

Canadian Association of Emergency Physicians Position Statement
Where is the Love? Intimate Partner Violence (IPV) in the Emergency Department (ED)

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CAEP Position Statement

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INTRODUCTION

DEFINITION AND CLINICAL PRESENTATION

Intimate Partner Violence (IPV) refers to any physical, psychological, or sexual harm within a current or past relationship that causes harm to those in the relationship [1]. IPV is about power and control on the part of the abuser. Even common colloquialisms such as the “Rule of Thumb” relate to IPV. Legal writings from the 18th century describe the Rule of Thumb as the limit on the thickness of an object a man could use to beat his wife [2].

Signs and symptoms concerning for IPV in a patient overlap significantly with those seen in child abuse [3]. These include historical features such as: delays in seeking care, longstanding untreated medical conditions, unwillingness to disclose a medical history, a history that changes over time, unexplained injuries that just appeared and injuries that are incongruent with the physical capabilities of the patient. Physical exam findings include: multiple injuries at various stages of healing, posterior rib fractures, defensive injuries, restraint injuries to wrists/ankles/neck and injuries that don’t match the given history. Additionally, multiple visits for the same presentation, chronic pain syndromes, mental health concerns and substance use are highly associated with IPV. The stereotypical “battered woman” is often the only image that comes to mind when thinking of IPV, when it can encompass things like stalking, threats to take away their children, workplace sabotage, or blackmail with nude photos.

A 2008 study found 44% of women murdered by their intimate partner had visited an ED in the last year; 93% of these victims visited specifically for IPV-related injury [5]. ED physicians identified 5% of IPV cases; only 13% asked about domestic violence, despite almost 40% of females presenting with violent injuries [6].

EPIDEMIOLOGY

The World Health Organization (WHO) estimates the prevalence to be 1 in 3 women worldwide, with no significant difference between continents [4], and North America’s prevalence being 29.8%. In France, a woman is murdered every 3 days by her current or ex-partner. Best population estimates find, at best, 20% of survivors of IPV report their abuse to anyone [7]. IPV transcends socioeconomic classes, ethnicities, gender, sexual orientation and physical borders, with recent unfortunate news events proving that no one is immune to IPV. More than half of IPV survivors are college or university educated [8]. They are not unstably housed nor immigrants; 86% are Canadian born and only 5% had no income [8]. We have seen several high-profile cases in Canada, including the murder of a physician by her husband [9].

Women exposed to intimate partner violence are twice more likely to suffer from depression and alcohol use disorders and 38% of all murders of women worldwide are IPV-related [4]. The COVID-19 pandemic has worsened the prevalence of IPV with shelter-at-home orders, increased calls to police and community support, and decreased recognized presentations in the ED [31].

CANADA

According to Statistics Canada, IPV which included both spousal and dating violence accounted for 1 in 4 of all police-reported crime in 2011 [11]. Among these, ex-partners were involved only 30% of the time [11]. Between 2009 and 2017, there were a total of 22,323 incidents of police-reported same-sex intimate partner violence in Canada—that is, violence among same-sex spouses, boyfriends, girlfriends, or individuals in other intimate partnerships. This represented approximately 3% of all police-reported incidents of IPV over this time period. IPV is found across provinces but most notable in the Prairie provinces, with Saskatchewan alone having an IPV female victim rate of 1,200 per 100,000 population. Police-reported IPV violent crimes are in fact much more prevalent in the territories, with prevalence being three times more than any other province [10]. While general crime rates have decreased across Canada in the past 10 years, the rates of IPV have increased, being one of the only crimes to do so [12]. Between 2009 and 2017, there were 36 homicides involving same-sex partners, representing 5% of all intimate partner homicides over this time period. In 2017, the most common method used for homicide in IPV in Canada changed from predominantly manual/blunt instrument to being equivalent to gun use. Currently, a woman is murdered in Canada every 6 days [12].

