



**EUSEM**  
EUROPEAN SOCIETY FOR EMERGENCY MEDICINE

## **ETHICS COMMITTEE**

# **Domestic Abuse & Violence**

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## *Recommendations for European Emergency Departments*

### **Summary of Recommendations**

Emergency Physicians should:

- be able to identify and assess patients for domestic abuse in all its forms towards children, intimate partners, elders, and other family members,
- be familiar with signs and symptoms of domestic violence and abuse,
- adopt clear protocols and methods for screening and information sharing,
- document medical findings and relevant information so that it could be used as evidence in court,
- refer victims of domestic violence, with their consent, to appropriate support services for help,
- report to the police according to the country's legal system,
- maintain knowledge of state legal requirements for reporting domestic violence.

Emergency Departments should:

- develop protocols and guidelines for suspected abuse cases of children, intimate partners and elders,
- have systems and guidance in place to help junior doctors identify and manage potential abuse in all its forms, or ask for advice if abuse is suspected,

- ensure that educational materials on domestic violence, with lists containing contact details of the available services, should be on display in waiting areas and examination rooms,
- develop training programmes to increase the knowledge, skills, attitudes and clinical competence of emergency personnel in identifying and addressing all forms of domestic violence.

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## Scope

These recommendations aim to help Emergency Physicians detect and identify domestic abuse and violence in relation to children, intimate partners and elders.

## **Domestic Violence: A Substantial Public Health Problem**

*Helen Askitopoulou*

*Domestic violence*, also named family violence, is a pattern of coercive behaviour used by a competent adult or adolescent to establish and maintain power and control over another adult, adolescent or child. *Domestic violence* is a serious and complex health and societal problem which affects people in all stages of life and has profound consequences in all its forms. Identification and assessment can be difficult as it may take many forms including neglect, physical, sexual or emotional abuse, financial exploitation and intimidation. All types of domestic violence and abuse from infants to the elderly continue to be under-recognised and under-reported in health services, to the police and social agencies and therefore grossly under-estimated. Hence, there has been a strong movement for health care providers to identify victims of domestic violence in the medical setting. Early detection can reduce exposure to harm, alleviate negative consequences and improve health outcomes. Emergency physicians (EPs) are in an ideal position to diagnose and intervene in suspected cases of domestic violence, as well as refer and report such cases to the relevant authorities.

In 1996, the World Health Assembly declared violence as a major and growing public health problem across the world and launched a global campaign on violence prevention. The Assembly drew attention to the serious consequences of violence –in the short-term and the long-term– for individuals, families, communities and countries, and stressed the damaging effects of violence on health care services [14]. The public health approach to *domestic violence* complements the activities of criminal justice and human rights responses in the different countries. It is important that health policies against violence are implemented, encouraged and shared by decision-makers in Europe. In 2009, the European Court of Human Rights in the case of *Opuz v. Turkey* ruled that “*domestic violence*, which can take various forms ranging from physical to psychological violence or verbal abuse ... is a general problem which concerns all Member States and does not always surface since it often takes place within personal relationships or closed circuits” [3].

## Definitions

*Violence* is an extremely diffuse and complex phenomenon, which it is difficult to define clearly because it is culturally influenced and constantly under review, as social values and norms evolve. The many different ways of defining violence have implications for policy and practice as well as consequences for health and preventive strategies. Inadequate definitions or lack of consistency in definitions serve to obscure important aspects of the problem and makes it difficult to compare data across communities or nations [15]. The legal definitions of *domestic violence* in Europe vary from state to state but generally refer to the following definitions.

In 2002, the World Health Organisation (WHO) released the first World Report on Violence and Health (WRVH), which advanced violence onto the public health agenda. The WHO definition of violence is wide and general as being: “*The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation*” [6]. This definition encompasses all types of violence caused by a person or group against another person or group and distinguishes injury or harm from unintended actions and incidents. The words “physical force or power” expand the conventional understanding of the nature of violent acts to include physical, psychological or sexual harm, as well as deprivation, omission or neglect.

In 2013, the UK Government revised and amended the definition of domestic violence and abuse to include coercive control and 16-17-year olds [4]. *Coercive behaviour* is defined as “an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim”, while *controlling behaviour* is defined as “a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour” [4]. This is not considered a legal definition. Coercive control highlights the importance of a complex pattern of overlapping and repeated abuse, besides physical violence, in order to gain power and control over the victim.

The WRVH divides violence into three broad categories according to who has committed the violence: self-directed, interpersonal and collective violence, which includes armed conflicts, genocide, other human rights abuses, and terrorism for political, economic or social objectives [15]. Interpersonal violence is further divided into two subcategories: family violence taking place in the home, and community violence between unrelated individuals generally taking place outside the home (youth violence, random acts of violence, rape or sexual assault by strangers, violence in institutional settings) [13, 15]. Domestic or family violence refers to interpersonal violence among family members, which can take various forms: child abuse, violence by an intimate partner, elder abuse. The European Parliament adopts the definition of *domestic violence* only for violence against women or men [49, 58], while it distinguishes violence towards children as a separate issue [18].

For the purpose of this guidance *domestic violence* is defined as *the intentional interpersonal violence or abuse of children of all ages, of adults regardless of gender or sexuality and of elders by a family member, intimate partner, or caretaker in a domestic setting*. The definitions of the specific forms of *domestic violence* are given in the relevant sections.

## **Addressing Violence in the ED**

The Emergency Department plays an important role in the recognition of victims who suffer from domestic abuse, as it is often their first contact with the healthcare system. Victims might present with injuries that are a direct consequence of abuse, or with the

specific goal of seeking protection. The key issues for the ED personnel in addressing violence, besides the management of injuries, are [11]:

- recognition of violence and abuse,
- supporting the victim,
- documentation of the violence and its impact (injuries, psychological impact, etc.),
- referral to other services and co-operation with other professionals to prevent further violence.

### ***Recognition of violence and abuse***

Domestic abuse is frequently not disclosed unless victims are directly asked. ED personnel are in a vital position to identify the victims and opportunities for confidential disclosure should be considered. They should be able to detect and recognise the emotional, psychological and physical harms arising from an act of domestic violence and abuse and initiate a conversation about violence. Simple, direct questions are usually acceptable and effective, such as “we know violence at home is a problem for many people, is there someone who is hurting you at home?” There is insufficient evidence to advocate screening all women for domestic abuse, but EPs should be prepared to ask if there is any clinical suspicion [2].

### ***Supporting the victim of violence***

If a patient mentions a violent or abusive situation, ED personnel should be patient and respectful, and should listen carefully in a non-judgemental, kind and sensitive manner to determine the patient’s wishes. Victims must feel supported and not being pressurised or judged by the persons they approach for help. The enquiry should be made in private on a one-to-one basis in an environment where the patient feels safe and anyone who may be the perpetrator cannot overhear the conversation [9]. They must be reassured that any information they give will be treated as confidential and will not be passed on without their permission. Additionally, ED personnel should remain supportive regardless of the victims’ decisions, when presented with options for referral to specialist support services.

