

# Domestic Violence Screening, Policies, and Procedures in Indian Health Service Facilities

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**Background:** Research shows that domestic violence against women in the United States is common, and the prevalence of domestic violence is high among Native American women. Victims of domestic violence can benefit from appropriate office intervention and referral. This study examined the effect of administrative and legal requirements on screening for domestic violence in Indian Health Service (IHS) hospitals and clinics.

**Methods:** A questionnaire was mailed using the total design method to all IHS hospitals and clinics regarding activities related to domestic violence: screening; policies and procedures; presence of committees; staff training; and state and tribal mandatory reporting requirements.

**Results:** The response rate was 65%. Eighty-eight (62%) of 142 facilities screen for domestic violence. A facility was more likely to screen if it had policies and procedures for domestic violence. Ninety-one (64%) of sites had policies and procedures for domestic violence. Less than one half these sites evaluated the use of these policies and procedures. Hospitals were more likely to have policies and procedures than clinics, as were sites administered by the IHS, rather than those administered by tribal contract. Fifty-eight (40.8%) facilities indicated 18 states have mandatory domestic violence reporting requirements. Thirty-three (23.2%) facilities indicated 31 different tribes mandate reporting of domestic violence. Forty-two (29.6%) facilities reported mandatory staff training in at least one topic related to domestic violence in the past year.

**Conclusions:** Domestic violence policies and procedures promote screening for this important health care problem. (J Am Board Fam Pract 2001;14:252–8.)

Research indicates that 30% of women in the United States experience domestic violence at some time in their lives.<sup>1</sup> Recognized as victims or not, many are seen by health care providers. Twenty-four percent of all women coming to the emergency department and 30% of those with injuries could be victims of domestic violence.<sup>2</sup> A review of studies of domestic violence in pregnancy shows that 3.9% to 8.3% of pregnant women sustained physical abuse during the pregnancy.<sup>3</sup>

Native American women are at least as likely as other women in the United States to experience domestic violence. Table 1 summarizes published direct measures of domestic violence prevalence in Native American women.<sup>4–7</sup> These studies use the

Conflict Tactics Scale<sup>8</sup> or its revision<sup>9</sup> to classify respondents as victims of domestic violence, but they differ in subject recruitment and interview methods. With one exception, these studies have findings that generally correspond with prevalence estimates in the general population. In addition, a review of female homicides in New Mexico found a disproportionately higher rate among Native American women, and domestic violence was the cause in almost one half of Native American cases.<sup>10</sup> Although the studies in Native American women are limited by small sample size, the weight of evidence suggests that the prevalence of domestic violence among all women is high, including Native American women.

Many health care organizations recognize the importance of screening for intimate partner and family violence. The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) has required policies and procedures for domestic violence screening in hospitals and clinics since 1992.<sup>11</sup> Several professional organizations advocate the recognition of domestic violence in the clinical setting by health care providers.<sup>12–15</sup> The Govern-

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**Table 1. Prevalence of Domestic Violence in Native American Women in Published Literature.**

Study, Year	Design	Percent in Past Year	Percent in Lifetime	Percent in Current Relationship
Bachman, 1992 <sup>4</sup>	Subset of national telephone family violence resurvey	15.5	Not reported	Not reported
Lapham et al, 1993 <sup>5</sup>	Computerized health survey at initiation of prenatal care in urban IHS hospital	16.0	Not reported	Not reported
Fairchild et al, 1998 <sup>6</sup>	Adult women in rural IHS medical and women's health outpatient clinics	14.4	41.9	Not reported
Hamby & Skupien, 1998 <sup>7</sup>	Volunteer men and women in-depth interview, rural SW reservation	47.9	Not reported	75

IHS — Indian Health Service.

ment Performance and Results Act (GPRA) required policies and procedures for domestic violence screening in 70% of Indian Health Service (IHS) hospitals, emergency departments, and urgent care facilities by the end of fiscal year 1999.<sup>16</sup>

