

Domestic Violence Is a Significant Public Health and a Health Administration Issue in the U.S.

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ABSTRACT

This paper discusses domestic violence as a public health concern and a health administration issue. People affected by domestic violence, such as physical, mental, sexual, and financial abuse, experience higher rates of trauma leading to PTSD. This study explored healthcare interaction with victims of domestic violence. Effective communication, proper domestic violence training, and screening should be used and implemented in healthcare settings to support victims regardless of where they may be within the abuse cycle. This paper adds to the dialogue on domestic violence by pulling together other previous research and by offering tools that can be implemented in emergency rooms, urgent care facilities, and medical practices to recommend standard processes focused on identifying dangerous situations and giving victims the support they need.

KEYWORDS

Domestic Violence, Health Administration, Hospital Administration, Public Health Leadership, Urgent Care, Victim Assistance

INTRODUCTION

Domestic violence is a significant healthcare problem affecting more than 10 million people in the United States and millions more globally each year (Huecker et al., 2022). The many faces of domestic violence are revealed as intimate partner violence (IPV), family violence, and emotional, psychological, sexual, and economic abuse, and are often difficult for healthcare providers, teachers, and friends and family to recognize, often leaving the victim isolated and alone (Huecker et al., 2022; Huecker and Smock, 2019; Houston, 2015; Usher et al., 2020). According to Houston (2015), terminology can evoke inferences, which can suggest that the phenomenon does not pertain to cultural and social influences. Such connotations can imply family dysfunction, discouraging individuals from seeking help, and can limit the scope of the problem for researchers and service providers (Finley, 2020).

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Houston (2015) recognized the implication of family dysfunction and realized that the terminology can discourage survivors of abuse from utilizing services under the most “normal” of circumstances.

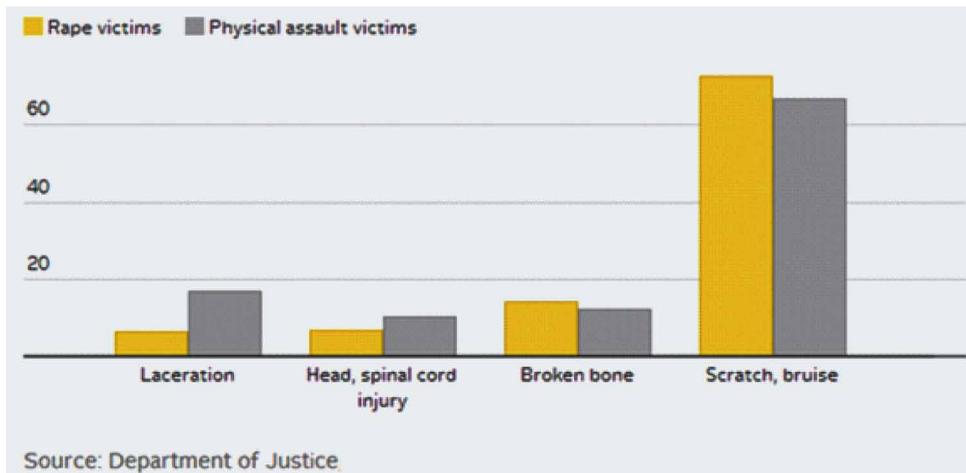
The world’s “normal” changed seemingly overnight in late 2019 with the COVID-19 pandemic. Individuals, families, businesses, schools, and governments were mostly unprepared for the world to essentially shut down. While the shut-down impacted everyone in one way or another, victims of domestic violence and abuse disparately impacted compared to their non-abused peers. The isolation and decreased ability to interact with non-abusive peers and family members due to the closure of schools and in-person work, left many victims of abuse in much more precarious, dangerous, and sometimes devastating situations (Kofman and Garfin, 2020; Mucci et al., 2020; Wong et al., 2021). With the economic and infrastructure shut-down caused by COVID-19 pandemic, victims of domestic violence experienced limited access to care, reduced reprieve from the abuse, and faltering hope (Feder et al., 2021). For example, during the COVID-19 shut down, Australia experienced a 5% increase in domestic violence emergency calls and a 75% increase in Google searches related to domestic abuse (Usher et al., 2020). In China, the Wuhan province saw domestic abuse cases increase threefold in February 2020 compared to the same time the previous year (Usher et al., 2020). In the United States, during the month of February 2020, the National Domestic Violence Hotline received more than 74,000 contacts (calls, chats, and texts), which is the highest number of monthly contacts in its 25-year history (National Domestic Violence Hotline, 2020) and June 2020 saw an 80% increase in contact (Kelly, 2022). The significant uptick in reported domestic violence during the COVID-19 pandemic led the United Nations to dub it the “Shadow Pandemic” (2020) and the BBC to call it the “epidemic beneath the pandemic” (Kelly and Graham, 2022). The American Journal of Emergency Medicine reports that there was an increase in cases of domestic violence globally from 25% to 33% in 2020 (Jones, 2021). The short- and long-term impacts on victims of domestic abuse due to the COVID-19 pandemic are still surfacing, driving healthcare experts to seek solutions to better support victims in the post-pandemic world.

