, and working with the prosecutor's office to educate emergency department staff.

RESULTS

Descriptive Profile of Emergency Departments (ED)

Information about EDs and their policies regarding domestic violence were collected from interviews with nurse managers. The reported number of patients in a typical month diagnosed with an injury caused by DV had a mean of 9.1 and a standard deviation of 19.55. The number of these patients varied significantly across hospitals and ranged from zero to 120 in a typical month. Given the literature report that only about 5 percent of cases are actually diagnosed as abuse by clinicians, the actual number of victims who are not identified and served in a month may be 170 with a maximum of 2,280. Of these victims, on the average, 97 percent were women and 91 percent were referred for help regarding battering.

Chart 1. Emergency Department Policies & Organizational Arrangements (Obtained from Nurse Interviews)



In the past year, an average of 22 percent of identified victims were subjected to repeated violence, suggesting possible gaps in the identification and tracking of patient's repeat visits and a need to implement more effective identification strategies. Despite all internal arrangements reported by a large number of hospitals, i.e., having written DV policies, referral lists of DV agencies and administration support (90%), only 38 percent of EDs reported working with their local DV programs, suggesting the presence of a disconnection and a need for more collaboration between hospital and community services. About 40 percent of hospital staff take photographs of victim's injuries and 17 percent reported having a committee with the primary purpose of addressing DV.

Descriptive Profile of Study Participants

Table 1 displays a general profile of the study's participants. A large proportion of physicians were male (88%), while as expected nurses, social workers and community service providers were predominantly female (85%, 80% and 94%, respectively). They were largely white and 40-54 years old. Only about 6 percent of clinicians were over 55 years of age. About 11 percent of physicians (3% black, 4% Hispanic) and 7 percent of nurses were non-white. Among social workers, 9 percent were black and 4 percent were Hispanic. The preponderance of whites in all groups and male physicians and female nurses/social workers is consistent, but slightly higher than the known national ratios of gender and race distributions for these professions. The selection of those with management responsibilities may explain this larger-than-expected representation, but it is not considered a threat to the reliability and validity of the findings.

Table 1. Hospital and Community Providers' Personal and Background Characteristics

	ED Medical Directors (n = 67)		ED Nurse Managers (n = 80)		Social Workers (n = 75)		Community Agency Dirs. (n= 18)	
	%	(No.)	%	(No.)	%	(No.)	%	(No.)
AGE								
Less than 40	27.3	(18)	27.8	(22)	29.3	(22)	17.7	(3)
40 – 54	66.6	(44)	64.6	(51)	64.0	(48)	70.5	(12)
55 or more	6.1	(4)	7.6	(6)	6.7	(5)	11.8	(2)
SEX								
Female	12.1	(8)	85.0	(68)	80.0	(60)	94.1	(16)
Male	87.9	(58)	15.0	(12)	20.0	(15)	5.9	(1)
RACE/ETHNICITY								
White	89.4	(59)	92.3	(72)	82.4	(61)	88.2	(15)
Non-white	10.6	(7)	7.7	(6)	17.7	(13)	11.8	(2)
LANGUAGE(S) SPOKEN								
No other language	17.9	(12)	44.4	(24)	55.4	(31)	72.7	(8)
A little Spanish	22.4	(15)	48.1	(26)	19.6	(11)	9.1	(1)
Spanish	22.4	(15)	7.4	(4)	7.1	(4)	18.2	(2)
Other	37.3	(25)	0	(0)	17.8	(10)	0	(0)

NOTE: (1) Percentages are calculated based on the number of respondents for each category. (2) Missing data are excluded.

English was the only language spoken by most providers (93% of nurses, 75% of social workers and 82% of community providers), except physicians who were mostly bi- or multilingual (82%). This could be partly explained by the higher number of foreign-born individuals in this group. These findings may suggest the need to train/educate both clinicians and interpreters on sensitivity to different cultural norms, customs and the best ways of interacting with victims.

Professional and Practice Characteristics

Only one-third of physicians and nurses had any training in DV as opposed to about 49 percent of social workers, suggesting the need for ongoing staff training. A large proportion of all providers (more than 75%) reported following specific protocols or set policies and procedures for identification, treatment,

documentation and referral of DV victims. Approximately 86 percent of physicians and 84 percent of nurses indicated that standardized policies and procedures would help them, as opposed to 55 percent of social workers. Suggestions to improve current directories included making them more comprehensive, updating them more frequently and creating computerized databases. It appears that providing victims with educational materials is not commonly practiced by these providers, since only about 25 percent of them reported doing so.