Victims of domestic violence benefit from appropriate office intervention and referral. At-risk prenatal patients found through screening can adopt violence-avoidance techniques after a 10-minute office safety planning intervention.<sup>17</sup> Participation in community-based domestic violence advocacy programs clearly decreases the risk of violence. Women randomly assigned to a community-based advocacy intervention experienced one half the risk of violence of women who did not receive these services.<sup>18</sup> The decline during 2 decades in the rate at which women murder their intimate male partners in self-defense is partly due to the increased availability of domestic violence services, such as hotlines and shelters.<sup>19</sup>

Administrative interventions increase compliance with domestic violence protocols. Screening for domestic violence improves after staff education and formal quality assurance feedback.<sup>20</sup>

A recent national survey of health maintenance organizations showed that 28% had policies, protocols, guidelines, or materials on screening for domestic violence.<sup>21</sup> The National Committee for Quality Assurance does not track any indicators related to domestic violence despite the recommendations of professional organizations and growing evidence of positive outcomes after clinical intervention.

The purpose of this research is to examine current domestic violence policies and procedures of hospitals and clinics administered by both the Indian Health Service (IHS) and tribal health pro-

grams. Both types of facilities are referred to here as IHS unless otherwise stated. The IHS can be described as a vertically integrated health care delivery system with an annual appropriation of approximately \$2.2 billion serving about 1.5 million of the nation's 2 million Native Americans and Alaska Natives, mainly on reservations and in rural communities in 34 states. The IHS clinical staff consists of approximately 840 physicians, 380 dentists, 100 physician assistants, and 2,580 nurses. All hospitals and 95% of the clinics are accredited by the JCAHO.<sup>22</sup>

## Methods

A questionnaire was mailed using the total design method<sup>23</sup> to the 223 clinics and hospitals listed in the 1996 Interim IHS Directory. The cover letter instructed each facility's chief executive officer to direct the questionnaire for completion to the person in that facility with the greatest knowledge about domestic violence. Health Centers and Health Stations were classified as clinics. Medical Centers and Hospitals were classified as hospitals. Two inpatient treatment centers for behaviorally troubled youth were grouped with hospitals. One dental clinic was classified as a clinic.

The survey instrument included questions in 6 areas: general information about the facility; specific questions about screening for domestic violence, policies and procedures, domestic violence committees, staff training, and mandatory reporting.

Responses were entered into Epi-Info Version 6, and analyzed.<sup>24</sup> *P* values are considered significant at .05 or less. Odds ratios (ORs) are reported with 95% confidence intervals by the Mantel-Haenszel

method, unless otherwise stated as exact (for small cell size).

Five IHS areas comprising 65 sites had a 100% response rate. These 65 responses were analyzed and the results compared with that of the national sample. This subset is referred to as the full reporting areas.

We called the medical directors of 63 nonresponding sites (nonrespondents subset) to validate the national sample in yet another way. Thirty-eight (63%) nonrespondents answered the four questions regarding domestic violence screening, policies and procedures, facility administration, and type of facility. These responses were analyzed separately and compared with the results of the national sample.

In a third validation, we combined the results of the 4 nonrespondent questions with the national sample by the method described by Fowler.<sup>25</sup> The results are reported as adjusted rates for these variables.

## Results

The response rate was 65%. The total responses numbered 146, of which four were omitted from analysis, because no patients were seen in those facilities. A total of 142 (64%) responses made up the data for analysis.

Of the respondents' position in the facility, 19 (13.4%) were administrators, 35 (24.6%) were physicians, 19 (13.4%) were nurses, 18 (12.7%) were mental health professionals, 35 (24.6%) were social workers, and 7 (4.9%) were community representatives. Personnel in some other position filled out six questionnaires. Three respondents did not state their position.

Frequency measures of key variables are presented in Table 2.

Of the responding facilities, 91 (66.2%) were administered by the IHS and 47 (33.1%) were administered by tribes. One respondent did not answer this question.

