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The Mandatory Reporting of Adult Victims of Violence: Perspectives From the Field

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ESSAY

The Mandatory Reporting of Adult Victims of Violence: Perspectives From the Field

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"How Dare You"
How dare you reduce me
To crying fetal on the floor
While yelling at me
I am nothing but a whore
How dare you punch me
Like a man in the face
After I found you at last
At your ex girlfriends place
How dare you enjoy
The fear in my eyes
And just getting madder
If I start to cry
How dare you isolate me
From my family and friends
No place to turn
The fighting never ends

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How dare you kill my spirit
The girl inside of me
By telling me I am worthless
Everyday and constantly
How dare you bring another
Into what was our bed
Did she know about me
I wonder what was said?
How dare ever think
I would never find myself free
My spirit is stronger than you
Alive and running free

Suzanne[1]

INTRODUCTION

The term "domestic violence" describes assault, physical injury, or fear of physical injury between family members or members of an unmarried couple.[2] Although violence in families has reportedly existed since man's earliest history,[3] it has only relatively recently been recognized as a public health issue. That domestic violence is a public health issue is underscored by the following facts:

- Medical expenses related to incidents of domestic violence are estimated to total between $3 billion and $5 billion per year.[4]
- Substantial percentages of workplace problems, including absenteeism, turnover, excessive use of medical benefits, and low worker productivity, are related to family violence.[5]

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[1] Suzanne, *How Dare You*, *at* http://www.famvi.com/howdare.htm (last visited May 24, 2002).

[2] *Cf.* BLACK'S LAW DICTIONARY 1564 (7th ed. 1999) (defining domestic violence as "[v]iolence between members of a household, usually spouses, an assault or other violent act committed by one member of a household against another").

[3] *See, e.g.*, *Genesis* 4:8 (New King James) (the murder of Abel by his brother Cain).

[4] COLO. DOMESTIC VIOLENCE COALITION, DOMESTIC VIOLENCE FOR HEALTHCARE PROVIDERS (3d ed. 1991).

[5] *Employee Assistance Program*, Minnesota, *at* http://www.silcom.com/aladin/madb/stats2.html. this cite doesn't expist

Domestic violence as a social and public health problem in Kentucky is underscored by the following facts:

- More than 4400 women and children seek refuge annually in Kentucky's fourteen state-funded spouse-abuse centers.[6]
- More than 22,000 emergency temporary orders and more than 14,000 emergency protective orders were issued in Kentucky in fiscal year 1999.[7]

Across the country, state laws approach the monitoring of, prevention of, and intervention into domestic violence in a variety of ways. The focus of this Essay is on the mandatory reporting of adult victims of known or suspected domestic violence. The Commonwealth of Kentucky is one of four states that have some form of mandatory reporting of domestic violence.[8]

This Essay resulted from a panel discussion on domestic violence that was part of a conference entitled *An Interdisciplinary Conference on State Law and Public Health* held in Lexington, Kentucky on October 19-21, 2001, sponsored by the University of Kentucky. The participants in that conversation have in common a passion for the elimination of domestic violence. They were chosen for this panel both for their expertise and for their different perspectives about the wisdom and effectiveness of a mandatory reporting law. The Essay begins with a brief review of the Kentucky Adult Protection Act.[9] We then present the perspectives of an academic dentist and a social science researcher. In this part, we review the multiple reasons that cause the law to be viewed with suspicion by many health care practitioners.[10] We then review a small, but interesting, data set that represents the voices of victims; this information challenges some of the assumptions reported by the health care personnel on the panel.[11] Although it is safe to say that no individual panelist's opinion was changed

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[6] Ky. Domestic Violence Ass'n, *Kentucky Spouse Abuse Program Statistics*, *at* http://www.kdva.org/kystats.html (last visited May 24, 2002).

[7] COMMONWEALTH OF KENTUCKY 1999 CRIME REPORT, KY. STATE POLICE, CRIME IN KENTUCKY 35 (2001), *at* http://www.state.ky.us/agencies/ksp/pdf/cik99.pdf.

[8] Michael A. Rodriguez et al., *Mandatory Reporting of Domestic Violence Injuries to the Police: What Do Emergency Department Patients Think?*, 286 JAMA 580 (2001).

[9] *See infra* Part I.

[10] *See infra* Part II.

