Health Care Screening for Domestic Abuse

- Domestic Abuse
  - Early Recognition
  - Prevention

Building a healthier and safer tomorrow while addressing escalating health care costs

Addressing our health care cost by enhancing collaboration between the medical profession and community agencies in recognition of a too often overlooked reason for many illnesses.

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I. Executive Summary

Problem

Domestic abuse is an under diagnosed social and psychological problem causing disabling illnesses in the United States.

- The problem of domestic abuse costs our health care system $**20-45 billion/year.**
- It has been identified that **only 2%** of domestic abuse injuries **are diagnosed** by physicians and that physicians are still too poorly trained on this topic to recognize signs of domestic abuse. Despite medical school training, only 10% of physicians report routinely screening for this problem.

Solution

This problem could be addressed and changed significantly by increasing awareness and educating the medical profession to recognize the signs and symptoms, routinely screen for this problem and by proper referral to trained professionals.

I. For every 1% of increase in detection by physicians in the United States, $250-450 million/year in health care costs would be saved.

Funding Requirement

In the initial phase of this project the plan will be to develop the basis for an advocacy program. The second phase is to implement the tools previously developed and the third phase will confirm the effectiveness of the proven approach.

II. Statement of Need

From present statistics the problem cost our health care system more than $5 billion a year. Since it is estimated that only 20% of abuse cases is actually reported, the estimated amount is than $**20 billion** a year. Physicians' lack of understanding of the source of the sickness exacerbates illnesses that may become chronic or worse over time, hence continued unnecessary medical care cost.

- Present statistics demonstrate that 3.3-10 million reported children are affected annually (1999), 3.9 million women annually, 1.01 million elders (1996). In summary: 31% of both genders were exposed to domestic abuse some time in their lives. This problem is more prevalent than diabetes, breast cancer and cervical cancer.

- The health care cost per victim is estimated to be $1700-3000 annually which confirms the estimated cost of $20-45 billion (15 million *(children, women and elderly)* x $3000 = $45 billion). Many statistics report only $5 billion. However, if we account for the fact that only 20% are reported, as well as children and elderly, the numbers do verify to the above amount. We also see that there are other hidden costs, that 54% miss work at least 3 days/month and a decrease in productivity was noted by 37% of employees. This accounts for nearly $1.8 billion in indirect costs of lost productivity or wages.

The above statistics show clearly that there is a significant need in this field.

1) As previously noted, the medical providers are insufficently trained to detect and prevent a problem that is more prevalent than breast and cervical cancer.

2) Only 2% of cases are diagnosed by physicians at this time. This puts health care providers in a unique position to help victims of abuse, if they know how to detect domestic abuse and provide victims with referral and support.

3) But, too often, health care providers do not discuss abuse with their patients or screen patients for domestic violence. Fewer than 10% of primary care physicians routinely screen patients for domestic abuse during regular office visits, according to a study published by the Journal of the American Medical Association in 1999.

i) Effectiveness of Intervention

- Researchers have consistently identified a positive benefit from AIP (Abuser Intervention Program) counseling in reducing the prevalence of intimate partner abuse.

- This work would improve the lives of women, children and the elderly as also some men, and eventually could affect 40% of the population of the United States in the future.

- An estimated $250-450 million in health care costs would be saved for every 1% increase in detection by physicians in the United States. If one was to look at the benefit to cost ration for one year, we would save $15-20 for every $1 spent on training, that is for health care only. Over a lifetime, we estimated the cost of training physicians across the country would be **very minimal** compared to the enormous benefits.

- Maltreatment can alter a child's physical, emotional, cognitive and social development and impact their physical and mental health throughout their lifetime. While we have yet to understand all of the ways which childhood maltreatment effects neurodevelopment, it is clear that the developing brain is exquisitely sensitive to and can be permanently altered by adverse experiences during childhood. Therefore, it is very difficult to estimate the extent of the cost we all pay. Unfortunately, while millions of children are maltreated each year, few resources are dedicated to solving the problem.

III. Project Description

i. Goals

 The overall plan is to:

- Develop and strengthen advocacy skills on issues related to domestic abuse affecting cost of health care of the United States.
- The main emphasis will be to focus on education for physicians in recognizing signs of the problem, following the guidelines of existing programs.
    - At this time, several resources are now available to enhance medical providers training through the Physicians for a Violence-free Society (PVS) and the American Women Medical Association.
- Develop an active program similar program to the PVS program in California, on the East Coast.
- Encourage medical societies and hospitals to offer courses in detection of domestic abuse.
- Give presentation to associations in hope of increasing public awareness.

ii. Summary of steps to achieve these objectives:

- **Analysis of existing data**
  - Address the preconceived ideas of ethnic and lower class focus in identifying patients and return with some quantified statistics on the full extent of the issues.

- **Promote solutions**
  - Promote solutions by identifying and learning to recognize the more subtle symptoms of abuse.
  - Increase participation among physicians in recognition of the problem through referral to local agencies or counseling.

- **Training or curriculum development and delivery of direct services**
  - Help develop training and new curriculum to give physicians tools to screen more effectively for domestic abuse to enhance maximum benefits for health care consumers.

- **Role modeling and benefits for health care consumers**
  - Educate health care consumers to report to physicians the possible link to their ailments.

- **Sustainable leadership**
  - Involve physicians in collaborating with organizations, by participating at the local level, such as medical societies, associations, and agencies.
  - Distribute teaching material and train advocate physicians to continue training.

- **Policy level changes**
  - It is my hope that the ripple effect of this work will bring policy changes such as a mandatory course for state licensing as well as support and participation in activities from other organizations that may involve policy level changes.

iii. Expected Outcomes

The following accomplishments are expected:

- An increase in physician awareness and ability to screen for signs of domestic abuse.
- Increased effectiveness in screening for domestic abuse.
- Decreased health care cost for illnesses and injuries due to domestic abuse.
- Sustainable training of physicians:

1. Ongoing training at medical societies level and at hospitals
2. Availability of material and resources for screening during physician's visit.
3. Network of physician to continue advocacy through workshops and speeches.
4. Identify sources of funding to have ongoing programs.

iv. Qualifications

I am confident that as a team we can bring a lot of strength to the field of domestic abuse screening.