Nearly two thirds (88, or 62.0%) of responding facilities reported some form of screening for domestic violence. Of the 88, 6 (6.8%) reported only verbal screening, while 40 (45.5%) used a written screening instrument. Thirty-eight (43.2%) used a combination of the two approaches. Three facilities used some other method of screening. One respondent did not know how women were screened.

**Table 2. Summary of Responses to Key Variables.**

Key Variable	Number	Percent*
Urban	23	16.2
Rural	119	83.8
Hospitals	34	23.9
Clinics	108	76.1
Indian Health Service administration	94	66.2
Tribal administration	47	33.1
Domestic violence screening	88	62.0
No domestic violence screening	42	29.6
Policies and procedures	91	64.1
No policies and procedures	49	34.5
Evaluation <sup>†</sup>	41	46.2
No evaluation <sup>†</sup>	37	40.2
Domestic violence committee	41	28.9
No domestic violence committee	99	69.7
State mandatory reporting	58	40.8
No state mandatory reporting	39	27.5
Tribal mandatory reporting	33	23.2
No tribal mandatory reporting	44	28.9

\*Percentages might not add up to 100 due to questions not answered and those marked "don't know."

<sup>†</sup>Of 91 policies and procedures.

Ninety-one (64.1%) responding facilities have policies and procedures for domestic violence, whereas 49 (34.5%) do not. The respondent did not know in two facilities.

Requirements of the JCAHO were ranked most important in influencing a facility's development of policies and procedures for domestic violence by 19 facilities (23.8%). JCAHO requirements for domestic violence went into effect 1 January 1992. Thirteen (16.9%) facilities formalized policies and procedures between 1980 and 1992. The remainder (63, or 81.8%) developed these policies since 1 January 1992.

Respondents were asked to estimate the number of women seen in a typical month for an injury caused by domestic violence. Eighty-five (60.7%) either checked "don't know" or did not answer this question. Of the remainder, 9 (6.4%) stated the facility saw no women for domestic violence injuries during a typical month.

**Table 3. Bivariate Analysis of Selected Key Variables (National Sample): P, Odds Ratio (95% Confidence Interval).**

Key Variable	Committee (n = 41/142)	Policies and Procedures (n = 91/142)	Evaluation (n = 42/91)	Screening (n = 88/142)
Urban site = 23	0.27, 0.60 (0.18–2.00)*	0.41, 0.81 (0.29–2.26)	0.53, 0.86 (0.21–3.47)	0.56, 0.95 (0.29–3.14)
Clinic = 108	0.06, 0.49 (0.20–1.20)	0.00, 0.13 (0.03–0.48)†	0.37, 0.76 (0.26–2.19)	0.59, 1.00 (0.38–2.57)
Tribal administration = 47	0.21, 0.66 (0.27–1.60)	0.00, 0.19 (0.08–0.43)†	0.29, 1.69 (0.45–7.12)*	0.47, 0.90 (0.39–2.11)
Committee - yes	—	0.02, 2.36 (1.03–5.50)†	0.00, 13.02 (1.83–558.68)*	0.04, 2.36 (0.90–6.37)
Policy and procedures - yes	—	—	—	0.02, 2.39 (1.03–5.57)†
Evaluation - yes	—	—	—	0.17, 1.91 (0.58–6.34)

\*Exact 95% confidence interval.

†Significant at  $P = .05$ .

Fifty-eight (40.8%) respondents in 18 states perceived that physicians are mandated to report domestic violence to police or social service agencies, whereas 39 (27.5%) reported no such requirement, and 41 (28.9%) respondents did not know. Twenty-three (39.7%) did not answer this question.

Thirty-three (23.2%) respondents reported that 31 different tribes mandate reporting of domestic violence, whereas 41 (28.9%) reported no such requirement, and 32 (22.5%) did not know. Thirty (21.1%) facilities were not on a reservation. Six respondents (4.2%) did not answer this question.

Responses indicate great concern and inconsistent knowledge about mandatory reporting requirements (not shown). For example, some facilities in Oklahoma believe that the state mandates reporting of domestic violence, while others do not. The same is true of facilities on the Navajo reservation and of other states and tribes.