The statistics on domestic violence, particularly intimate partner violence, are harrowing. Most of the domestic violence is perpetrated against women (Houston, 2015), but men are also victims, making up nearly 15% of all reported domestic partner abuse cases (Huecker et al., 2022). In a lifetime, 70% of women will encounter physical or sexual violence by a partner (United Nations Women, 2014), and 50% of lesbian women will experience domestic violence in their lifetimes (Vagianos, 2017). Annually, domestic violence is responsible for over 1500 deaths in the United States (National Domestic Violence Hotline, 2019). Three women are murdered every day by a current or former male partner in the U.S. (Vagianos, 2017). 18,000 women have been killed by men in domestic violence disputes since 2003 (Vagianos, 2017). Eighty-one percent of women who are stalked by a current or former male partner who were also physically abused by that partner (Vagianos, 2017). Only 25% percent of physical assaults perpetrated against women are reported to the police annually (Vagianos, 2017). Figure 1 highlights the most common types of assaults reported by female rape and physical assault victims. Scratches and bruises are most commonly reported for respective assaults. IPV also impacts our youth. Approximately 10,000 children are exposed to or witness domestic violence toward a loved one every year (Vagianos, 2017). Exiting an intimate abusive relationship is complicated, as a woman is 70 times more likely to be murdered in the few weeks after leaving her abusive partner than at any other time in the relationship (Vagianos, 2017).

Problem Statement

Domestic violence is a serious public health problem globally, and especially in the United States (National Domestic Violence Hotline, 2019; World Health Organization, 2021). Additionally, domestic violence has major economic implications across multiple systems. There are over 38,028,000 women who have experienced domestic violence in their lifetimes. Women with disabilities are at an especially high risk of experiencing domestic violence (Hague et al., 2011; Thiara et al., 2011), nearly 40% more likely than non-disabled women (Vagianos, 2017). Annually, 4,774,000 women in the U.S.

Figure 1. Most Common Injuries Reported by Female Assault Victims



experience physical abuse (Vagianos, 2017), and every nine seconds a current or former spouse or partner (Domestic Violence Statistics, 2015) abuses a woman. Every year domestic violence is the cause of 18,500,000 mental health care visits (Alejo, 2014; Vagianos, 2017). Every year women lose 8,000,000 paid days of work, equaling 32,000 full-time jobs (Vagianos, 2017). Domestic violence falls into a grey area between medical and mental health and should be approached using both a medical and social-psychology framework. This paper fills a gap in research related to medical provider best practices for screening approaches for victims to seek treatment in medical setting.

Contexts From the Literature

Psychological Consequences of Domestic Violence

According to the literature, domestic violence, characterized by a series of traumatic experiences, is associated with negative psychological consequences such as post-traumatic stress disorder and depression (Alejo, 2014; Finley, 2020; Newnham et al., 2022; Vagianos, 2017). These two diagnoses can become serious as it can lead to more negative consequences. Houston (2015) identified four categories of responses to traumatic experiences: (a) emotional responses that include shock, guilt, horror, irritability, anxiety, hostility, and depression; (b) cognitive responses which are reflected in significant concentration impairment, confusion, self-blame, intrusive thoughts about the traumatic experience, lowered self-efficacy, fears of losing control, and fear of reoccurrence of the trauma; (c) biological responses that involve sleep disturbances, exaggerated startle responses, and psychosomatic symptoms; and (d) behavioral responses which include avoidance, social withdrawal, interpersonal stress, and substance abuse. Gilbertson (1998) emphasized the importance of not blaming the abused for the abuse, commonly referred to as victim-blaming or victim-shaming, and instead prioritizing empowering survivors of abuse by helping them to understand how to change patterns of behavior. In a study conducted on physicians by Garimella et al., (2000), 30% of physician respondents held victim-blaming attitudes toward victims of abuse. According to Gilbertson (1998), changing these patterns of behavior can be exceedingly difficult, especially in the presence of people in positions of authority blaming them, implicitly or explicitly, for the abuse.

Economic Impacts of Domestic Violence

The economic impact of domestic violence is significant, some figures say between \$3 and \$5 billion annually (Moreno, 2013), while others state the cost is estimated at over \$8 billion (National

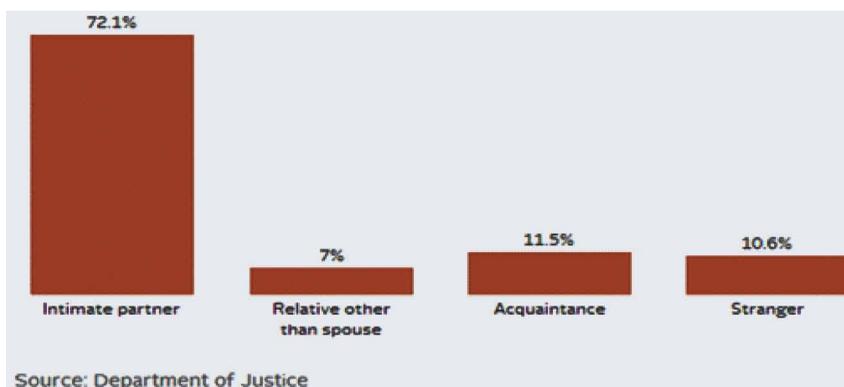
Domestic Violence Hotline, 2019). These costs include emergency room visits, clinical visits, hospital stays, lost work, mental health counseling, and other domestic violence services (Center for Domestic Peace, 2003; National Domestic Violence Hotline, 2019; Moreno, 2013; Sharma and Borah, 2020). Omitted from these estimated annual costs of domestic violence are annual costs of legal expenses, law enforcement services, and incarceration costs for detained and convicted perpetrators as consequences of domestic violence. Other fees are paid by the legal system when the victims are uninsured, receive assistance from federally funded programs, or cannot afford an attorney to prosecute their attacker (Truman & Morgan, 2014). Thus, recognizing domestic violence abuse may lower the annual judicial cost spent yearly on domestic violence cases (Kirst et al., 2012). Improving screening for domestic violence procedures may, therefore, save lives and reduce the financial burden on United States taxpayers (Moyer, 2013).