### ***Documentation in the ED of domestic violence***

In order to effectively respond to a case of *domestic violence* in the ED it must be accurately documented for the legal rights and the protection of the victims, when/if they decide to make a formal report of an offence [11]. In busy EDs with clinical and time



pressures, medical notes often are not of a consistently high standard. However, in cases of *domestic violence*, accurate and complete documentation in the medical record, without omissions and inaccuracies, are critical as it will assist in future prosecution when medical records become an integral part of legal proceedings. It is essential for EPs to establish the credibility of the abused person and also to guard against malpractice suits for missed injuries, failure to report to the appropriate authorities or cases of abuse unsuccessfully prosecuted [5]. EPs are frequently called to testify in civil or criminal cases involving their patients and they have a responsibility to appropriately document the events surrounding the injury [5]. Furthermore, appropriate documentation of injury-related attendances in the ED will assist in collecting accurate data on incidence, prevalence, settings, and victim and perpetrator characteristics for violence surveillance systems.

Each ED should develop specific protocols to address and to record all medical findings and information in such a way to be used as evidence in court, if needed. Documentation should be comprehensive and should include:

- a thorough description in the patient's records of the history of abuse including the type, time and place, who and how,
- the findings of the physical examination with an accurate recording of any injuries present including the nature, shape, colour,
- comments on co-morbidities, pregnancy, if present, and degree of disability,
- diagrammatical representation of injuries or use of body maps to record injuries,
- if possible, photographs of any physical injuries obtained with the patient's permission can be helpful to supplement written descriptions, including a scaling object to enable accurate assessment of the size of the injury,
- results of any laboratory or other diagnostic procedures ordered and medications prescribed,
- the perpetrator's identity and the use of alcohol and drugs by using patient's quotes, when possible,
- options discussed and referrals offered and accepted or not..

If the patient chooses not to release the information to the police, the documentation should be kept as part of the patient's medical record. The patient should be informed that the documentation could be released at any time in the future if the patient provides the necessary consent to do so [10].

### ***Referral of victims to specialist support services***

EDs should ensure that formal referral pathways to specialist social or legal support services are in place for victims of domestic violence and abuse. EPs play a critical role in responding to disclosure of domestic violence of children, intimate partners and elders, and making appropriate referrals of victims and perpetrators. Support services can help to address the emotional, psychological, physical and sexual harms arising from domestic violence and abuse and to improve the safety and well-being of those affected. They can offer advocacy and advice to develop plans for the future, outreach support and provision of tailored interventions for victims and their children and to increase their safety [9]. Victims should be supported to make their own decisions so that they feel in control of their lives. If, however, they choose not to accept the offer of referral to support services, the ED personnel should be sensitive to their wishes and needs, respect their choice and provide them with ongoing support and a follow-up plan for the next step.

The referral of victims of *domestic violence* to specialist support services includes:

- information to the victim about the referral process and referral options,
- support of the victim through the referral process,
- information sharing with specialist support services.

It is essential that ED personnel ensure the most appropriate response to the disclosure of domestic violence and check that victims seeking help are informed appropriately. They should find time to talk to victims and their family in a language that is easily understood, with the help of an interpreter, if needed, and to listen to their needs. When EPs discuss the range of referral options and services available, they should be able to assess what type of support service the patient needs immediately as well as in the long term [9]. They should help patients to identify and choose the most suitable option(s) for their particular requirements, to make an informed decision and give their consent for a referral.

During the referral process, it is best practice for EPs to seek support from a senior colleague experienced in the often complex issues associated with domestic and family violence. EPs should distinguish between situations that involve only adults and those where children are involved. They should obtain consent before they refer or share information about a patient, be sensitive to the patient's wishes and respect their choice. Information sharing about domestic violence without the victims' consent risks losing their trust and may

endanger their safety. Information sharing without consent, or where consent is not given, is necessary when children's safety is at risk [9].

ED personnel should support victims who disclose that they have been subjected to domestic violence, the perpetrators, and the children who have been affected by it. They should provide the victims with ongoing support to make their own decisions about available options for referral and health information sharing, which are consistent with the ethical and legal requirements of each country. They should ensure that the support matches the victim's needs or the child's developmental stage [9].

ED personnel should be able to provide patients with written information (including telephone numbers) on legal assistance, local counselling, social service agencies, crisis intervention services, shelters, and support and community resources, which can inform victims about their legal rights, housing, welfare applications and legal advice. Information regarding support services for the victims should be readily accessible. Educational materials on domestic violence, with lists containing contact details of the available local domestic abuse services, should be on display in waiting areas and examination rooms so that patients can take them away with them or read the information in private [1, 12].

### **Risk Factors for Domestic Violence**

Victims of violence are at increased risk of a wide range of physical, psychological and behavioural problems, including depression, self-harm, drug and alcohol misuse, anxiety, suicidal behaviour, as well as reproductive health problems. Besides the toll of human misery, violence places a substantial burden on national economic expenditures on health services. As a general rule, victims of violence have more health problems and more frequent visits to emergency departments throughout their lives than those without a history of abuse [15]. Up to 12% of emergency department attendances are suffering domestic abuse [12]. WHO predicts that violence and suicide will both individually feature in the top 20 causes of death and burden of disease issues confronting global health in 2030 [8].

The lack of knowledge of the risk factors for domestic violence is thought to contribute to the low detection of abuse. Violence is a complex problem rooted in the interaction of biological, social, cultural, environmental, economic and political factors with huge human and economic costs. According to the WHO, no single factor can explain why certain individuals abuse others or why abuse in certain situations is more common than in others [46]. While some risk factors may be unique to a particular form of interpersonal

violence, more often the various forms share many common underlying risk factors. Some are psychological and behavioural such as poor behavioural control, low self-esteem, or personality and conduct disorders. Some stand out as the important community and societal factors such as growing up in a violent or broken home, substance abuse, social isolation, rigid gender roles, poverty, income inequalities. Others are tied to experiences, such as lack of emotional bonding and support, early experience or witness of family violence and history of divorce or separation [15]. Meta-analyses of childhood maltreatment, especially emotional abuse and neglect, have shown an elevated risk for severe, early-onset, treatment-resistant depressive disorders with a chronic course [32]. Addressing the key risk factors is important because it shows the potential for prevention of violence by appropriate interventions and supports the need for greater collaboration between the different support groups [7].

The risk to the victim may be related more to the characteristics of the perpetrator than to those of the victim. There may be a family history of violence or substance abuse, exacerbated by alcohol or drug abuse, legal or financial difficulties, or mental or physical problems. A domineering, violent, or bullying category of the perpetrator has been described, who is prone to physical abuse and neglect as well as sexual abuse. Older adults who require assistance with activities of daily living or have poor social networks have been found to be at higher risk.