There is an increased risk of homicide after separation; leaving is the riskiest action patients take. At the time of leaving, the risk of homicide increases 4-fold, thus the survivor of IPV needs to be able to make a clean escape, often cutting ties completely with their abuser [13].

The 2009 General Social Survey (GSS) finds that 1,186,000 Canadians aged 15 and older in the provinces reported being physically or sexually victimized by a spouse in the preceding five years [8]. In 2009 alone, 335,697 Canadians were victims of 942,000 spousal violence incidents [10]. Less than one quarter of victims stated that the incident in the previous five years had come to the attention of police, meaning the IPV statistics discussed thus far are not reflective of the burden of this disorder in the population [13]. The prevalence of reporting has decreased from 36% in 2004 to 22% in 2009. Police-reported IPV is most common in the age 15-34 age group with a rate of approximately 600 per 100,000 population [12]. While this decreases significantly in elderly age categories, it does not drop to zero, indicating that this is an issue across the age spectrum [14,15]. Reasons for decreased reporting as age increases include: increased dependence factors (caregiver roles), decreased means to access care and increased privacy cultural norms. So, if violence survivors are not being seen by police, who are they seen by? As a result of the emergent nature of their exit, IPV survivors often find refuge in the emergency department during this transition period [16].

ECONOMIC IMPACT

Estimating the economic impact of a social phenomenon naturally would help policymakers with resource allocation and program funding and helps with comparisons to other disease entities. A

Justice Canada costing study published in 2012 estimated the cost of IPV to be \$7.4 billion dollars [17]. This studied the impact borne by primary victims, and the impact borne by third parties and others and captured relationships of married, common-law, separated, or divorced partners of at least 15 years of age and of all types of gender pairings. Two complementary data sources reflect the incidents of spousal violence in Canada: the police-based Uniform Crime Reporting Survey 2 (UCR2) [11] and the self-reported 2009 General Social Survey (GSS, cycle 23, Victimization) [8]. While the UCR2 captures detailed information on all *Criminal Code* violations reported to police services, the GSS interviews Canadians aged 15 and older regarding their experience of physical or sexual victimization regardless of whether the incident was reported to police. Comparatively, \$7.4 billion dollars is equivalent to the Gross Domestic Product (GDP) of Bermuda and is double what is spent on care of congestive heart failure patients in Canada [18].

The healthcare costs alone totaled \$81 million, broken down into: mental health care \$48 million; acute hospitalizations \$15 million; medical costs of suicide attempts \$12 million; ED visits \$6 million; and family physician visits \$189 thousand [17]. The study estimated the cost of ED IPV-related visits were 30 x more costly than Family practice visits, and patients are three times more likely to visit the ED than their own family doctor for IPV-related health concerns.[17].

EMERGENCY DEPARTMENT EPIDEMIOLOGY AND RECOGNITION

The 2009 Justice Canada costing study found that there were 3x the number of visits to an ED for IPV than people seen by their FP [17]. There may be numerous reasons for this difference in visit numbers including the fact that the ED is always open and visiting the ED can be done anonymously without anyone knowing of the visit, unlike a family doctor's office where familiar office faces are seen every visit. Furthermore, unlike the family doctor office, the ED doctor does not have a pre-existing relationship with the abuser which may be a major factor in patients' choice to visit the ED. The emergency department is truly the perfectly imperfect setting for helping patients with IPV as a point of entry to the healthcare system often seeing patients who do not regularly see a physician. Victims of IPV come to the ED more often and they come at the most vulnerable times as they try to leave toxic relationships.

A 2008 study found 44% of women murdered by their intimate partner had visited an ED in the last year; 93% of these victims visited specifically for IPV-related injury [5]. ED physicians identified 5% of IPV cases; only 13% asked about domestic violence, despite almost 40% of females presenting with violent injuries [6]. Even though IPV survivors were not asked, 89% of those surveyed stated they would have been comfortable disclosing if someone had asked [19,20].

