Women's Opinions About Domestic Violence Screening and Mandatory Reporting

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Background: The purpose of this paper is to describe women's opinions and policy preferences concerning domestic violence screening and mandatory reporting.

Methods: This case–control study included 202 abused women and 240 randomly selected non-abused women recruited from a large metropolitan health maintenance organization who were interviewed by telephone. Of these women, 46.6% had a college degree, 53.4% were white, and 60% had a household income of $50,000 or more.

Results: Forty-eight percent of the sample agreed that health care providers should routinely screen all women, with abused women 1.5 times more likely than non-abused women to support this policy. For mandatory reporting, 48% preferred that it be the woman's decision to report abuse to the police. Women thought it would be easier for abused women to get help with routine screening (86%) and mandatory reporting (73%), although concerns were raised about increased risk of abuse with both screening (43%) and reporting (52%) policies. Two thirds of the sample thought women would be less likely to tell their health care providers about abuse under a mandatory reporting policy. Interventions offered in managed care settings that would be well received, according to the women in this study, include counseling services, shelters, and confidential hotlines.

Conclusions: Women expressed fears and concerns about negative consequences of routine screening and, even more so, for mandatory reporting. Domestic violence policies and protocols need to address the safety, autonomy, and confidentiality issues that concern women.

Medical Subject Headings (MeSH): domestic violence, spouse abuse, mandatory reporting, battered women, health personnel, preventive health services (Am J Prev Med 2000;19(4): 279–285) © 2000 American Journal of Preventive Medicine

Introduction

It is now well established that domestic violence (DV) is a widespread problem with serious consequences for women's physical and mental health and their use of health services.[1–7] Without identification, abused women are denied documentation for future reference in court cases, education on prevention, safety planning, options for leaving the abuse, and referrals to resources in the community.[8] Many professional health care organizations have called for routine screening of women for intimate partner violence (IPV).[9–11] In addition, six states have mandated that health care providers report IPV to the criminal justice system.[12,13]

Both screening and mandatory reporting are controversial because of a lack of demonstrated effectiveness in reducing the risk of violence and because of concerns about infringing on women's autonomy.[12,14–16] These debates about screening and reporting protocols should be informed by an understanding of women's policy preferences. Incorporating the perspective of the intended audience in policy development is not only respectful of individuals' autonomy and privacy, but should also lead to initiatives that are more widely supported and, thus, more likely to reach the goal of protecting women from further abuse.

Only two studies could be found that address abused and non-abused women's preferences for DV screening and reporting in health care settings. In an anonymous survey, 1128 women from 11 community emergency departments (EDs) were queried.[17] Although 80% to 97% of all women agreed with routine screening in the ED, those who were being abused currently or recently

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were significantly less likely to agree than women who were not being abused. Similarly, although 92% of non-abused women agreed with mandatory reporting to police, significantly fewer of the currently abused (76%) and recently abused (82%) women did so. Caralis and Musialowskie[18] interviewed 406 female patients in ambulatory clinics in a medical center that served veterans. Of these patients, 85% agreed that physicians should routinely screen women, and 79% thought that physicians should report abuse, findings that did not differ between abused and non-abused women.

In our study of a large, ethnically diverse sample of women enrolled in a health maintenance organization (HMO), we addressed the following aims: (1) to describe women's opinions and policy preferences about DV screening and mandatory reporting, (2) to compare these opinions and preferences between abused and non-abused women, (3) to examine the extent to which sociodemographic characteristics and disclosure of abuse are associated with women's opinions and policy preferences, and (4) to describe women's preferences for services that HMOs should provide to abused women.

Methods

Subject Recruitment

The study was approved by the Johns Hopkins University Institutional Review Board (IRB), the U.S. Army Research IRB, and the participating HMO's national and regional IRBs. Letters asking women to participate in a women's health survey were sent to a total of 21,426 female enrollees of a metropolitan Washington, DC–area HMO in two separate mailings in fall 1997 and fall 1998. Women were selected for the mailing if they were between the ages of 21 and 55 years at the time of the recruitment and had been enrolled continuously in the HMO from 1995 through 1997. For safety reasons, no reference to "abuse" was made in the recruitment letter. Twelve percent or 2535 women returned consent forms that gave permission for our interviewers to call. Of these women, 447 (17.6%) could not be located. Of those located, 76 (3.6%) refused to participate and 7 (<1%) were ineligible because they were no longer in the HMO. Thus, a total of 2005 women completed the telephone screening interview, from which case and control subjects were selected.

