American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Domestic Family Violence

Policy Resource and Education Paper (PREP)

This policy resource and education paper (PREP) is an explication of the policy statement "Domestic Family Violence"

The American College of Emergency Physicians encourages emergency personnel to assess patients for family violence in all its forms, including that directed toward children, elders, intimate partners, and other family members. Such patients should be appropriately referred for help and detailed evaluation. Identification and assessment can be difficult since violence and maltreatment can encompass abuse in many forms including neglect, physical abuse, sexual abuse, emotional abuse, financial exploitation and intimidation.

The American College of Emergency Physicians (ACEP) recommends that:

- Emergency personnel assess patients for intimate partner violence, child and elder maltreatment and neglect.
- Emergency physicians are familiar with signs and symptoms of intimate partner violence, child and elder maltreatment and neglect.

Family violence, including child maltreatment, intimate partner violence (IPV) and elder maltreatment is a widespread public health problem.

The shift in terminology from screening to assessment is believed to lead to a more appropriate evaluation of the importance of routine inquiry for IPV in the health care setting.
http://www.endabuse.org/programs/healthcare/files/Consensus.pdf

It is imperative that emergency personnel assess patients for child maltreatment, IPV, and elder maltreatment. Routine inquiry, specifically as it relates to IPV, includes "what happened, when, where and whom." Included in the assessment are questions on immediate safety, health impact and patterns of abuse as well as potential for lethality.[1] Early detection of child maltreatment, IPV and elder maltreatment and neglect can reduce exposure to harm, mitigate the negative consequences of abuse and neglect, improve health outcomes, and reduce the need for future health services.[2]

Evidence of child maltreatment include multiple and recurrent injuries, injury history inconsistent with physical findings and injuries inconsistent with the child developmental capability to sustain them on their own.[2] Similarly, IPV can manifest itself as acute injuries and chronic injuries. IPV can also present as chronic stress and a range of medical, obstetric and mental health problems such as chronic headaches, atypical chest pains, abdominal and GI complaints as well as sexually transmitted diseases.[3] Elder maltreatment can present as physical, emotional, and financial abuse as well failure to thrive.[4]

Detection of child maltreatment, IPV and elder maltreatment by emergency personnel requires immediate and direct intervention. Documentation of the violence, consultation with law enforcement, children and

adult protective services, and advocacy programs are essential components needed for child maltreatment, IPV and elder maltreatment, respectively.

Education and Training

ACEP recommends that:

- **Emergency medical services, medical schools, and emergency medicine residency curricula should include education and training in recognition, assessment and evidence-based interventions in intimate partner violence, child and elder maltreatment and neglect.**

The ability to recognize domestic family violence is based on education, experience, and the training to include screening for violence as part of patient assessment. Training on family violence is not standardized at medical schools and in residency programs.[5,6] Training on screening for violence, recognition of signs and symptoms of possible violence, and knowledge of resources to draw upon when there is concern for violence is necessary at all levels of training. Training should begin with medical students and continue through residency programs.[7]

Rosenberg, et al[8] note: "Education and training for physicians should begin in medical school, with emphasis on the cycle of violence across the life span, development of safety plans, legal options and reporting requirements, and referral methods. Different formats should be used to ensure that all medical students have ample opportunity to practice history taking."

Training programs can include formal didactics, videotapes, and simulated patient encounters.[9] Training programs are positively received by residents,[10] do not necessarily demand a lot of time, and may result in significant improvement in screening and identification rates for domestic family violence. The available evidence, however, indicates that training by itself is not sufficient to produce desired outcomes. Unless clinical settings demonstrate commitment to their staff addressing the problem of family violence as well as providing resources to do so, the effects of training will be short-lived and erode over time.[11]

Surveys from prehospital providers show that they have limited formal training on recognition of family violence including child and elder maltreatment.[12,13]

Given the prevalence of victims of domestic family violence in our emergency departments (EDs), training our prehospital providers, medical students and residents is the first step towards identifying and addressing this epidemic. In addition, a supportive environment alongside training is critical to producing desired outcomes.[11]

Education on Reporting

Mandatory reporting and mandated education laws have been developed as a strategy to ensure that health professionals receive training in identifying and addressing family violence. Reporting mandates are enacted in child maltreatment for all states, the majority of states for elder maltreatment and in a few states for IPV.[11] In addition, some states mandate family violence education for health professionals though there have been no formal evaluations of the impact of this education as a result of those laws.[11] While ACEP opposes mandatory reporting of IPV to the criminal justice system, ACEP recommends that mandatory reporters be granted immunity from liability for compliance with the existing state law. ACEP encourages reporting to the criminal justice system, social services, and resources that provide confidential counseling and assistance only if it is in accordance with the patient's wishes.

- **ACEP maintains that hospitals and EDs maintain appropriate education regarding state legal requirements for reporting intimate partner violence, child and elder maltreatment.**

Within the US, most states have enacted laws, each with different mandatory reporting requirements on the reporting of specific injuries and wounds, suspected abuse or IPV for individuals being treated by a health care professional (http://www.endabuse.org/health/mandatoryreporting/ - see Tables 1, 2, and 3). Due to the state-by-state variation,[14] all health care providers should know their state's IPV reporting law, including:

a) who is required to report, and
b) under what conditions (http://www.aaos.org/about/abuse/ststatut.asp).

