

Research & Policy Brief

Maine Rural Health Research Center • Institute for Health Policy

July, 1999

Domestic Violence Is A Rural Health Issue

By Barbara Leitenberg, Editor, Rural Health News

In spite of a lack of resources and isolation, many rural communities are dealing with domestic violence with the help of their health care providers — an approach that the victims prefer and the providers are learning.

“Rural people tend not to report domestic violence incidents to the police, because family and friends are policemen,” says Laine Gibbs, director of the Colorado Domestic Violence Coalition. “While urban areas tend to have more resources such as shelters and special programs for Spanish language speakers, children and gays and lesbians, rural areas must make do with less,” she says.

“Rural victims of domestic violence suffer from isolation,” says Polly Campbell of Maine’s Muskie School of Public Service: “No phones, no transportation, longer police response times, and cultural norms that stress family loyalty and traditional gender roles.”

When asked about preferred confidants, victims of domestic violence, both urban and rural, overwhelmingly choose physicians — not clergy or police. But studies reported in the *Journal of the American Medical Association* have shown that although almost 90 percent would like to speak to their doctors, less than 10 percent of physicians take the time to ask them questions about violence in their lives.

“We think all physicians should screen for violence as part of a routine physical,” says Maine physician Dr. Robert McAfee, who helped launch the American Medical Association’s Campaign Against Family Violence in 1993. “Not screening because you’re in a rural area with few resources is a cop-out.”

Several states and communities have experimented with different approaches to engage rural health care providers in the battle against domestic violence. Whether the program starts in a rural health facility or as a state program, initiated by the state’s Attorney General’s office or by farm

worker women in California, the dual theme running through all of these approaches is: on-going staff training for the rural providers and community collaboration to expand resources for referral.

Getting local health care providers involved is a key because they are on the front lines, according to several domestic violence experts.

“One of the most common reasons for females aged 15 - 45 to go to the Emergency Room is domestic violence,” says Dr. John Nelson, obstetrician/gynecologist in Salt Lake City and spokesman for the AMA’s National Coalition of Physicians Against Family Violence. “As physicians, we miss the diagnosis of family violence 85 percent of the time,” he says. “If I can ask a patient questions about the most intimate details of her sex life, I can certainly

“Health care providers must realize that they can gather information about family violence rather quickly like they do other information—in ways that are not detailed or costly. Then they can make a referral, provide the basic information to reduce concern and go on to the next step.”

Gwen Wright, Director, Health and Human Services Bureau, New York’s state Office for Prevention of Domestic Violence.

make clear that she can talk to me about family violence. Rural is not an excuse for doing nothing.”

But health care providers often hesitate to ask these questions because they lack training and information, and they fear the amount of time it may take to respond, says Gwen Wright, director of the Health and Human Services Bureau in New York’s state Office for Prevention of Domestic Violence.

This Research and Policy Brief is funded by a grant from the Federal Office of Rural Health Policy, Health Resources and Services Administration, DHHS (Cooperative Agreement # CSUR00003-03-0). The conclusions and opinions expressed are the author’s and no endorsement by the University of Southern Maine or the funding source is intended or should be inferred.

“One advantage rural providers may have, however, is familiarity with their patients,” says Wright. “Unlike urban physicians who often rotate in clinics, rural providers know their patients well, and the patients are familiar with and rely on them. These kinds of relationships, she says, can lead to useful interventions.”

Maine Home To Several Rural DV/Health Care Projects

After a 1995 needs assessment noted domestic violence as a top concern among staff, patients, and community leaders in its eleven federally supported rural health centers, HealthReach Network decided to systematize its approach to the problem.

Serving towns in central and western Maine, with populations that range from 3,500-14,000, these clinics have decided to make themselves the place for people to get information, support, and resources for domestic violence problems. “They started with staff training,” says Kathy Calder, Rural Health Outreach Director. Then they developed and began to use a screening tool as a regular part of patient assessments. Each clinic has a site specific resource directory for domestic violence referrals, and they are developing in-house counseling because, says Calder, “it is not realistic to send patients out.”

For the past year, Richmond Area Rural Health Center in central Maine has had a battered woman’s advocate from the Maine Coalition to End Domestic Violence on staff. Funded through a grant from the Department of Justice, the advocate has trained the entire staff (including receptionist, maintenance personnel, and medical records clerk) in domestic violence issues. She has worked with a staff committee to develop a screening tool for use during all pre-natal and well-women visits and a logging system to record assessments and referrals. And she consults with patients upon referral by staff.

“We’ve always been concerned about domestic violence,” says Carol Browne, Practice Manager, “but we never had a formal policy or a screening tool to address it.”