## **SECTION 1: Child Abuse and Maltreatment**

*Tom Beattie - Rodrick Babakhanlou*

Maltreatment of children is a major public health concern, affecting children from all social classes, religious and racial groups in all countries and societies [41]. In Europe, children are as vulnerable to violence as in any other region globally [18]. Conservative estimates suggest that at least 18 million children in the WHO European region will suffer from maltreatment during their childhood. At least 850 children aged under 15 yrs die from child maltreatment annually in the European region, with rates higher in children under 4 yrs compared to older children aged 5-9 and 10-14 yrs [46]. Although prevalence studies suffer from methodological difficulties, the estimated prevalence rates of childhood sexual abuse are 13.4% for girls and 5.7% for boys, of physical abuse 22.9% in both sexes and of emotional abuse 29.1% [27, 46].

Children, who are more likely to become victims of domestic violence, include the very young, those with a history of abuse and those with co-morbid conditions [41]. Children under the age of 4 years are at greatest risk of severe injury with 79% of fatalities of child maltreatment occurring in this age group. An abused child has a 50% chance of experiencing recurrent abuse. Co-morbid conditions, including learning disabilities, chronic illnesses, mental retardation or prematurity are important risk factors for child abuse.

### **Forms of Child Abuse and Violence**

Article 19 of the United Nations Convention on the Rights of the Child (UNCRC) defines child violence as “*all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse*” and includes exposure of children to violence both inside and outside the home [43]. The World Health Organization’s definition of child maltreatment is more general and includes “*all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power*” [45].

Violence towards children is a complex and multidimensional issue that takes many different forms relating to human rights and child protection, as well as public health [18]. The four main types of child abuse in decreasing order of frequency are deliberate neglect, physical, sexual, and emotional or psychological abuse [18, 29, 34, 41].

#### ***Deliberate neglect***

Neglect, deprivation or failure to provide the necessary care is the most prevalent form of child abuse. It is defined as “*the persistent failure of the caregiver to provide for the child’s physical, emotional, educational and medical needs, which can result in developmental delay, physical and psychological harm* [29, 41]. The subtypes of neglect include educational, emotional, nutritional, physical and medical neglect [29].

#### ***Physical abuse***

Physical abuse is defined as “*acts that cause actual physical harm or have the potential for harm*” [18]. It is one of the most common forms of child maltreatment and includes hitting, shaking, poisoning, burning, drowning or suffocating the child [29, 41]. The most common injuries identified in physical abuse include soft-tissue injuries and fractures.

The most common dermatologic signs of child abuse include bruises, followed by scratches, soft-tissue oedema, strap marks, burns and bites [41].

### ***Sexual abuse***

Sexual abuse in children is defined as “*any sexual activity that the child cannot understand or give consent to*”. It may include fondling, oral-genital contact, rape, genital or anal penetration, exhibitionism, voyeurism and exposure to pornography [21, 28, 36]. Of the three million cases of maltreatment in children, approximately 20% are reported to be as sexual abuse. Most cases are committed by men and in 70-90% of these cases, the perpetrator is known to the child. [21, 28, 36, 41].

### ***Emotional and psychological abuse***

There is no universally agreed definition of psychological abuse. Emotional or psychological abuse encompasses both the cognitive and affective components of maltreatment and is characterised by the repeated behavioural pattern of the caregiver that affects the child’s emotional, developmental or psychological wellbeing [20, 22, 23, 24]. Such behaviours of the caregiver include acts of omission (ignoring the need for social interaction) or commission (terrorizing, spurning) and may be verbal or non-verbal and passive or active, which negatively affect the cognitive, social, emotional and physical development of the child [20]. Table 1 summarises the different types of psychologically abusive behavioural patterns of caregivers.

**Table 1.** Types of psychologically abusive behaviours by caregivers (adapted from [20]).

Spurning	<ul style="list-style-type: none"> <li>• rejecting</li> <li>• ridiculing for showing normal emotions</li> <li>• humiliating in public</li> </ul>
Terrorizing	<ul style="list-style-type: none"> <li>• placing in chaotic circumstances</li> <li>• placing in dangerous situations</li> <li>• having unrealistic expectations accompanied by threats if not met</li> </ul>
Isolating	<ul style="list-style-type: none"> <li>• restricting social interactions in community</li> </ul>
Exploiting/Corrupting	<ul style="list-style-type: none"> <li>• modelling, permitting or encouraging antisocial behaviour</li> <li>• restricting psychological autonomy</li> </ul>
Denying emotional	<ul style="list-style-type: none"> <li>• detached and uninvolved</li> </ul>

responsiveness	<ul style="list-style-type: none"> <li>• no nurturing or praise during any development in childhood</li> </ul>
Mental health/medical/educational neglect	<ul style="list-style-type: none"> <li>• limiting child's access to any necessary healthcare</li> <li>• refusing to provide for physical health or educational needs</li> </ul>

## Recognition and Assessment

Identification of child maltreatment is crucial, not only for treating the current condition, but also to prevent further episodes of abuse. Assessment of child abuse is based on four sources and should cover history, including family history, physical examination, laboratory and radiologic tests and observation of the child-caregiver interaction [19, 30, 31, 35].

### *History*

A comprehensive history, including the mechanism of injury, the medical history of the patient and the family history, should be obtained. If the child can communicate verbally then the history should be obtained from the child. If suspicion of maltreatment is raised, permission should be sought to interview the patient alone. Refusal should raise the suspicion of abuse. History taking should occur with open questions and in a non-judgmental manner [30, 31]. Evidence of child maltreatment includes multiple and recurrent injuries, injury history inconsistent with physical findings and injuries inconsistent with the child's developmental capability to sustain them on their own [48].

The past medical history should cover information about past injuries, hospitalisations and any illnesses that can mimic child abuse [41]. Both birth history and also growth and development should be assessed and recorded. Historical aspects that should raise the suspicion of child abuse include [19, 23, 30, 31, 41]:

- inconsistent and vague history, lacking in detail,
- history provided by a caregiver is inconsistent with the presenting injuries of the child,
- no history offered at all,
- un-witnessed injury,
- conflicting histories by the caregiver or different family members,

- significant delays between the occurrence of an injury and seeking medical attention without explanation,
- aggressive responses from caregivers,
- type of injury inconsistent with the mechanism of injury provided,
- history inconsistent with the developmental age of the child,
- developmental regression including enuresis in previously dry children, speech and language delay and behavioural deterioration and in older children truanting, deteriorating schoolwork and antisocial behaviour.

### ***Physical assessment***

The physical examination of the child includes both the evaluation of the general appearance of the child, levels of hygiene, a behavioural assessment and a thorough physical examination, including the height, weight and assessment of the Tanner stage [23, 30, 31], as well as detailed neurological examination. The physical examination should be performed with all the cloths removed and should include assessment of the skin, the musculoskeletal system, the mouth and the genitals.

#### *Assessment of the skin*

The inspection of the skin should look for swelling or deformities, bone tenderness, bruises, abrasions, strap marks, haematomas, burns or bite marks. Soft-tissue injuries are the most commonly identified injury in physical abuse presenting in the form of bruises, followed by fractures [29, 34, 41]. Physical abuse should be suspected if bruises are present in form of hand-, stick- or teeth marks, bruises over non-bony structures or the presence of multiple bruises of a similar shape or size [29, 41].