All three groups of hospital providers were asked about the number of times during an average month they refer a victim for DV services. Nurses were found to refer victims more than the other two groups, with a mean of 8.47 referrals in a typical month. Overall, reported referral patterns indicate a need for a better working relationship with DV shelters/outreach programs and/or a need for more hospital-based services and case management for victims.

Physicians and nurses were asked to describe their current method of management for care of DV victims. They mostly reported that they assess, identify and refer victims (68% and 48%, respectively). About 25 percent of physicians and 33 percent of nurses reported following hospital policy, and a few (4% and 10%) indicated they notify their local police departments of abuse cases.

During a typical month, an average of 212 women were served by participating county shelters and about 57 percent of these women were reported as being referred from hospital settings. Other sources of referral included social service agencies, police/criminal justice system, former shelter residents, Division of Youth and Family Services (DYFS) and national and state DV hotlines. All service agencies reported using volunteers who participate in mandatory training programs. About 83 percent reported being involved in collaborative programs with local hospitals and other organizations that provided training for hospital staff. All of these agencies had hotline support, 24-hour live coverage and provided an interpreter service on their hotline if needed. Approximately 89 percent reported serving victims from other counties or states, and 33 percent reported tracking cases of repeated abuse.

Clinicians' Practice Behavior and Attitudes on the Care of Victims

To assess physicians' and nurses' communication style and practice behavior regarding domestic violence victims, 14 statements were developed regarding clinician's interactions. These measures revealed they only occasionally screen their female patients for domestic violence, ask direct questions about DV or track for recidivism. Spending enough time with victims was also sometimes perceived to be a problem (Table 2).

Using analysis of variance, the difference of means of clinical behavior of these clinicians was tested. No significant differences were found between physicians and nurses on these items except for the item of feeling uncomfortable with domestic violence victims if they cannot speak English, where nurses reported being significantly more uncomfortable ($p < .01$). Some of the practice behavior items were recoded from 1-5 to 5-1 to make all items consistent in the direction of responses, i.e., higher score meaning more acceptable behavior. These items were added to construct a composite index of clinical behavior. The difference of these indicators between the two groups of providers was not found to be statistically significant based on analysis of variance.

Table 2. ED Clinicians' Practice Behavior

Based on scales/mean range: 1 = Rarely, 2 = Sometimes, 3 = Occasionally, 4 = Mostly, 5 = Always

	ED Medical Directors (n = 67)		ED Nurse Managers (n = 80)		F Ratio
	Mean	(StDev)	Mean	(StDev)	
I allow patient opportunity to ask questions	4.68	(.64)	4.53	(.62)	2.16
I refer DV patients to other agencies/services	4.62	(.63)	4.74	(.55)	1.43
I try to get patient's trust/confidence	4.59	(.70)	4.61	(.56)	.025
I listen carefully to patients	4.45	(.53)	4.46	(.55)	.008
I assess safety of a patient experiencing DV	4.38	(.91)	4.35	(.79)	.030
I express supportive feelings and emotions	4.30	(.84)	4.40	(.77)	.526
I ask direct questions about DV	3.55	(1.25)	3.30	(1.24)	1.40
I assess for recidivism (repeated ER visits)	3.34	(1.30)	3.65	(1.17)	2.29
I screen my female patients for DV	3.02	(1.20)	3.16	(1.18)	.555
I don't have enough time to spend with victim	2.83	(1.34)	2.86	1.32)	.015
I feel uncomfortable if DV patient can't speak English well	**2.02**	**(1.12)**	**2.56**	**(1.27)**	**7.31***
I formulate a written safety plan in collaboration with DV victim	1.85	(1.37)	2.12	(1.51)	1.21
I feel uncomfortable with women I suspect are DV victims	1.64	(.92)	1.95	(1.09)	3.43
I feel uncomfortable with DV victims if they are of another culture/ethnicity or race	1.58	(.88)	1.87	(1.01)	3.31
The composite index of clinical behavior	54.68	(6.6)	54.13	(6.9)	.245

* p=<.01 (Statistically significant differences based on one-way analysis of variance).

