Improving Health Care for Victims of Abuse in British Columbia

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Executive Summary

Abuse is an important health care issue because of the vulnerable proportion of the population that are affected, the adverse health effects of abuse, and the high cost to the health care system needed to treat the abused. Younger women, pregnant women, Aboriginal women, women in common law relationships and people with disabilities experience significantly higher rates of family violence (Doherty, 2002). As of 2004, the estimated number and rate of spousal violence incidents against women and men 15 years of age and over the past five years in BC was 183 000 or 8% (Statistics Canada, 2006). The negative impacts of abuse include several long-term adverse emotional, mental and physical health effects. In Canada, it is estimated that the health care costs that result from violence against women is approximately $1.5 billion/year (Morrow and Varcoe, 2000).

Given that 8% and 39% of abused women seek medical care (Ferris et al., 1997), health care professionals are the most likely to encounter abuse victims, potentially multiple times. Thus, it is critical that all health care professional properly identify victims of abuse. The lack of abuse awareness, sensitivity and/or knowledge and the poor diagnosis of abuse victims among health care workers are two critical health care related issues that are discussed.

Several potential solutions for improving the health care of abuse victims are presented including: making the reporting of abuse mandatory; the creation of a province-wide 24 hour toll free help line for all abuse victims; and recommendations for raising awareness about abuse (i.e. ad campaigns that include television commercial) and reaching out to victims of abuse in health care settings.
Topic: Improving Health Care for Victims of Abuse in British Columbia

Explanation:

Abuse can be defined as “the misuse of power with the intent of harming or controlling another. It can be physical, mental, sexual or economic”. A person of any gender, sexual orientation, age, socioeconomic status or culture can be abused (Vancouver Coastal Health, 2007). Abuse is an important health care issue because of the vulnerable proportion of the population that are affected, the adverse health effects of abuse, and the high cost to the health care system needed to treat the abused.

A person of any gender, sexual orientation or gender identity; any age, socioeconomic status or culture can be an abuser or abused (Vancouver Coastal Health, 2007). However, younger women, pregnant women, Aboriginal women, women in common law relationships and people with disabilities experience significantly higher rates of family violence (Doherty, 2002). The following statistics emphasize the impacts and prevalence of abuse in Canada:

- In Canada, it is estimated that 4% or 98,000 seniors have been abused (Morrow and Varcoe, 2000).
- As of 2004, the estimated number and rate of spousal violence incidents against women and men 15 years of age and over the past five years in BC was 183,000 or 8% (Statistics Canada, 2006).
- In a 2004 survey, 21% of abused women were assaulted during pregnancy, and in 40% of these abuse cases, abuse during pregnancy was the first occurrence of abuse in the relationship (Statistics Canada, 2006).
- In BC, approximately 36% of women who had ever been married or lived in a common-law relationship reported being physically or sexually assaulted by a marital partner at least once during the relationship” (Morrow and Varcoe, 2000).
- Child abuse occurs in up to 70% of families in which woman abuse occurs (Morrow and Varcoe, 2000).
- In 1999, 35% of girls and 16% of boys between grades 7 - 12 in BC had been sexually and/or physically abused (BC Ministry of Children and Family Development, 2007).

The adverse health effects of abuse are not limited to physical injury – abuse has long term emotional and mental impacts. Exposure to family violence may increase a person’s risk of acquiring: diabetes, heart disease, high blood pressure, sleep disorders, fibromyalgia, chronic pain/disability, cancer, osteoporosis, asthma, anemia, hepatitis, lung and liver disease, and thyroid disease (Doherty, 2002). Long term physical impacts of violence include: arthritis, hearing loss, sexually transmitted diseases, chronic bowel problems, pelvic inflammatory disease and neurological damage (Morrow and Varcoe, 2000). The mental health of abuse victims is also negatively affected; for example, abused women are more likely to attempt suicide. It is also estimated that up to 60% of abused women experience post-traumatic stress syndrome (Morrow and Varcoe, 2000).
The economic cost of abuse in Canada is staggering. In Canada, the costs of child abuse to child victims and adult survivors in terms of criminal justice, compensation, health, education, social services and lost earnings was $15 billion in 1998 (Statistics Canada, 2006). The cost of abuse in the form of violence against women has been estimated separately. In BC, the cost of violence against women is estimated to be $400 million/year (Morrow and Varcoe, 2000). In Canada, it is estimated that the health care costs that result from violence against women is approximately $1.5 billion/year (Morrow and Varcoe, 2000). Overall, abused women use a higher proportion of health care services compared to non-abused women.

Health Care for Abuse Victims Challenges

There are several challenges that need to be addressed in order to improve health care for abuse victims; however only two will be discussed. Abuse is complex and cyclical in nature and therefore cannot be easily solved; a multidisciplinary and coordinated approach is needed given that abuse is affected by cultural, racial, social and economic factors.

Given that 8% and 39% of abused women seek medical care (Ferris et al., 1997), health care professionals are the most likely to encounter abuse victims, potentially multiple times. Physicians and nurses in particular have the opportunity to reach out to the abused, provide critical information, and potentially prolong the time the abuse victim spends away from the abuser. Thus, it is critical that all health care professional properly identify victims of abuse (i.e. including x-ray technicians). The lack of abuse awareness, sensitivity and/or knowledge and the poor diagnosis of abuse victims among health care workers are two critical health care related issues that are discussed below.