RECOMMENDATIONS

1. UNIVERSAL SCREENING SHOULD BE PERFORMED IN THE ED

Screening is encouraged in the emergency department. The idea that there is "No evidence for screening" is based on literature that never studied intervention.

In terms of how to screen patients, there are some hospitals in Ontario that have already been implementing standardized screening at initial presentation. The Ottawa Hospital initial intake

note asks patients “do you feel safe at home? Has someone hurt you?”. Other phrases that may be used are: “Are you in a relationship that makes you feel scared?” or “Are you facing any physical or emotional abuse?” or “do you fear for your safety?”. There are various ways of bringing up the topic of intimate partner violence and it’s important to use whichever phrases fit your patient care style - it is only an awkward question if we approach it that way or are uncomfortable ourselves with the topic.

The literature on screening women for intimate partner violence is controversial with studies showing strong evidence for screening and others lacking evidence to screen. In 2008, Director et al found that ED physicians were able to identify 5% of IPV cases with only 13% ever asking about domestic violence, despite almost 40% of females presenting with non-accidental injuries [6]. We cannot identify IPV if we do not ask patients. Furthermore, an empathetic response to a disclosure of IPV results in a 6-fold reduction in substance use and mental health symptoms (particularly PTSD) post-assault [21].

The largest screening study is an RCT which included over 6700 women in 12 primary care settings, 11 emergency departments and 3 OBGYN clinics in Ontario [22]. Patients were divided into two groups, those screened and those not screened. The healthcare professionals seeing these women, for various unrelated medical problems, were informed of positive screens and the intervention was left to the judgment of the clinician; this meant that the intervention itself was not standardized and involved clinicians providing resources such as hotlines, crisis lines and referrals. The primary outcomes studied were exposure to abuse and quality of life 18 months post screening, with one of the secondary outcomes being depression. Quality of life and depression symptoms did show statistically significant improvement; after multiple imputation due to a very high loss to follow-up (41 and 43% in each group) the data was no longer statistically significant, and the conclusion was that there was no evidence that screening helped patients of IPV. However, in this study they didn't implement anything immediately for those that screened positive, as treatment/intervention was left up to the physician. At best, those who screened positive were given the phone numbers of community resources for them to follow up with - no wonder it didn't show a major benefit!

Does screening harm patients? A 2008 study conducted in the ED using a computer kiosk to screen over 2000 ED patients in the waiting room found a 25% positive screen rate [5]. If a patient screened positive, a printed list of community resources was printed for them to contact. There was no discussion of their IPV with any healthcare provider on that visit. 35% of patients contacted one of the resources, 20% called an IPV hotline, 12% joined an IPV support group, 34% made a safety plan and 33% moved out of their abuser’s home. During the study period, there were no increased calls to security and no increased 911 calls to the patient’s home address, suggesting there was no additional harm to the patients.

A systematic review published in Annals of Emergency Medicine December 2013 concluded that screening is beneficial, low risk and low cost but intervention for screening is yet to be studied [23]. Screening itself works, health professionals can identify patients with high sensitivity/specificity using numerous validated screening tools such as the Woman Abuse Screening Tool (WAST), which was not designed for use in the ED. With regards to whether

screening benefits patients, the literature lacks studies on intervention and thus the question has not been fully answered yet.

Barriers to screening/disclosure by patients include: lack of trust in the healthcare provider, fear of mandatory police/child protection reporting, fear of the abuser, feelings of shame/humiliation, fear of losing support (financial, childcare, housing), language and cultural barriers [20]. Barriers to screening by ED healthcare providers include: lack of IPV education/training, lack of time, perceived lack of an effective intervention, having biases as to who to screen (particular demographic groups, only those with visible injuries), fear of offending patients, and discomfort with someone screening positive (not knowing what to do next) [24].