#### *Assessment of the musculoskeletal system*

Fractures that are highly suggestive of physical abuse include femur fractures in a child who is too young to walk, bilateral long bone fractures, skull fractures, fractures of the sternum or scapula, rib fractures, metaphyseal corner fractures, multiple fractures in various stages of healing [17, 33, 39, 44]. Further findings to raise the suspicion of physical abuse include [23, 24, 28, 34, 41]:

- injuries not consistent with history,
- multiple fractures in various stages of healing, associated with coexisting injuries,
- sudden onset of altered mental status,



- bruising to the pinna, neck or abdomen,
- genital injuries,
- oral injuries,
- anogenital signs and symptoms,
- inflicted injuries (burns).

### *Burn injuries*

Approximately 6-20% of inflicted child abuse is caused by burn injuries. Most injuries occur in children younger than three years [34, 41]. The most common mechanisms to inflict injury include immersion in scalding water, burns by hot objects and cigarettes. Suggestive of abuse are partial- or full thickness burns to the hands or feet in a stocking like distribution. Further characteristics of immersion burns are scald injuries around the buttocks or the perineum [34, 41]. Cigarette burns are usually full thickness burn injuries with a punched out appearance, which can be found on the face, the ears, the palms and soles and the genitalia. Characteristics of inflicted burns are [34, 41]:

- burns older than would be expected considering the explanation given,
- a delay of > 2h in seeking medical attention,
- symmetric distribution of burns,
- burns located on the buttocks and perineum (doughnut sign),
- signs of forced immersion (stocking pattern, sparing of flexural creases),
- burns on posterior upper body,
- burn marks on multiple parts of the body,
- burn marks resembling the shape of an instrument.

Once the entire surface area of the skin has been examined, the location, size and approximate age of any skin lesion should be documented. Sketches and photographs can be helpful for documentation.

### ***Laboratory evaluation***

A laboratory evaluation can help to differentiate child maltreatment from other medical conditions that can mimic signs and symptoms of abuse. In case of maltreatment laboratory tests can help to evaluate the extent of the injury and should cover full blood count, biochemistry (liver and renal function tests), clotting studies and septic screening.

## Urinalysis

In abused children urine should be tested for haematuria when abdominal or genitourinary trauma is suspected. In the first instance, the search should be for evidence of occult trauma by simple bedside stick testing urinalysis. If no blood is present then no other tests are required. If blood is present then further testing including microbiology will be required.

## Radiologic evaluation

In suspected cases of child abuse imaging modalities such as skeletal radiography, ultrasonography, computed tomography (CT) and/or magnetic resonance imaging (MRI) can be helpful [17, 33, 44, 37, 39, 40]. In non-verbal patients and those younger than two years, a skeletal survey should be performed, according to the recommendations of the Royal College of Radiologists (Table 2) [37]. Ultrasonography via the anterior fontanelle in young infants can be helpful in clarifying the presence of intracranial fluid collections and in the detection of skull fractures [17]. Computed tomography should be performed as part of the initial assessment for suspected intracranial injury [17, 33, 44, 37, 39, 40]. A sonographic evaluation of the abdomen can help detecting intra-abdominal fluid collection [17]. In verbal and ambulatory children the diagnostic imaging should be restricted to the area of injury, as a skeletal survey would expose the patient to an unnecessarily increased dose of radiation.

**Table 2.** Skeletal survey for non-accidental injuries in children (adapted from [37]).

<b>Axial skeleton</b>	<b>Appendicular skeleton</b>
• thorax (AP), right and left oblique views of the ribs	• humeri (AP)
• pelvis (AP)	• forearms (AP)
• lumbosacral spine (lateral)	• hands (PA)
• cervical spine (lateral)	• femora (AP)
• skull (frontal and lateral)	• lower legs (AP)
	• feet (AP)

## Ophthalmologic evaluation

In children younger than five years of age, where abusive head trauma is suspected, a fundoscopic examination by an Ophthalmologist is recommended. The examination should take place between 24-72h in order not to miss transient retinal changes [16, 25, 40, 42].

### ***Assessment of sexual abuse***

For the evaluation of sexual abuse, the clinician must have an understanding of the appropriate interview technique, childhood developmental milestones, normal and abnormal sexual behaviour and the normal paediatric genital anatomy. When obtaining the history, the abused patient may complain of a variety of symptoms, which may be non-specific, such as sleep disturbance, abdominal pain, enuresis, encopresis or phobias [41]. The examination of the female patient should occur in the supine position and include inspection of the labia majora, labia minora, the vaginal introitus and hymen for lacerations, lesions, abrasions, tears or erythema [21, 28, 36, 41]. If visualisation of the posterior aspect of the hymen is difficult, the knee-chest position can be more helpful [21, 41]. The examination of the male patient includes an evaluation of the genitals for erythema, abrasions, lacerations or bite patterns which are suggestive of abuse as well as discharge from the urethral meatus and circumferential injuries to the shaft or glans penis. Penile secretions should be cultured for sexually transmitted diseases [21, 28, 36, 41]. The perianal region should be examined for fissures, lacerations, bleeding, haematomas and anal dilatation. Testing for sexually transmitted diseases should include Neisseria gonorrhoea, Chlamydia, Trichomonas, genital warts, herpes, syphilis and HIV, while pregnancy testing should be offered [21, 28, 36, 41]. As the oral cavity is often a site of sexual abuse, an inspection should be carried out to assess for bruising, petechiae of the hard and soft palate or tears of the frenulum [41].

### ***Assessment of psychological abuse***

Psychological abuse is difficult to identify and poses a challenge to the clinician. Interviews will need to address the relationship between patients and their caregivers, the patient's feelings of self-worth, safety and any history of sexual abuse. Caregivers need to be interviewed individually in order to check for partner violence. Further information can be gathered from schoolteachers or childcare personnel. The observation of the relationship between parents and the child can provide valuable information about the quality of their relationship. The child's growth and developmental behaviour –regression or deterioration– needs to be assessed, as they can be impaired as a result of psychological abuse [20, 22].

### **Interventions**

Once concerns about child abuse have been raised or even confirmed, ED personnel have the obligation to report it and to inform child protection services, social services and the paediatric team.

### ***Case management in the ED***

In case of physical abuse, injuries should be assessed and managed in the Emergency Department (ED) accordingly and the child hospitalised in order to provide a safe environment. While dealing with families of an abused child, the ED physician needs to maintain a neutral and non-accusatory attitude throughout the time spent with them.

Victims of sexual abuse should be offered post-coital contraception if they are in the childbearing age. Also if there is high suspicion of infection, treatment for sexually transmitted diseases should be initiated in the ED. Involvement of a mental health specialist is helpful in assisting with the burden of trauma [47].