Healthcare Approach to Addressing Domestic Violence

Interventions to break the cycle of domestic violence should focus on the systems interacting with the individual (Gilbertson, 1998). Due to the prevalence and mental and medical short- and long-term consequences of domestic violence, the healthcare system is integral to addressing this issue. Houston (2015) stated psychological IPV leads to both physical health and mental health challenges. It is critical for clinicians to screen for psychological IPV when treating physical medical conditions, just as they would screen for physical assault or sexual assault when treating a person presenting with bodily injuries as medical conditions (Houston, 2015). Figure 2 demonstrates of reported assaults on women, intimate partner assault is the most common. Garimella et al. (2000) found that 97% of physicians surveyed felt it was their responsibility to assist victims of domestic abuse, but 70% did not feel they had the resources to do so. Most assessment tools used to assess individuals who have experienced domestic violence only assess for physical violence and sexual assault, not psychological abuse (Houston, 2015).

Due to the prevalence in our society, it is expected that mental and medical healthcare professionals will at some point in their careers evaluate and treat a victim or perpetrator of domestic or family violence (Huecker & Smock, 2019). As a public health issue, exacerbated by a public health pandemic, it is critical for medical professionals to take the lead in identifying, addressing, and treating cases of abuse (CDC, 2020). However, according to a survey from the CDC (2020), 93.3% of female neglect and abuse victims did not inform their healthcare practitioners about the occurrences of their abuse (National Institute of Justice, 2011). Having an improved screening process for domestic violence and abuse in treating medical facilities as well as providing healthcare education regarding mandated reporting laws and the nuances surrounding them and the intrusiveness of current hospital practices

Figure 2. Perpetrator-Victim Relationships in Assaults against Women



when domestic abuse is suspected. Healthcare providers can aid in early identification of cases of abuse and may stop further abuse prevent premature death at the hand of her abuser. Moreover, healthcare practitioners should initiate the reassurance for safety plans, be informed on existing policies, and procedures that may assist patients in identifying signs of abuse (National Institute of Justice, 2011).

Fowler, and Niolon, (2014) noted that there is a plethora of research and information available about domestic violence, but gaps in this research exist around barriers to screening for domestic violence. It is an important issue and requires healthcare practitioners to be able to understand their patients' contact with abuse to treat the whole patient (Chapin & Coleman, 2009). Domestic violence can be difficult to identify because it does not always leave a physical mark, nor does it only occur in a specific demographic or socio-economic level. Domestic violence can be as subtle as threats and intimidation, or any behavior as part of a pattern to control and exert power over one's partner (Carroll & Meyer, 2011). Since health professionals care for multiple patients throughout the day for many reasons other than domestic violence-related injuries, it is possible domestic violence is missed as it is often not the primary reason for the visit. A National Institute of Justice (2011) study indicated some healthcare practitioners do not classify, analyze, or provide interventions for women due to an ineffective domestic violence screening process. As such, domestic violence victims being identified and triaged for the necessary and appropriate services is crucial to prevent continued abuse, injuries, and death.

METHODS

Using the key words: domestic violence, intimate partner violence, toxic relationships. the authors search several databases for abstracts. Databases searched were Google Scholar, ProQuest, Web of Science, ResearchGate, Academia.edu, Scopus. Of the 1500 abstracts that were retrieved using key words, 55 studies were reviewed for inclusion in this paper. After the authors reviewed the 55 studies, only ten met the standard for analysis determined by the authors which included domestic violence and intimate partner violence where medical providers could engage through screening and intervention during a treatment visit (Kirst et al., 2012; Sprague et al., 2012; World Health Organization, 2021; Fontenot, Haggerty, Hawkins, & Lewis-O'Connor, 2011; Ahmadi-Javid, Seyedi, & Syam, 2017; Cassell, Mitchell, & Edwards, 2014, Breiding, Chen, & Black, 2014, Olivares, 2014; Wallace & Robertson, 2015; Moreno, 2013). Several studies were eliminated because they did not adequately evaluate the effectiveness of barriers to screening domestic violence. The most concerning information was the insufficient amount of data accessible that defined assessment tools and screening processes. Although some of the inaccurate data may ascend from the non-reported abused victims, other sources identified a lack of assessing and screening for domestic violence (Sprague et al., 2012). Numerous researchers mentioned the need for further research on screening barriers and identified possible reasons healthcare practitioners failed to identify domestic violence victims (World Health Organization, 2019; Fontenot, Haggerty, Hawkins, & Lewis-O'Connor, 2011).

