Domestic Violence Advisory

Diagnosis/Condition:	Child abuse Adult physical abuse Adult sexual abuse
Discipline:	Integrated
ICD-10 Codes:	T74.11XA, T74.21XA, T74.92XA, T7611XA, T76.21XA T76.92XA
Origination Date:	2008
Review/Revised Date:	07/2025
Next Review Date:	07/2027

Domestic violence and abuse is defined as *a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner*. The term intimate partner violence (IPV) is often used synonymously with domestic violence and abuse (DVA). According to the CDC, IPV is abuse or aggression that occurs in a romantic relationship and refers to both current and former spouses and dating partners. Data from CDC's National Intimate Partner and Sexual Violence Survey (NISVS) indicate:

- About 41% of women and 26% of men experienced contact sexual violence, physical violence, or stalking by an intimate partner during their lifetime.
- Over 61 million women and 53 million men have experienced psychological aggression by an intimate partner in their lifetime.[1]

In the US, estimates suggest ~10 million people are affected each year; as many as one in four women and one in nine men.[2] Due to these high rates it is suggested that *"virtually all healthcare professionals will at some point evaluate or treat a patient who is a victim of some form of domestic or family violence."* Considered a major public health issue, DVA has been shown to increase the incidence of long-term physical and mental health.[3] It is suggested that providers have a professional responsibility to screen, provide resources and appropriate referrals for patients affected by DVA to decrease the incidence and improve treatment outcomes.[4,5,6]

Overview

In its broadest sense, DVA also involves violence against children, parents, or the elderly. According to the Office on Violence Against Women (OVM) US Department of Justice and the End Violence Against Women International it can assume multiple forms:

- Physical violence
- Sexual violence

- Emotional or psychological abuse
- Verbal abuse
- Social abuse
- Spiritual, religious or cultural abuse
- Elder abuse
- Legal abuse
- Financial abuse
- Technology-facilitated abuse or tech abuse[7]
- Reproductive abuse

This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone. DVA can happen to anyone of any socioeconomic background, education level, race, age, sexual orientation, religion, or gender. It can occur within a range of relationships including couples who are married, living together or dating. There are also types of financial abuse (e.g., withholding money).[8]

The effects of DVA are far reaching. Children of an abusive domestic relationship demonstrate adverse health outcomes throughout their lifetime. Taken as a whole, DVA is among the most underreported crimes worldwide for both men and women.[9,10] Many barriers exist to identifying abuse survivors including patients being reluctant to disclose a history of abuse and practitioners reluctant to inquire or not knowing how.

Incidence
(**Note, statistics are likely an underestimate due to under-reporting)*

DVA
- Affects ~1 in 3 women & ~1 in 10 men >18yrs[1]
- ~1,500 deaths in the US annually[1]

Child Abuse
- ~1 in 7 children have experienced abuse or neglect in the past year in the United States (ref needed)
- In 2020, 1,750 US children died of abuse/ neglect (ref needed)

Intimate Partner Violence
- A US-based national survey reports: ~36% of women and 29% of men have experienced rape, physical violence, and/or stalking by an intimate partner.[11]

Elder abuse
- Common with an increasing trend; 7.6-10% of persons >60yrs abused each year.[12,13]

Reporting Standards
All 50 states have passed some form of legislation mandating that professionals report any suspected child abuse, and most states require health care providers to report suspicion of elder abuse too.

In Oregon Mandatory Reporter status:

- Elder abuse: https://www.oregon.gov/odhs/report-abuse/Pages/mandatory-reporting.aspx
- Child abuse: https://www.oregon.gov/odhs/report-abuse/Pages/mandatory-reporting.aspx

In Washington Mandatory Reporter status:

- Elder abuse: https://www.dshs.wa.gov/altsa/adult-protective-services-aps
- Child abuse: https://www.dcyf.wa.gov/safety/report-abuse

In Colorado Mandatory Reporter status:

- Elder abuse: https://cdhs.colorado.gov/mandatory-reporting-of-adult-mistreatment
- Child abuse: https://cdhs.colorado.gov/colorado-child-abuse-and-neglect-hotline-reporting-system

In Idaho Mandatory Reporter status:

- Elder abuse: https://aging.idaho.gov/stay-safe/online-reporting-tools/
- Child abuse: https://healthandwelfare.idaho.gov/services-programs/children-families-older-adults/child-and-family-services-and-foster-care-3

In Montana Mandatory Reporter status:

- Elder abuse: https://dphhs.mt.gov/SLTC/APS/
- Child abuse: ttps://dphhs.mt.gov/cfsd/index

In Utah Mandatory Reporter status:

- Elder abuse: https://daas.utah.gov/adult-protective-services/
- Child abuse: https://dcfs.utah.gov/services/child-protective-services/

In Alaska Mandatory Reporter status:

- Elder abuse: https://health.alaska.gov/en/services/aps-report-harm/
- Child abuse: https://dfcs.alaska.gov/ocs/Pages/Report-Child-Abuse.aspx

Practitioners may face a daunting task when they must report allegations of DVA as most situations are not 'clear-cut'.