No facility acknowledged mandatory reporting of domestic violence to state or tribal officials for the purpose of public health surveillance.

One hundred (70.4%) respondents reported no mandatory training for any topic related to domestic violence in the past year for any staff, whereas 42 (29.6%) reported mandatory training in at least one topic. At least one topic of domestic violence training in the past year was mandatory for physicians in 32 (22.5%) facilities and for nurses in 40 (28.2%) facilities. Thirty-seven (26.1%) facilities had mandatory training in at least one domestic violence topic for other staff members as well.

**Bivariate Analysis**

Bivariate analysis of the influence of key variables on each other is summarized in Tables 3 and 4.

Screening was much more likely to occur in a facility with policies and procedures for domestic violence. These results were unaffected by stratification for type of facility (hospital or clinic), even though hospitals were significantly more likely to be administered by the IHS (not shown). The presence of a domestic violence committee tended to be associated with an increased probability of screen-

**Table 4. Bivariate Analysis of the Effect of State and Tribal Mandatory Reporting on Selected Key Variables (National Sample, n = 142): P, Odds Ratio (95% Confidence Interval).**

Key Variable	Committee (n = 41/142)	Policies and Procedures (n = 91/142)	Evaluation (n = 42/91)	Screening (n = 88/142)
State, yes, 58	0.01, 0.28 (0.10–0.77)*	0.32, 1.35 (0.52–3.50)	0.36, 1.41 (0.42–4.81)	0.44, 0.83 (0.29–2.32)
Tribe, yes, 23	0.13, 0.49 (0.15–1.57)	0.20, 1.70 (0.57–5.09)	0.04, 3.79 (0.86–17.65)*	0.12, 2.14 (0.65–7.18)

\*Significant at  $P = .05$ .

**Table 5. Full Reporting Areas Sample, Bivariate Analysis of Selected Key Variables, n = 65: P, Odds Ratio (95% Confidence Interval).**

Key Variable	Screening n = 43/65	Committee n = 27/65	Policies and Procedures n = 49/65	Evaluation n = 24/49
Clinic - 47	0.38, 0.66 (0.13–2.69)*	0.00, 0.17 (0.04–0.65)†	All hospitals had policy and procedures; therefore, no odds ratio	0.35, 0.65 (0.16–2.56)*
Tribal administration - 11	0.19, 0.43 (0.11–1.81)*	0.26, 0.26 (0.03–1.46)	0.00, 0.06 (0.01–0.33)†	0.55, 1.82 (0.09–112.55)*
State - yes, 24	0.51, 0.77 (0.31–4.14)*	0.02, 0.19 (0.04–0.91)†	0.54, 0.77 (0.10–4.82)*	—
Tribe - yes, 16	0.07, 4.33 (0.70–48.85)*	0.59, 0.93 (0.21–4.19)	0.55, 1.27 (0.20–9.68)*	—

\*Exact 95% confidence interval.

†Significant at  $P = .05$ .

ing. Clinics were no more likely to screen for domestic violence than hospitals, nor did facility administration, facility location, or evaluation measures affect the probability of screening. Perceptions of state or tribal mandatory reporting requirements had no effect on screening.

A facility was more likely to have policies and procedures for domestic violence if the facility was a hospital rather than a clinic, if the facility had a domestic violence committee, and if that facility was administered by the IHS rather than by a tribe.

Predictors of domestic violence screening were further examined using multiple logistic regression. The effect of policies and procedures on screening persisted and remained statistically significant ( $P = .04$ , OR = 2.6) in a model that included indicator variables for policies and procedures, facility administration, and type of facility.

#### **Full Reporting Areas Comparison**

Significant differences between the full reporting areas and the national IHS samples were found in two key variables only. The national IHS sample was significantly less likely to be under IHS administration and less likely to screen for domestic violence. (Table 5).

