Protection Order Petitioners’ Health Care Utilization

Catherine Cerulli, Elizabeth A. Edwardsen, Jeremy Duda, Kenneth R. Conner, and Eric Caine

Abstract

Little work has explored the extent to which female victims of intimate partner violence use medical and legal services. In this cross-sectional study of a sample of women seeking orders of protection at family court (N = 95), we report descriptive, self-report data on health care utilization and insurance coverage. Although 85% of the petitioners had private or public health insurance, 39% reported delayed medical care, and 14% had not obtained medical care of any kind. The response to address interpersonal violence victimization should attempt to connect women using the courts with needed health care services.

Keywords
domestic violence, family court, health care utilization

Introduction

Recognition of the high prevalence and incidence of intimate partner violence (IPV) has led to widespread public health initiatives to address the problem, including updated medical practices (Eisenstat & Bancroft, 1999) and innovations in the civil and criminal legal arenas. Coordinated responses to IPV include, but are not limited to, civil and criminal courts and the educational, social services, and health care systems. Up to 30% of individuals, mostly women, suffer IPV at some time in their lives (Tjaden & Thoennes, 1998). Although IPV victimization among women is associated with indicators of lower socioeconomic status, such as younger age, lower education, lower income, and receipt of public

1University of Rochester School of Medicine and Dentistry, Rochester, NY

Corresponding Author:
Catherine Cerulli, University of Rochester School of Medicine and Dentistry, 300 Crittenden Boulevard, Box: Psychiatry, Rochester, NY 14642
Email: Catherine_Cerulli@URMC.Rochester.edu
assistance (Vest, Catlin, Chen, & Brownson, 2002), IPV occurs across all socioeconomic strata, including highly educated health care providers (deLahunta & Tulsky, 1996). Indeed, a study of women enrolled in a health maintenance organization (HMO), who are likely to be employed and have higher household incomes than average, found that 6.1% had experienced IPV in the past year (Tollestrup et al., 1999).

Access and utilization of health care services is an important concern for women who are victims of IPV, as they experience a wide range of physical and psychological symptoms related to the abuse, including acute injuries, hypertension, gastrointestinal and genitourinary problems, headaches, chronic pain, depression, anxiety, and posttraumatic stress disorder (Campbell, 2002). These difficulties may persist even after violence has subsided (Campbell, 2002). For instance, a large community study in the United States showed that women who have experienced IPV are at significantly greater risk for stroke (80% more likely), asthma (60% more likely), heart disease (70% more likely), arthritis, heavy alcohol use (70% more likely), and risky sex (Centers for Disease Control and Prevention, 2008). This study also identified a large health gap in delivery of services to this population.

Studies of IPV survivors have previously reported high rates of health care utilization, including emergency care, routine care for chronic conditions, and preventive care (Bergman, Brismar, & Nordin, 1992; Hathaway et al., 2000; Wisner, Gilmer, Saltzman, & Zink, 1999). In 1995, IPV accounted for nearly 0.5 million emergency department visits, 0.8 million outpatient visits, and 18.5 million mental health visits (Hathaway et al., 2000). Despite the high prevalence, IPV often goes undetected in health care settings (Gerbert et al., 1996). Thirty-eight percent of respondents in one shelter population reported medical providers were unaware of their abusive relationships. Only 32% of these women who had a primary care physician (PCP) reported their PCP routinely inquired about IPV at office visits (Bansal, Park, & Edwardsen, 2007). Efforts to link survivors with medical services with awareness of the violence may influence diagnoses, treatment plans, and the patients’ abilities to adhere to treatment. Providers aware of partner violence may be more likely to incorporate routine inquiry into clinical practices, seek additional training, and provide effective intervention on behalf of these patients (Centers for Disease Control and Prevention, 2008).

Integral to a public health approach to IPV is the availability of both medical and legal help for victims when they choose to use services to either leave their abusive partner or obtain enhanced safety. Although studies have explored IPV victims’ medical service utilization and the associated costs in medical settings (Rivara et al., 2007; Ulrich et al., 2003), we have little understanding of care seeking among other samples, such as victims encountered when seeking orders of protection at court. They are accessing the legal system for a protection order, either intending to leave their relationships or, at a minimum, hold the perpetrators accountable for their violent behavior.