State mandatory reporting laws are categorized into four groups:

1) states that require reporting of injuries inflicted by weapons;
2) states that require reporting of injuries caused in violation of criminal laws, as a result of violence or through non-accidental means;
3) states that specifically address reporting in IPV cases; and
4) states that have no mandatory reporting laws.

Federal privacy regulations require providers to inform patients of health information use and disclosure practices whenever a specific report has been made. Thus, the health care provider should inform the patient or guardian of the obligation to file a report if the state has mandatory reporting, and the intention to do so.

Health care providers should familiarize themselves with how their local law enforcement responds to the reported event because it will help the provider know how to facilitate safety planning for the victim.

Some state laws are unclear about whether child exposure to IPV in the absence of injury would require a report to the child protective services (CPS).

The ED should ensure that their IPV protocols and training materials regarding screening, safety assessment, documentation,[15] and referrals[16] address their state's reporting laws and federal regulations.

The most effective means to enhance the healthcare system's response to family violence is through educating the health care provider about family violence policies and procedures for reporting.[11] Thus, the ED should have regularly scheduled training regarding family violence protocols.

Research

- **Hospitals and EDs should encourage clinical and epidemiological research regarding the incidence and prevalence of family violence as well as best practice approaches for detection, assessment, and intervention for victims of family violence.**

Currently, there are no systematic data concerning family violence training programs.[17] Training is lacking across all fields of medicine in the comprehensive coverage of family violence. Less than half of pediatric residencies teach screening for family violence[6] and few medical schools have integrated curricula for the broad scope of family violence.[18]

Screening rates for incidents of family violence is low in most medical fields. The incidence of screening by third year medical students in a study of the Objective Standardized Clinical Exam (OSCE) was 34%.[19] Rates of screening for family violence in the US are less than 10% on average[20] in the medical setting but increase to 79% if an injury is present.[21] Kothari[22] demonstrated only 30% of victims of intimate partner violence were screened resulting in only 6% of known victims screened positive. In 1997, only 42% of surveyed ACEP members felt they could accurately detect elder abuse.

In 2004, The Joint Commission instituted new standards for hospitals on how to respond to domestic abuse, neglect and exploitation. Specifically, that health care organizations develop or adopt criteria for identifying victims of child maltreatment, IPV and elder maltreatment.[1]

The dramatically high screening rates in the presence of an injury may show that in the emergency setting there exists the greatest opportunity to screen and detect family violence. Preparedness is the most useful tool to improve rates of detection.[21] While many professional groups such as the American College of Obstetricians and Gynecology and American Medical Association recommend routine screening, there has been little research to support these recommendations or to map their impact.[21] Further research on family violence and the best practices for detection assessment and methods of intervention will provide a better guide to emergency physicians and health care professionals when they are identifying and acting on behalf of victims of family violence.

Collaboration with Outside Agencies

- **Hospitals and EDs are encouraged to participate in collaborative interdisciplinary approaches for the recognition, assessment, and intervention of victims of family violence. These approaches include the development of policies, protocols, and relationships with outside agencies that oversee the management and investigation of family violence.**

Once an abused person is identified or suspected, ED staff must evaluate risk and persuade the victim to contact law enforcement or referral agencies. Disposition is seldom simple and necessarily involves the provision of protection and personal safety to those involved. The victim may not cooperate, but safe and proper disposition often requires contact with the web of legal and community agencies that facilitate this process. The law in some states may require the emergency physician to report family violence episodes.[23] The same frustrations confront others who encounter a victim of family violence. These can include EMS workers, police, employers, clergy, teachers, family, friends or neighbors. Identifying a victim is only the first step, and few who do have any perspective as to the scope of the different areas of potential intervention encountered by the victim, the abuser, and the innocent bystander.

Every ED should develop a plan for training staff in abuse identification and management. The plan should detail the agencies and resources that are integral parts of this coordinated community response. Representatives can be invited to ED meetings to clarify problems, coordinate efforts, and exchange information. Other areas of the hospital and hospital administration should also be involved. ED case reviews expanded to include details of services rendered by legal, law enforcement and social services which could offer a practical method of illustrating the workings of these multiple systems.

The coordinated community response is broad and scattered often with ill-defined borders and areas of responsibility. At the center is the criminal justice system employing police, prosecutors, and judges. One duty of the system is to ensure the health and safety of victim. Family court may include a mediation service to resolve family disputes. Other forms of action include arrest of abusers, civil protective orders, the use of parole and probation, shelters, group homes, hospitals, and IPV centers.

Social Services are an integral part of the workings of the court system and can be responsible for problems of child support, elder abuse, mental health services, substance abuse treatment, and Medicaid enrollment and payment. Child protective services are involved in helping children who have been abused or who live with people who were abused. They may organize parenting programs, find foster homes, and identify children who have been neglected. Responsibilities of juvenile courts can involve psychological evaluation of children, custody investigations, emergency assistance, visitation services, and legal representation.

Problems engaging the coordinated community response include the fact that many are underfinanced, therefore, understaffed and unable to cope with an increasing population. Case workers are burdened with overwhelming case loads, slowing the system considerably. If the system is perceived as slow or distant, those abused have little confidence in promised outcomes or their own protection by the court. Training is widely needed for child protective services workers, social workers, judges, and counselors and must work efficiently at all hours of the day and night.

Conclusion

ACEP remains committed to responding to family violence in its myriad presentations. As such, ACEP recognizes the complexity of the issue and fully engages in working with health professional organizations and other stakeholder groups to educate emergency personnel.

Created by the Public Health and Injury Prevention Committee, reviewed by the Board of Directors - April 2008

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