The full reporting areas comparison confirms that hospitals are more likely to have policies and procedures for domestic violence than clinics, that IHS-administered facilities are more likely to have policies and procedures than tribally administered ones, and that screening is more likely to occur in facilities with policies and procedures for domestic violence.

#### **Nonrespondents Comparison**

Of the nonrespondents, 22 (34.9%) were reservation or rural facilities, and 41 (65.1%) were urban. The national sample was much more likely to have reservation facilities. Nine (14.2%) nonrespondents represented hospitals, whereas 54 (85.7%) represented clinics. This difference was not statistically different from the national sample.

The IHS administered 15 (39.5%) of 38 sites, and the tribes administered 20 (52.6%); 3 (7.9%) did not answer this question. Nonrespondent facilities were significantly more likely to be tribally administered than the national sample. Thirty (78.9%) nonrespondent facilities reported screening, and 21 (55.3%) had policies and procedures for domestic violence. These rates are not significantly different from the national sample. Neither the nonrespondent administration or facility location had a significant effect on whether the facility screened for or had policies and procedures for domestic violence.

Combination of respondent and nonrespondent data in this survey yields an adjusted response rate of 98.1%, with adjusted screening and policy and procedures rates of 65.9% and 60.2%, respectively. The adjusted percentage of facilities administered by the IHS is 55.4%, and the adjusted percentage of hospitals is 21.8%.

#### **Discussion**

Several points indicate that we can generalize these results to the entire IHS. The full reporting areas comparison shows that the national sample is representative in most respects. Nonrespondents were

as likely as the national sample to screen or have policies and procedures for domestic violence. The combination of nonrespondent data with the national sample shows rates for screening and policies and procedures very similar to the national sample. The lack of an effect on screening or policies and procedures for domestic violence in the nonrespondent group could be a result of this small sample size.

Selection bias undoubtedly occurred in this survey. The IHS 1996 interim directory was the most up-to-date listing of the IHS and tribal hospitals and clinics at the time this survey was conceived and executed. The composition of the IHS is changing, and new sites are not listed in the directory.

A respondent's position in the hospital or clinic might result in misclassification of responses to the more straightforward questions about the presence or absence of screening or evaluation. For example, the person most knowledgeable about domestic violence in the facility might be a mental health or social worker who has little knowledge of the specifics of screening in the medical or prenatal clinics. Alternatively, the respondent might have completed the questionnaire with a perspective limited to his or her own department. For example, screening all women who come to the Emergency Department with injuries is not universal screening of all women who come to the facility for care.

The survey can only address the existence of screening for domestic violence and the existence of supporting policies and procedures. This survey has no way to verify implementation of policies and procedures; rather, it attempts to ascertain this information with questions about evaluation. It is disturbing, but not surprising, that many respondents misunderstood these questions about the evaluation of the implementation of policies to mean the annual review and update required of all hospital and clinic policies and procedures. Although this question might be poorly worded, such misunderstandings more likely reflect a general lack of understanding of the importance of evaluation procedures.

The following are important implications of this survey: IHS hospitals should link with clinics to develop community-appropriate screening and policies, IHS project officers of tribally administered hospitals and clinics need to encourage tribes to address domestic violence in the health care setting,

and IHS legal counsel needs to clarify state and tribal mandatory reporting requirements.

## Conclusions

Domestic violence affects all aspects of a woman's health. It is a condition suitable for screening in the health care setting. Screening for domestic violence in IHS hospitals and clinics is promoted by the presence of relevant policies and procedures. This national survey of IHS facilities shows that 88 (62%) screen for domestic violence, and that screening is more likely to occur in facilities with policies and procedures for handling domestic violence. Ninety-one facilities (66%) have policies and procedures for domestic violence.