The affiliations as well as consultants for this project should make a definitive impact.

v. Organization expertise

The following organizations will provide the advisory committee and resource needed:

A. PVS: Physicians for a Violence-free Society

B. FVPF: Family Violence Prevention Fund's

C. AMWA: American Women Medical Association

D. NYMC: New York Medical College

C. NCADV: The National Coalition Against Domestic Violence

1. Physicians for a Violence-free Society

Since 1993 PVS (Physicians for a Violence-free Society) has been involved in expanding the awareness that violence is both a social justice as well as a public health issue. PVS has been developing leadership and advocacy in the health care community. At the time PVS was established, there was little formal training for physicians and other health care providers to help them to recognize and intervene in cycles of family violence.

Well-established as a leading voice in domestic violence prevention, The Physician's Guide to Domestic Violence was published in 1995 by Drs. Salber and Taliaferro in order to address this training deficit. This book was a revolution in connecting the physician's role to screen and support victims of domestic violence and the prevention of continued abuse.

2. Family Violence Prevention Program

For more than a decade, the Family Violence Prevention Fund's (FVPF's) groundbreaking and highly successful National Health Initiative on Domestic Violence

has been improving the health care response to domestic violence through public policy reform and health education and prevention efforts. The National Health Initiative on Domestic Violence develops educational resources, training materials and model protocols on domestic violence and screening to help health care providers better serve battered women. Together with PVS, FVPF developed educational presentations to promote advocacy.

3. **New York Medical College, Coalition for Domestic Abuse**

The New York Medical College as well as the Coalition for Domestic abuse will serve as resources also and as a testing ground. More information on their background is available in the appendix.

v. Consultants expertise

David McCollum, MD, *Chair, Steering Committee*, National Advisory Council on Violence and Abuse of the American Medical Association

Ellen Taliaferro, MD *Co-Founder & Alumni Co-President of Physicians for a Violence-Free Society.* She is recognized as one of the nation's leading violence prevention experts and has educated thousands of physicians on violence prevention, through courses, lectures, and publications. She co-authored **The Physicians Guide to Domestic Violence**.

Carole Warshaw, M.D., *Founder of American College of Women's Health Physicians.* She served as Chair of the AMA Committee for Guidelines on Domestic Violence and has written and spoken extensively on issues related to domestic violence.

Elaine J. Alpert, MD, MPH., FACP. *Co-editor of Educating the Nation's Physicians About Family Violence, published in January 1997.* She has been on the faculty of Boston University since 1984. She currently serves as Associate Professor of Public Health and Medicine in the School of Public Health and the School of Medicine, and as Assistant Dean for Student Affairs in the School of Medicine.

Leigh Maracek, *Executive Director for PVS in California.* Leigh was the Director of Development and Program Director of the Oakland (California) RAP (Relationship Abuse Prevention) Project.

Nicolette Andrews, MD, founder of GetWell.org. Dr Andrews has been an advocate and very active on many medical boards.

Don Parsons, MD, Board of Director, National Patient Safety Foundation.

vi. Timeline

The above plan would be carried out over two years.

1. In the initial phase of this project the plan will develop the basis for an advocacy program.
2. The second phase will implement the tools previously developed by other organizations. This phase will require additional funding from other sources to accomplish its complete sustainable long term goals, such as for training materials and cost of training.
3. The third phase will confirm the effectiveness of the proven approach.
4. For the sustainable efforts, it is estimated that with the present project there will have been enough media exposure to impress the granters to contribute support for continued goals.

vii. Measurement of results

During the project, results will be measured to prove the effectiveness of the developed approach.

- A test will be given to physicians before and after their training and scores will be used to determine whether they are detecting domestic abuse more readily.
- Patients with known abuse will be evaluated for changes in health care needs to confirm the expected saving in medical costs.

IV. Conclusion

The problem of domestic abuse costs our health care system more than $**20-45 billion** a year.

It has been identified that **only 2%** of domestic abuse injuries **are diagnosed** by physicians at this time. Physicians are still too poorly trained on this topic, despite medical school training to recognize signs of domestic abuse as only 10% screen for this problem.

I feel strongly that it is important to advocate that by increasing awareness and educating the medical profession to recognize the signs and symptoms with routine screening and by proper referral to trained professionals, this problem could be addressed and changed significantly. For every 1% of increase in detection by physicians in the United States, $250-450 million/year in health care cost would be saved. My work will provide greater strength to several organizations and be mutually beneficial as well as benefit those affected by domestic abuse.

Your organization would be a perfect match for this program in assisting in a better communication between physicians and community organizations and by improving access to appropriate assistance. It is a leader in the engagement of physicians in civic life and in efforts to improve the quality and accessibility of health care and it inspires the profession to greater participation in civil society, a service to the community.

I sincerely hope that you will recognize the vital importance of this project.

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A. Background on consultants

David McCollum, MD, Chair, Steering Committee
National Advisory Council on Violence and Abuse of the
American Medical Association

Ellen Taliaferro, MD *Co-Founder & Alumni Co-President of Physicians for a Violence-Free Society*

Ellen H. Taliaferro, MD, FACEP, is the Medical Director of the Trauma Foundation in San Francisco, California, a Professor of Surgery, Division of Emergency Medicine. Ellen H. Taliaferro, MD is the Director of Research and Training at the Family Justice Center in San Diego. She is co-president and co-founder of Physicians for a Violence-free Society (PVS), a non-profit organization dedicated to helping physicians, other health care providers, and individuals play an active role in reducing violence in our society.

Dr Taliaferro is Board Certified in Emergency Medicine and completed a Pew Fellowship in Health Policy at UCSF. She is recognized as one of the nation's leading violence prevention experts and has educated thousands of physicians on violence prevention, through courses, lectures, and publications. She co-authored **The Physicians Guide to Domestic Violence**.