Irrespective of the type of abuse clear documentation of all findings during the physical examination and the results of diagnostic tests, including laboratory findings and imaging is mandatory. Including photographs of bruises and skin lesions can be very useful, provided local policies on photographic evidence have been followed. Furthermore, clear documentation of the names of the people involved is crucial. It is important to evaluate whether the patient will require immediate protection and collaboration with child protection services and the police can facilitate finding accommodation in a safe environment.

### ***Prevention strategies***

The challenges for this strategy are prevention, protection, provision and participation. “Nationally, throughout Europe generally, there are insufficient policies targeting prevention of child abuse, training professionals and raising public awareness of children as Rights holders [27]. Approximately 50% of children, who have been abused, will be abused again and 10% will be at risk of death if not detected early [34]. Hence, appropriate recognition and early intervention are crucial to avoid further episodes of abuse. Training of staff in the identification of risk factors and the development of a child protection plan are important steps for preventing further episodes of abuse.

### ***Training***

All staff that come into contact with children have a responsibility to protect and promote their welfare. This includes recognizing risk factors and signs of abuse and taking the appropriate steps when there are concerns about child abuse. In order to fulfil these responsibilities, all staff should have access to child protection training, learning opportunities and support to facilitate their understanding of child protection and information

sharing. This aims to: (a) promote child-friendly services and systems, (b) eliminate all forms of violence against children, (c) guarantee the rights of children in vulnerable situations, (d) promote child participation [26, 27, 38].

### *Identification of risk factors*

Risk assessment is a complex procedure and requires necessary skills and tools. Training and education will enable identification of risk factors and recognition of signs of child abuse and will provide the necessary knowledge of how to take the appropriate action, including reporting and involvement of appropriate agencies. Failure to identify risk can result in a serious and even fatal outcome [26, 38].

### *Child protection plans*

Article 19 of UNCRC requires the States Parties to “take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental violence while in the care of parents, legal guardians or any other person who has the care of them” [46]. Having identified the risks and their potential impact on the child, it is important to implement strategies to reduce those risks. Such protection plans clearly need to identify the following [26, 38]:

- perceived risks and needs,
- what is required to reduce those risks and meet those needs,
- outcomes and timescales,
- support and resources required,
- people involved and their responsibilities,
- access to specialist resources,
- contingency plans,
- long-term needs of the child,
- the process of monitoring and reviewing,
- agreed outcomes for the child.

## **SECTION 2: Intimate Partner Violence**

*Roberta Petrino – Barbara Gabrielli – Helen Askitopoulou*

The term “intimate partner” defines “a person with whom one has a close personal relationship that can be characterised by the following: emotional connectedness, regular

*contact, ongoing physical contact and/or sexual behaviour, identity as a couple and familiarity and knowledge about each other's lives*" [52]. This is a general definition that includes heterosexual as well as same-sex relationships of current or former intimate partners of women or men. However, the majority of the victims of intimate partner violence are women. The 2011 Istanbul Convention of the Council of Europe focuses only to the forms of violence against women defined as: *"a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life* [55]. One of the most common forms of violence against women is "intimate partner violence" (IPV), a term that includes a wide variety of behaviours that coerce, control, or demean victims [56]. In relation to IPV the WHO uses the term "battering" meaning: *"a severe and escalating form of partner violence characterized by multiple forms of abuse, terrorization and threats, and increasingly possessive and controlling behaviour on the part of the abuser"* [71].

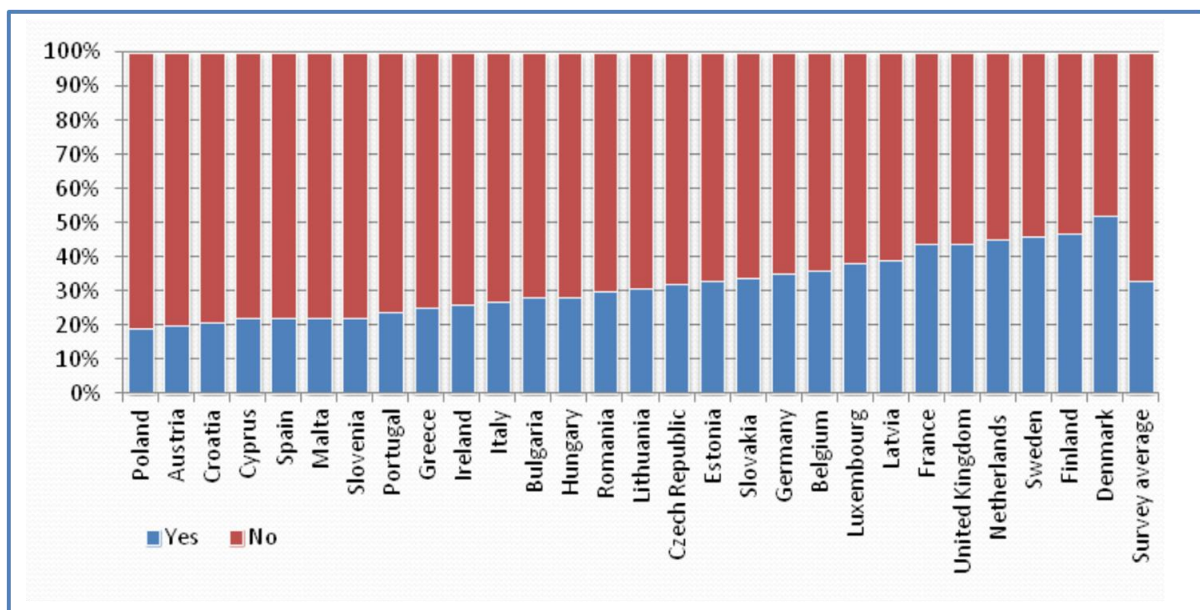
For the purpose of this guidance, *intimate partner violence* is defined as *the violence or abuse against women that includes all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim*" [57].

### **Forms of Intimate Partner Violence**

Violence against women by intimate partners is increasingly recognised as a serious violation of both women's health and human rights, which occurs in all domestic settings and among all socioeconomic, religious and cultural groups [72]. IPV has received increasing attention at the international and the European level [49, 55, 58, 59]. The United Nations established a Task Force on "Violence against Women" to provide enhanced and systematic support at the national level [69]. At the regional level, the Council of Europe Convention on preventing and combating violence against women and domestic violence obliges its Parties to criminalise psychological violence, stalking, physical violence, sexual violence, including rape, and sexual harassment [55]. However, there is currently no legislation in place at the level of the EU that addresses violence against women in a comprehensive manner [57]. In 2014, the first survey on violence against women was conducted across the 28 Member States

of the European Union (EU), based on interviews with 42,000 women about their experiences of physical, sexual and psychological violence, including incidents of intimate partner violence [59]. The survey showed that violence against women is a widespread problem across the EU with an average prevalence for all forms of violence of 33 % by any person (Figure 1) or of 22 % by a current or previous partner [59].