[11] *See infra* Part III.

by participation on the panel, we conclude the Essay by identifying the issues on which the panel did reach consensus.

I. THE KENTUCKY ADULT PROTECTION ACT

Kentucky Revised Statutes ("K.R.S.") § 209.030(2) states that "[a]ny person, including, but not limited to, a health care provider, who has reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made" to the Cabinet for Human Resources.[12] Even if the suspected or known victim is a competent adult who dictates that no report be made, the person with reasonable cause is required to report.[13] Upon receiving such a report, the Department for Social Services is required to notify the appropriate law enforcement agency, to conduct an investigation of the allegation, and to offer protective services for the victim. Although notification of the appropriate law enforcement agency is mandated, this does not mean that a police authority follows up on each notification. Kentucky's law provides immunity from civil and criminal liability for anyone acting upon reasonable cause and making such a report. Further, neither spousal privilege nor psychiatrist-patient privilege is considered grounds for refusing to report known or suspected adult abuse.

II. PERSPECTIVES OF HEALTH CARE PROFESSIONALS

The mandatory reporting of domestic violence is controversial among health practitioners across all states where such legislation exists. Although physicians report most cases of suspected child abuse that they identify,[14] physicians and other health care providers express concerns about the confidentiality and safety of their patients after reports of domestic violence.[15] Gerbert and colleagues identified mandatory reporting as a barrier to screening for domestic violence in a sample of San Francisco Bay

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[12] KY. REV. STAT. ANN. § 209.030(2) (Michie 1997).

[13] *See id.*

[14] E.G. Flaherty et al., *Health Care Providers' Experience Reporting Child Abuse in the Primary Care Setting*, 154 ARCHIVES PEDIATRIC & ADOLESCENT MED. 489 (2000).

[15] *See* A. Hyman & D. Schillinger, *Laws Mandating Reporting of Domestic Violence: Do They Promote Patient Well-being*, 273 JAMA 1781 (1995); Michael A. Rodriguez et al., *Mandatory Reporting of Intimate Partner Violence to Police: Views of Physicians in California*, 89 AM. J. PUB. HEALTH 575 (1999).

area emergency department, OB-GYN, and primary care physicians.[16] Recently, the American Medical Association adopted a policy opposing mandatory reporting of competent non-elderly adult victims without their consent if the reporting included identity information, stating that such activity was a violation of medical ethics.[17] The American College of Emergency Physicians has adopted a policy opposing mandatory reporting to the criminal justice system but encourages reporting to social services and other agencies in accordance with patients' wishes.[18] New York's Commission on Domestic Violence Fatalities recommended limited mandatory reporting in cases of life-threatening or serious physical injury.[19]

The health care practitioners on this panel—a dentist and a physician—both reported discomfort with the mandatory reporting law in Kentucky. Although most of the applicable literature discusses the reaction of physicians and emergency room personnel to mandatory reporting laws, Dr. Karen West presented data on the responses given by Kentucky dentists to a series of focused questions. Often, injuries resulting from domestic violence occur to the head and neck region. Dentists may be the first or only health care professional to see victims of domestic violence. The dentist is likely to see the signs of abuse while performing an oral examination or while delivering dental treatment related to trauma.

Dr. West discussed domestic violence and Kentucky's mandatory reporting law with twenty-five dentists, including private practitioners in the central Kentucky region and academic dentists. In general, dentists were aware of mandatory reporting requirements for child-abuse victims and stated that they comply with these laws. On the other hand, many were unclear about mandatory reporting laws for adult victims of domestic violence.

All dentists indicated that, if confronted with a patient with facial trauma consistent with the effects of abuse, they would inquire about the cause of the trauma. Most dentists stated that they would not probe further

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[16] B. Gerbert et al., *A Qualitative Analysis of How Physicians With Expertise in Domestic Violence Approach the Identification of Victims*, 131 ANNALS INTERNAL MED. 578 (1999).

[17] Am. Med. Ass'n, *AMA Data on Violence Between Intimates (I-00)* (Dec. 2000), *available at* http://www.ama-assn.org/ama/pub/article/2036-5298.html.

[18] Am. Coll. of Emergency Physicians, *Mandatory Reporting of Domestic Violence to Law Enforcement and Criminal Justice Agencies* (adopted June 1997 and reaffirmed Oct. 2001), *available at* http://www.acep.org/1,615,0.html.