This study documents the health insurance status and care utilization for a court-based sample of victims filing for orders of protection in an IPV court in western New York. Previous utilization analyses in the literature rely on data from health care plans or random samples of the population. No published studies have documented health care access and use in a court-based sample. This study fills that gap in the literature. Based on earlier
research, we hypothesized petitioners seeking orders of protection would use medical services to a greater extent than a national sample. An exploratory aim was to identify previously unmet health needs for these individuals who seek legal assistance and examine opportunities for greater coordinated care.

**Method**

We collected quantitative data from adult female IPV victims at a domestic violence intensive intervention court (“court”) in upstate New York between February and July 2004. Victims may file for orders of protection in the court if they experience disorderly conduct, harassment, assault, stalking, or menacing. Petitioners are eligible to use the court to gain temporary orders of protection if they are related by blood or marriage, a former marriage, or a child in common.

The court provides victims seeking orders of protection a secured waiting area apart from the perpetrators. The location provides offices for legal counsel as well as an advocacy service for petitioners. We approached the court petitioners in the secure, semiprivate (wall dividers) waiting room as they awaited their hearings. Participation was voluntary and anonymous. Petitioners did not provide their name or any identifying information. No compensation was provided for their participation. The university human subject review board approved the study.

We administered instruments including (a) a demographic survey that included the petitioner’s age, race, number of people in household, education, household income (see

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<th>Table 1. Sociodemographics</th>
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<tr>
<td><strong>Age, M (SD)</strong></td>
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<tr>
<td><strong>Range</strong></td>
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<tr>
<td><strong>Race, M (SD)</strong></td>
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<tr>
<td>White</td>
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<tr>
<td>Non-White</td>
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<tr>
<td>Missing</td>
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<tr>
<td><strong>Number in household (% of total), n (%)</strong></td>
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<tr>
<td>1</td>
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<td>2-3</td>
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<td>4-5</td>
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<td>6-7</td>
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<td>8+</td>
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<tr>
<td><strong>Education (% of total), n (%)</strong></td>
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<tr>
<td>Some high school</td>
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<td>Graduated high school/GED/vocational</td>
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<td>Some college</td>
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<td>Some graduate school</td>
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<td>Completed graduate school</td>
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Note: N = 95.
Table 1), and items pertaining to health insurance and (b) an excerpt from the Community Tracking Household Study to assess participants’ medical service utilization histories (see the appendix). This national household study instrument was first administered in 1996-1997 and again in 1998-1999, 2000-2001, and 2003. We compared petitioners’ health care utilization with data from the Community Tracking Survey’s Web-based data (Center for Studying Health System Change, 2003). We compared our data with the 2003 U.S. Census Bureau (DeNavas-Walt, Proctor, & Mills, 2004) to explore whether the sample’s economic and insurance characteristics resembled national and statewide data.

Results

We approached 170 petitioners, and 109 (64.1%) agreed to participate, 95 (87.2%) of whom were women who composed the sample for the analyses. Their mean age was 33.8 ($SD = 10.7$) years with a range from 18 to 69 years. The racial distribution included 60% White and 40% non-White. Sixty-nine percent of participants reported between 2 and 4 household members. Six percent of the participants lived alone. Fourteen percent had not completed high school, whereas 26% had completed high school or a GED, 32% had some college, and 27% had completed undergraduate college or higher.

Eighty-seven percent of participants reported an income below US$50,000 (whereas only 56% of American households earn in this range). Twenty-seven percent of participants earned between US$10,000 and US$20,000. Income data revealed 22% of the sample households earn less than US$10,000 (more than double the United States). The sample’s insurance profile was compared with corresponding data from the U.S. Census and New York State (Table 2). The proportion of individuals with health insurance in this study (85%) is almost identical to the national (84%) and New York State (85%) data. However, a higher percentage of participants were covered by public insurance (34%) than those reflected nationally (12%) and in statewide data (17%).