Attitudes of physicians and nurses regarding DV, the victim and the provision of care and services was measured through 15 statements describing a health professional's role in treatment of DV victims. Providers were asked to report the degree of their agreement with each of the statements, using a five-point scale ranging from strongly disagree to strongly agree. Physicians and nurses were significantly different in some of these reports.

Overall, nurses reported higher levels of agreement than physicians (Table 3). The only item that physicians significantly agreed more with than nurses was the statement that "Emergency department providers are not aware of all signs and symptoms of domestic violence." These items were added to construct a composite index of clinicians' attitudes on DV. The difference of mean of attitude scale of these clinicians was tested using analysis of variance, and their difference was found to be statistically significant ($p < .001$). Physicians and nurses appear to be similar in their clinical behavior and different in their attitudes about domestic violence.

Table 3. ED Clinician's Attitudinal Characteristics

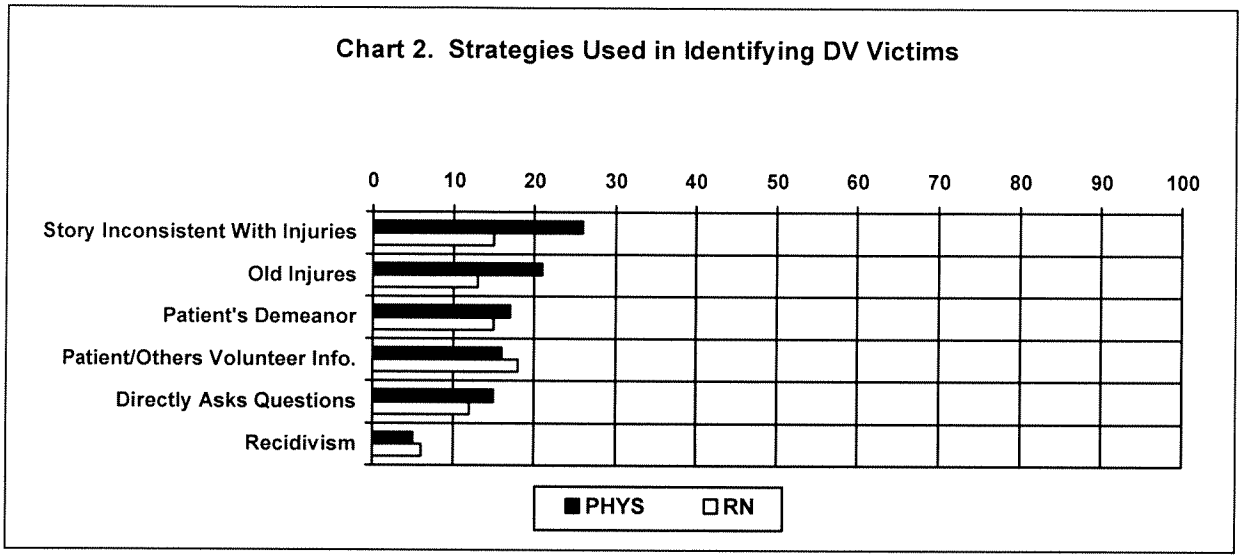
Based on scales/mean range: 1 = Strongly Disagree, 2 = Disagree, 3 = Uncertain, 4 = Agree, 5 = Strongly Agree