The James D. Mills Outstanding Contribution to Emergency Medicine Award was presented to Dr. Taliaferro in 1995 in Washington, D.C. In September 1996, the American Association of Women Emergency Physicians presented Dr. Taliaferro with the AAWEP Violence Prevention Award for developing programs to reduce violence in America. In March of 1999, *The Dallas Morning News*, in celebration of Women's History Month, published an article on The Texas 100. In this article, Dr. Taliaferro was included as one of 100 notable Texas women in recognition of her work as a physician and author working to break the cycle of domestic violence.

Carole Warshaw, MD, Founder of American College of Women's Health Physicians

Carole Warshaw, M.D. is board certified in Internal Medicine, Emergency Medicine and Psychiatry. She is currently the Director of Behavioral Science for the Primary Care Internal Medicine Residency at Cook County Hospital in Chicago. She also serves as Co-Director of the Hospital Crisis Intervention Project, a collaborative program of the Chicago Abused Women Coalition and the Cook County Bureau of Health Services. She served as Chair of the AMA Committee for Guidelines on Domestic Violence and has written and spoken extensively on issues related to domestic violence.

Warshaw, C. Domestic violence: Changing theory, changing practice. *JAMWA* 1996; 51 (3): 87

Warshaw, C. *Domestic violence: Treatment verus advocacy: Developing collaborative approaches for meeting the mental health need of battered women.* Commissioned report. Harrisburg, PA: National Resource Center on Domestic Violence; in press.

Warshaw, C. *Psychological abuse*. Presentation at Centers for Disease Control Conference, Des Moines, IA, 1995a.

Warshaw, C, Ganley, AL. *Improving the health care response to domestic violence: A resource manual for health care providers*. San Francisco: Family Violence Prevention Fund, Pennsylvania Coalition Against Domestic Violence; 1995b.

Warshaw C, Conway T, Hu T, Coffey V, Bullon AE, Kim P. Prevalence of victimization amongst women patients in an ambulatory walkclinic. 1995; Unpublished abstract.

Elaine J. Alpert, MD, MPH., FACP. Co-editor of Educating the Nation's Physicians About Family Violence, published in January 1997

Elaine Alpert, M.D., M.P.H. has been on the faculty of Boston University since 1984. She currently serves as Associate Professor of Public Health and Medicine in the School of Public Health and the School of Medicine, and as Assistant Dean for Student Affairs in the School of Medicine.

Dr. Alpert received her M.D. degree from the University of Michigan Medical School in 1977, and her M.P.H. from Boston University School of Public Health in 1985. She did her internship and residency in Internal Medicine at Boston City Hospital from 1977-1980. She then served as Medical Director of Mattapan Hospital, a chronic care and rehabilitation hospital of the Department of Health and Hospitals in Boston. She then undertook fellowship training in Rheumatology and then in General Internal Medicine. She joined the faculty of the Section of General Internal Medicine in 1984, and was appointed Assistant Dean of Student Affairs in 1987. She has been teaching in the School of Public Health since 1995 and joined the faculty of the School of Public Health's Department of Social and Behavioral Sciences in 1996. Dr. Alpert was elected as a Fellow in the American College of Physicians in 1999.

Dr. Alpert has been active for several years in health professions education and community outreach in family violence. She chaired the Committee on Violence for the Massachusetts Medical Society from 1992 to 1996, and chaired the Subcommittee on Family Violence for the Boston University School of Medicine Curriculum Committee. She founded and is the faculty advisor for the Boston University Family Violence Advocacy Project, serves on the Massachusetts Governor's Commission on Domestic Violence, and is a member of the Health and Public Policy Committee of the American College of Physicians. Dr. Alpert spearheaded the development of a model curriculum on family violence for Boston University School of Medicine, and has created a comprehensive post-graduate curriculum on domestic violence in collaboration with the Massachusetts Medical Society and the Stanford Faculty Development Program. She is also a faculty trainer for the Family Violence Prevention Fund's National Health Initiative. In recognition of her efforts in health professions education in family violence, Dr. Alpert was awarded the AMA Foundation Health Education Award in 1999.

Dr. Alpert has authored numerous articles and book chapters about curriculum development and patient care related to family violence and violence prevention, and is the lead author of a comprehensive domestic violence curriculum for physicians and other health care providers entitled The Massachusetts Medical Society Seminar Series on Domestic Violence. She is co-editor of Educating the Nation's Physicians About Family Violence, published in January 1997 as a Supplement to Academic Medicine. Dr. Alpert serves on numerous state and national advisory panels concerned with the health professions' response to family violence, and has spoken extensively to physicians, other

health professions groups, and community organizations about the role of health care professionals in responding to and preventing family violence and abuse. In addition to her expertise in family violence, Dr. Alpert has completed formal training in alternative dispute resolution and mediation through the Center for Health Care Negotiation.

Dr. Alpert lives near Boston with her three children who are now 11, 16 and 19, and enjoys singing, and folk and contra dancing. She also plays flute for a folk dance band in her free time.

1: Alpert EJ. Domestic violence and clinical medicine: learning from our patients and from our fears. J Gen Intern Med. 2002 Feb;17(2):162-3.

2: Alpert EJ. Have we overlooked the most common cause of maternal mortality in the United States? J Midwifery Womens Health. 2001 Jan-Feb;46(1):3.

3: Alpert EJ et al. Massachusetts Medical Society Seminar Series on Domestic Violence. Acad Med. 1999 May;74(5):589-90.

4: Alpert EJ et al. Family violence curricula in U.S. medical schools. Am J Prev Med. 1998 May;14(4):273-82.

5: Alpert EJ et al. Interpersonal violence and the education of physicians. Acad Med. 1997 Jan;72(1 Suppl):S41-50.

6: Alpert EJ et al. Family violence curricula in U.S. medical schools. Am J Prev Med. 1998 May;14(4):273-82.

8: Alpert EJ. Violence in intimate relationships and the practicing internist: new "disease" or new agenda? Ann Intern Med. 1995 Nov 15;123(10):774-81. Review.

9: Alpert EJ. Making a place for teaching about family violence in medical school. Acad Med. 1995 Nov;70(11):974-8.

Leigh Maracek, Executive Director for PVS in California

Leigh joined PVS during April of 2000. Since then, she has worked diligently to diversify the PVS funding base, expand PVS programs and build organizational infrastructure. Leigh has more than ten years of experience in grassroots, community-based organizations reflecting years of dedication to battered women, young adults and violence prevention.