Medical mandated reporting can be complicated, especially when it intersects with the forensic compliance provisions of the Violence Against Women Act (VAWA) and other alternative reporting options. The term *medical mandated reporting* is used to refer to any legal requirement that health care providers must report to law enforcement when a patient discloses – or the provider has a reasonable basis for suspecting – that the patient has been the victim of a certain crime.

Laws vary dramatically in terms of what activates a reporting requirement:

- All states require medical professionals to report sexual assault when the victim is a child (as defined by state law).
- In addition, most states require medical professionals to report sexual assault when the victim is a dependent adult. The definition of what constitutes a dependent adult is also defined in state law, but it generally includes such factors as advanced age, severe cognitive disability, or other factors.
- Most state laws also require mandated reporting of any sexual assault committed by a caregiver or other authority figure, although the exact provisions of these reporting requirements vary by state.
- Most states *do not* require health care providers to report sexual assault of a competent adult. However, a few states do. In these jurisdictions, a report is required every time someone presents to a health care facility as a result of being sexually assaulted.
- Some states also require a report when patients present with certain types of injuries, such as gunshot or knife wounds, or other injuries that are non-accidental, result from violent crime, or involve the use of a deadly weapon. In these states, health care providers are required to notify law enforcement that a patient has presented with the specified injury, however, they may not have to say that the patient was also sexually assaulted.
- Finally, a few states have medical mandated reporting for intimate partner violence. In these states, health care providers are required to notify law enforcement when a patient discloses that a sexual assault occurred within the context of intimate partner violence (or when the health care provider has reason to suspect this is the case).

For medical mandated reporting requirements in each US state, please see the legal compilation created by the National District Attorneys Association: Mandatory Reporting of Domestic Violence and Sexual Assault Statutes (2010). Also see State Laws and the Nurse Practice Act by the US Department of Justice, Office for Victims of Crime (OVC).

The following recommendations are from StatPeals:[1]

- Battering is a crime, and patients should be made aware that help is available
    - If the patient wants legal help, the local police should be called
- Healthcare provider role extends beyond reporting laws; primary obligation is to protect the life of the patient
- Document all findings and recommendations, including statements made denying abuse
- If DVA is admitted by the patient, the medical record may become a court document; be objective and accurate
    - Documentation should include the history, physical examination findings, laboratory and radiographic finds, any interventions, and the referrals made

    - May include pictures

- Reassurance that additional assistance is available at any time is critical to protect the patient from harm and break the cycle of abuse
- Do not discharge the patient until a safe haven has been established.

History & Physical

The majority of DVA presentation is not for "injury," but survivors are seen for other non-traumatic conditions. For example, a history of frequent use of emergency department services is a red flag for domestic abuse in adults and children.[14]

In adults with a history of prior abuse, physical examination is unlikely to give direct clues to the causes of the presenting complaints, whether they are physical or mental-emotional. This lack of correlation is a clue that there is a history of DVA.

- Somatic complaints in the absence of an explanatory diagnosis.
- Obstetric or gynecologic problems (including sexually transmitted infections or injuries)

Patients may present with injuries that do not have a good explanation. This may include wounds or injuries on any part of the body, including the head and neck, teeth, and genitals. Bruising may be present due to attempted strangulation or when the victim has tried to defend themselves. There may also be evidence of sexually transmitted infections or unintended pregnancy (consider testing).[15]

<u>Intimate Partner Violence (IPV)</u>

- A 2020 systematic review found a high correlation of persistent pain in women with a history of IPV.[16]
- A 2021 review of health and health related behaviors demonstrates that women subjected to IPV are at increased risk of poor health outcomes in a variety of areas (e.g. cardiovascular disease, endocrine dysfunction and neurological conditions).[17]

<u>Child Abuse</u>

- A systematic review notes that exposure to childhood abuse leads to increased risk of psychopathology, obesity, smoking, drug abuse, alcoholism, IV drug use, and sexual risk behaviors as adults.[18]
- Exposure to domestic abuse as a child shows a dose-response relationship to many chronic health problems.
- Experiencing violence during childhood/adolescence increases the likelihood of experiencing violence as an adult (specifically sexual violence, intimate partner violence, and stalking).[19]
- Adverse childhood experiences (ACES) are increasingly recognized as a source of chronic toxic stress that are contributors to life-long risks of ill-health (e.g. asthma, cardiovascular disease, chronic pain, substance abuse, and depression).[20]

    - Sources of ACES include not only direct abuse but living in a home experiencing or witnessing DVA.[21]
- Likelihood of abuse is higher the younger the age of the child (e.g. abusive fractures are more common in children <12 months than those >2 years).
- Over half of fractures identified in children <1year are attributable to abuse
    - children <4 months having the highest incidence

Radiographic evidence that raises suspicion

- Delay in seeking medical attention
- Injury in non-ambulatory/totally dependent child
- Multiple fractures (of different ages) with no family history/ clinical features of bone disease.
- History of household fall resulting in fracture (falls are common, fractures are not)
- Certain fractures increase likelihood: rib, skull (specific), isolated vertebral, metaphyseal, and the 3 S's (scapula, sternum, spinous process)[22]

Assessment Considerations/Techniques

Healthcare providers can enhance Public Health by increasing public awareness about DVA and its varied forms of abuse. This can be accomplished by inquiring about abuse with all new patients or having pamphlets/referral resources available. In addition, it may assist patients not yet ready to disclose their situation with DVA.