The main, often interrelated and overlapping, forms of violence against women are physical aggression (such as slapping, hitting, kicking and beating), psychological abuse (such as intimidation, constant belittling and humiliating), sexual violence (such as rape and other forms and other forms of sexual coercion), and also various controlling behaviours [52, 58, 72]. Information on the magnitude and characteristics of the different forms of violence against women in Europe is provided by the Department of Citizens' Rights and Constitutional Affairs of the European Parliament. However, the comparison of data between EU member states is challenging due to differences in the legal definitions of violence against women. Moreover, not all member states have criminalised all forms of violence against women [58].

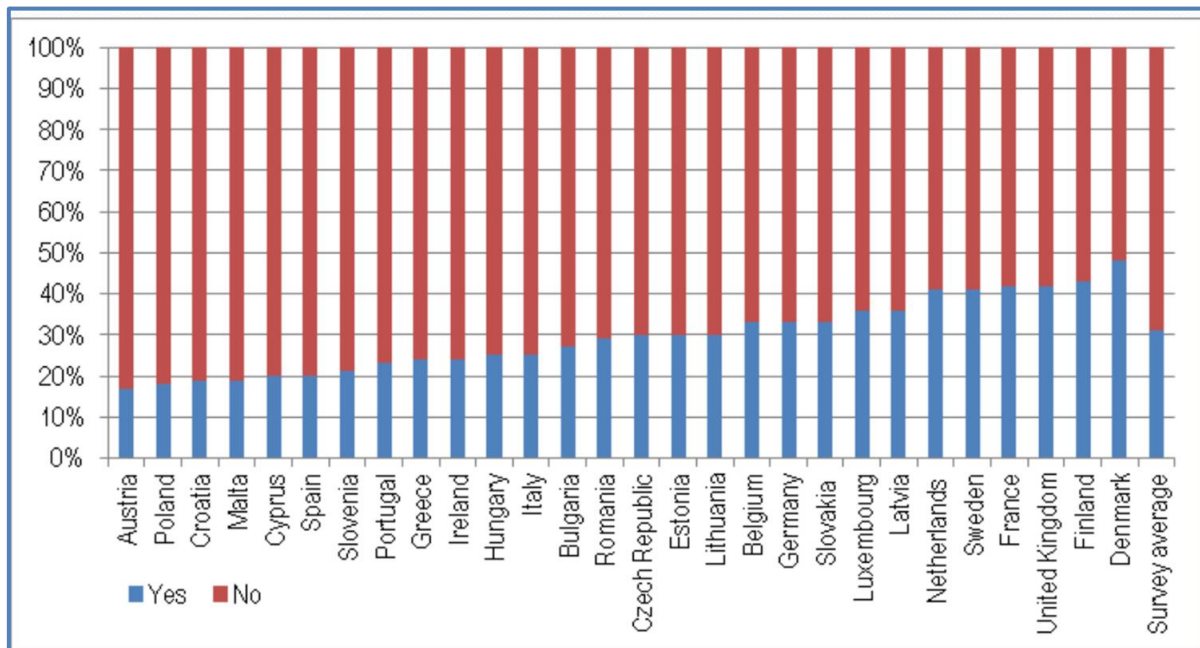


**Figure 1.** Prevalence of women who have experienced all forms of violence by any person since the age of 15 in the Member States of the EU. Data adapted from the Agency for Fundamental Rights of the European Union (EU FRA) [59, 67].

***Special populations***

Women with undocumented or dependent immigration status are particularly vulnerable to partner abuse, given the social isolation and financial, emotional and

psychological dependence on their partners, traditional gender customs in their homeland, and the stress with the process of assimilation [54].



**Figure 2.** Physical violence experienced by women since the age of 15 years in the Member States of EU. Data adapted from the Agency for Fundamental Rights of the European Union (EU FRA) [59, 67].

### ***Physical violence***

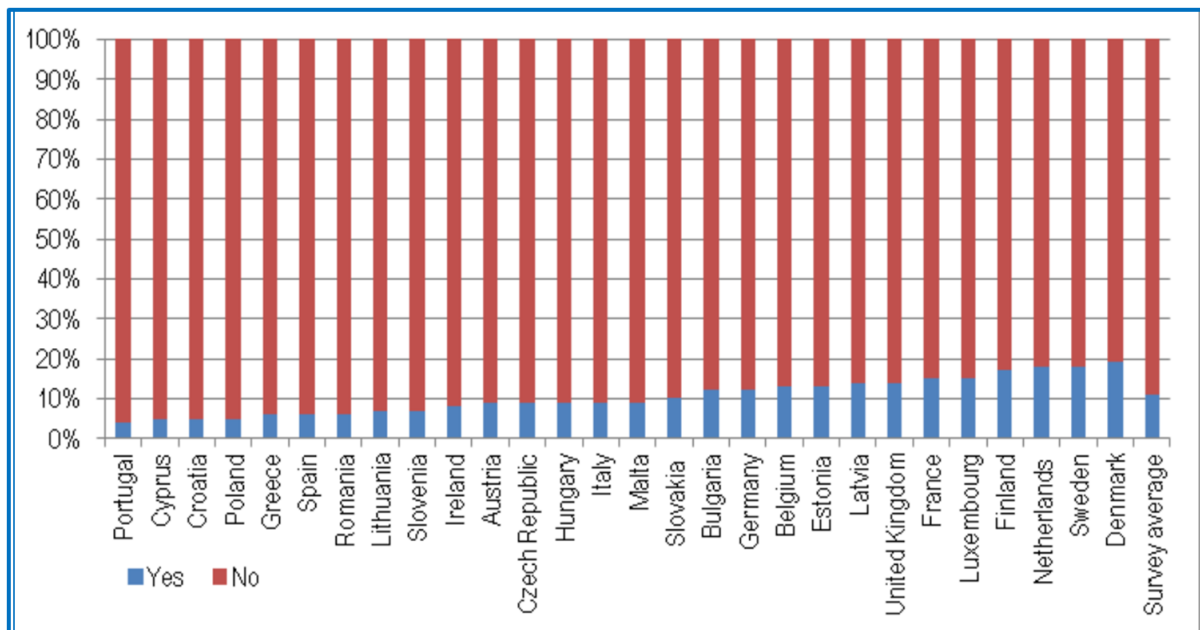
*Physical violence* is defined as *the intentional use of physical force with the potential for causing death, disability, injury, or harm* [52]. Physical abuse ranges in scope from minor injuries due to slapping or pushing to more severe assault, such as punching, kicking, or choking or even homicide, the most severe outcome [56]. In the European Union, 31 % of women on average have experienced physical violence by any person (Figure 2) [59].

### ***Sexual violence***

Although there is no universally accepted definition of sexual violence by an intimate partner, sexual assault is a form of abusive behaviour which is often a way to maintain power and control over a woman [58]. Sexual violence is divided into five categories: rape or penetration of victim, the victim made to penetrate someone else, non-physically pressured unwanted penetration, unwanted sexual contact, non-contact unwanted sexual experiences [56]. Any of these acts may be either attempted or completed and occur without the victim's free consent. Additionally, they include cases in which the victim is unable to consent due to



being intoxicated by voluntary or involuntary use of alcohol or drugs [52]. In the European Union, 11% of women on average have been victims of sexual violence (Figure 3) [58].