	ED Medical Directors (n = 67)		ED Nurse Managers (n = 80)		F Ratio
	Mean	(StDev)	Mean	(StDev)	
Providers should send partners elsewhere when patients are questioned or examined.	.65	(.59)	4.74	(.57)	.794
It is necessary that providers have a holistic approach to treatment and consider non-medical issues as well.	**4.55**	**(.66)**	**4.74**	**(.44)**	**4.38***
It is not easy for women to leave an abusive partner.	**4.39**	**(.52)**	**4.59**	**(.59)**	**4.32***
Providers need to understand the issues and concerns of immigrants and people of different ethnicity.	**4.38**	**(.68)**	**4.76**	**(.43)**	**16.69*****
Involvement in patients' non-medical issues limits provider's time for treatment, but is crucial to the care for DV patients.	4.36	(.48)	4.34	(.83)	.051
Providers need to be trained on how to help a suspected DV patient who denies any DV.	**4.36**	**(.67)**	**4.75**	**(.49)**	**16.10*****
Clinicians should ask direct questions about DV.	4.35	(.69)	4.43	(.73)	.420
Women's noncompliance and failure to follow up on referrals frustrate the providers.	4.21	(.85)	4.19	(.78)	.033
All hospital clinicians need to get ongoing training on DV and how to handle victims.	**4.14**	**(.96)**	**4.76**	**(.51)**	**25.43*****
Providers should use photographs to document DV.	4.11	(.88)	4.20	(.91)	.399
Emergency Department providers are not aware of all signs and symptoms of DV.	**3.86**	**(.93)**	**3.35**	**(1.11)**	**8.92****
Clinicians need to strictly follow guidelines or protocols on how to identify and document cases of DV.	**3.68**	**(.96)**	**4.41**	**(.65)**	**28.12*****
Finding the needed referral sources for patients is a challenge for providers.	3.65	(1.16)	3.59	(1.26)	.100
Perpetrators are dangerous to healthcare providers.	3.23	(.99)	3.50	(1.10)	2.42
Clinicians should screen all female patients for DV.	**3.12**	**(1.07)**	**3.93**	**(1.02)**	**21.48*****
The composite index of clinical behavior.	**61.04**	**(6.32)**	**64.25**	**(4.8)**	**12.20*****

* p=<.05, ** p=<.01, *** p= <.001 (Statistically significant differences based on one-way analysis of variance).

Strategies Used and Perceived Barriers in Identifying Domestic Violence Victims

Clinicians were asked to describe how they identify DV victims. The most frequently reported strategies and signals for both groups were inconsistency of patients' stories of how they were injured along with the nature of actual injuries, presentation of old injuries, patient's demeanor and by asking victims direct questions. The low utilization of these strategies in identifying victims (26% or less) suggests a tremendous opportunity for intervention.



There are many obstacles to healthcare providers' identification of abused adult patients. Clinicians were asked to indicate the degree to which they would consider each obstacle a barrier in identifying a patient as a DV victim, using a three-point scale ranging from not a problem to a major problem. The obstacles presenting the highest degree of problems were primarily patient-related factors. (Table 4) However, staff's lack of training, time and knowledge were also highly reported.

Table 4. Hospital Providers' Perceived Obstacles to Identification of Victims

Based on scales mean, range: 1 = Not a problem, 2 = Minor Problem 3 = Major Problem

	ED Medical Directors (n = 67)		ED Nurse Managers (n = 80)		Social Workers (n = 75)	
	Mean	(StDev)	Mean	(StDev)	Mean	(StDev)
Patient under influence of drugs/alcohol	2.82	(.46)	2.78	(.48)	2.56	(.71)
Patient fears repercussions of being identified as battered	2.78	(.52)	2.77	(.48)	2.70	(.54)
Patient denies battering as cause of injury	2.65	(.57)	2.69	(.59)	2.72	(.54)
Patient does not mention battering during history-taking	2.50	(.66)	2.49	(.57)	2.64	(.59)
Different cultural norms/customs interfere with discussion of battering	2.50	(.64)	2.60	(.61)	2.42	(.72)
ED staff is not aware of the problem	2.48	(.94)	2.37	(.70)	2.28	(.67)
Patient's primary language not English	2.42	(.70)	2.49	(.64)	2.31	(.70)
Patient lacks privacy (accompanied by partner/children)	2.38	(.67)	2.33	(.76)	2.32	(.74)
ED staff too busy to ask about anything other than physical injuries	2.23	(.78)	2.14	(.76)	2.06	(.81)
ED staff lacks training how to ID DV as cause of injury	2.15	(64)	1.94	(.74)	2.10	(.78)
ED staff believes nothing can be done for victims	1.65	(.78)	1.75	.79)	1.64	(.75)
Too much paperwork	1.65	(.75)	1.65	(.72)	1.31	(.54)
ED staff fears being called to court to testify	1.62	(.71)	1.71	(.72)	1.43	(.68)
Patient does not have insurance coverage	1.08	(.27	1.19	(.58	1.30	(.66)

Besides medical records, body charts and photographs were also reported to be used for documentation, but they were not commonly used strategies. These findings suggest the need for education regarding identification and documentation strategies and barriers.