ANALYSIS

Sprague et al. (2012) reviewed surveys with data that concentrated on barriers to screen for domestic violence by healthcare practitioners. According to the authors there is a need for training as some healthcare professionals lack experience in comprehending the purpose of assessing domestic violence when a patient initially comes for an appointment. Additionally, according to a research brief by The National Institute of Justice (2001), considering potential legal obligations to report suspected abuse, medical providers are not typically educated on the importance of how good documentation in medical records can help domestic violence victims win in court. It is recommended for healthcare practitioners to seek additional domestic violence training on the issues and understand how to refer patients to a professional who specializes in domestic violence matters (Kirst et al., 2012). Medical

facilities where domestic violence may be identified include emergency departments, doctors' offices, small clinics, urgent care centers, and hospitals. One of the barriers to seeking medical care for domestic violence is that the exam can be intrusive and contain scientific-legal answers from healthcare practitioners, mainly in the hospital's emergency department (Ahmadi-Javid, Seyedi, & Syam, 2017). Ahmadi-Javid, Seyedi, & Syam (2017) stated that health facilities are any locations where an individual can receive healthcare. Healthcare facilities range from doctors' offices, small clinics, urgent care centers, and hospitals with emergency rooms or trauma centers. The exams can take place at any location where the victim can give information about an abusive situation. These are all places where victims can go to seek medical attention after an injury (Ahmadi, Seyedi & Syam, 2017). Determining the health behaviors of patients who are victims of domestic violence might improve if they receive medical assistance. Once victims accept treatment, this created an enhancement to their everyday living inspiring them to convey the necessary support for additional domestic violence educational training (Kirst et al., 2012).

The victims of domestic violence sometimes believed they were helpless and defenseless when it came to screen for abuse by a medical professional. Carroll and Meyer (2011) found the attentiveness of healthcare practitioners in health care environments is essential in evaluating and focusing on the immediate care for pain and injuries. Researchers (Carroll & Meyer, 2011) agreed that healthcare practitioners evaluated domestic violence screening as lack of experience and improper training which lessen the integrity of the findings for domestic violence.

Advocates for survivors of domestic violence attempted to forge a stance on mandatory reporting, as it was useful to have an awareness of the laws that occurred around the nation (Smith et al., 2014). Healthcare practitioners and organizations need to attempt to decrease the harm to the victims under existing reporting laws (Breiding, Chen, & Black, 2014). The facilities of health care should guarantee that their victims' practices and training addresses at least the minimum matters regarding reporting (Ahmadi-Javid, Seyedi, & Syam, 2017). With the ever-increasing interest in domestic violence as a healthcare concern, awareness should evolve with how healthcare practitioners' best mediate barriers to screening (Cassell, Mitchell, & Edwards, 2014). Medical providers should consistently ask about domestic violence, deliver safety to patients, record the abuse, and offer materials about alternative resources (Olivares, 2014). What is not clear, is if healthcare practitioners should be required to bring cases of domestic violence to the attention of state officials (Moreno, 2013). The goals prospectively performed by mandatory reporting included improving patient safety, developing healthcare practitioners' reaction to domestic violence, ensuring that batterers are held accountable, and data collection (Wallace & Robertson, 2015). During scrutiny of domestic violence, it has become evident that mandatory reporting has not necessarily achieved the goals. Furthermore, the effects of mandatory reporting for patient health and safety arose by such policies that disagreed with the common purpose (Olivares, 2014).

One of the latest dilemmas with domestic violence that six states (Alaska, Arizona, Arkansas, Connecticut, Illinois, and South Dakota) have mandatory reporting laws on domestic violence (Moreno, 2013). Primarily, these laws demanded that a practitioner's report acts of alleged domestic violence to local law enforcement or another specific state agency (Halket et al., 2013). Numerous states have laws non-specific to domestic violence, although, they alluded to it.

The National Network End Domestic Violence (NNEDV) (2017) a 24-hour survey conducted in 2017 discovered that United States domestic violence programs assisted nearly 72,245 victims and answered over 24,030 crisis hotlines calls in one day. The NNEDV (2017) survey regarding reporting noted in San Francisco, California, (mandatory reporting state) and Pittsburgh, Pennsylvania (a state without mandatory reporting) showed controversy about the risk and benefits of mandatory reporting laws. The purpose was to measure the conflict of mandatory reporting to police and the characteristics linked with this principle. These results (Cassell, Mitchell, Edwards, 2014) reflected 52% of victims were for mandatory reporting; however, 48% were against mandatory reporting. Among non-abuse women, 75% supported, and 25% opposed mandatory reporting (VPC, 2018). The advocates of these

laws believed they would help improve patient safety by developing legal intervention and increasing documentation. Opponents of mandatory reporting laws recognized some dilemmas with the laws that this study failed to mention (NNEDV, 2017).

One drawback of this study was that the survey only sought out emergency departments' patients seeking medical care (NNEDV, 2017). Also, the study did not give information about victims of domestic violence possibly being a little frightened to request assistance because they were afraid of the police involvement. This limitation may increase the number of women victims that opposed mandatory reporting to the police (AAPOR, 2011). Other flaws in the study stated that immigrant women might fear deportation if they obtained help, and the abuse was reported to the legal officials (CDC, 2016). The advocates who supported the victim's liberation believed that having knowledge about domestic violence assisted with their decisions regarding safety plans (Turanovic & Pratt, 2014). However, if reporting is without consideration of children's needs, it may compromise their safety (AAPOR, 2011).