**Figure 3.** Sexual violence experienced by women since the age of 15 years in the Member States of EU. Data adapted from the survey about violence against women of the Agency for Fundamental Rights of the European Union (EU FRA) [59, 67].

### Screening and Assessment

Intimate partner violence is associated with poor health outcomes including acute injuries as well as chronic physical and mental health conditions. Victims of IPV use more emergency department, hospital outpatient, primary care and mental health services than non-abused women, though rarely they disclose IPV [50, 54]. The frequent contact of emergency personnel with such victims, places them in a unique position to screen, recognise and intervene in cases of IPV and to be alert to violence perpetrators characteristics [56]. EPs should recognise behaviour which might indicate that the person is a perpetrator and record it e.g. “patient appears frightened of her partner, who tries to answer all questions for her; partner became inappropriately angry when asked to leave the room, so I could examine the patient.” Nevertheless, several studies have demonstrated that emergency personnel have identified only a small percentage of domestic abuse victims or inquired about it during assessment in the ED.

## ***Screening***

Screening for intimate partner violence is advocated in some healthcare settings as having the potential to identify patients at future risk. In 2011, the Institute of Medicine (IOM) in the USA recommended: “screening and counselling for all women and adolescent girls for interpersonal and domestic violence in a culturally sensitive and supportive manner” [62]. The American College of Emergency Physicians has changed “the terminology from screening to assessment”, which is believed to lead to a more appropriate evaluation of the importance of routine inquiry for IPV in the health care setting [48]. In 2014, the National Institute of Health and Care Excellence (NICE) in the UK published recommendations on routinely asking patients in high-risk settings whether they have experienced domestic violence, regardless of presentation [65].

Women who have experienced domestic abuse and present to the ED, often have non-traumatic presenting complaints and frequently choose not to disclose IPV unless asked directly by ED personnel in a safe and private setting [51, 56, 61]. By not inquiring about the risk of domestic violence against women, the emergency physician overlooks a causative factor in the patient’s illness and an opportunity to prevent further violence. Fear of objection by the patient is not a valid reason to withhold questioning for IPV [61]. However, IPV screening remains controversial as outcome data regarding the efficacy of routine screening are still lacking [56, 66]. In the USA, the US Preventive Services Task Force recommended that “clinicians screen women of childbearing age for IPV, such as domestic violence” although “the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults for abuse and neglect” [64]. In the UK, NICE recommends “selective screening” as it acknowledges that there is insufficient evidence to advocate universal screening in all healthcare settings [65]. It has been shown that implementing selective domestic violence screening by frontline hospital clinic staff for high-risk groups successfully identifies people who have experienced past or current domestic violence and promotes good uptake of referrals for in-house domestic violence support [70].

Screening of IPV in the ED involves simple, targeted questions using screening tools with sound psychometric properties that ideally will identify most victims experiencing abuse. However, each of these screening tools has limitations making practical use in clinical settings difficult. Even the most common tools have been evaluated in only a small number of studies and no single IPV screening tool had well-established psychometric properties, while sensitivities and specificities varied widely within and between screening tools [66]. A

sample of brief validated screening tools appropriate for use in the ED is available from the Centres for Disease Control and Prevention (CDC) (Table 3) [54]. Routine inquiry relating to IPV includes “what happened, when, where and whom” and questions on immediate safety, health impact and patterns of abuse as well as a potential for lethality [48]. Although the questions included in these screening tools are important, performing a screening itself is more important than its content [56].

**Table 3.** Example of screening tools for intimate partner violence (adapted from [54]).

Screening tools	Questions
<b>HITS</b>	<p><b>H</b>ow often does your partner physically hurt you?</p> <p><b>I</b>nsult you or talk down to you?</p> <p><b>T</b>hreaten you with harm?</p> <p><b>S</b>cream or curse at you?</p>
<b>PVS</b> ( <b>P</b> artner <b>V</b> iolence <b>S</b> creen)	<ul style="list-style-type: none"> <li>▪ Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? Of so, by whom?</li> <li>▪ Do you feel safe in your current relationship?</li> <li>▪ Is there a partner from a previous relationship who is making you feel unsafe now</li> </ul>

In a busy ED screening for IPV could be incorporated into triage, whether through standardised intake processes or electronic medical records. This should be available also for patients who miss triage on entering the ED because of the severity of their health status, before leaving the ED. Screening of immigrant women is critical and should be conducted with confidentiality use, if possible, of a culturally specific interpreter [54]. Emergency physicians should also be careful in screening and assessment of teenagers experiencing high levels of relationship abuse [4]. However, there are several challenges and arguments associated with implementing domestic violence screening in the ED. Adding screening for various conditions, such as domestic violence, may make triage cumbersome to the point that it becomes totally inefficient. Regular training is needed of the staff undertaking the screening about asking and responding appropriately. Private space should be available for

victims to be asked safely without the risk that the abusive partner is present. Additionally, clear integrated referral pathways to support services are essential [70].

### ***Assessment***

Detection of IPV by emergency personnel requires immediate and direct intervention. The intervention after the first evaluation is a multifaceted process that includes history taking, physical examination, injury treatment, consultation with law enforcement and adult safeguarding/protection services, and documentation of the violence [48]. It also includes referral, resourcing, advocacy and safety planning. During the encounter with a victim of domestic abuse, the emergency physician should use a direct, empathetic, non-judgemental and understanding approach with open-ended questions and should ensure the emotional and physical safety of the victim [12, 14].

### ***History***

It is essential for emergency physicians to recognise patients who are victims of intimate partner abuse. Initially, physical injury is less common and victims may present with vague, nonspecific complaints. IPV may present as chronic stress and a range of medical, obstetric and mental health problems such as chronic headaches, asthma, diabetes, hypertension, atypical chest pains, abdominal and GI complaints as well as sexually transmitted diseases which may be exacerbated or poorly controlled [48]. The victims may be isolated from their abusers or feel separated because of feelings of shame or guilt. Additionally, victims are more likely to report symptoms of decreased self-esteem, increased daily stressors, depression, anxiety, substance abuse, eating disorders and posttraumatic stress disorder [59].

If the patient discloses domestic abuse, the emergency physician should try to obtain a chronologic history of the violence. EPs should assess risk factors for serious injuries, such as increased frequency or severity of violence or weapons at home. They should evaluate the victim for signs of depression, anxiety, posttraumatic stress disorder, or suicidal thoughts. Specific attention should be paid to the presence and age of children living in a violent household. Attempts should be made to find out whether children are at risk of abuse by direct questioning or use of child protection services [12].

### *Physical examination*

After an episode or disclosure of IPV, the emergency physician should evaluate the patient for severe injuries that require immediate attention. During the physical examination, the EP should empower the victim by requesting permission to perform the examination, explaining each step of the examination, and stating that the patient can stop the examination at any time. The patient should be fully undressed to enable evaluation and treatment of unreported or unseen injury and to assess signs of previous injuries.