Perceived Difficulties in Providing Care and Referring Victims

Physicians and nurses were asked about the extent of difficulty they experience in providing care to victims of domestic violence using a five-point scale, ranging from no difficulty to great difficulty or unable to perform. Table 5 shows the top ten areas with the highest mean on perceived difficulty and assesses the significance of the difference between the two groups of providers, using one-way analysis of variance. Overall, the physicians mean difficulty was slightly higher than nurses. Nurses, however, perceived significantly more problems than doctors in asking direct questions about domestic violence and how injuries were sustained ($p < .01$).

Table 5. ED Clinician's Perceived Difficulties in Different Areas of Care for DV Victims
Based on scales mean, range: 1 = No Difficulty, 2 = A Little Difficulty, 3 = Some Difficulty, 4 = A lot of Difficulty, 5 = Unable to Perform

	ED Medical Directors (n = 67)		ED Nurse Managers (n = 80)		F Ratio
	Mean	(StDev)	Mean	(StDev)	
Discuss DV issues and nature of injuries with patients who do not want to discuss it.	2.97	(.94)	2.99	(.96)	0.12
Mark injuries on a body chart and include pictures of injuries for the medical report.	2.84	(1.47)	2.4	(1.36)	3.132
Communicate with patient when the primary language is not English.	2.78	(1.06)	2.65	(1.11)	.489
Elicit patient's acknowledgement of abuse/battering in suspected cases.	2.78	(.95)	2.78	(.93)	.000
Discuss battering and abuse behavior issues due to different cultural norms and customs.	2.70	(1.09)	2.68	(.95)	.025
Follow a consistent protocol when DV is suspected.	2.28	(1.10)	2.00	(1.01)	2.63
Determine signs and symptoms of abuse.	2.21	(.96)	2.06	(.93)	.874
Provide appropriate care/consultation/help if patient breaks down, cries or becomes angry during the discussion.	1.78	(.92)	1.65	(.90)	.702
Ask direct questions about DV and how injuries were sustained.	**1.76**	**(.87)**	**2.15**	**(.99)**	**6.226***
Provide information on appropriate service systems and make referrals.	1.71	(.99)	1.54	(.86)	1.196

* p=<.01 (Statistically significant differences based on one-way analysis of variance).

There are many obstacles to healthcare providers' referral of adult DV patients to different service systems. Clinicians were asked to indicate the degree to which they would consider each obstacle as a barrier in referring patients and linking them to other services, using a three-point scale ranging from not a problem to a major problem. The top most frequently mentioned barriers perceived by all providers are listed in Table 6. Physicians consistently perceived higher degree of problems than the other two groups. Inadequate communication of information across service systems and lack of desire of battered patients

for referral were reported by a great majority of all groups as the most problematic barriers. As shown, statistically significant differences were found among the groups in five of these obstacles. Furthermore, social workers had specific problems (not included in Table 6) with inadequate supply of services, lack of enough time to monitor and follow up, insufficient capacity of shelters and finding a place for victims, poor quality of services and inadequacy of available information. These findings suggest the need for more accessible hospital and community services, allocation of more resources for providers enabling them to spend more time with victims, development of better communications across different service systems and stronger relationships among providers and more education on referral sources.

Table 6. Hospital Providers' Perceived Barriers in Linking Victims to Different Service Systems (Combined Minor-Major Problem)

	ED Medical Directors (n = 67)		ED Nurse Managers (n = 80)		Social Workers (n = 75)		F Ratio
	%	(No.)	%	(No.)	%	(No.)	
Battered patient does not want referral	98.5	(64)	84.9	(74)	98.6	(72)	.369
Communication of information across different service systems is inadequate	**78.0**	**(39)**	**67.9**	**(53)**	**76.7**	**(56)**	**4.89****
In-hospital services are difficult to access	61.5	(40)	53.2	(42)	28.7	(21)	.564
ED staff is too busy to treat anything other than physical injuries	61.5	(40)	45.0	(36)	NA*f*	NA*f*	NA*f*
There are no in-hospital services	58.7	(37)	48.8	(38)	40.2	(29)	1.60
Community agencies and resources are difficult to access	**58.5**	**(31)**	**57.4**	**(43)**	**50.0**	**(37)**	**4.22***
Lack of commitment to follow these patients	**55.3**	**(26)**	**51.3**	**(39)**	**21.2**	**(15)**	**11.23*****
Too much paperwork	52.4	(33)	46.2	(36)	32.4	(24)	2.34
Relationship of staff of service systems are not friendly and cooperative	**49.0**	**(25)**	**35.6**	**(27)**	**42.4**	**(31)**	**5.16****
There is no list of existing community agencies and resources	**30.0**	**(18)**	**22.8**	**(18)**	**17.4**	**(13)**	**3.02***