A higher proportion of participants visited an emergency department in the last year (42%) than a 2003 national comparison sample (22%); 15% of those using the emergency department visited three or more times (Table 3). Nineteen percent of participants had more than 7 visits compared with 16% nationally. However, participants made primary care visits (for ongoing health problems, including asthma, diabetes, heart conditions, hypertension, and cancer) to their physician in a comparable rate (Table 3) as the rest of the country: 66% of participants received routine preventative care (physical examinations and checkups) in the sample compared to 61% nationally. Twenty-two percent of participants did not see a physician within the previous 12 months compared to 20% of the national sample.

Although only 14% of participants reported that they did not get needed medical care, 40% reported delaying medical care in the last year. Twenty-three percent of participants reported delaying care due to concerns about cost, more than double the national sample. Notably, 27% of participants reported delays in medical care because they were too busy and 15% did not think the reason was serious enough. Other reasons cited for delaying care were primarily (a) financial—her insurance was not accepted by the hospital (5.3%), and
the health plan would not pay for the treatment (4.2%) or (b) logistical issues—she could not get an appointment soon enough (15%), she could not get to the office when it was open (13%), she could not get through on the telephone (7.4%), and it took too long to get to office from home or work (3%). In addition, of the 40 participants who cited personal perceptions as responsible for delaying their care, 48% felt they were too busy and 25% felt their issue was not serious enough. These reasons were not mutually exclusive. Seventy-six percent of those delaying seeking care had insurance coverage. As expected, participants without insurance tended to both not receive care and delay seeking care. Figure 1 provides information on how these three themes—logistics, finances, and personal

<table>
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<th>Table 2. National and State Insurance Comparison (%)</th>
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<tr>
<td>Sample (N = 95)</td>
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<tr>
<td>Insurance status</td>
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<tr>
<td>Any</td>
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<tr>
<td>Private—Employer</td>
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<tr>
<td>Private—Direct</td>
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<td>Government—Medicaid</td>
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<td>Government—Military</td>
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Note: NA = not applicable.

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<th>Table 3. Health Care Utilization</th>
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<td>Nationally (%)</td>
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<tr>
<td>Community Tracking Study—Year 2003</td>
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<tr>
<td>Emergency department visits</td>
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<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Missing</td>
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<tr>
<td>Primary care visits</td>
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<tr>
<td>0 times</td>
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<tr>
<td>1-2 times</td>
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<tr>
<td>3-4 times</td>
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<tr>
<td>5-6 times</td>
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<tr>
<td>More than 7 times</td>
</tr>
<tr>
<td>NA/missing</td>
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<tr>
<td>Routine preventative care visit</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
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Note: NA = not available.
perceptions—overlapped for the 36 of the 40 participants who delayed care and provided a reason specified in the appendix.

A closer look at the sociodemographic profile of participants delaying care (n = 37) reveals that the subgroup is well educated (65% have at least some college), has low household income (62% have less than US$20,000), and a majority (81%) has between 2 and 5 people in their households. The reasons cited by this subsample for postponing care are more pronounced than for the whole sample. Forty-nine percent claim cost as a concern, 27% could not get to the office or clinic during business hours, and 46% reported being too busy to see a physician. When asked whether victims would seek help if it was provided on site at court, 88% said they would use medical care if available at court.

**Discussion**

This study addresses the paucity of data on insurance coverage and health care utilization for a court-based sample of IPV survivors. Findings reveal order of protection petitioners at court in this sample are insured to the same extent as the data sets of New York and the United States. However, the type of insurance coverage and emergency service utilization of this population differs from national data. The study sample was more likely to be covered under public insurance.

Petitioners at court in this sample visit a primary care physician at a similar rate as other U.S. residents. This finding is contrary to our hypothesis and earlier research conducted in
health care settings documenting victims of partner violence access more health care (Anderson & Saunders, 2003; Griffing et al., 2002; Zink, Elder, Jacobson, & Klostermann, 2004) than average. The IPV victims who access family court may be different from those victims who seek medical care only. The study settings may be dictating the results. However, this also speaks to the consideration that IPV survivors are not a homogeneous population and suggests the need to study their medical care needs in multiple settings, both medical and court venues.

A characteristic of the sample is the high percentage (87%) of individuals making appointments for chronic problems such as asthma, diabetes, heart conditions, hypertension, or cancer. The study sample was more likely to use the emergency department than the rest of the population, which supports earlier studies (deLahunta & Tulsry, 1996; Hathaway et al., 2000).