For almost three years, four rural health centers in north coastal Maine have been building in-house expertise and encouraging community connections to fight domestic violence. The clinics are participating in a Centers for Disease Control funded project, “Rural Response to Intimate Partner Violence.”

“Each health center works inside and outside,” says project manager Alice Ann Carlton. Clinic teams, which include a physician, a physician assistant, and a nurse practitioner review screening and clinical response procedures and look for gaps in referrals. Clinicians have been trained in recog-

nizing the subtle signs of abuse and their long-term consequences. All staff have been trained in safety issues—procedures for reacting in a scenario where an angry spouse comes to the clinic with a drawn gun.

Citizens’ coalitions in each community develop awareness campaigns and figure out resources for specific needs—how to get food to someone, how to get transportation to school or to a support group.

“By the end of the grant period, we hope that each clinic will have developed enough of an inside and outside network to continue the work,” says Carlton. “You do it one health care center, one community at a time.”

Contact: Polly Campbell, Muskie School of Public Service, Institute for Public Sector Innovation, 207-780-5864; Tracy Cooley, Maine Coalition to End Domestic Violence, 207-941-1194.

States Join Project to Improve Domestic Violence Response in Clinical Settings

Ten states, including several rural communities, are participating in a Family Violence Prevention Fund (FUND) project to educate health care workers about domestic violence issues and improve prevention and treatment for victims.

“Health care alone cannot resolve the issues of domestic violence, nor can the justice system,” says Deborah Robinson, deputy director of Rural Initiatives at the Florida Governor’s Task Force on Domestic and Sexual Violence. “You need a total community approach, especially in rural areas, where a three-minute police response time is not likely and where you cannot have a confidential safe-house.”

In order to receive the FUND’s technical assistance and be able to improve services at 15 community health care sites, each participating state must develop a leadership team of health care providers, state health administrators, managed care representatives, and domestic violence organization staff. They agree to oversee and assist with the work of 15 community health agencies which want to improve their domestic violence responses.

Each community site chooses its own leadership team, composed of an administrator, a physician, a nurse, a social worker, and a domestic violence advocate from a non-profit

“It takes patience and perseverance to get a victim of domestic violence to talk to you,” says John Nelson, M.D., obstetrician and gynecologist. “Twenty percent of patients need 11-12 visits before sharing. Twenty-three percent of patients need 5-10 visits.”

agency. After several days of training, the community sites develop plans for screening and referral protocols, quality assurance, and community education. As the community sites work through their system changes, they meet with the state team to suggest statewide policy changes.

Clinicians need to know that asking questions about violence need not open a Pandora's Box of impossible requests, says Robin Hasler, director of the Florida Task Force. "Make the question as normal as asking about an allergy to penicillin," she says. "Then make the referral. Every rural area has a domestic violence agency connection."

In West Virginia, the eleven hospitals and four primary care centers participating in the FUND project are largely rural, says state project coordinator Diane Reese. The state's health plan includes a section on family violence, and the FUND project final report will inform that section. "One of our recommendations will involve requiring domestic violence training in state medical schools," Reese says.

The Joint Commission on the Accreditation of Hospitals and Health Care Organizations (JCAHO) mandated the development of protocols for the identification and treatment of abused women in emergency rooms in 1990 and hospital-wide in 1992.

A survey showing great differences between patient and provider perceptions of domestic violence (published in *Morbidity Mortality Weekly Report*, 47(32):670-3, 1998 Aug 21) spurred West Virginia's interest in the FUND project, Reese says. "Health care providers need the same kind of training in

domestic violence as other service providers. They can fix a broken arm, but they don't understand why the arm keeps getting broken."

Tiny Broadus Hospital in Philippi, West Virginia is participating in the FUND project. A community needs assessment involving health care providers, law enforcement, and town officials revealed domestic violence as a problem people wanted to work on, says Norma Workman, project coordinator. "Our team has been trained and is working on recommendations for screening and follow-up procedures," she says. Broadus is a Critical Access Hospital with 12 acute care beds.

Nurses in St. Joseph's Hospital emergency department and in the medical-surgical unit are instructed to ask about family violence, but a formal program is not yet in place, says Kimberly Farry, M.D., an obstetrician/gynecologist at this small hospital in rural Buckhannon, West Virginia (pop. 9000). "We are promoting domestic violence awareness among all employees and plan to screen every patient," she says. One example of the success of the hospital's information outreach has been a request by the local ambulance

squad for a full day's training.