Definition of Case and Control Subjects

Women were screened for two dimensions of abuse (physical or sexual), using a modified Abuse Assessment Screen.[19,20] First, women were considered to have been physically abused if they answered yes to either of the following two questions: "Have you ever as an adult been physically abused by a husband, boyfriend, or female partner?" and "Have you ever been hit, slapped, kicked, pushed, or shoved, or otherwise physically hurt by a current or previous husband, boyfriend, or female partner?" Women were classified as having been sexually abused if they gave a positive response to "Have you ever, as an adult, been forced into sexual activities by a husband, boyfriend, or female partner?" Dates of the abuse were recorded, and women who reported having been physically or sexually abused since 1989 were selected as case subjects. Women who answered no to all three of these questions were eligible to be control subjects. A random selection process was programmed into the Computer Assisted Telephone Interview (CATI) system such that one of every nine eligible control women were selected.

Sample

Immediately after completing the screening interview, women selected as case and control subjects were asked to participate in an in-depth interview, which required an average of 25 minutes to complete. Among 231 case subjects asked to participate, 202 (87.4%) completed the in-depth interview and 29 (12.6%) refused. Of the 264 control subjects asked to participate, 240 (90.9%) completed the interview and 24 (9.1%) refused.

Measures

In addition to standard demographic variables, the survey included items to measure women's opinions, operationalized as beliefs about the consequences of routine screening and mandatory reporting. This process was introduced by reading, "We are interested to know how women who experience abuse can be assisted. Every woman's perspective is unique and valuable. Please tell me if you agree or disagree with the following items." **Beliefs about the consequences of routine screening** were measured by reading women six items (Table 1). Women's **policy preference for routine screening** was then ascertained with the answer to a single yes or no item, "Do you think doctors and nurses should ask all women at all visits if they are being physically or sexually abused?"

For **beliefs about the consequences of mandatory reporting**, women were asked: "If health care providers were required by law to report abuse to the police, do you agree or disagree that the following will happen" and five items followed (Table 1). Women's **policy preference for mandatory reporting** was ascertained by the following item: "Two ways have been proposed for how health providers should respond when a woman says she is abused. I'd like to know which one you think is better: The health care provider is required by law to report the abuse to the police; or it is up to the woman to decide if the health provider reports the abuse to the police" (Table 1).

Abused women were asked if they had ever talked about their abuse with a health care provider and, if so, to rate how helpful the provider was on a 4-point scale from "not helpful" to "entirely helpful." A final open-ended item was included, asking abused women what services they thought their health plan should offer to help abused women. Interviewers recorded verbatim responses, which were data entered, coded, and tallied.

Statistical Analyses

We employed multivariate regression for significance testing and adjustment methods to obtain prevalence rates. Because case and control subjects were significantly different in education, income, race, and marital status (Table 2), all com-

Table 1. Women's beliefs and policy preferences concerning routine screening and mandatory reporting, weighted proportions

	Agreeing with item (%)		
	Total sample (N=1988)	**Case subjects abused women**	**Control subjects non-abused women**
Consequences of routine screening			
Women would be offended or embarrassed	48.9	48.2	49.6
Women who are not being abused would be insulted	27.6	33.4	22.3
It would be easier for abused women to get help	86.1	85.2	87.0
Abused women might lose their health insurance	11.0	10.4	11.7
It would put women at more risk for being hurt by their abuser	42.9	39.5	46.3
Women would be glad someone took an interest	95.6	96.9	94.3
Consequences of mandatory reporting			
Women would find it easier to get help	73.1	71.5	74.7
Women would be at greater risk for being abused	52.0	54.2	50.0
Women would like having someone else be responsible for calling the police	85.8	81.1	90.4
Women would be less likely to tell their health care provider about the abuse	67.3	68.0	66.7
Women would resent losing control over when to call the police	41.7	45.0	38.6
Policy preferences			
Agree that health care providers should routinely screen all women for physical and sexual abuse at all visits	47.8	54.5	41.5
Prefer that reporting abuse to police is the woman's decision	47.6	53.7	42.1

parisons of these two groups had to account for these differences.