Prior to joining PVS, Leigh was the Director of Development and Program Director of the Oakland (California) RAP (Relationship Abuse Prevention) Project. She supervised a six agency collaborative, in conjunction with the Oakland Unified School district. This program addresses the root causes of dating violence while examining the interconnectedness of all forms of violence and oppression. She authored the Educator's Guide and Appendix to the Oakland RAP Curriculum and was instrumental in the development and implementation in middle and high schools throughout Oakland.

Leigh is one of only thirty participants to receive a scholarship for the Community Development Institute's Professional Development for Consultants Program. This six-month program specializes in non-profit management and consulting in progressive social justice organizations. Their mission is to assist poor communities and communities of color while promoting racial and economic justice.

In late January 1999, Leigh was one of fifty women in California to graduate from the Women's Health Leadership Institute (WHL). Leigh received special notoriety for her thesis, which focuses on ethical nonprofit management and abuses of power in the non-profit sector. Leigh continues to develop this model and hopes to publish this work in the non-profit management literature.

Before moving to San Francisco, Leigh lived in Athens, Georgia where she was the Community Outreach Coordinator of Project Safe. Project Safe is a battered women's shelter serving a 10 county region in northeast Georgia. Leigh has provided numerous trainings on a city, county and state level including the Georgia Nurses Association, Athens Clarke County Police and Temporary Assistance for Needy Families (TANF) counselors.

Don Parsons, MD, Board of Director, National Patient Safety Foundation.

Dr. Parsons is a board certified surgeon who recently retired from Kaiser Permanente after 28 years in surgical practice, medical group management and health policy activity. He currently serves as Medical Director and Vice President of E Health Solutions Group, Inc.

 **Nicolette Andrews, MD,** founder of GetWell.org

- **Professional Activities:**

  Dr Andrews was a GEC associate at Mount Sinai Medical Center, on staff at Paukman Medical Associates, Executive Health, Amsterdam House and DeWitt Nursing Home. She also was on the Board of "The Doctor's Consultants" as well as with "Corporate Wellness". She worked extensively in the **primary care** sector as well as in occupational health.

  She has been very involved in **preventive** aspect of medicine and founded "Personal Wellness Programs". She worked with programs involving the American Cancer Society, the American Heart Association. In the corporate sector she was very involved with the New York Business Group on Health. As a staff member of **Corporate Wellness** she was the Medical Review Officer for many companies such as DLJ, BBDO, Associated Press, First Boston, Swiss Banks.. She was the Medical Coordinator for The Doctor's Consultants Physicians Service PC, a multi specialty practice. She was also very involved on the Corporate Development of these practices.

  In 1998 she left the private practice of medicine to pursue other goals. The practice of medicine was governed more and more by HMO's, she felt very strongly that it posed many ethical issues that made the practice of medicine very difficult. She continued to be involved in the corporate sector and has been active in nonprofit organizations such as GetWell, National Federation of Women and Red Cross.

- **Public Activities:**

  Dr Andrews, MD was very active with the New York Medical County Society, the Women Medical Association of New York and New York Business Group on Health. She served as a Board member in many capacities. She is a member of the American Medical Association, the American Medical Association Political Action Committee and the New York Academy of Sciences. Dr Andrews has given speeches, written articles and participated in political activities involving patient's **rights** and **physician's advocacy**. She has been involved in causes such as *preventing insurance abuse by employees* as well as *protecting patient's rights* when medical necessity was disputed.

She participated in the creation of GetWell as a project intended to **reduce health care cost** and addressing the public needs. This web based information system is intended to be used by State Health Medical Resources Help lines, towns, schools, youth drug and alcohol preventive programs... She was also very instrumental in the formation of the **On-line Post Trauma Counseling** after the September 11th, 2001 terrorist attack for families of victims as well as the youth sector.

B. Background on NYMC (New York Medical College)

New York Medical College specializes in the education of primary care physicians and is interested in offering clinical settings for some portion of the training and development of new curriculum.

- Through its various hospital and clinic affiliation, NYMC would offer a perfect testing environment.
- "Leading the nation in response to a shortage of primary care physicians, the School of Medicine developed a program early in the decade with the goal of doubling the number of medical school graduates who, after completing their residencies, enter generalist practices. The program, known as the generalist physician initiative, was awarded major funding from The Robert Wood Johnson Foundation, one of only 18 nationwide to be so designated. One innovative aspect of the generalist physician initiative, offered in conjunction with academic health center partner Saint Vincent's Hospital and Medical Center of New York, affords eligible fourth-year medical students an opportunity to begin a residency program in Internal Medicine and thereby complete training in six years rather than the traditional seven."

Contact: Donald Brand, Ph.D., Director for Primary Care Research

C. Background on PVS (Physicians for a Violence-free Society)

- "Since 1993 PVS (Physicians for a Violence-free Society) has been involved in expanding the awareness that violence is both a social justice as well as a public health issue.

- PVS has been developing leadership and advocacy in the health care community. At the time PVS was established, there was little formal training for physicians and other health care providers to help them to recognize and intervene in cycles of family violence. Well-established as a leading voice in domestic violence prevention, The Physician's Guide to Domestic Violence was published in 1995 by Drs. Salber and Taliaferro in order to address this training deficit. This book was a revolution in connecting the physician's role to screen and support victims of domestic violence and the prevention of continued abuse.

- PVS had envisioned that the CPN (California Physician Network) would create an educated network of physician activists that would

    - support and further the work of existing community-based family violence prevention organizations; meaningful and long-lasting connections between physicians and their communities; and

    - A statewide organizing model for physicians that can be applied nationally.

- The California Physician Network (CPN) launched in the fall of 2000 as a PVS pilot program designed to build collaborations and connections among California health care professionals concerned with family and intimate partner violence.