[19] N.Y. Comm'n on Domestic Violence Fatalities, *The Role of the Medical Profession in Domestic Violence* (Oct. 1997), *available at* http://www.opdv.state.ny.us/publications/fatality/part6.html.

if the patient either did not report abuse or denied abuse. Several dentists had a clear plan for intervention if the patient reported abuse, but many did not feel competent to deal with the practical and emotional aspects of such a report.

In addition to lack of knowledge about the law, most dentists reported discomfort with the mandatory reporting component of the law. Many stated that they would not report the violence over the patient's objections; several noted that they would not place written documentation of the violence in the patient's record. Reasons given for keeping silent mirror those reported in published articles. These health care professionals feared making the situation worse, placed a high value on respecting the autonomy of a competent patient, and wished to protect the confidentiality of the patient's visit. Concerns about frightening patients away from necessary dental services because of fear of being reported were raised, as were the special confidentiality issues that arise in small rural communities. Also, several dentists admitted that their lack of familiarity with the law and the processes of the social service system made such reporting even more intimidating.

One group of dental practitioners stood apart from the rest. Oral and maxillofacial surgeons, the dental practitioners who might be expected to encounter the greatest number of severe domestic violence cases in their practice, reported consistently that they felt confident about dealing with domestic violence. They also reported knowing about the mandatory reporting law and professed willingness to comply and experience in complying with it.

These focused interviews suggest that education and experience are crucial factors to consider. Some of the reticence about reporting appears to stem from ignorance about domestic violence. Published articles suggest that dentists are, in fact, less knowledgeable about domestic violence than is necessary to deal with this complex issue. In a 1998 survey of U.S. dental schools, forty percent of the responding schools reported that the topic of domestic violence (defined broadly to include child abuse) was part of a required course.[20] Only five percent of schools required a separate course on domestic violence; two percent of schools covered the subject in an elective course.[21] Twenty percent of responding schools reported that domestic violence was not covered in the curriculum at all.[22]

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[20] HEALTH RES. & SERVS. ADMIN., DEP'T HEALTH & HUM. SERVS., WOMEN'S HEALTH IN THE DENTAL SCHOOL CURRICULUM: REPORT OF A SURVEY AND RECOMMENDATIONS (1999).

[21] *Id.*

[22] *Id.*

A similar survey was given to medical schools.[23] Seventy-four percent of responding medical schools included domestic violence as part of a required course, whereas fifteen percent covered the subject in an elective course.[24] Six percent of medical schools at that time did not cover domestic violence in the curriculum.[25] A 1997 U.S. survey of primary care physicians found that more than half believed that their medical education had not adequately trained them to deal with domestic violence victims.[26] Of the respondents, seventy-five percent reported no training in the diagnosis of domestic violence, and ninety percent agreed that more should be done to educate physicians about domestic violence.[27]

There is no guarantee that education will result in more comfort with reporting or in increased compliance with reporting requirements. A 1994 survey of 1521 practicing dentists, physicians, dental hygienists, social workers, psychologists, and nurses indicates that more education increases clinicians' awareness of the likelihood of child, spousal, or elder abuse.[28] However, the effect on intervention or reporting was less clear. Only social workers and psychologists would report *suspected* abuse most of the time. Most dentists and hygienists would not report it.[29]

The University of Kentucky Colleges of Dentistry and Medicine are examples of educational institutions that are proactively incorporating women's health—and domestic violence in particular—as a topic area into their curricula. It is hoped that the practitioners of tomorrow will be prepared to recognize signs of domestic violence, communicate empathetically with a victim of abuse, and administer legal responsibilities as health care professionals. Such practitioners can then deliberately exercise a decision-making process based on knowledge and experience that will determine whether a domestic violence case is reported or not. However, at present, it appears that substantial numbers of practitioners may be failing to report because of a lack of knowledge or skill rather than because of a deliberate decision not to do so.

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[23] HEALTH RES. & SERVS. ADMIN., DEP'T HEALTH & HUM. SERVS., WOMEN'S HEALTH IN THE MEDICAL SCHOOL CURRICULUM: REPORT OF A SURVEY AND RECOMMENDATIONS (1998).