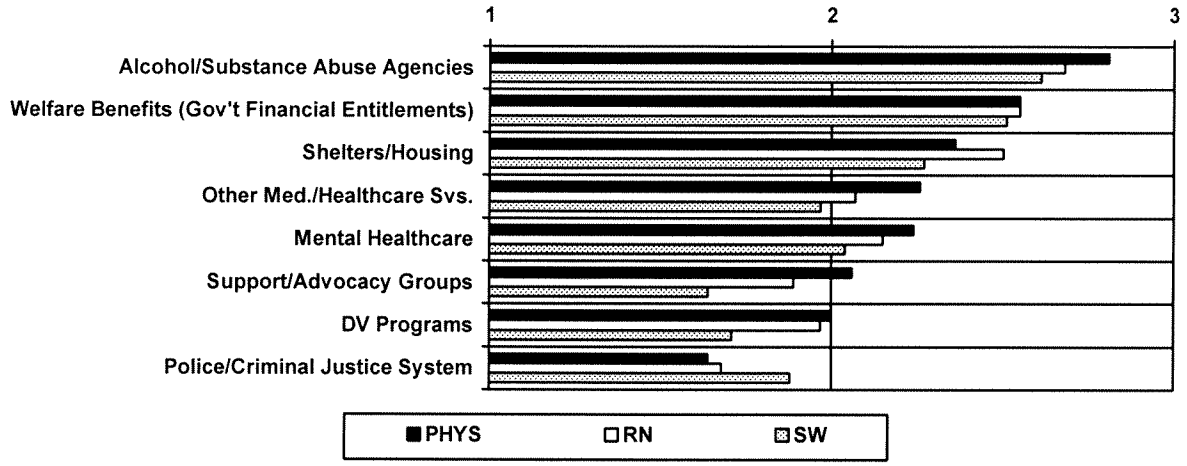
NOTE: (1) Percentages are calculated based on the number of respondents for each category. (2) Missing data are excluded.
(3) Questions specific for each category are not included in the joint tables and are only presented in their own data set.
f Not Applicable since this item was not included for this category of providers.
* p=<.05, ** p=<.01, *** p= <.001 (Statistically significant differences based on one-way analysis of variance).

Hospital providers were also asked about different service systems and the extent of difficulty they create in referring and linking patients to services, using a five-point scale ranging from none to great. As shown in Chart 3, alcohol and substance abuse, welfare and shelters were reported as the most problematic service systems. Again, a higher level of difficulty is reported by physicians.

Social workers also perceived a great deal of difficulty with legal services, employment/vocational services and transportation services. No statistically significant differences were found among these providers on the level of difficulty they reported with different service systems.

Chart 3. Hospital Providers' Perceived Difficulty with Different Service Systems When Referring Victims of DV

Based on Scale's Mean, Range: 1 = No Difficulty, 2 = A Little Difficulty, 3 = Some Difficulty, 4 = Muc Difficulty, 5 = Great Difficulty



Providers suggested some strategies to remove or improve barriers in linking patients to services. More staff training and updated information on services were highly reported by all providers, especially by physicians. Overall, physicians felt stronger about these remedies than nurses or social workers and reported that these remedies would improve referral barriers.

Table 7. Hospital Providers' Suggestions for Removing Barriers in Linking DV Victims to Different Service Systems

	ED Medical Directors (n = 67)		ED Nurse Managers (n = 80)		Social Workers (n = 75)		F Ratio
More staff training	**84.8**	**(56)**	**81.3**	**(65)**	**79.7**	**(59)**	**3.11***
Updated information regarding services	**81.8**	**(54)**	**92.5**	**(74)**	**69.3**	**(52)**	**4.08***
Expansion of case worker staff	72.7	(48)	67.5	(54)	69.3	(52)	2.76
More services	72.7	(48)	71.3	(57)	82.7	(62)	1.82
Improved communication among service providers	72.7	(48)	66.3	(53)	70.7	(53)	2.81
Hospital-wide task force	53.0	(35)	52.5	(42)	62.7	(47)	1.32

NOTE: (1) Percentages are calculated based on the number of respondents for each category. (2) Column percentages exceed 100 due to multiple response. (3) Missing data are excluded.
* p=<.05 (Statistically significant differences based on one-way analysis of variance).