As for mandatory reporting, it may damage the provider-patient confidentiality (Bair-Merritt, 2010). Moreno (2013) believed there was no assurance that law enforcement would improve women's safety. If a safety escape plan for domestic violence victim's arrangement is before the intervention, this may put the women at a higher risk for abuse of having an encounter with the abuser (Truman & Morgan, 2014). Some providers are not sure about knowing if their patient is a victim and experience ambivalence about screening as they would have to report a positive finding because of the mandated reporting laws (Smith et al., 2014).

Screening for Domestic Violence

Routine screening for circumstances related to domestic violence occurs at a rate equivalent to or less than customary domestic violence (Moyer, 2013). Domestic Violence is as common as breast cancer, thyroid problems, colon cancer, and hypertension, for which primary healthcare practitioners regularly screen (Bradbury-Jones et al., 2011). Screening for domestic violence meets the requirements for healthcare practitioners to conduct routine check-ups (Moyer, 2013). Staying in an abusive situation diminishes a person's lifestyle quality and, in some cases, causes premature death (Carroll & Meyer, 2011).

A previous research study that included 743 women ages 18 to 64 conducted in 11 emergency departments, 12 family practices, and three obstetrics/gynecology clinics implied that these settings did nothing to drop subsequent instances of domestic violence (Preidt, 2009). The study found 360 women were victims of abuse before even finishing the domestic violence questionnaire. Then after completing the study 347 women stated, they might have some experiences of abuse after seeing the licensed healthcare practitioner (Preidt, 2009). The study results were not enough evidence to support many intimate partner violence (IPV) in healthcare environments where the absence of a successful intervention to lessen or prevent reoccurrence of IPV. Mainly, in the circumstance of the additional resources necessary to manage, screen, and handle the number of women acknowledged by screening tools (Smith et al., 2014). This study explored the barriers to screening domestic violence by healthcare professionals practicing in Metropolitan Atlanta, Georgia. Domestic violence is increasing in the United States and investigating barriers to screening domestic violence may assist the patients to get help or lower the reoccurrences and prevent death (Carroll & Meyer, 2011).

A systematic assessment of screening barriers for domestic violence established that healthcare practitioners presented a series of explanations for not routinely examining women about domestic violence (Sprague et al., 2012). They are as follows; lack of experience or education on domestic violence screening and fear of offending or exposing patients. Other barriers included the lack of effective interventions, patients not revealing or not complying with screening, and the limited amount of time spent with each patient (Sprague et al., 2012).

For screening procedures to become functioning, the licensed healthcare practitioner should screen women during every routine visit (Moyer, 2013). This elucidates the need for further research on domestic violence screening. Additionally, healthcare practitioners should screen for domestic

violence if the patient's interval of visits consistently involves some signs of physical abuse that the patient is trying to hide (Truman & Morgan, 2014). In assessing for abuse on a regular basis, screening for domestic violence achieved a level of reassurance by giving patients the message that their health and safety concerns were important to healthcare practitioners. If patient screens negative for domestic violence and a healthcare provider suspects there may be abuse, they may provide the patient information about the cycle of domestic violence and how to protect themselves from a dangerous situation (Moyer, 2013).

Healthcare practitioners are not typically trained in communicating about sensitive and complex issues, such as domestic violence. They report they have concerns expressing to victims that they have done nothing to deserve the abuse and that they did not cause the abuse and that seeking help is within reach (Brieding, Chen, & Black, 2014). Sometimes, approaching this topic in privacy is difficult, as the abusers are often the ones who bring their loved ones to the appointment to obtain treatment (Sprague et al., 2012). Numerous abusers declined to leave the victim by themselves, and it is not uncommon for them to try to answer the questions for those whom they have abused (Bair-Merritt, 2010).

Not knowing how to screen appropriately for domestic violence may be dangerous or have consequences to the victim (Sprague et al., 2012). Thus, it is crucial for medical professionals to have applicable domestic violence training. For instance, healthcare practitioners' inexperience's could jeopardize the patient by threatening to expose the abuser or disclose information about the abuse without taking precaution that guaranteed safety (Truman & Morgan, 2014). Categorizing domestic violence and not understanding what to say to the victim can intensify emotions of loneliness and misery (Sprague et al., 2012). Imposing insensitive legal involvement or disclosing the violence to law enforcement against better judgment, discouraging the victim from seeking healthcare in the future (Karmen, 2010). Following the screening process, further assessment should involve intervention, safety escape plans, proper documentation, and referrals (Karmen, 2010).

Measuring for Domestic Violence

Measuring for domestic violence is essential to the effort to decrease violence in relationships (Brieding, Chen, & Black, 2014). Healthcare practitioners working within the healthcare system play a significant role in recognizing and preventing the abuse cycle of domestic violence. Truman and Morgan (2014) proposed that a primary place to start with identifying domestic violence occurrences is during a routine evaluation, with a recommendation to concentrate on initial detection of families, and victims irrespective of any apparent symptoms. Bunch, Clay-Warner, and McMahon-Howard, (2014) suggested an interactive assessment that contained individual interview and self-reporting as the most critically successful screening methods for domestic violence on a regular basis. The researchers found that if victims are alone in the room, they are more likely to reveal their abuse (Olivares, 2014).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated all hospitals to screen patients for domestic violence (JCAHO, 2011). Providing education to healthcare practitioners about domestic violence and screening for domestic violence helps improve the ability to recognize and manage abused victims (Fontenot et al., 2011). The educational strategic plan was developed with domestic violence medical professionals and specialists to improve educational programs for specific areas so that victims can feel safe in their homes and ensure that abusive partners comply with the law (Brieding, Chen, & Black, 2014). Different agencies should be involved in educating the community about barriers to screen for domestic violence.