This sample clearly reflects a sociodemographically diverse group of women who have varying levels of education and resources. Although domestic violence can affect women of all sociodemographic strata, poverty and low education have been linked to increased risk for IPV and are correlated with being either without insurance or underinsured (Vest et al., 2002). This sample of survivors, some educated, are nonetheless low-income women with those more educated more frequently delaying routine visits with their physicians.

Shame, embarrassment, fear, and lack of resources have been shown to prevent women from leaving abusive relationships and accessing available resources (Fugate, Landis, Riordan, Naureckas, & Engel, 2005). These issues still may be present for women once they have left. Although a large proportion of IPV court petitioners in this descriptive study have health coverage, many delay needed health care. Participants cite reasons both personal (cost, time) and system related (office hours, availability of appointments, transportation). Given many of this subset of women are employed, have low household incomes, and have several others in the household, these factors may prevent them from seeing their personal physicians in a timely manner. Three quarters of these participants delaying care have insurance coverage. It is possible that factors such as shame and embarrassment play a factor in delayed care.

It is also possible that these women experience similar reasons for delaying care as non-IPV involved women do. Other research has noted that for many women, taking care of themselves is viewed as a luxury—even for seeking health care (Currie & Wiesenberg, 2003). In earlier work, women have also noted time, transportation, and accessibility (both hours of operation and locations) as barriers to care (Currie & Wiesenberg, 2003). For those who did receive care, it is important to note for many, it was for routine care for chronic health issues, underscoring that opportunities exist for routine IPV inquiry in the primary care setting. Ideal advocacy for IPV victims includes routine inquiry in all medical settings, regardless of the presenting condition. Our results further emphasize that all clinicians, especially those who serve the uninsured or those with public insurance, should prioritize routine IPV inquiry.

This study raises an important question regarding whether an IPV survivor who is unable to afford a deductible or copay or to take time off from work has access to health care, despite being insured. The provision of on-site health care services or referrals from advocates within the courthouse, available as these women seek legal action, might
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remove some of their barriers to care. On-site health care may begin to relieve the potential long-term health consequences of the abuse from which they are seeking safety. At court, victims might access more timely health care, seek assistance for securing insurance if not currently carried, and receive appropriate referrals indicated by the petitioners’ health status.

Limitations of this study are important to acknowledge. This study represents a subset of IPV victims who presented at one community’s family court as petitioners for orders of protection in 2004. Clients seeking court-based services are limited to those who may access family court based on relation by blood or marriage, former marriage, or a child in common. Participation, although a majority, was suboptimal. The data were collected over a brief time frame and based on self-report. There was no retrospective chart review to verify the data.

Conclusion

Monitoring the health status and insurance status of IPV survivors after acquiring orders of protection would offer insight into how the court process might affect participants’ well-being. Women may experience fewer injuries and mental effects over time once receiving an order. Likewise, health insurance status might change due to employment status changes, income adjustments (either survivor or perpetrator), or health plan termination/acquisition. If so, the rate of coverage in this sample might initially skew toward independently insured women, further limiting appropriate health care access for others without such resources. A longitudinal study of participants in this setting might address such potential positive and negative consequences on medical service use post legal action to seek orders of protection.

Whereas medical professionals are encouraged and often mandated to educate their IPV patients about their legal rights, attorneys are not mandated to provide clients with medical referrals. Perhaps court-based professionals might be trained to connect IPV survivors with health care resources when they appear in court for orders of protection to ensure a truly coordinated community response to IPV.