Regression

All statistical testing for differences in beliefs and policy preferences between case and control subjects was accomplished with the use of SPSS software[21] and employed methods of multiple logistic regression that allowed us to examine the association of case and control status and to adjust for the variables on which the two groups differed. All regression models contained indicator variables for case or control status, education, income, race, and marital status; $p<0.05$ was used as the criterion for statistical significance. Odds ratios (OR) and 95% confidence intervals (CI) are presented for all statistically significant variables. When comparing within cases for those who disclosed their abuse versus those who did not (Table 3), chi-square statistics computed on the unweighted data were used.

Standardization

When calculating the proportions for the two groups of women holding certain beliefs or preferring certain policies, we employed methods of direct adjustment to account for the differences in the two samples with respect to education, race, income, and marital status. For the direct adjustment to obtain proportions for case and control subjects, we identified a "standard" population that would ensure comparability on education, race, income, and marital status.[22] We chose as the standard population the group of women who were screened for eligibility for our study (N=2005), which was thought to be ideal as these women represent the population to which we wish to generalize results —that is, a group of HMO enrollees.

To accomplish the standardization, we assigned weights to each of the case and control subjects. We obtained weights by stratifying the case and control subjects, separately, on four adjustment variables: edu-

Table 2. Sociodemographic characteristics

	Case subjects abused women (n=202)	**Control subjects non-abused women (n=240)**	**Total sample (n=442)**	**Weighted sample (n=1988)**
Education* (% college graduate)	34.2	54.2	45.0	46.6
Ethnicity* (% white)	40.6	55.0	48.4	53.4
Marital status* (% married)	37.1	47.5	42.8	57.6
Household income* (% ≥$50,000/year)	39.8	57.0	49.2	60.0
Age (% <40 year)	55.0	55.8	55.4	53.9

*$p<0.05$ by χ^2 analysis.

Table 3. Multiple logistic regression analysis of women's beliefs and policy preferences concerning routine screening and mandatory reporting among 202 abused women and 240 non-abused women, odds ratios (95% confidence intervals)

Beliefs about consequences and policy preferences	Case/control status (abused vs non-abused)	Ethnicity (African-American vs white/other)	Income (<$50,000 vs ≥$50,000)	Education (<college vs other)	Marital status (married vs other)
Routine screening					
Women would be offended or embarrassed	—	2.27 (1.48–3.49)	—	—	—
Women who are not being abused would be insulted	1.72 (1.10–2.68)	1.85 (1.15–2.97)	—	—	—
Abused women might lose their health insurance	—	—	—	0.50 (0.25–1.02)	—
It would put women at more risk for being hurt by their abuser	—	1.50 (0.97–2.32)	—	1.60 (1.03–2.48)	—
Women would be glad someone took an interest	—	—	0.30 (0.11–0.88)	—	—
Mandatory reporting					
Women would find it easier to get help	—	1.61 (0.98–2.65)	—	—	—
Women would like having someone else be responsible for calling the police	0.50 (0.27–0.92)	—	—	—	—
Women would resent losing control over when to call the police	—	—	1.52 (0.96–2.42)	—	0.62 (0.4–0.9)
Policy preferences					
Agree that health care providers should routinely screen all women for physical and sexual abuse at all visits	1.53 (1.02–2.3)	—	—	—	—
Prefer that reporting abuse to police is the woman's decision	1.41 (0.93–2.13)	0.54 (0.35–0.83)	—	—	—

cation (graduate degree vs up to a four-year college degree vs high school degree or less), race (white vs all others), annual household income (<$50,000 vs ≥$50,000), and marital status (married vs all others). For case subjects, control subjects, and the standard population, we identified the number of women within the 24 strata of education, race, income, and marital status. We then obtained strata-specific ratios of standard population to the case and control subjects. We created the weights (separately for case and control subjects) by applying the strata-specific ratio to each woman within the strata. We applied the weights such that the case and control subjects would each represent half the standard population, as they are approximately equal in number when not weighted. All proportions presented concerning the sample of case and control subjects are based on the weighted data. Because the weighted data are much larger in size than our case and control population, performing statistical tests on the weighted population would result in inappropriate p values; therefore, statistical tests were performed with the use of the multivariate logistic regression method with unweighted data described above.

