In reply to Dr Goodyear-Smith

I wish to clarify issues raised in Dr Felicity Goodyear-Smith's letter – *NZFP 2003; 313–314*.

'The New Zealand Economic Cost of Family Violence', (Susan Snively Dec 1994) incorporates costs provided by DSW, Ministries of Justice, Health and Education, Te Puni Kokiri, Department of Labour, Police, the Pubic Health Commission, Commissioner for Children, Women's Affairs, ACC, Institute of Criminology, Women's Refuge and Men for Non Violence.

1. Three scenarios were used.

a. Direct costs associated with recorded numbers of police calls to domestic incidents in 1992/3, considered the minimum number of families acknowledging violence.
b. A conservative 'five times call-out' level, estimating incidents which were unreported.
c. An 'income forgone' scenario, which added labour losses due to days off, and was calculated on a well below average proportion of women in work experiencing loss of earnings.

Internationally, prevalence rates for partner abuse vary between 1:4 and 1:10, but research on this sensitive issue is notoriously difficult.

Conservative costs for New Zealand in 1993 based on a 1:10 prevalence and actual call-out costs, is $1.187 billion, increasing to $3.770 billion when labour costs are included. Clearly an enormous sum.

The template remains available for contemporary computation, and the Family Violence Unit made a commitment in 1994 to undertake this task.

Updated information that reflects actual costs in 2003 would be most welcome.

2. The internationally accepted view, and that of the Ministry of Health and the RNZCGP, is that regular inquiry of patients about relationship safety following education and training is a recognised strategy to identify abuse early and offer intervention. Education and training of health providers is essential for this to be done appropriately and safely. Without routine inquiry, only 2% of partner abuse is identified.

3. With respect to acceptability of routine inquiry, one paper published in the *BMJ* 10 August 2002 by J Ramsey et al. stated that in four surveys 43–85% of women respondents found enquiry about domestic violence acceptable. The lower percentages were in relation to a telephone survey asking about acceptability of questioning at all consultations – a position not advocated by any reputable organisation of which I am aware.

Surveys used different questions and methods, including written questionnaires and face-to-face or telephone interviews, different sub populations, genders, and had response rates of 63–91%. Total numbers questioned varied from 94 to 516, in settings ranging from public and private hospital outpatient departments, Health Maintenance Organisations, and a domestic violence programme, all in the USA. State rules on reporting to police vary and can influence victim opinion markedly, making these results difficult to generalise. In the largest group of 516 patients, 85% of women agreed with screening and 50% strongly agreed.

The paper stated that while there was insufficient research data to recommend screening, health services should aim to identify and support women who were experiencing domestic violence. It also highlighted the importance of education and training for clinicians before promoting disclosure.

One must consider whether 'acceptance' surveys find such high levels of agreement for questions on obesity, alcohol consumption, eating habits, smoking, gambling and sexual activity. Also if, in fact, we should be overly concerned about a minority finding this unpalatable, given that the issue of partner abuse is so clearly a health risk for women and children.

Legitimate reasons for discomfort about being questioned, and for non-disclosure or denial, include a bad past experience with a GP around any sensitive issue, no relationship with a GP, fear of disbelief, shame, and concerns that the incident may be reported to police or other family members, a feeling that the situation is her fault or too hard to help by anyone, and threats by the perpetrator of consequences if abuse is revealed to others.

Questions asked in a non-judgemental manner, in a consultation where timing and context are appropriate by a general practitioner or practice nurse well known to the patient, or in a 'first visit' consultation where all general health parameters

are inquired into, will be less likely to have problems with 'acceptability' than methods reviewed above.

4. Partner abuse is associated with a number of life circumstances. However, just as we would not in good practice make a decision to ignore the possibility that a patient may be a smoker or a diabetic (and thus be at an increased risk for a number of negative health outcomes), on the basis of our knowledge about their socio-economic status, education, ethnicity or marital status, neither should we make an assumption that any individual is necessarily in a safe and healthy relationship.

5. While the quoted 1996 NZ Survey of Crime Victims, a self-report questionnaire, had some interesting findings with respect to partner abuse in the Women's Safety Survey (which was taken from a subset of 500 females), we need to know that only 57% responded to the original survey; we know nothing of the experience or the 43% who refused to be involved.

It must be understood that sensitive issues are often not revealed to an 'unknown' interviewer. There were also some serious sampling errors with respect to sexual assault/abuse, which frequently also occurs as part of current or recent intimate relationships.

Findings with respect to psychological abuse however were illuminating – one commented that *'the cumulative effects of psychological abuse were more damaging...than the effects of physical abuse.'*

Only 1:10 who disclosed violence had reported this to the police – and the majority of women believed that their children who had seen or heard violent abuse, had been affected by it.

Tacket et al., in an article entitled '*Routinely asking women about domestic violence in health settings'* (BMJ 2003; 327:673–676), believe that a strong case exists for routine enquiry. To reinforce the fact that domestic violence does not always reveal itself with broken bones and black eyes, the term partner abuse is preferred, which also encompasses both forced sexual activity and psychological abuse, taking into account that this may continue to be perpetrated long after the relationship has ended. This term also recognises that males can be abused.

Your correspondent is concerned about extreme violence in a few cases – the ugly tip of the iceberg. The point of educating health professionals to routinely address relationship health and safety issues is precisely to recognise, respond and if necessary refer appropriately in a safe and confidential environment, before patterns of violence, injury, and illness develop.

Dr Faye Clark