The Agency for Healthcare Research and Quality (AHRQ, 2013) survey found that various healthcare clinics, nurse practitioners, and medical assistants, lack confidence in their capability to administer and care for domestic violence victims. Only 22% were present at the domestic violence educational programs within the past year (AHRQ, 2013). More than 25% of healthcare practitioners and almost 50% of nurses, practitioners, and medical staff were not confident with inquiring about physical abuse with patients (Smith et al., 2014). Less than 20% of healthcare practitioners' question

patients about domestic violence during their visits to high-risk situations such as depression, anxiety, migraines, and injuries. Only 23% of healthcare practitioners believed their strategies about domestic violence could assist the victims (AHRQ, 2013). Although, documenting the wounds and health issues are prominent and healthcare practitioners frequently do not inquire about domestic violence or interfere with patients who suffered abuse (Smith et al., 2014). The purpose of this study is to educate medical professionals with the knowledge to inform victims of assistance, safe escape plans, and provide information regarding domestic violence. It also sought to inform medical professionals about the domestic violence screening barriers, how to obtain a temporary safe place, security, and offered healing treatment programs.

This study lacked detailed explanations of training programs and screening tools that healthcare practitioners, social advocates, and facilities need to provide improved care for victims of domestic violence. Administrative modifications, procedures, and alterations to standardized medical records that supported screening for domestic violence increased identifying victims (Turanovic & Pratt, 2014) that sustained change over the years. Further research may be necessary to determine gaps in domestic violence to indicate a need to create stronger factual support for screening, discovering, and care for the victims (Herring, 2014). The information from the research generated screening tools to help assist with counseling, evaluation of quality programs, cross development of organizations, and enhanced treatment.

Improving Outcomes by Screening

Numerous researchers are investigating the routine barriers to screening for domestic violence (Moreno, 2013). Healthcare practitioners repeatedly mentioned the insufficient amount of time, lack of education, and anxiety of offending patients as routine screening barriers. Several studies explored the barriers to routine screening (Sprague et al., 2012). The study showed contributing barriers to be the breakdown of a targeted plan to amplify screening.

Gaps in Literature

Evaluation of domestic violence has its origins in the current emergence of healthcare practitioners. Before 2004, there was a shortage of literature that addressed domestic violence screening tools (Bair-Merritt, 2010). Since 2004, the attention of domestic violence was directed to the designs of assessment tools and educational programs that emphasized literature. During earlier screening detection efforts to evaluate domestic violence, some providers used a simple assessment tool called the Conflict Tactics Scale (CTS) (Carroll & Meyer, 2011). Fontenot et al., (2011) noticed that CTS, known as the gold standard, ignored addressing the seriousness and extent of violent occurrences. Thus, (Fontenot et al., 2011) produced the Composite Abuse Scale to counteract the missing pieces of the Conflict Tactics Scale. His work brought clarity and enhanced consistency in screening for domestic violence (Fontenot et al., 2011). At the beginning of a routine domestic violence screening, healthcare practitioners stated that less than 15% of patient interactions addressed or was related to domestic violence (Moyer, 2013).

DISCUSSION

The review of the five studies demonstrated there are benefits and pitfalls to initiating domestic violence screening during medical appointments. Many of the pitfalls can be avoided or resolved with an appropriate education plan for medical professionals to become knowledgeable in best practices to screening for domestic violence. Further research should be conducted on domestic violence screening in medical environments by medical personnel and on developing educational training that includes information about the law, communication, resources, trauma-informed approaches, and thorough medical documentation. This review revealed medical professionals were mostly willing to screen for domestic violence, but they lacked training and confidence on appropriate approaches.

In a successful health care interaction within a diverse client population, the provider effectively communicates with the patient, is aware of personal assumptions, asks questions in a culturally sensitive way and provides relevant interventions. Universal screening, on the other hand, involves a standardized assessment of all patients, regardless of their reasons for seeking medical attention or patient history recommends that screening occur regularly including as part of routine health histories and during every new patient encounter.

The concept of screening in the medical model usually involves use of a standardized clinical test to detect disease in asymptomatic patients. Psychosocial health issues like IPV do not fit well into a disease-based approach, particularly when identification of the health concern relies primarily on the patient's response to questions.

RECOMMENDATIONS

Inquiry and initial response to screening should be conducted by a health care provider who:

- Has been educated about the dynamics of IPV, the safety and autonomy of abused patients, and elements of culturally competent care.
- Has been trained how to ask about abuse, to provide information about IPV and local community resources and to intervene with identified victims.
- Is authorized to record in the patient's medical record.
- Has established a relationship or some trust with the patient in a primary care setting.
- Has a clearly defined role in a specialty, urgent care, or emergency setting.

Inquiry for present and past IPV victimization should be:

- Conducted routinely, regardless of the presence or absence of indicators of abuse.
- Conducted orally as part of a face-to-face health care encounter.
- Included in written or computer-based health questionnaires.
- Direct and nonjudgmental using language that is culturally/linguistically appropriate.
- Conducted in private: no friends, relatives (except children under 3) or caregivers should be present.
- Be confidential: prior to inquiry, patients should be informed of any reporting requirements or other limits to provider/patient confidentiality.
- Assisted, if needed, by interpreters who have been trained to ask about abuse and who do not know the patient or the patient's partner, caregiver, friends, or family socially.