- Just 3 years later, The **National Physician Network (NPN)** launched a year ahead of schedule thanks to the proven success of the CPN pilot and the interest of PVS members nationwide! "

Contact: Leigh Maracek, Executive Director

Physicians for a Violence-free Society
160 14th Street
San Francisco, CA 94103 Phone: 415.621.3582 Fax: 415.621.3438 Leigh@PVS.org

D. Background on AMWA (American Medical Women Association)

The American Medical Women's Association (AMWA) is an organization of 10,000 women physicians and medical students dedicated to serving as the unique voice for women's health and the advancement of women in medicine.

AMWA was founded in 1915, at a time when women physicians were an under-represented minority. As of 1998, 23% of all practicing physicians are women.

As women in medicine increase in numbers, new problems and issues arise that were not anticipated. Other medical organizations are starting to recognize these problems and are looking at ways to address them. AMWA has been doing this for over 85 years.

Some of the women's health issues AMWA has worked to improve include smoking prevention and cessation, osteoporosis, violence against women, heart disease, gender equity, breast cancer, and reproductive health. AMWA has worked to improve the financing mechanisms for medical students and for gender equity in medical education. Association members have testified before Congress on many of these issues. AMWA's policy agenda includes a focus on tobacco control and prevention, reproductive health, affirmative action, and managed care. Click here for a list of Resolutions and Position Papers.

- In 1999 AMWA completed its first on-line CME project on domestic abuse.
- With estimates that up to 4 million women are battered every year in the United States, leading to a lifetime prevalence of 10 to 15 percent, there is no doubt that domestic violence is a health issue for many, many American women. Yet, while health care providers are often the first professionals to access the victim, many domestic violence cases go undetected because health care professionals **are not trained** in how to recognize the signs and symptoms of abuse.

Contact: Project Leader: Marjorie Braude, MD (703) 838-0500/ (310) 476-2055

American Medical Women's Association
801 N. Fairfax Street, Suite 400
Alexandria, VA 22314
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info@amwa-doc.org

E. Background on NACDV (National American Coalition for Domestic Violence)

Mission Statement and Purpose

- NCADV is dedicated to the empowerment of battered women and their children and therefore is committed to the elimination of personal and societal violence in the lives of battered women and their children.

- NCADV serves as a national information and referral center for the general public, media, battered women and their children, allied and member agencies and organizations. NCADV has a strong track record of providing programs with information and technical assistance, and has promoted the development of innovative programs, which address the special needs of all battered women, and the battered women's programs. NCADV has sponsored eight National Conferences on domestic violence, which provide a unique forum within the battered women's movement for networking, dialogue, debate, leadership development and celebration.

- NCADV also serves to impact public policy and legislation, which affects battered women and their children. NCADV organized testimony for the Attorney General's Task Force hearings on Family Violence; worked with federal legislators to develop priorities for Victims of Crime Act (VOCA) funds for battered women's programs; supported the development and passage of the Violence Against Women Act (1994); and was active in the passage of the Domestic Violence Offender Gun Ban (1996).

Contact: Kathryn Doud, Director

Domestic Abuse Services

259 E. Putnam Ave
Greenwich, CT 06830
Phone: 203-869-6501 Ext 172 Fax: 203-629-8187

Budget			**Advocacy**		**Research**		**Training**
Expenses							
Personnel Services							
Executive Director	60000	50%	30000	25%	15000	25%	15000
Assistant	40000	50%	20000	25%	10000	25%	10000
Program Coordinator (s)	40000		0		0	100%	40000
Consultants (not a fixed cost)	200000	40%	80000	50%	100000	10%	20000
Temporary	20000		0	50%	10000	50%	10000
Fringe Benefits	52800	20%	10560	30%	15840	30%	15840
Non-Personnel Services							
Overhead	50000	20%	10000	40%	20000	40%	20000
Equipment	10000	20%	2000	40%	4000	40%	4000
Program and office supplies	15000	10%	1500	45%	6750	45%	6750
Testing Supplies	5000	0%	0	100%	5000	0%	0
Travel	20000	10%	2000	45%	9000	45%	9000
Telephone and postage	10000	10%	1000	45%	4500	45%	4500
Printing	10000	10%	1000	45%	4500	45%	4500
Maintenance	5000	20%	1000	40%	2000	40%	2000
	Total		Advocacy		Research		Training
Total budgeted expenditure	**$537,800**		$159,060		$206,590		$161,590
Income							
Foundations	$387,000						
Private contributions	150,800						
Total anticipating income	**$537,800**						

PHYSICIANS FOR A VIOLENCE-FREE SOCIETY
160 14TH STREET □ SAN FRANCISCO, CA 94103
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Claudia Calhoon, MPH
Program Officer
Open Society Institute
400 West 59th Street
New York, NY 10019

January 21, 2004

Dear Ms Calhoon:

This letter is to express our support for the application by Dr. Nicolette Andrews to receive a Soros Advocacy Fellowship for Physicians.

As Dr. Andrews application states, failure to properly assess and treat domestic violence abuse adds extremely large but often unrecognized costs to our medical system. If more physicians put into practice appropriate methods for assessing domestic violence abuse and responding, the escalating cycle of domestic violence would often be cut short. Not only would the waves of serious short and long-term consequences be avoided and the costs not incurred, but the human suffering and anger that help to re-create the cycle of violence in future generations would be avoided.

Physicians for a Violence-free Society is the only organization dedicated to helping physicians assess, treat and prevent domestic violence. We also aid physicians in understanding and preventing domestic violence as it intersects with child abuse, elder abuse, gun violence and the mental health needs of patients.

I can recommend funding of her impressive proposal without reservation.

Yours sincerely,

LeighMerecek

Leigh Merecek,
Executive Director

Preventing Violence Is Good Medicine.

Internal Revenue Service

Department of the Treasury

P. O. Box 2508
Cincinnati, OH 45201

Date: July 26, 2000

Person to Contact:
Ms. Regina Parker 31-03074
Customer Service Representative
Toll Free Telephone Number:
8:00 a.m. to 9:30 p.m. EST
877-829-5500
Fax Number:
513-263-3756
Federal Identification Number:
94-3192196

Physicians for a Violence-Free Society
% Ellen Taliaferro
1001 Potrero Bldg. 1 Room 300
San Francisco, CA 94110-3518

Dear Sir or Madam:

This letter is in response to your request for a copy of your organization's determination letter. This letter will take the place of the copy you requested.