Results

Sample

Abused and non-abused women differed significantly on all indicators except age (Table 2). Abused women were less likely to be college graduates, white, married, or have an annual household income of ≥$50,000 per year.

Beliefs About the Consequences of Routine Screening and Mandatory Reporting

Virtually all women (86%) agreed that routine screening would make it easier for abused women to get help, 96% agreed that they would be glad someone took an interest, and 11% thought that women might lose their health insurance (Table 1). Almost three quarters of the sample thought mandatory reporting would make it easier for abused women to get help; at the same time, two thirds thought that women would be less likely to tell their health care provider, and one half of the sample thought it would put women at increased risk from their abuser (Table 1).

Table 4. Abused women's beliefs and policy preferences concerning routine screening and mandatory reporting by disclosure of abuse to health care provider[a]

	Agreeing with item		
	Disclosed (%)	Did not disclose (%)	*p* value*
Consequences of routine screening			
Women would be offended or embarrassed	47.9	60.4	0.13
Women who are not being abused would be insulted	35.4	37.7	0.86
It would be easier for abused women to get help	77.1	86.3	0.17
Abused women might lose their health insurance	12.8	9.0	0.57
It would put women at more risk for being hurt by their abuser	29.2	46.1	**0.04**
Women would be glad someone took an interest	91.8	95.2	0.47
Consequences of mandatory reporting			
Women would find it easier to get help	63.3	76.6	**0.07**
Women would be at greater risk for being abused	47.7	55.6	0.39
Women would like having someone else be responsible for calling the police	79.2	80.6	0.84
Women would be less likely to tell their health care provider about the abuse	55.3	71.3	**0.04**
Women would resent losing control over when to call the police	39.6	45.3	0.51

*Based on chi-square analysis.
[a]*n* varies between 180 and 195 because of elimination of ''don't know'' responses.

After the adjustment for socioeconomic variables, abused women relative to non-abused women were 1.7 times more likely to believe that routine screening would insult women who are not being abused and 1.5 times more likely to believe that it would put women at more risk for being hurt by their abuser (Table 3). Controlling for abuse status and other sociodemographic variables, African-American women relative to women of other ethnic groups were more likely to think that routine screening would offend, embarrass, and insult women, although they were more likely to believe that mandatory reporting would make it easier for women to get help. Women with family incomes <$50,000 compared with higher-income women were significantly less likely to think that routine screening would make women feel "glad someone took an interest" and significantly more likely to think that mandatory reporting would make women resent losing control over when to call the police.

Policy Preferences for Routine Screening and Mandatory Reporting

A higher proportion of abused women than non-abused women supported routine screening (54% vs 42%) and preferred a policy under which reporting abuse is the woman's decision (54% vs 42%) (Table 1). Abused women relative to non-abused women were 1.5 times more likely to support routine screening and 1.4 times more likely to prefer woman-controlled reporting over mandatory reporting by health providers, adjusting for sociodemographic variables (Table 4). Of all the sociodemographic variables examined, only ethnicity was a significant correlate of policy preferences: African-American women were less likely than women of other ethnic groups to support woman-controlled reporting over mandatory reporting by health providers.

Disclosure of Abuse to Health Care Providers

Of the 202 abused women, 51 (25.4%) had talked to a health care provider about the abuse; of those women, 9.8% said the experience was not helpful, whereas 74.5% said it was either somewhat or entirely helpful. Women who had not discussed their abuse with a health care provider were significantly more likely than those who had to think that routine screening would put women at greater risk for being hurt by their abuser (46% vs 29%) and that they would be less likely to tell their health care provider about the abuse if there were a policy of mandatory reporting (71% vs 55%) (Table 4). Policy preferences did not differ by whether or not the women had disclosed the abuse to a health care provider (data not shown).