Hospital and community providers were all asked to indicate what improvements in service delivery would help them better serve victims of DV. Suggested improvements included: more staff coverage (for hospital's emergency and social worker departments and for county shelters and domestic violence programs); more information on services; more staff training; and improved communication among

providers of different service systems. Social workers also suggested that a hospital DV response team would help them improve their services.

Educational Needs and Preferences

In order to determine the educational needs of providers, a list of information areas relevant to the provision of care for domestic violence victims was prepared. The four groups of providers were asked about the extent of their knowledge in each area, using a four-point scale ranging from none to a lot, as well as the areas they would like to learn more about in order to improve the quality of their services.

Information areas with the lowest mean on perceived knowledge were: insurance policies for coverage of DV victims; barriers due to ethnicity; culture or immigration status that prevent victims from recognizing DV and/or searching for assistance; differences in cultural response to DV; relationship between DV and pregnancy; factors that affect victim's ability to cope with traumatic events such as what is involved in DV; characteristics/behavior of perpetrators of DV; use of clinical protocols as a means of evidence gathering and documentation; evaluation and reporting requirements for DV; and safety needs of victims and how to assess them.

Table 8. Hospital Providers' Perceived Information Need Areas

	ED Medical Directors (n = 67)		ED Nurse Managers (n = 80)		Social Workers (n = 75)		F Ratio
	%	(No.)	%	(No.)	%	(No.)	
Barriers due to ethnicity/culture/immigration status	77.6	(52)	76.3	(61)	68.0	(51)	1.02
Differences in cultural response to DV	71.6	(48)	77.5	(62)	64.0	(48)	1.72
Forensic aspects of healthcare	70.1	(47)	71.3	(57)	82.7	(62)	1.88
Evaluation/reporting requirements of DV	68.6	(46)	53.8	(43)	65.3	(49)	1.97
How and what DV questions to ask	68.6	(46)	70.0	(56)	54.7	(41)	2.38
Use of clinical protocols for documentation	68.6	(46)	58.8	(47)	68.0	(51)	.015
Characteristics & behavior of DV perpetrators	65.6	(44)	58.8	(47)	57.3	(43)	.577
Relationship between DV and pregnancy	65.6	(44)	53.8	(43)	62.7	(47)	1.20
Factors affecting victim's DV coping ability	64.1	(43)	55.0	(44)	49.3	(37)	1.60
How to interact with DV victims	64.1	(43)	68.8	(55)	53.3	(40)	2.04
What to do and not to do in DV situations	64.1	(43)	67.5	(54)	56.0	(42)	1.14
Signs/symptoms of abuse	62.7	(42)	43.8	(35)	50.7	(38)	2.67
Insurance coverage for DV victims	**62.7**	**(42)**	**76.3**	**(61)**	**82.7**	**(62)**	**3.90***
Referral sources for DV	61.2	(41)	48.8	(39)	42.7	(32)	2.52
Why a battered woman might not disclose abuse	59.7	(40)	45.0	(36)	46.7	(35)	1.83

NOTE: (1) Percentages are calculated based on the number of respondents for each category. (2) Missing data are excluded.
* p=<.05 (Statistically significant differences based on one-way analysis of variance).

Statistically significant differences were found among the three hospital groups in almost all knowledge areas, except three: the provider's role in detecting domestic violence; forensic aspects of healthcare; and use of clinical protocols as a means of evidence gathering and documentation. Social workers consistently perceived a greater level of knowledge in these areas. Only in the area of forensic aspects of healthcare did physicians report a higher level of knowledge than social workers.