Appendix

Community Tracking Study 2003 Household Survey (Excerpt 2004)

1. During the past 12 months, how many times have you gone to a hospital emergency room (ER)? Count all visits to the ER, including visits where you received a brief exam, but were sent elsewhere.
   Your best estimate is fine.
   _____ Number of times
   _____ Don’t know

   (continued)
Appendix (continued)

2. In the last 12 months, about how many times have you seen a doctor? (Do not include doctors seen while an overnight patient in a hospital or in the ER. Do not include dentist or chiropractor visits or telephone calls to doctors.)
   *Do* include osteopathic doctors and psychiatrists.
   *Do* include outpatient visits and outpatient surgeries.
   Your best estimate is fine.
   _____ Number of times
   _____ None (if none, SKIP Questions 3 and 4.)
   _____ Don’t know

3. Were any of these visits for routine preventative care such as a physical examination or checkup?
   Yes ______  No ______  Don’t know ______

4. Were any of these visits a routine checkup for an ongoing health problem?
   Examples of ongoing health problems include asthma, diabetes, heart condition, hypertension, cancer, and so on.
   Yes ______  No ______  Don’t know ______

5. Not counting the doctor visits you have already told me about, have you seen a nurse practitioner, physician’s assistant, or midwife during the past 12 months?
   Yes ______  No ______  Don’t know ______
   If yes, how many times? ______

6. Were any of these visits for routine preventative care such as a physical examination or checkup?
   Yes ______  No ______  Don’t know ______

7. Were any of these visits a routine checkup for an ongoing health problem?
   Examples of ongoing health problems include asthma, diabetes, heart condition, hypertension, cancer, and so on.
   Yes ______  No ______  Don’t know ______

8. Next, during the past 12 months, was there any time when you didn’t get the medical care you needed?
   This question is limited to medical care. Do *not* include dental care.
   Yes ______  No ______  Don’t know ______

9. And was there any time during the past 12 months when you put off or postponed getting medical care you thought you needed?
   Yes ______  No ______  Don’t know ______

10. Did you not get or postpone getting medical care for any of the following reasons?
    Please check all that apply below:
    _____ Worry about the cost
    _____ The doctor or hospital wouldn’t accept your health insurance
    _____ Your health plan wouldn’t pay for the treatment

(continued)
Appendix (continued)

____ You couldn’t get an appointment soon enough
____ You couldn’t get there when the doctor’s office or clinic was open
____ It takes too long to get to the doctor’s office or clinic from your house or work
____ You couldn’t get through on the telephone
____ You were too busy with work or other commitments to take the time
____ You didn’t think the problem was serious enough
____ Or any other reason
____ None
____ Don’t know

11. I trust my doctor to put my medical needs above all other considerations when treating my medical problems.
____ Strongly agree
____ Somewhat agree
____ Neither agree nor disagree
____ Somewhat agree
____ Strongly disagree
____ Not applicable
____ Don’t know

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**Bios**

**Catherine Cerulli** is the director of the Laboratory of Interpersonal Violence and Victimization (LIVV), associate professor with the Department of Psychiatry in the School of Medicine and Dentistry at the University of Rochester, Rochester, New York. The National Institute of Mental Health recently awarded her a K01 5-year career development award. She maintains a joint appointment as the director of research at the State University of New York at Buffalo School of Law, Family Violence Clinic, she cofounded in February 1992.

**Elizabeth A. Edwardsen** graduated from Colgate University with a major in mathematics in 1982. She graduated from the University of Rochester Medical Center (URMC) in internal medicine in 1989. Passing her board exam in September 1989, she has been working in emergency medicine since July 1999. She is currently an associate professor of emergency medicine at URMC.

**Jeremy Duda**, a 2005 Babigian fellow, graduated from the University of Rochester Medical Center in 2008. Since graduation, he has been working at the University of Rochester Medical Center in the internal medicine department.

**Kenneth R. Conner**, PsyD, MPH, is associate professor of psychiatry at the University of Rochester Medical Center and codirector of the Center for the Study and Prevention of Suicide. He has been on the faculty at URMC since 1995. In 2007, he joined the newly established Canandaigua VA Center of Excellence. He is currently the principal investigator of a grant sponsored by NIH to examine attempted suicide in treated alcoholics. He is also presently the chair of the Treatment Improvement Protocol (TIP) on substance abuse and suicide sponsored by the Center for Substance Abuse Treatment, a component of SAMHSA.

**Eric Caine** joined the faculty of the University of Rochester in 1978, following medical school at Harvard, residency training at the Massachusetts Mental Health Center and the National Institute of Mental Health, and further postdoctoral research at NIMH. He is currently the chair and John Romano Professor of Psychiatry at the University of Rochester Medical Center.