Our records indicate that a determination letter issued in May 1994 granted your organization exemption from federal income tax under section 501(c)(3) of the Internal Revenue Code. That letter is still in effect.

Based on information subsequently submitted, we classified your organization as one that is not a private foundation within the meaning of section 509(a) of the Code because it is an organization described in sections 509(a)(1) and 170(b)(1)(A)(vi).

This classification was based on the assumption that your organization's operations would continue as stated in the application. If your organization's sources of support, or its character, method of operations, or purposes have changed, please let us know so we can consider the effect of the change on the exempt status and foundation status of your organization.

Your organization is required to file Form 990, Return of Organization Exempt from Income Tax, only if its gross receipts each year are normally more than $25,000. If a return is required, it must be filed by the 15th day of the fifth month after the end of the organization's annual accounting period. The law imposes a penalty of $20 a day, up to a maximum of $10,000, when a return is filed late, unless there is reasonable cause for the delay.

All exempt organizations (unless specifically excluded) are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of $100 or more paid to each employee during a calendar year. Your organization is not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the excise taxes under Chapter 42 of the Code. However, these organizations are not automatically exempt from other federal excise taxes.

Donors may deduct contributions to your organization as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to your organization or for its use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Physicians for a Violence-Free Society
94-3192196

Your organization is not required to file federal income tax returns unless it is subject to the tax on unrelated business income under section 511 of the Code. If your organization is subject to this tax, it must file an income tax return on the Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your organization's present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

The law requires you to make your organization's annual return available for public inspection without charge for three years after the due date of the return. You are also required to make available for public inspection a copy of your organization's exemption application, any supporting documents and the exemption letter to any individual who requests such documents in person or in writing. You can charge only a reasonable fee for reproduction and actual postage costs for the copied materials. The law does not require you to provide copies of public inspection documents that are widely available, such as by posting them on the Internet (World Wide Web). You may be liable for a penalty of $20 a day for each day you do not make these documents available for public inspection (up to a maximum of $10,000 in the case of an annual return).

Because this letter could help resolve any questions about your organization's exempt status and foundation status, you should keep it with the organization's permanent records.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

This letter affirms your organization's exempt status.

Sincerely,

John E. Ricketts

John E. Ricketts, Director, TE/GE
Customer Account Services

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Domestic Violence: Confronting A Healthcare Epidemic

by Ellen Taliaferro, M.D.

Domestic violence has reached epidemic proportions in this country, and yet it remains one of the least reported and most misunderstood health issues facing our society today. If fully recognized and treated like other illnesses, domestic violence would likely be as common, if not more so, than breast cancer, and far more prevalent than hypertension, colon cancer, hepatitis and many other medical conditions which healthcare providers routinely screen and treat. (1)

According to a study by the Bureau of Justice Statistics, released in May 2000, as many as 850,000 women each year are victims of violent crimes committed by an intimate partner. Clearly, domestic violence has an enormous health impact on the victims and their families, as well as the entire healthcare system. It is estimated that direct medical expenses for the care of battered women is around $1.8 billion per year(2) a cost hospital administrators must manage. Fortunately, great strides are being made to expose and treat this epidemic.

Healthcare Providers Lead The Fight

In the medical arena, the challenges of fighting domestic violence are significant. Especially since many healthcare providers have not been trained to identify and respond to victims of domestic violence. In response, charitable, non-profit organizations such as Physicians for a Violence-free Society (PVS) have formed to help stop the cycle of violence by promoting leadership and advocacy in violence prevention in the healthcare community.

PVS acknowledges that it takes training, courage, time and sensitivity to recognize, inquire and properly document the results of a domestic violence situation. And, armed with the proper skills presented in the PVS Assessment Response Course: Systems Approach to Partner Violence Across the Life Span, a Polaroid Spectra Close-up Instant Camera Kit and film, and the desire to make a difference, many health and law professionals nationwide are embracing a simple philosophy -- ask the question, take the picture and break the cycle.

Breaking The Cycle

To effectively break the cycle of domestic violence, healthcare providers must acquire an understanding of its repetitive and escalating nature. What starts as a push or shove today, becomes a kick or a head-blow tomorrow. The injuries worsen as the cycle continues.

The more quickly police, hospital staff, employers and other service providers intervene in

a domestic violence situation, the sooner the victim will realize that they need not be victimized. This realization is a critical link in breaking the cycle.

Good Documentation Is Key

Through collaborative efforts between law enforcement, healthcare providers, and other community-based programs, many metropolitan areas across the country are taking a stand against domestic violence. One of the more effective weapons in this fight is the Polaroid Spectra Close-up Camera Kit that police and medical personnel typically use for documenting injuries. Toward this end, Sergeant Andrea Perez, who heads up the Family Violence Unit for the Dallas Police Department, turned to the Violence Intervention Prevention (VIP) Center of Parkland Hospital to train police officers from major precincts to document domestic violence. Utilizing the PVS Assessment Response Course and Polaroid Spectra cameras, instructors from the Polaroid company and the VIP Center trained police officers to document domestic violence injuries in the field and in follow-up visits.

The use of instant photography for evidence documentation in domestic violence cases can be extremely effective in helping with prosecutorial efforts to obtain guilty pleas. Through photographic documentation, victims feel more empowered to support the prosecution; abusers are often more likely to plead guilty, or in those cases where they contest the charges, the pictures significantly enhance evidence to support the prosecution.

By the time the trial takes place, the victim's injuries have healed, and the bruises have faded. Presenting photos of the injuries can preserve the extent of those injuries, dramatizing them for both judge and jury.

While various types of photo and video documentation exist, many healthcare providers rely on the Polaroid instant camera and film because of its ease-of-use, close-up capability and the ability to obtain solid, tamper-proof evidence, available for review instantly. Capturing a good, clear picture of the injuries, on the spot, is critically important. Digital cameras also offer instant results, but present a more complicated issue when it comes to the important chain of evidence issue stipulated by the legal system. Because digital images can be manipulated through computer programs, it becomes necessary to painstakingly maintain the chain of evidence to assure that no modifications that have been made to the digital images before presenting them to the district attorney.