What do patients think of universal screening? A study conducted in Atlantic Canada EDs in 2005 questioned patients as to whether it was appropriate for all women to be asked if they had experienced violent or threatening behaviour from someone close to them [25]. Patients in significant pain or in extremis were not approached. 86% of all patients screened supported universal screening for women. This has not been further explored to include genders other than women.

A Cochrane review evaluated 8 studies of over 10,000 women and found the screening rates were low compared to the best evidence of IPV population prevalence [26]. They concluded that screening increases the identification of IPV in healthcare settings but found no evidence of an effect for other outcomes, such as referral to a specialized IPV service, health measures or harm arising from screening.

Taking all the evidence into account, screening is low cost, low risk (safe) and can detect a high prevalence of previously undetected abuse in the ED, where patients are presenting for care. And the studies show that screening works in identifying these patients. Incorporating screening into medical care requires training of staff on what questions to ask and what local resources are available if someone screens positive.

APPROPRIATE MEDICAL CARE

Injuries should be assessed and treated in the same manner as any other mechanism of the same injury. Medical care always comes before any forensic considerations. Perform a physical examination as guided by your history - you do not need to do a full head-to-toe exam. Using a trauma-informed approach to your examination is ideal. Briefly, this consists of informing the patient of what you will be doing for each step of your exam (like your OSCE experiences in medical school), never approaching a patient from behind, and allowing the patient full control to halt the examination at any time. Provide analgesia and tetanus updates as per the usual guidelines. Image as you would as per the usual guidelines and act on any findings just like any other traumatic mechanism. Patients presenting with a possible strangulation injury need evaluation for any signs of significant force, such as a history/proxy signs of a loss of consciousness, vascular injury signs, neurological signs of injury or changes in phonation that may indicate an airway issue. Imaging in this case should comprise a CT angiogram of the head and neck [30]. If the patient is stable, this patient can be imaged when a safe transfer can be arranged.

2. REFERRAL TO SPECIALIZED CARE CENTRE

Specialized care services are a team who provide private and confidential trauma sensitive medical care to any person who has experienced sexual or intimate partner violence in their region. They are a collaborative multidisciplinary trauma-informed medical team prepared to care for patients one-on-one in a private, confidential space, providing a compassionate, non-judgmental, and self-empowering approach to care for all people using our services. Patients need to be able to consent to care from the specialized team - there is no assumption of implied/emergency consent in these cases. Patients may choose any of the following services as part of their care.

Health Care Services

- Injury Assessment, documentation, and treatment of injuries
- Sexually Transmitted Infection (STI) testing
- Emergency contraception (Plan B)
- Pregnancy testing
- Post exposure prophylaxis for HIV (HIV PEP)
- Immunization for Hepatitis B, Hepatitis A, Gardasil (as provincially funded)
- Photo documentation of injuries
- Crisis counselling
- Safety planning
- Risk/Threat Assessment
- Referral for trauma counselling

Forensic Services

- Collection and storage of the Sexual Assault Evidence Kit (with or without police involvement)
- Anonymous reporting to police

There are many short-term and long term consequences to being a survivor of IPV. Follow up care by specialty services provides an opportunity to screen and manage potential short term and long-term consequences, which are less appropriate for the immediate ED setting. Examples include:

- Emergency contraception in form of Copper IUD insertion
- Management and further prescriptions of HIV PEP
- Serial assessment of injuries (e.g., strangulation), referral to MD where applicable
- Photo documentation of injuries
- Ongoing pain management
- Mental health assessments with screening for depression and post-traumatic stress disorder.
- Diagnosis and medical management of depression, anxiety, PTSD.
- Follow up assessment, testing and treatment for sexually transmitted diseases (HSV, HPV, Chlamydia, Gonorrhoea).