Women's Suggestions for HMO Services

Of the 120 responses provided, 78 (65%) suggested that counseling services be provided for abused women. Some women elaborated on types of counseling, examples of which included mental health services, self-esteem, and education on how to get help. Other frequently mentioned services were referral to shelters (16%) and hotlines (6%).

Discussion

A far lower percentage of both abused and non-abused women in this managed care sample agreed with routine screening than did those in the other previous

large-scale survey of emergency room and ambulatory care patients.[17,18] The differences in settings and data collection methods may explain these discrepant results. Women seeking medical care at the time of the interview[17,18] may be different from women reached at home for a telephone interview, as in our study. Another possible explanation is that we obtained more carefully considered responses from the women in our sample because we elicited their policy preferences after a series of items that required them to think about potential positive and negative consequences of routine screening. The lowered enthusiasm we found may reflect some of the real complexities of the issues that the women became more aware of as they answered the prior questions.

Nevertheless, women for whom routine screening is designed to help—abused women—were 1.5 times as likely as non-abused women to support routine screening, even after adjusting for sociodemographic differences between the two groups. Moreover, the majority of women in both groups believed that screening would make it easier for women to get help and would make women feel glad that someone was taking an interest. These results lend support to a continued recommendation for routine screening.

Mechanisms are needed to minimize the potential negative consequences of screening that concerned women. We found a high percentage (49%) of women saying that they would be offended or embarrassed. More troubling is the finding that 39.5% of all abused women and 46.1% of the abused women who had *not* discussed their abuse with a health care provider thought routine screening would put abused women at greater risk for being hurt. Screening protocols and patient information materials must incorporate safety planning and honest discussion with women about the safest options for them to pursue as they try to end the abuse.

Support for a policy of mandatory reporting was not widespread in this sample. More than one half of the abused women (53.7%) preferred a policy under which reporting abuse to the police is the woman's decision. Abused women were 1.4 times as likely as non-abused women to take this position. Given that the policy is designed to help abused women, their preferences and concerns warrant serious consideration in the design of such policies.

Abused women were half as likely as non-abused to believe that women would like having someone else be responsible for calling the police. The loss of autonomy inherent with mandatory reporting that has been discussed in the literature[15,16,23] was reflected in the item that women would resent losing control over when to call the police, which was endorsed by slightly more abused (45%) than non-abused women (39%).

Two thirds of all women felt that mandatory reporting would decrease women's likelihood of disclosing their abuse to their health care provider. Abused women who had not discussed their abuse with a health care provider were more likely to think that mandatory reporting would be a barrier to disclosure, suggesting that fear may have been the reason these particular abused women had not discussed the abuse with their health care provider. However, one quarter of women in this sample had in fact talked with their health care provider and reported that the health care provider was helpful, which lends further support to the potential benefit of routine screening.

Nevertheless, it is important to recognize that women expressed fears and concerns about the negative consequences of routine screening and, even more so, of mandatory reporting. Neither routine screening nor mandatory reporting has ever been evaluated for its effect on women's safety in any kind of experimental study,[14] and this evaluation is clearly needed. Meanwhile, policy and the protocols to implement them must find ways to minimize the likelihood that more harm than good comes from routine screening and mandatory reporting. Interventions offered in managed care settings that would be well received, according to the women in this study, include counseling services, shelters, and confidential hotlines.

Conclusions

Although non-abused women were not as sure about routine universal screening in this managed care setting, a slight majority (54%) of the abused women supported the practice. Both groups believed that it was a way for women to get help and for health care professionals to show interest and concern about IPV. Women who had discussed their abuse with a health care provider generally found this discussion to be a helpful experience. Women's fears of being offended, embarrassed, or at greater risk from an abuser need to be addressed in routine screening policies. Women would appreciate the health care provider offering to call the police to take on this responsibility for them, while at the same time there was strong support for leaving the ultimate decision about calling the police up to the woman. Such an approach is respectful of the concerns for safety, autonomy, and confidentiality expressed by the abused women in this sample.

Any errors are the authors' own.

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