Goals of the Screening Assessment

The goals of the assessment are to (a) create a supportive environment in which the patient can discuss the abuse; (b) enable the provider to gather information about health problems associated with the abuse; and (c) assess the immediate and long-term health and safety needs for the patient to develop and implement a response.

For patients who discloses current abuse, assessment should include at a minimum:

- "Are you in immediate danger?"
- "Is your partner at the health facility now?"
- "Do you want to (or have to) go home with your partner?"
- "Do you have somewhere safe to go?"
- "Have there been threats or direct abuse of the children (if s/he has children)?"
- "Are you afraid your life may be in danger?"
- "Has the violence gotten worse or is it getting scarier? Is it happening more often?"

- “Has your partner used weapons, alcohol or drugs?”
- “Has your partner ever held you or your children against your will?”
- “Does your partner ever watch you closely, follow you or stalk you?”
- “Has your partner ever threatened to kill you, him/herself or your children?”

Assessment of the pattern and history of current abuse:

- “How long has the violence been going on?”
- “Have you ever been hospitalized because of the abuse?”
- “Can you tell me about your most serious event?”
- “Has your partner forced you to have sex, hurt you sexually, or forced you into sexual acts that made you uncomfortable?”
- “Have other family members, children or pets been hurt by your partner?”
- “Does your partner control your activities, money or children?”

For the patient that discloses history of IPV victimization:

- “When did the abuse occur?”
- “Do you feel you are still at risk?”
- “Are you in contact with your ex-partner?” “Do you share children or custody?”
- “How do you think the abuse has affected you emotionally and physically?”

What to do if a patient says “no”:

- Respect her/his response.
- Let the patient know that you are available should the situation ever change.
- Assess again at previously recommended intervals.
- If patient says “no” but you believe s/he may be at risk, discuss the specific risk factors and offer information and resources in exam and waiting rooms, or bathrooms.

Provide validation:

- Listen and speak non-judgmentally.
- “I am concerned for your safety (and the safety of your children)”.
- “You are not alone, and help is available”.
- “You don’t deserve the abuse and it is not your fault”.
- “Stopping the abuse is the responsibility of your partner not you”.

Provide information:

- “Domestic violence is common and happens in all kinds of relationships”.
- “Violence tends to continue and often becomes more frequent and severe”.
- “Abuse can impact your health in many ways”.
- “You are not to blame, but exposure to violence in the home can emotionally and physically hurt your children or other dependent loved ones”.

Respond to safety issues: Offer the patient a brochure about safety planning and go over it with her/him:

- Review ideas about keeping information private and safe from the abuser.
- Offer the patient immediate and private access to an advocate in person or via phone.
- Offer to have a provider or advocate discuss safety then or at a later appointment.
- If the patient wants immediate police assistance, offer to place the call.
- Reinforce the patient's autonomy in making decisions regarding her/his safety.
- If there is significant risk of suicide, the patient should be kept safe in the health setting until emergency psychiatric evaluation can be obtained.
- Make referrals to local resources.
- Describe any advocacy and support systems within the health care setting Refer patient to advocacy and support services within the community.
- Refer patients to organizations that address their unique needs such as organizations with multiple language capacities, or those that specialize in working with specific populations (i.e., teen, elderly, disabled, deaf or hard of hearing, ethnic or cultural communities or lesbian, gay, transgender, or bisexual clients).
- Offer a choice of available referrals including on-site advocates, social workers, local DV resources or the National DV Hotline (800) 799-SAFE, TTY (800) 787-3224.

Confidentiality Procedures

Inappropriate disclosure of health information may violate patient/provider confidentiality and threaten patient safety. Perpetrators who discover that a victim has sought care may retaliate with further violence. Employers, insurers, law enforcement agencies, and community members who discover abuse may discriminate against a victim or alert the perpetrator. It is imperative that policy, protocol, and practice surrounding the use and disclosure of health information regarding victims of IPV should respect patient confidentiality and autonomy and serve to improve the safety and health status of victims.

Documentation

- Documentation should be conducted by a health care provider who is authorized to record in the patient's medical record.
- Providers should document the patient's statements and avoid pejorative or judgmental documentation (e.g., write "patient declines services" rather than "patient refuses services," "patients states" rather than "patient alleges").
- Record details of the abuse and its relationship to the presenting problem.
- Document any concurrent medical problems that may be related to the abuse.
- Summarize past and current abuse including:
 - Social history, including relationship to abuser and abusers name if possible.
 - Patient's statement about what happened, not what lead up to the abuse (e.g., "boyfriend John Smith hit me in the face" not "patient arguing over money").
 - Include the date, time, and location of incidents where possible.
 - Patients' appearance and demeanor (e.g., "tearful, shirt ripped" not "distraught").
 - Any objects or weapons used in an assault (e.g., knife, iron, closed or open fist).
 - Patients accounts of any threats made or other psychological abuse.
 - Names or descriptions of any witnesses to the abuse.

Recommend Physical Examination

Findings related to IPV, neurological, gynecological, mental status exam if indicated:

- If there are injuries, (present or past) describe type, color, texture, size, and location.
- Use a body map and/or photographs to supplement written description.