Lack of abuse awareness, sensitivity and/or knowledge
The response of health care providers to abuse victims when abuse has been recognized is generally perceived as being negative among women who have been abused. The results of the study by McMurray and Moore (1994) showed that “women admitted to hospital for abuse-related injuries experienced disengagement from hospital staff, loss of status, lack of control and disempowerment, stigma and social isolation, and a sense of being misunderstood” (McLean et al., 1999). The lack of sensitivity to the impacts of abuse may be a result of the focus of health care professionals on the abuse victim’s physical injuries, negative attitudes towards battered women, a lack of knowledge of abuse and poor coordination among health care providers (McLean et al., 1999).

Poor diagnosis of abuse among health care professionals
Rates of recognition of abuse by health care professionals are extremely low. The following statistics illustrate this problem:

- In Emergency Units, it is estimated that 2%-8% of female trauma patients are clinically recognized as being abused compared to the estimated actual abuse prevalence of 30%. Up to 23% of obstetrical patients are estimated to be abused (McLean et al., 1999).
The results of a self-reporting questionnaire completed by 392 primary care physicians showed that approximately 72% of those responding reported no exposure or only minimal exposure to the physical, emotional, or sexual abuse of the elderly. More than half of the respondents reported that they had never identified a case of elder mistreatment. The estimated prevalence of elder abuse by primary care physicians was less than 25% of the prevalence documented in the medical literature. More than 60% of clinicians had never asked their elderly patients about abuse (Kennedy, 2005).

Correct diagnosis is critical in the treatment of abuse victims - “failure to diagnose domestic violence may result in inappropriate treatment, including prescription of sedatives or antidepressants, which may increase the risk of suicide or place the woman at greater risk of injury from escalating violence” (Ferris et al., 1997).

Positive changes

Overall there is a greater awareness of abuse and the development and implementation of innovative programs such as the Vancouver Coastal Health’s Domestic Violence Program has improved the treatment of patients who are victims of abuse that have access to the Program. However, there is much that can and must be improved to address the complex and significant impacts of abuse on the population of BC. Education and increased awareness are likely the two most effective strategies that can be utilized within the health care system. For example, the results of a study by Wong et al. (2006) showed that training improved the awareness of intimate partner violence (IPV) and active questioning of patients by general practitioners who had non-obvious reasons to suspect/discuss abuse. The awareness of physicians of partner abuse in the case of non-obvious signs was significantly higher among the group of physicians that received full training on IPV compared to physicians in the untrained groups (odds ratio for number of patients diagnosed and/or actively questioned about IPV was 5.92; 95% CI = 2.25 to 15.62; P<0.01) (Wong et al., 2006).

Solutions:

- Make injuries that are result of abuse (i.e. injuries sustained by the abused or the abuser) reportable. By making abuse injuries reportable will improve surveillance of abuse and provide a means of monitoring the incidence of abuse over time. However, it will require improved physician/nurse recognition/diagnosis of abuse symptoms. Requiring physicians or nurses to report abuse is highly unlikely because mandatory reporting would place an additional workload on health care staff; however, if the information was extractable from Electronic Health Record, surveillance would be financially and practically feasible.

- Once the Electronic Health Record has been implemented, patients with specific injury/behaviour patterns that indicate abuse should be flagged and possibly followed up/investigated by a trained health professional. Confidentiality of the patient and endangering the patient’s safety is a concern. Thus, the identification of and
investigation of abuse victims may be limited to children since it is required by law to report child abuse.

- Provide a toll free, 24-hour number for victims of abuse (not just for children). Alternatively, nurses who provide services on BC Nurseline should be trained to counsel, provide critical information (i.e. numbers of transition houses) and/or direct victims to resources (e.g. Women Against Violence Against Women or Battered Women Support Services crisis lines) for help. Regardless of whether or not a separate line for abused individuals is created, BC Nurseline nurses should be trained to recognize and deal with abuse victims.

- Educate nurses and physicians about the signs and symptoms of someone who is abused or is an abuser, the nature of abuse, and measures they can take to help abuse victims i.e. as a mandatory course/topic to be covered in post-secondary institutions. Access to domestic violence education programs should not be limited to physician or nursing training programs; all health care workers in hospitals and general practitioners should be aware of abuse and what they can do to help. Educational materials have been developed by various organizations including:

  - Canada's Treatment Programs for Men Who Abuse Their Partners (by the National Clearinghouse on Family Violence) http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/2004Men_e.pdf

- Develop domestic violence public service announcements, ad campaigns or posters similar to those developed by Homefront Calgary (http://www.homefrontcalgary.com/tvspots.htm), the Family Violence Prevention

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1 The websites for the educational materials listed were all accessed on August 1, 2007.
2 An independent agency that assists victims of domestic violence.
Place posters about domestic violence in emergency rooms, physician offices (including pediatricians, obstetricians and gynecologists), walk-in clinics and midwifery clinics and provide information cards/pamphlets (http://eduhealth.org/PDFs/CE/CE.150.H369.pdf or http://www.vch.ca/programs/doc/dv_resource_card.pdf) with numbers to women’s shelters, crisis lines, and transitions houses and important steps to take when planning to leave the abusive relationship (e.g. making copies of and/or hiding all key documents (such as birth certificates), memorizing important numbers, making an extra copy of house/car keys) in women’s bathrooms in all health care facilities/clinics. Cost will be a limiting factor; thus, bathrooms in hospital emergency rooms, physician offices that primarily treat women and children and walk-in clinics (including student health services areas in post secondary institutions) may be given a higher priority.

Ensure that domestic violence awareness campaigns, education programs and information are accessible to all persons. Information should be available in multiple languages and awareness campaigns/education programs must be culturally sensitive. Possible methods of reaching different cultural and ethnic groups in BC include holding focus groups to get feedback and consulting health care leaders with a variety of backgrounds.

Expand the existing Domestic Violence Program offered by Vancouver Coastal Health to the major hospitals all other Health Authorities.

References