[24] *Id.*

[25] *Id.*

[26] S.A. Reid & M. Glasser, *Primary Care Physicians Recognition of and Attitudes Toward Domestic Violence*, 72 ACAD. MED. 51-53 (1997).

[27] *Id.*

[28] P. Tilden et al., *Factors that Influence Clinicians' Assessment and Management of Family Violence*, 84 AM. J. PUB. HEALTH 628 (1994).

[29] *Id.*

Should we explore a mandatory continuing education requirement regarding domestic violence for health professionals, much like that for HIV education? Would such education take away the fear of the unknown that practitioners experience? The health care professionals on the panel were reluctant to call for legislative intrusion into health professions' curricula. However, all agreed that it was important for the health professions to take up the challenge of improved education in this area.

III. VOICES OF THE VICTIMS—A SOCIAL SERVICE PERSPECTIVE

Concerns about patient safety, respect for patient autonomy, respect for confidentiality, and lack of knowledge are voiced as reasons to dispute the Kentucky Adult Protection Act and to avoid complying with its requirements. Many of these reasons focus on the victim. However, there is a paucity of input from the victims. Dr. Linda Bledsoe and colleagues, Drs. Anita Barbee and Pam Yankeelov, have studied the reaction of victims of domestic violence to the law by carrying out a two-part study employing quantitative and qualitative research methods. Complete details of the methods and the results are available from the investigators and will be reported elsewhere.[30] Their work provides valuable insights into the topic under discussion.

To complete their work, Dr. Bledsoe and colleagues conducted a chart file review (format developed in collaboration with the Kentucky Governor's Task Force on Domestic Violence) of Adult Protective Services ("APS") cases. Eight counties in Kentucky were randomly chosen to represent different quadrants of the state; both rural and urban areas were included. Using the state's information system, the researchers randomly selected one hundred domestic violence cases from each of the eight counties. An experienced caseworker in each county completed the case file review form after being trained by University of Louisville faculty members.

A total of 631 files were located and reviewed (78.8% of the target cases). Approximately twenty-five percent of the cases reviewed had occurred in urban areas. The victims were mostly women (89.1%) with a mean age of 33.2 years (the range was from fifteen to eighty-nine years). Most of the victims were white (92.4%); 5.9% were African American. Almost half (44.8%) of the families involved included children under eighteen.

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[30] Linda Bledsoe, Ph.D., Kent School of Social Work, University of Louisville, Louisville, Kentucky.

Social workers in each of the eight counties attempted to contact victims based on all completed case reviews to invite participation in telephone interviews. As always with this population, safety concerns were very important. Social workers checked case records and other sources of community information before attempting to call any potential participant. If there were any concerns about safety, no contact was attempted. If the women agreed to be interviewed, the social workers compiled a list of possible "safe" times at which each participant could be interviewed by telephone. All of the sixty victims contacted by social workers agreed to participate; however, researchers were only able to complete twenty-four interviews. The other victims either never answered the telephone or their telephones were no longer in service.

For the actual interview, a female researcher from the University of Louisville called victims, briefly introduced herself, asked whether this was a good or safe time to talk, explained the study again, and reminded the victims of safety strategies (i.e., "just say goodbye and hang up at any time if you need to"). After verbal consent had been obtained, the interview proceeded. A structured interview guide was used, and completed interviews lasted from thirty to sixty minutes. The twenty-four completed interviews were with women who had previous contact with APS after a domestic violence report.

The focused interview dealt with many aspects of each victim's experiences. In this report, we focus on the mandatory reporting law and the women's experience "in the system."

After briefly explaining the law to the participants, the researcher asked victims, "Should professionals be required to report domestic violence?" In general, the women answered affirmatively. Of those interviewed, twenty-two said that physicians should report, and twenty victims said that other health professionals should report. Similar affirmative response rates were given when victims were asked whether mental health therapists, law enforcement workers, or attorneys should report. Twenty-one of the respondents stated that even shelter workers should be required to report domestic violence.

Reasons given by the victims for mandated reporting include the following:

- "Protects victims' lives and safety. Might save a life."
- "Keeps him from doing it again."
- "I feel that anyone including neighbors should report. Better safe than sorry. I think it is a good thing for a social worker to come out to the house and check on safety."