Contact: Debbie Lee, Family Violence Prevention Fund, 415-252-8900. The ten states participating in the FUND project are: Alabama, Alaska, California, Florida, Iowa, New Hampshire, New Mexico, Nevada, Texas, and West Virginia.

Attorney General Helps Hospitals Address Domestic Violence

Illini Hospital in rural Silvis, Illinois is taking part in a project run by the state attorney general's office to develop domestic violence prevention teams in every one of the state's hospitals. Through an initial survey, Illini staff found out they needed to do a better job of screening for domestic violence.

"We found that our log of 19,000 patients showed only one or two notations for domestic violence," says Janet Eckhart, director of Emergency and Trauma Services. "We knew that wasn't right."

Now Illini is identifying 5-7 cases each month and referring them to appropriate resources, says Eckhart. "The hospital's public information campaign has tripled the calls made to the local domestic violence service agency," she says.

"Today teachers, social workers, health promotion experts, health care providers, medical and nursing associations, justice agencies, law enforcement agencies, and federal and state governments have [domestic violence] programs in place....Unfortunately, many of these programs operate side by side, rarely, if ever, intersecting. This lack of coordination may cause care to be fragmented, prolonged, and less effective than it could be." **Violence Against Women in the United States: A Comprehensive Background Paper**, The Commonwealth Fund Commission on Women's Health, November 1995.

"Started in 1996, the Attorney General's project has already reached every hospital in the northern half of the state," says coordinator, Nancy Carlson. "Participating hospitals have found that during the first six months, they were identifying more domestic abuse victims than they had during the past full year," she says. "But implementation of screening protocols is tough. It is impossible without the participation of a broad-based team, and especially a high-level administrator."

Contact: Nancy Carlson, Illinois Attorney General's Office, 312- 814-5846.

California Farm Women Organize Community Response to Domestic Violence

A grass roots domestic violence prevention project in California has found that success comes in small steps.

“Domestic violence is a personal and cultural issue, and it must be dealt with one person at a time,” says Mily Trevino-Sauceda, director of Organizacion en California de Lideres Campesinas (Farmworker Women’s Leadership Project). Since 1991, the project has trained 65 farmworker women to work for change in twelve rural California communities.

One of the farmworker women trainees counsels women at the Santa Rosa Del Valle Health Center, a migrant health center in the Coachella Valley. She tells the women where they can get help, that they are not alone, that domestic violence is neither right nor normal. “We are planning a domestic violence curriculum for health center staff,” says Trevino-Sauceda, “one that will be sensitive to existing cultural norms among farm workers.”

Contact: Mily Trevino-Sauceda, 909-865-7776

Arizona Hospital Builds Its Own Shelter

Almost two years ago, Parker Indian Hospital, serving the Colorado River Indian Tribes in La Paz County, Arizona opened a ten-room shelter for women and children fleeing domestic violence. With state and federal support and contributions from local health agencies and community groups, they are able to accommodate 25-30 people at a time and staff the building 24 hours a day, seven days a week. Over 100 women and children have used the shelter so far, says Gene Carnicum, social worker at Parker.

With assistance from the Family Violence Prevention Fund, Parker Indian Hospital has developed screening protocols for all women aged 14 and older. “It soon became clear to us that we needed a shelter on site,” says Carnicum. The closest alternative shelter is in Yuma, two hours away.

Contact: Gene Carnicum, 520-669-2137

Health Care and Domestic Violence in Rural Areas: Information and Resources

The Rural Face of Domestic Violence

• **Rural Woman Battering and the Justice System: An Ethnography**, by Neil Websdale, *Sage Series on Violence Against Women*, Vol. 6, January 1998. How cultural norms influence domestic violence and must be recognized by service providers.

• **Not In My Country**, by Kathryn Fahnestock. *Judges’ Journal*, Summer 1992. Addresses rural domestic violence victims’ use of and access to the courts and judicial education, attitude, and responsibilities.

• **Rural Task Force Resource Packet: Reflections on Rural Realities, National Coalition Against Domestic Violence**, 2nd ed., 1991. 150 page booklet includes **Rural Outreach Manual**, developed by the Pennsylvania Coalition Against Domestic Violence. For copies,

contact: National Coalition Against Domestic Violence, P.O. Box 18749, Denver, CO 80218; PH: 303-839-1852; FAX: 303-831- 9251.

• **Batterer Programs: What We Know and Need To Know**, by Edward W. Gondolf. *Journal of Interpersonal Violence*, 12(1), 83-98, 1997 February. Includes brief discussion about ways to extend programs to rural and minority communities.