- Referral/collaborative care with specialists – counseling options for birth control- IUD insertion for Mirena/Jaydess, head injury clinic, ORTHO, ENT, Neuro etc
- Crisis intervention and community support services

Hospitals in most provinces have a Memorandum of Understanding with a specialized Sexual Assault and Domestic Violence treatment centre. In Ontario, the locations can be found at <https://www.sadvtreatmentcentres.ca/> under the “Get Help” box. The International Association of Forensic Nursing maintains a worldwide list of forensic programs at <https://www.forensicnurses.org/> Additionally, your own hospital Social Work services can act as an expert consultant for managing the complex social safety aspects of the patient’s care. All of these services are recommended to be consulted for these patients, should they consent to this, as their care encompasses a multitude of social, forensic, psychological and safety aspects that are difficult to manage in a busy ED.

In Canada, you cannot call the Police without the express consent of the patient, even if you are concerned for their safety. The only way you are allowed to break confidentiality is in cases where children are in the home (even if they are not victims of the abuse), elder abuse in a long-term care setting or gunshot wounds.

3. DOCUMENTATION

Once an emergency doctor has identified a case of IPV, the assumption should be that the medical records may be summoned to court and documentation of the events should be clear and legible to any. In a study published in Annals of Emergency Medicine, ED documentation of intentional assault showed that two-thirds of charts had no documentation of who the patient reported the assailant to be and in over one-third of cases the object used, and type of assault was not documented [5]. Many other studies have shown a lack of recognition and coding of ED visits for IPV, which impacts population information on the burden of this disease and downstream funding for IPV specialized care programs [27-29]. With just small adjustments to medical charts, they can be much more accurate and useful in court. Here are some pointers in documentation for your charting:

- Using words like ‘patient states’ or ‘patient reports’ remain factual and non-judgmental. Writing “patient was punched in face” may obscure the identity of who is speaking. Avoid commenting on any speculated mechanism of injury, if not explicitly told.
- Do not use words like ‘claims’ or ‘alleges’ as they imply skepticism and are legal terms that should not be used.
- Avoid commenting on suspected age of injuries such as bruises. Avoid the use of terms such as “old bruising” as this has been shown to be inaccurate and can be controversial in court. Simply describe the location, size and colour of any injuries seen.
- Write legibly; if the average person is unable to read the documentation, it is unlikely to be helpful in court and you may be subpoenaed to explain your charting.
- If your observations have clear discrepancies with the patient’s statements it is still very important to remain factual and write the HPI as per what the patient reports
- Have your sexual assault team take photographs of the injuries. Never take photos yourself as there is a specific way to take photos for them to be permissible in court.

- Record the time you see the patient, the time you examine the patient and the approximate time as per the patient states of when the injuries/events occurred.
- Write out the patient's vital signs and always *describe* the patients' demeanor. Write whether the patient is tearful, shaking, crying, angry, agitated, calm or indifferent. Writing "NAD" aka no acute distress does not accurately describe your patients' demeanor.
- For the final diagnosis, if the patient came in for IPV-related injuries then one should have the Final Diagnosis as Intimate Partner Violence or Domestic Violence. Diagnoses like 'assault' or 'social situation' do not help the hospital's coding process which has implications for funding, community resources and research.

SUMMARY OF RECOMMENDATIONS

1. IPV should be recognized as having similar presentations as non-accidental traumas or child abuse. IPV transcends social economic status, race, age and gender and should be considered in all demographics.
2. IPV should be considered in patients presenting multiple times for the same complaint, chronic pain syndromes, mental health concerns and substance use disorders.
3. Universal screening is encouraged in the emergency department. The idea that there is "No evidence for screening" is based on literature that never studied intervention.
4. We recommend treating IPV-related injuries in the same manner as we do as any accidental traumas.
5. Referral of all consenting patients to a specialized IPV treatment centre is recommended, as their complex care is difficult to achieve in a busy ED.
6. In documenting IPV-related charts, avoid legal words and use clear and factual statements.
7. Your final diagnosis should contain IPV to capture accurate data for the population prevalence in your area. This also has important funding implications for specialized treatment programs.

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