When asked, "Why might mandatory reporting not be helpful?," fourteen women could not list any negative aspects of the law. Ten women were concerned about the possibility of increased risk of injury after reporting. Seventeen women said that they would *not* have prevented a report if they could have stopped it. Those women who indicated that they would have prevented a report expressed concern about retaliation by the abuser and talked about their own feelings of shame.

These twenty-four victims were also asked about their experiences with APS social workers. Twenty of the women interviewed were satisfied with the APS process after a report. The following quotes illustrate positive responses from the participants:

- "Like someone out there cares."
- "Felt a lot of support."
- "The social worker was very supportive. She has given me a lot of information about resources.... She has been right there the whole way."

Several participants expressed relief that someone was checking on their safety:

- "It was a good thing that they were checking on me to see how I was doing."
- "Felt safer."
- "I was very pleased with contact with my social worker. If I needed to, I could call for help. It made me feel safer. Social worker gave me her phone number."

However, eight of the twenty-four women interviewed were anxious about contact with the social worker:

- "It makes me nervous. I don't like talking to social workers ever."

When asked about the social worker's behavior, this victim replied,

- "They weren't rude or mean, you just have to watch everything you say and do in front of them all the time."
- "I was afraid of losing custody of my four children. The social worker said she would have to speak with all four children separately to see if they were being hurt or needed more services. This made me feel nervous."

One concern expressed by physicians, some victims interviewed in this study, and others is that victims will suffer retaliation from abusers as a result of efforts to report domestic violence. It is reasonable to assume that one outcome of reporting would be an increased numbers of arrests, especially in a state like Kentucky which has a pro-arrest policy for domestic violence. To better understand the effects of arrest on intimate partner violence, the National Institute of Justice ("NIJ") supported five studies that were completed between 1981 and 1991.[31] These studies, known as the Spouse Assault Replication Program ("SARP"), consisted of multi-site replications of the original Minneapolis Domestic Violence Experiment begun in 1980. The sites included were Charlotte, North Carolina; Colorado Springs, Colorado; Dade County, Florida; Milwaukee, Wisconsin; and Omaha, Nebraska. These studies were designed to empirically test whether arrests deterred subsequent violence against victims. Maxwell and colleagues analyzed 4032 incidents from the pooled data from all sites and found no association between arrest of the offender and an increased risk of subsequent aggression.[32] In fact, arresting the offenders was consistently related to reduced subsequent violence against female intimate partners.[33]

There still remains a strong need for increased coordination on the reporting process that would include feedback to health care providers about what happens to their patients after a report is made. Physicians and others have legitimate concerns about what happens to patients after a report. It is hoped that the findings presented here will help address those concerns.

CONCLUSION

Domestic violence is an important issue in the Commonwealth of Kentucky and throughout our nation. Kentucky is one of the few states that have instituted a mandatory domestic violence reporting law for adult victims via the Kentucky Adult Protection Act. This law requires all persons, including but not limited to health care practitioners, to report known or suspected cases of abuse, neglect, and exploitation. The findings

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[31] *See* C.D. MAXWELL ET AL., DEP'T OF JUSTICE, THE EFFECTS OF ARREST ON INTIMATE PARTNER VIOLENCE: NEW EVIDENCE FROM THE SPOUSE ABUSE REPLICATION PROGRAM, *available at* http://www.ncjrs.org/pdffiles1/nij/188199.pdf.

[32] *Id.* at 13.

[33] *Id.*

presented by this panel and the experiences of the panel's participants suggest that the compliance of health care practitioners with this law is limited.

Reasons given for lack of compliance include lack of education, concerns about patient confidentiality, respect for patient autonomy, and concerns about patient safety. However, information presented by this panel suggests that dangers to patients from mandatory reporting may be less than feared and that reporting suspected abuse to local social service agencies may benefit patients. The findings presented here also suggest that health care practitioners may have limited knowledge of the domestic reporting requirement and the means by which such reports may be made.

Potential solutions include enhanced opportunities to learn more about domestic violence during the education of health professionals and as part of continuing education programs. Although panel participants disagree about the relative merits of Kentucky's mandatory reporting law and whether or not domestic violence education for health professionals should be legislatively mandated, they agree that enhanced education of health care professionals about the identification and management of domestic violence cases is necessary and that the voices of victims must be heard in discussions about laws such as the Adult Protection Act.