The Cost of Caring

Healthcare costs in this country continue to skyrocket. National health expenditures in 2002 are expected to reach $1.5 trillion.(3) And, the sheer magnitude of the domestic violence problem makes it one of the mostly costly to our healthcare system.

The multibillion-dollar burden domestic violence places on taxpayers and the medical community is only the beginning when one considers the following: 22 to 35 percent of women visiting emergency departments in the U.S. are there for symptoms related to ongoing abuse.(4) In addition, families in which domestic violence occurs use doctors eight times more often, seek emergency room treatment six times more often, and use six times more prescription drugs than the general population. (5)

Hospital administrators are quickly becoming aware of the tremendous value that

intervention efforts can yield. Time spent identifying domestic violence victims may actually result in time and cost savings, since many of these patients will continually return to the medical setting with abuse related symptoms throughout their lifetime - unless the cycle can be broken.

Administrators, while caught in a balancing act with precious healthcare resources, have started to see the importance of screening for family violence, just as they do for alcohol abuse, drug abuse and mental illnesses. Through early detection it is possible to reduce the impact on healthcare budgets.

Programs that utilize instant photography and written documentation have been effective in reducing hospital cost by helping victims take a legal stand against their abusers, thus breaking the cycle of violence before additional injury can be inflicted. In addition, detailed documentation can help decrease expenditures by eliminating the need for medical personnel to appear in court - a huge benefit for practitioners, nurses and other hospital personnel. Proper documentation can also be beneficial in protecting healthcare providers from possible liability for failure to screen and provide safety assessment and referrals of victims.

A Matter Of Conscience

Domestic violence is not simply a personal matter, nor is it just a law enforcement or criminal justice concern. Because it profoundly affects patients' health, as well as their children's health, healthcare professionals need to identify, document, treat, and refer victims of domestic abuse.

Fitting with the social mission of healthcare organizations, the ultimate goal of providers should be to empower the victim with knowledge and resources so she can make her own decisions and take the necessary steps to break free from the violence in her life.

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(1) Sassetti MR: Domestic violence. Primary Care 1993; 20

(2):289-305 Wisner, et at, Journal of Family Practice, 1999; 48(6):439-43

(3) Heffler et al, Health Affairs, 2002

(4) Colorado Domestic Violence Commission: Domestic Violence for Healthcare Providers, 3rd Edition, 1991

(5) Domestic Violence Intervention Calls for More than Treating Injuries, Journal of the American Medical Association, 1990

Physician Training Improves Domestic Violence Outcomes

by Arline Kaplan

Psychiatric Times •April 2001 •Vol. XVIII •Issue 4

"It is very compelling when you see a woman in a domestic violence situation that was unrecognized, and then she gets murdered," psychiatrist Marjorie Braude, M.D., told *Psychiatric Times*. Braude is founding chair of the Los Angeles City Domestic Violence Task Force and course director of the American Medical Women's Association's (AMWA) domestic violence online education course <www.dvcme.org>.

The incidence and prevalence of domestic violence is high, according to Braude. Findings from the National Violence Against Women Survey estimate that approximately 1.5 million women and 834,732 men are raped and/or physically assaulted by an intimate partner annually in the United States. Because many victims are assaulted more than once a year, researchers estimate that, annually, some 4.8 million intimate-partner rapes and physical assaults are perpetrated against women and approximately 2.9 million physical assaults are committed against men (Tjaden and Thoennes, 2000).

Domestic violence is also linked to homicide, injuries and suicide, as well as depression and many other psychiatric disorders. According to Federal Bureau of Investigation reports, 1,218 women and 424 men in 1999 were murdered by their past or present intimate partners (Fox and Zawitz, 2000). In a study of female trauma patients treated in an emergency department (ED), nearly one-third were identified as having injuries caused by battering (McLeer et al., 1989). Furthermore, domestic violence is a factor for one in three women who attempt suicide and may be the "single most important cause of female suicidality, particularly among black and pregnant women," according to Stark and Flitcraft (1995). In a study of psychiatric ED patients, 49% (17 of 36) of the female patients and 8% (4 of 48) of the male patients reported being the victim of spousal abuse when interviewed by clinicians who had received trauma awareness training (Currier and Briere, 2000).

Based on findings like these, Braude believes the psychiatric community should be doing much more to increase awareness of the frequency and dangers of domestic violence and should give psychiatrists some tools for diagnosing and treating it effectively.

A recent study by Garimella and colleagues (2000) assessed the domestic violence training of specialists in psychiatry, emergency medicine, family practice, and obstetrics and gynecology. Surveys were sent to 150 physicians affiliated with an urban hospital in Virginia, and 76 (51%) responded. Of the respondents, 21% received no training about domestic violence while in medical school, 59% received little training and 20% received moderate training. None said they received a great deal of training. Additionally, approximately 80% of the respondents said they had never received postgraduate training about domestic violence.

The study authors also used previously validated scales to measure physicians' attitudes about their roles in domestic violence cases, beliefs about victims and beliefs about resources available to them to assist victims. While all 10 of the psychiatrists who responded said part of their role was to assist victims of domestic violence, only 44% held supportive (non-blaming) attitudes toward victims. Of the four specialties represented, psychiatrists were the least supportive; 56% of family practice practitioners, 57% of ED physicians and 88% of obstetricians and gynecologists had supportive attitudes toward victims.

Responses to selected items on the attitude scales proved instructive. Of all the physician respondents, 55% said they had patients "whose personalities cause them to be abused"; 49% said the victim's "passive-dependent personality often leads to abuse"; and 34% said "a victim must be getting something out of the abusive relationship, or else she would leave."

Psychiatrists were significantly more likely to believe they have resources available to them to assist battered women than were physicians in other specialties. Ramani Garimella, M.D., principal author of the study, said in an interview with *PT* that psychiatrists also scored much higher on verbal statements reflecting behaviors toward domestic violence victims. For example, on a question probing whether they had enough time to ask about spousal abuse, 100% of the psychiatrists said yes, compared to 91% of ED physicians, 84% of OB-GYNs and 67% of family physicians. On a question of whether they would suspect domestic violence in patients presenting with chronic pain, depression or other illnesses, 40% of the psychiatrists said yes, compared to 46% of OB-GYNs, 20% of ED physicians and 6% of family practitioners.