The top information need areas of hospital providers, arranged in descending order of physician needs, are presented in Table 8. Information on barriers due to ethnicity, differences in cultural response to DV, forensic aspects of care, evaluation and reporting requirements, how and what questions to ask and the use of clinical protocols as a means of documentation were the highest areas of need. Overall, hospital providers expressed more informational needs than did community providers. Areas with the highest need for community providers (not presented here) were also information on cultural response to DV and barriers due to ethnicity/culture affecting victims' help-seeking behavior. Provider groups were not significantly different in their report of information needs, except in the area of information on insurance policies covering victims, where social workers perceived a much higher need.

Almost all providers reported that they would participate in continuing education programs on domestic violence. Both medical directors and nurse managers mentioned that their staff would also participate in such programs. Fewer physicians have reported attending an educational session on domestic violence than nurses and social workers. Physicians and nurses preferred receiving education through on-site training and audiovisuals. Other means included department meetings, self-training packets and computer-based learning. Conferences and seminars were the least preferred means. (Table 9)

Table 9. Hospital and Community Providers' Preferred Vehicles to Receive Educational Materials

	ED Medical Directors (n = 67)		ED Nurse Managers (n = 80)		Social Workers (n = 75)		Community Agency Dirs. (n = 18)		F Ratio
Printed	50.0	(33)	56.3	(45)	64.0	(48)	66.7	(12)	2.37
Audiovisuals	53.0	(35)	63.8	(51)	58.7	(44)	50.0	(9)	.39
Conferences/Seminars	**39.4**	**(26)**	**48.8**	**(39)**	**80.0**	**(60)**	**83.3**	**(15**	**22.43****
On-site training	**56.1**	**(37)**	**60.0**	**(48)**	**77.3**	**(58)**	**83.3**	**(15)**	**6.45***

NOTE: (1) Percentages are calculated based on the number of respondents for each category. (2) Column percentages exceed 100 due to multiple responses. (3) Missing data are excluded.
* p=<.01, **p=<.001(Statistically significant differences based on one-way analysis of variance).

Domestic Violence Protocols

Review of hospitals' domestic violence protocols revealed they are accomplished in some areas and need to make improvements in others. A positive aspect of the protocols included: use of bullet points/easy-to-read format, inclusion of domestic violence definitions and indicators, procedures for patient questioning, documentation and evidence collection, as well as inclusion of body charts and photograph consent forms. Listings of referral sources/phone numbers, as well as the identification of different points of hospital entry for victims, were also positive elements.

Overall, there was no standardization among domestic violence protocols. Protocols had inconsistent information and presentation style. Hospitals showing similarities in the information incorporated into

their protocols seemed to have adapted it from either of two documents distributed to hospitals in 1985 and '90, respectively, by the New Jersey Department of Community Affairs, Division on Women: *Domestic Violence: A Guide for Emergency Medical Treatment (1985)* and *Domestic Violence: A Guide for Health Care Professionals (1990).* Improvement is needed especially to avoid occlusion of document/evidence collection. Additionally, training materials were also inconsistent, outdated and inadequate. To address these gaps, new interventions and proper strategies will be developed and recommended in the next phase of this project.

RECOMMENDATIONS

This study has indicated a significant need for the development and implementation of services for treating and responding to the needs of battered patients. Based on identified barriers, assessed needs and providers' suggestions, many interventions will be developed in the next phase of the project. To assist providers in identifying abuse, breaking the cycle of violence and facilitating timely help for victims, it is strongly recommended that hospitals:

- Create a centralized office and/or designate knowledgeable personnel to perform domestic violence tasks as part of their job responsibility, e.g., establish DV protocols, training programs for all hospital staff addressing identified needs, collect all needed manuals and make them available as needed, keep all necessary directories and referral resources updated, etc.

- Improve ongoing communications between hospital and community service providers (shelters and outreach programs) and develop stronger working relationships.

- Develop a consistent tracking system throughout the hospital to record instances of domestic violence for more accurate statistics.

- Increase social worker coverage of the ED to include evenings and weekends for care management of DV, elder abuse and child abuse/neglect.

- Provide a private room to encounter DV victims.

- Routinely screen all patients for DV and document signs of abuse in medical records.

- Develop cultural competency guidelines to help healthcare providers improve screening and intervention services for victims from diverse backgrounds.

- Develop a Domestic Violence Community Education/Awareness Campaign for hospital internal and external audiences.

- Serve as a gateway to assist victims of violence through development of response team for onsite crisis counseling, follow-up, link to in-house and community resources.

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