• **Rural Domestic Violence and Child Victimization Enforcement and Stop Violence Against Indian Women** are federal Department of Justice grant programs, authorized by the Violence Against Women Act of 1994. Contact: Lauren Nassikas, 202-307-6026, or go to the web site: www.ojp.usdoj.gov/vawgo

continued

Health Care and Domestic Violence in Rural Areas: Information and Resources Continued

New Resources

• **Journey Beyond Abuse: A Step-by-Step Guide to Facilitating Women's Domestic Abuse Groups**, 21 group sessions based on a program developed by the Wilder Foundation (\$45); and **Moving Beyond Abuse: Stories and Questions For Women Who Have Lived With Abuse** (\$10). Contact: Amherst H. Wilder Foundation Publishing Center, 800-274- 6024.

• **You Are Not Alone/Usted No Esta Sola**, printed in English and Spanish, includes information and suggestions for women facing violence in their lives. 65 cents each for quantities of 1 - 999; 50 cents each for more than 1000. Contact: Novella Health Education, 800-677-4799.

• **No Woman Deserves To Hurt**, a two-volume video package with a companion manual designed to teach health care providers how to help prevent, detect, and treat domestic abuse and to provide referral services. Developed by the Pharmacia and Upjohn Foundation, Maternal Child Health Bureau, and American College of Nurse-Midwives, \$95. Contact: ACNM Publications, 202-728-9879.

• **Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers**, by the Family Violence Prevention Fund and the Pennsylvania Coalition Against Domestic Violence, 250 pages, \$75. Contact: FVPF, 415-252-8900.

• **Instant Evidence**, free informational video describing the use of an instant camera in documenting family abuse. Contact: Polaroid, 800-811-5764, ext.734.

Domestic Violence Resources For Health Care Providers

Several health professional organizations distribute information about domestic violence, including: guidelines, sample tools and protocols for diagnosis and treatment, and patient information packages. Contact:

- American Academy of Nursing, 202-651-7238
- American Association of Medical Assistants, 800-228-2262
- American College of Obstetricians/Gynecologists, 202-863-2518
- American College of Nurse Midwives, 202-728-9860
- American College of Physicians, 800-523-1546
- American Medical Association, 312-464-5066
- American Physical Therapy Association, 703-684-2782
- American Psychological Association, 202-336-6046
- Nursing Network on Violence Against Women, Jacquelyn Campbell, 410-955-2778
- Physicians for a Violence-Free Society, 415- 821-8209

Special contact: Family Violence Prevention Fund, Health Resource Center on Domestic Violence, 888-Rx-ABUSE (9-5 PST). Besides distributing a multi-disciplinary protocol for health care settings, information packets for various health specialties, health care resource and training manuals, and descriptions of best practices, the Fund publishes *Health Alert*, a newsletter about domestic violence issues for health care providers.

National Domestic Violence Hotline: 1-800-799-SAFE (7233). Funded by the federal Department of Justice and available in several languages, 24 hours a day, seven days a week, this service connects callers to state and community domestic violence agencies, shelters, and police in 50 states.

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Established in 1992, the Maine Rural Health Research Center (MRHRC) is one of five national rural health services research and policy analysis centers funded by the federal Office of Rural Health Policy. The Center is also one of five rural managed care centers funded by the federal Agency for Health Care Policy and Research (AHCPR). The Center has three areas of special interest in its research agenda: (1) the availability, organization, and financing of rural mental health services, (2) institutional and community-based services for rural elders, and (3) changes in the organization and financing of rural health services.

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Recently Published and Forthcoming Working Papers:

- Developing Non-medical Residential Care in Rural Areas: Current Approaches and Needed Policies (#18)
- Multiple Hospitalizations Among Older Nursing Home Residents: Is Rural Residence a Risk Factor? (#17)
- Effects of Managed Mental Health Care on Service Use in Rural Areas (#16)
- How Do Older Rural Medicaid Beneficiaries With Depression Access Care? (#14)
- Urban-Rural Differences in Employer-based Health Insurance Coverage of Workers (#13)
- Treatment and Outcomes Among Rural and Urban Nursing Home Residents with Depression (#12)
- Nursing Home Residents with Depression: What Mental Health Services Are Available to Them? (#11)
- Rural Models for Integrating and Managing Acute and Long-term Care Services (#10)
- Mental Health Carve Outs Under Medicaid Managed Care: Impact on the Rural Mental Health Delivery System (#9)
- Differences in Nursing Home Discharge Rates for Urban and Rural Nursing Facility Residents with Hip Fracture (#8)
- How Do Primary Care Practitioners Manage Depression: Treatment or Referral? (#7)