In order to increase the recognition and treatment of patients experiencing domestic violence, mental health care professionals need to recognize that any patient who is depressed, anxious or suicidal may be responding to a crisis in domestic violence, Braude said. In addition, clinicians need to take a history that will discover domestic violence and "give it profound consideration in the treatment plan," she added.

Possible questions that can elicit such information include:

- Have you recently experienced violence at the hands of someone close to you?
- Is there someone in your immediate environment of whom you are afraid?
- Do you have any history of violence from a significant other?

It is important that patients be interviewed in private, Braude added.

"If the [significant] other is present, the patient is not free, [since] telling the truth may precipitate another episode of violence. It is also very important that in cases in which the physician knows both the perpetrator and the victim that they be interviewed and treated separately…That is the only way the victim can feel free to pursue her own therapeutic needs. And the perpetrator needs to be approached separately from the point of view of his needs."

Clinicians need to carefully assess the danger to the victim and others in the household by determining if the perpetrator abuses alcohol or drugs; if there is a gun in the house; if the violence is escalating; if, in addition to the victim, children or pets are being abused; and if there have been threats of murder. If the victim is not ready to leave the abuser, she will need help in formulating a safety plan to keep her and other household members out of danger. That plan might include identifying a support network and prearranging help, teaching children to call the police if necessary, and becoming familiar with basic legal options and local emergency resources.

Braude also advised mental health care professionals against a rush to diagnosis, noting that it is preferable and diagnostically more accurate to defer diagnosis until the person is

out of danger and has had the opportunity to heal. She particularly warned against an early diagnosis of personality disorder.

"It is my belief that you cannot diagnose a personality disorder in someone who is being terrorized, for two reasons. First, I have seen a person's personality and responses change remarkably when the source of the terror is removed. Second, one needs to be cautious, since the personality-disorder label implies that the patient has some basic flaw in how [she] as a personality meets with situations in her life. That [label] can be used by the perpetrator in court who wants to assign the responsibility to the victim," Braude said.

She added that "victims of domestic violence are slow to come to psychiatrists, because they fear (and their fear is often justified) that any psychiatric records will be used against them if they confront the perpetrator in court."

Because the records may be subpoenaed, psychiatrists need to keep very good and careful records, ensuring that the patient is recognized as a victim of domestic violence.

Prescribing psychotropic medications is also a concern. In AMWA's course, clinicians are advised to evaluate the victim for substance abuse (alcohol and drugs often play a role in episodes of violence between intimates) and to obtain a detailed list of prescribed and over-the-counter psychotropic medications that the victim is taking before further prescribing medications.

Antidepressants and, to a limited extent, antianxiety medications can be useful in treating victims of domestic violence, Braude said. Still, they must be given in the context that the victim has realistic reasons for terror and may benefit from medication that enables her to feel less paralyzed by anxiety and depression, so that she can function and cope with her situation. At the same time, it is important not to overmedicate the victim, because she needs to be fully alert and aware in case of further attack and in order to plan how to handle the situation.

It is also important that clinicians are aware of community resources to which they can refer the victim in an emergency, such as shelters and hotlines, Braude said. *(For more information on this topic, please visit www.psychiatrictimes.com/dvhelp.html and "National and State Responses to Domestic Violence Challenge" in this month's Special Report-Ed.)* Even when patients do not initially admit to being victims of domestic violence, they can be helped. Courses such as the AMWA's online course can provide significant guidance to mental health care professionals. For instance, it suggests a generic form providing the numbers of local, state and national domestic violence hotlines be given to all patients as well as placing posters with appropriate referral numbers in waiting rooms.

Garimella, who worked with victims of domestic violence in India and completed an internship at a domestic violence training program in New York City, also believes that training for physicians needs to be revamped.

In their study, Garimella and colleagues found that training (either in medical schools or postgraduate) does not affect physician attitudes. "This [lack of change] may be because most domestic violence curricula are didactic in nature and are theory driven," she explained.

"Many physicians I've talked with feel hopeless about making a difference in the lives of victims of domestic violence," she added. "They are frustrated, believing that they have given the victims a prescription to leave the violent environment, and the victims are being noncompliant…There needs to be some way to have a positive association between medical intervention and outcomes of ending the violence. It might be more useful to have former victims of domestic violence talk with physician groups about how medical services have helped them."

Other components suggested by Garimella and her study co-authors include the use of interactive learning strategies (e.g., role-playing and simulated patients and computer-based models to reinforce information given in a didactic manner). Also valuable to physicians is a list of local domestic violence resources and face-to-face contact with representatives of those resources.

"Ultimately, women make their own decisions as to when they are ready to leave a violent situation," said Garimella. "Physicians can help by listening to the victims without feeling embarrassed, by acknowledging that a problem exists rather than…overlooking the black eye when a patient says she bumped into a wall and by assuring the patient that they can help in specific ways."

References

Currier GW, Briere J (2000), Trauma orientation and detection of violence histories in the psychiatric emergency service. J Nerv Ment Dis 188(9):622-624 [letter].

Fox JA, Zawitz MW (2000), Homicide trends in the United States. U.S. Department of Justice, Bureau of Justice Statistics. Available at: www.ojp.usdoj.gov/bjs/homicide/homtrnd.htm. Accessed Feb. 1, 2001.

Garimella R, Plichta SB, Houseman C, Garzon L (2000), Physician beliefs about victims of spouse abuse and about the physician role. J Womens Health Gend Based Med 9(4):405-411. McLeer SV, Anwar RA, Herman S, Maquiling K (1989), Education is not enough: a systems failure in protecting battered women. Ann Emerg Med 18(6):651-653.

Stark E, Flitcraft A (1995), Killing the beast within: woman battering and female suicidality. Int J Health Serv 25(1):43-64.

Tjaden P, Thoennes N (2000), Extent, Nature, and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey. Sponsored by the National Institute of Justice and Centers for Disease Control and Prevention.