- Obtain a consent form prior to photographing patient. Include a label and date.
- Record the results of any lab tests, x-rays, or other diagnostic procedures and their relationship to the current or past abuse.

At least one follow-up appointment (or referral) with a health care provider, social worker or DV advocate should be offered after disclosure of current or past abuse.

At every follow up visit with patients currently in abusive relationships:

- Review the medical record and ask about current and past episodes of IPV
- Communicate concern and assess both safety and coping or survival strategies:
 - “I am still concerned for your health and safety”.
 - “Have you sought counseling, a support group or other assistance?”
 - “Has there been any escalation in the severity or frequency of the abuse?”
 - “Have you developed or used a safety plan?”
 - “Told any family or friends about the abuse?”
 - “Have you talked with your children about the abuse and what to do to stay safe?”
- Reiterate options to the patient (individual safety planning, talking with friends or family, advocacy services and support groups, transitional/temporary housing, etc.).

Framing questions:

- “Because violence is so common in many people’s lives, I’ve begun to ask all my patients about it”.
- “I am concerned that your symptoms may have been caused by someone hurting you”.
- “I do not know if this is (or ever has been) a problem for you, but many of the patients I see are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I have started asking about it routinely”.

Direct verbal questions:

- “Are you in a relationship with a person who physically hurts or threatens you?”
- “Did someone cause these injuries? Was it your partner/husband?”
- “Has your partner or ex-partner ever hit you or physically hurt you?”
- “Do you (or did you ever) feel controlled or isolated by your partner?”
- “Do you ever feel afraid of your partner? Do you feel you are in danger?”
- “Is it safe for you to go home?”
- “Has your partner ever forced you to have sex when you did not want to? Has your partner ever refused to practice safe sex?”
- “Has any of this happened to you in previous relationships?”

Abuse Assessment Screen

1. Have you ever been emotionally or physically abused by your partner or someone important to you?
Yes _____ No _____
If yes by whom? _____
Total number of times _____
2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
Yes ___ No _____
If yes by whom? _____
Total number of times _____

3. Within the last year, has anyone forced you to have sexual activities?
Yes ___ No
If yes by whom? _____
Total number of times _____
4. Are you afraid of your partner or anyone you listed above?
Yes ___ No
5. Have you experienced any of the following? Check all that apply:
Threats of abuse including use of a weapon _____
Slapping, pushing; no injuries and/or lasting pain _____
Punching, kicking, bruises, cuts, and/or continuing pain _____
Beating up, severe contusions, burns, broken bones _____
Head injury, internal injury, permanent injury _____
Use of weapon; wound from weapon _____

Physical environment should:

- Allow for confidential interviewing, ideally establishing a policy that requires a portion of the interview be conducted in private.
- Have posters on IPV that are multicultural and multilingual; that present available resources; and that include information about victims, perpetrators, and/or other family and community members affected by abuse.
- Have brochures/pocket cards for victims, perpetrators, and resources that describe the impact of IPV on children.
- Have brochures placed in exam rooms and private places such as bathrooms.

Training for staff should include:

- Survivors' perspectives.
- Cultural competency.
- Dynamics of victimization and perpetration.
- Physical and mental health consequences of IPV on victims and children exposed.
- How to assess, intervene, support and document appropriately.
- Interactive role playing and modeling of assessment and response techniques.
- Information on where employees in abusive relationships can access assistance.

Training

Training should be part of staff orientation; ongoing, repeated, and institutionalized; and mandatory for all employees. Continuing Medical Education credits should be offered to providers. Providers who will be assessing and documenting in the medical record should receive training on dynamics and clinical response as well as other staff and allied health professionals.

Provider resources should include:

- Chart prompts in the medical record.
- Documentation and assessment forms.
- Posters and practitioner pocket cards.
- Materials that are easily accessible to providers and regularly updated.
- Consultation with on-site or off-site DV advocates, legal and forensic experts, counselors with expertise in trauma treatment, and community experts from diverse (LGTB, disability, elder, teen, ethnic specific and immigrant) communities.

CONCLUSION

This paper reviewed ten studies relevant to our problem statement. The purpose was to review the literature around medical provider best practices for screening approaches for victims to seek treatment in medical setting. Using the following key words: domestic violence and intimate partner violence 1500 abstracts were returned. Of those 1500, we narrowed the relevant studies to 55. After a third review, the authors agreed that only ten studies met our criteria for which included domestic violence and intimate partner violence where medical providers engage through screening and intervention during a treatment visit (Kirst et al., 2012; Sprague et al., 2012; World Health Organization, 2021; Fontenot, Haggerty, Hawkins, & Lewis-O'Connor, 2011; Ahmadi-Javid, Seyedi, & Syam, 2017; Cassell, Mitchell, & Edwards, 2014, Breiding, Chen, & Black, 2014, Olivares, 2014; Wallace & Robertson, 2015; Moreno, 2013). After reviewing the ten studies, three overarching themes were identified: (a) The healthcare system is an appropriate setting to screen for domestic violence; (b) most medical professionals believe they lack the knowledge and confidence to screen for domestic violence; and (c) medical professionals should receive training and educated on screening for domestic violence. More research is needed on this topic, especially focusing on developing training modules developed in conjunction with several agencies involved in domestic violence (lawmakers, justice system, mental/behavioral health, medical) and delivery methods that can be effective within the current healthcare system in the United States (telehealth training, CMEs during professional conferences or online, and in medical school).

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