Partner abuse

Dr Clark is to be lauded for the energy and commitment she brings to the topic of recognition and detection of partner abuse.[1] However, in her eagerness to address the problem, it is important that emotionally charged topics such as domestic violence are not over-stated. While there is no doubt that partner abuse is a serious problem with significant sequelae for a subset of our population, statistics that inflate this problem serve to diminish credibility to the cause.

For example, Dr Clark writes that a conservative estimate of the cost of domestic violence to Vote Health was $140 million in 1994, with the total cost to the country between $1.2 and $3.4 billion. However this claim is based on one study which is anything but conservative – it has severe methodological flaws with gross over-estimates of many parameters used in its calculations.[2]

It assumes an annual prevalence of one out of every seven women and one out of every seven children requiring medical intervention as a result of domestic violence (301 700 people in 1994). The costing is based on the assumption that each person required an average of two GP visits per year; that half of them also needed an accident and emergency consultation; that 5.5% (16 895 people) of these abused people required hospital admission at an average cost of $17 000 per admission; and that one in eight victims of domestic violence sustained dental injuries requiring an average of $200 per dental treatment. The costs were calculated from the assumed annual prevalence not from actual clinical records. Examination of clinical data demonstrates flagrant over-inflation.

For example, the study figures suggest that in 1994, about 28 300 women and girls needed dental care following domestic abuse. However in the year 2002/2003 there were 2175 ACC female claims for dental injuries from being 'struck by a person or animal'. This adjusts to about 2050 female claims in 1994. Not all of these will be due to domestic violence – some will have sustained injuries from other causes, for example, from sporting contacts or kicks from horses. Similar critical appraisal of the other parameters demonstrates that these costs are wildly exaggerated.

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Dr Clark advocates annual routine questioning of women for partner abuse. A systematic review concluded that *'about half to three quarters of women patients in primary care'* found domestic violence screening acceptable (three or four out of every ten object to being asked).[3] In the Auckland study to which Dr Clark refers, involving a convenience sample of 56 abused women at a women's refuge, 11 (19%) said they would not have liked their GP to ask them about domestic violence.[4] GPs will be reluctant to ask these questions even if only 10% of women are offended.

Dr Clark says that partner violence *'occurs with little regard for race, age, income or education level'*. However partner violence has been shown to be strongly linked to cohabitation at an early age; a variety of mental illnesses; a background of family adversity; early school leaving and juvenile aggression; conviction for other types of crime, especially violent crime; drug abuse; long-term unemployment; and motherhood at an early age.[5] The 1996 NZ National Survey of Crime Victims reported a life-time prevalence of ever experiencing at least one act of physical or sexual abuse from a partner as 14.6% and 6.8% for NZ European women and men respectively, and 26.9% and 11.9% for Maori women and men.[6] The report highlights an extremely uneven distribution of violent victimisation. A small percentage of the population are victims of significant recurrent violence – the vast majority of people have little exposure to violence or threats. However for a tiny percentage of the population violent

events are nearly commonplace. '*Only 0.5% of the sample (or 6% of those who had been victimised) had been victims of a violent offence five or more times, but they accounted for a massive 68% of such offending. Among such victims, the average number of violent and sexual offences was twelve.*' The report recommends focusing prevention efforts on those small pockets of the population who are particularly at risk of multiple victimisation. These data suggest a case could be made for targeted screening of high-risk adults, for example from low socio-economic and socially deprived backgrounds, rather than the routine questioning of every woman every year.

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