The goal of routine screening is to identify, acknowledge, and validate the patient's situation, and to provide appropriate support and referrals. This may involve assisting the patient to a safe place if they are in immediate danger. It is important to respect the patient's right to self-determination and refer or help create a safety plan.**Error! Bookmark not defined.**

Of note, research suggests that patients who have disclosed DVA have perceived that their provider advocated leaving their relationship without concurrent safety planning and despite recognition of the associated risks with leaving.[23]

Specific interviewing techniques are required to elicit relevant information from patients.[24,25] This includes questioning and exam done in privacy, which can sometimes be difficult if abusers are present. Resistance of others to leave may be a red flag. Assuring confidentiality and not judging the patient is important to establishing trust and rapport.

There are several short surveys that can be helpful as screening tools:

- HITS%20(Hurt,%20Insult,%20Threaten,%20Scream)%20(https:/www.mdcalc.com/calc/10417/hurt-insulthttps://www.mdcalc.com/calc/10417/hurt-insult-threaten-scream-hits-score-threaten-scream-hits-score)
- STaT (Slapped, Threatened, and Throw)
- HARK (Humiliation, Afraid, Rape, Kick)
- CTQ-SF (Modified Childhood Trauma Questionnaire-Short Form)
- WAST (Woman Abuse Screen Tool)

- ACES scoring tool (predict/explains the presence of chronic problems, e.g. chronic pain).[26] https://www.acesaware.org/wp-content/uploads/2019/12/ACE-Clinical-Workflows-Algorithms-and-ACE-Associated-Health-Conditions.pdf

Plan

Survivors of abuse may be in various stages of recovery and the importance of a history of abuse has its potential to complicate other presenting illness and disease. Recognizing complications and obstacles to recovery created by abuse can be an important component of effective treatment planning, establishing treatment goals, and setting expectations for recovery.

If the patient is in immediate danger

- Determine if there are family or friends to stay with; or
- Access to a shelter; or
- Police contact.
    - If needed provide access to a private phone to assist with any/all of the above.

If there is no immediate danger or the patient doesn't want immediate access to a shelter

- Offer written information about shelters and other community resources or instructions on how to find this information. Agencies and community resources may include:
    - Children's services, counseling, legal and employment services and law enforcement.
    - The most commonly reported interventions include:
        - Discussing the concern for safety with the patient,
        - Recording the report and physical findings of battering in the patient's chart,
        - Making referrals to counseling, and
        - Giving information about shelters and services.

Providers should maintain current information about referrals, help lines, and other community resources devoted to helping victims of abuse. **The National Domestic Violence Hotline number** is **1-800-799-SAFE**.[27] http://www.thehotline.org/

Resources for Clinicians

National Network To End Domestic Violence. The Family Violence Prevention Fund. https://nnedv.org/

Curry SJ, Krist AH, Owens DK, et al. Interventions to Prevent Child Maltreatment: US Preventive Services Task Force Recommendation Statement. JAMA. 2018;320(20):2122-2128.

Futures Without Violence. https://www.futureswithoutviolence.org/

Useful phone numbers include:
The National Domestic Violence Hotline**, (800) 799-SAFE (7233) http://www.thehotline.org/**
The National Resource Center on Domestic Violence**, (800) 537-2238 http://www.nrcdv.org/**

TEDMED talk on ACES.
https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en

Resources for Patients
The Rape, Abuse & Incest National Network (RAINN) Among its programs, RAINN created and operates the **National Sexual Assault Hotline** at **1.800.656.HOPE**. This nationwide partnership of more than 1,100 local rape treatment hotlines provides victims of sexual assault with free, confidential services around the clock. http://www.rainn.org/

The Oregon Coalition Against Domestic and Sexual Violence (OCADSV) is a non-profit organization that was founded in 1978. Our mission is to raise awareness about or regarding violence against all women and children, and to work towards non-violence through leadership in advocacy, public policy, training, resource development and social change. Oregon Coalition Against Domestic and Sexual Violence. http://www.ocadsv.com/ Portland, OR 503-230-1951

Washington Coalition of Sexual Assault Programs (WCSAP) is a membership agency comprised of individuals and organizations dedicated to ending sexual assault in their communities. WCSAP's mission is to unite agencies engaged in the elimination of sexual violence through education, advocacy, victim services, and social change.
Washington Coalition of Sexual Assault Programs (http://www.wcsap.org/)
Olympia, WA 360-754-7583

Clinical Advisory Feedback
Heraya desires to keep our clinical pathways and advisories customarily updated. If you wish to provide additional input, please use the e-mail address listed below and identify which clinical pathway or advisory you are referencing. Thank you for taking the time to give us your comments.

Clinical Services Department: cs@herayahealth.com

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https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf
[27] National Domestic Violence Hotline. 2019 at: http://www.thehotline.org/