## References

1. Wilt S, Olson S. Prevalence of domestic violence in the United States. *J Am Med Womens Assoc* 1996; 51(3):77-82.
2. Muelleman R, Reuwer J, Sanson T, et. al. An emergency medicine approach to violence throughout the life cycle. *SAEM Public Health and Education Committee. Acad Emerg Med* 1996;3:708-15.
3. Gazmararian JA, Lazorick S, Spitz AM, Ballard TJ, Saltzman LE, Marks JS. Prevalence of violence against pregnant women. *JAMA* 1996;275:1915-20.
4. Bachman R. Death and violence on the reservation: homicide, family violence, and suicide in American Indian populations. Westport, Conn: Auburn House; 1992;331-7.
5. Lapham SC, Henley E, Kleyboecker K. Prenatal behavioral risk screening by computer among Native Americans. *Fam Med* 1993;25:197-202.
6. Fairchild DG, Fairchild MW, Stoner S. Prevalence of adult domestic violence among women seeking routine care in a Native American health care facility. *Am J Public Health* 1998;88:1515-7.
7. Hamby S, Skupien M. Domestic violence on the San Carlos Apache reservation: Rates, associated psychological symptoms, and current beliefs. *IHS Provider* 1998;Aug:103-6.
8. Straus MA. Measuring interfamily conflict and violence: the Conflict Tactics (CT) scales. *J Marriage Fam* 1979;41:75-88.
9. Straus MA, Hamby SL, Boney-McCoy S, Sugarman DB. The revised Conflict Tactics (CTS2): development and preliminary psychometric data. *J Fam Issues* 1996;9:249-58.
10. Arbuckle J, Olson L, Howard M, Brillman J, Anctil C, Sklar D. Safe at home? Domestic violence and other homicides among women in New Mexico. *Ann Emerg Med* 1996;27:210-5.
11. 1996 Accreditation manual for hospitals. Vol. 1. Standards. Oakbrook Terrace, Ill: Joint Commission

- on the Accreditation of Healthcare Organizations, 1996:54.
12. Violence against women. Relevance for medical practitioners. Council on Scientific Affairs of the American Medical Association. *JAMA* 1992;267:3184-9.
  13. Family violence: an AAFP white paper. The AAFP Commission on Special Issues and Clinical Interests. *Am Fam Physician* 1994;50:1636-6.
  14. Domestic violence. Chicago, Ill: American College of Obstetricians and Gynecologists, 1995. (Technical bulletin no. 209.)
  15. Paluzzi PA, Houde-Quimby C. Domestic violence: implications for the American College of Nurse-Midwives and its members. *J Nurse-Midwifery* 1996;41:430-5.
  16. Indian Health Service fiscal year 1999. Government Performance and Improvement and Results Act. September 14, 1998.
  17. McFarlane J, Parker B, Soeken K, Silva C, Reel S. Safety behaviors of abused women after an intervention during pregnancy. *J Obstet Gynecol Neonatal Nurs* 1998;27:64-9.
  18. Sullivan CM, Bybee DI. Reducing violence using community-based advocacy for women with abusive partners. *J Consult Clin Psychol* 1999;67:43-53.
  19. Dygan L, Nagin D, Rosenfeld R. Explaining the decline in intimate partner homicide: the effects of changing domesticity, women's status, and domestic violence resources. *Homicide Studies* 1999;3:187-214.
  20. Larkin GL, Rolniak S, Hyman KB, MacLeod BA, Savage R. Effects of an administrative intervention on rates of screening for domestic violence in an urban emergency department. *Am J Public Health* 2000;90:1444-8.
  21. National survey of managed care organizations. San Francisco, Calif: Family Violence Prevention Fund, 1999.
  22. Indian Health Service fact sheet. Available from <http://www.ihs.gov/AoutIHS/ThisFacts.asp>.
  23. Dillman DA. Mail and telephone surveys: the total design method. New York: John Wiley & Sons, 1978:21-8.
  24. Dean AG, Dean JA, Coulumbier D, et al. Epi Info, version 6. A word-processing, database and statistics program for public health on IBM-compatible microcomputers. Atlanta, Ga: Centers for Disease Control and Prevention, 1995.
  25. Fowler FJ Jr. Survey research methods. 2nd ed. Newbury Park, Calif: Sage Publications, 1993:49.