Recurrent or frequent injuries, possibly with increasing severity over time, and multiple injuries in varying stages of healing are significant physical examination clues. Studies have shown that the strongest predictor of IPV is frequency, rather than severity. Victims often present with injuries to the face, head, neck, extremities and central body areas, such as breasts, abdomen and chest, but the victim's report of injury is incompatible or inconsistent with the mechanism or location of injury [68]. Contusions on normally protected areas, rug burns, human bites, burns and injury outlines suggesting a specific weapon also should prompt consideration of abuse.

Victims who report sexual assault should be evaluated for perineal injury, sexually transmitted diseases and pregnancy. Additionally, injuries suggesting defensive posturing should warn physicians about the possibility of domestic abuse. Any injury during pregnancy should be a red flag for physicians; lack of prenatal care also can indicate domestic abuse [48, 59, 60].

### *Documentation*

Documentation of IPV is essential, as the medical record can provide corroboration for a victim even years after the injuries have healed. The record may be helpful in criminal complaints, when obtaining restraining orders, in custody and visitation disputes, and to facilitate specialised housing and entitlements. If a patient does not disclose abuse, the EP can document the nature and location of injuries that are inconsistent with the patient's explanation. EPs should contact primary care providers, whenever possible, to ensure the continuity of care, as an ongoing medical problem may become chronic [54].

### *Assessment of the safety of the victim*

The ED personnel should assess and ensure the patient's immediate safety and also help the patient reduce the danger to herself and her children when she is discharged. Safety

planning can be complex and is accomplished best with the help of a social worker, advocate or local support team. To this effect a brief formal danger assessment tool may be used as a follow-up to calculate the risk of severe future intimate partner violence; it has been shown to perform better than the self-assessment of risk [53]. If the patient does not feel safe to go home, she will need to be placed in contact with domestic violence agencies to seek alternative housing. In some countries, hospitals may admit patients in danger of violent victimization, who do not feel safe to go home and have no other options [54].

## **Interventions**

Intimate partner violence is a chronic issue that requires interventions with a positive outcome such as prevention, empowerment, safety discussion, and referral to community support resources. The response network for victims of IPV should start from the emergency department.

### ***Prevention***

Traditional public health interventions addressing intimate partner violence are characterised by three levels of prevention. Primary prevention aims to prevent violence between intimate partners before it occurs, using innovative programmes at both national and local level. Secondary prevention focuses on the immediate responses to violence, such as pre-hospital care, emergency services or treatment for sexually transmitted diseases following rape. Tertiary prevention focuses on long-term care in the wake of violence, such as rehabilitation and reintegration, and attempts to lessen trauma or reduce the long-term disability associated with violence [15].

Secondary prevention of IPV should start in the ED and should be extended to social services, police and policymakers. Screening for IPV in the ED and offering of referrals has the potential to interrupt and prevent recurrence of IPV and associated trauma, therefore, becoming part of preventive care [54, 63]. Disclosure of abuse during assessment was associated with a reduction in violence and increase in safety behaviours.

### ***Support of the victims***

During the encounter with a victim of IPV, emergency physicians should work closely with other professionals, such as social workers to refer the patient to specialists trained to help victims cope with all aspects of the abuse. They should take time to review options available to the victim and her family and give the victim written information. EPs

should be familiar with the country's laws on violence and when to call authorities, such as law enforcement if appropriate, or offer patients experiencing abuse assistance in contacting law enforcement to make a report. If patients do not wish to initiate this process while in the ED, they should be given information on how to do so and made aware that domestic violence services include providing psychological, social and legal aid [54].

In May 2011, the Council of Europe (comprising 47 countries in Europe) adopted the Istanbul Convention, which will enter into force when at least 10 Council of Europe Member States have ratified it (see Appendix). Article 50 of the Convention obliges parties to the convention to take the necessary measures to ensure that the police responds to all forms of violence “promptly and appropriately by offering adequate and immediate protection to victims” [55].

## **SECTION 3: Elder Abuse and Neglect**

*Robert Leach, Helen Askitopoulou*

The abuse of older people by family members or others in a trusting relationship, although dating back to ancient times, remained largely hidden from public view until the last quarter of the 20th century. As a result of growing concerns about human rights, gender equality, domestic violence and population ageing elder abuse was recognised as a social and health problem with serious consequences for the health and wellbeing of old people [87, 97].

Elder abuse is a widespread problem that is often under reported [74]. It constitutes a violation of human rights and is recognised internationally as a pervasive and growing problem that leads to a serious loss of dignity and respect [87, 88, 91, 92]. WHO has estimated that 15.7% of people over the age of 60 are subjected to abuse, a prevalence rate predicted to increase with a rapidly ageing population [98]. The problem is without doubt underestimated in the medical literature since the elderly are often scared to report abuse or maltreatment. They are afraid that they will not be believed, or are afraid of retaliation and even placement in an institution, of becoming socially isolated and of the administrative procedures that accompany a complaint.

### **Forms of Elder Abuse**

Elder abuse is defined as “a single or repeated act or lack (neglect) of appropriate action, occurring within any relationship where there is an expectation of trust, which causes

*harm or distress to an older person*” [97]. This definition was originally developed in 1995 by Action on Elder Abuse (AEA), a UK charitable organisation [73] and later was adopted by the WHO and the International Network for the Prevention of Elder Abuse (INPEA) [97].

Elder abuse is an intentional act or a failure to act by a caregiver or a person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older (aged  $\geq 60$ ) adult [84, 90]. The notion of trust is crucial for the understanding of abuse that differentiates it from “simple” assault. Elder abuse can take place in any setting (nursing homes, social care institutions, hospitals and medical care centres, home care services, domestic settings, prisons and everyday life), and can be inflicted by any person holding a position of trust (acquaintances, neighbours, professionals) [82]. However, the evidence about where abuse takes place indicates that almost two-thirds (64%) of all reports of abuse are related to the older person’s own home. In the European region around 70% of the perpetrators of elder abuse are members of the family, the majority being their partners, followed by their children [82, 99].

Elder abuse can take various forms such as physical, psychological, emotional, financial, sexual, and intentional or unintentional neglect, with prevalence rates of 4.3% for physical abuse, 10.8% for verbal abuse, 25% for psychological abuse and 4.3% for financial exploitation [77]. The cross-national study of seven EU countries, ABUEL (Abuse and health among Elderly in Europe), has uncovered a prevalence of 19.4% for mental abuse, 2.7% for physical abuse, 0.7% for sexual abuse, 3.8% for financial abuse and 0.7% for injury [82].

### ***Physical abuse***

Physical abuse is defined as the use of physical force that can result in bodily injury, physical pain, or impairment [75]. It involves violent acts (beating and physical manhandling), confinement, or even administration of un-prescribed medications as well as withdrawal of medication [73, 97]

### ***Psychological or emotional abuse***

Psychological abuse is defined as the infliction of mental anguish, emotional pain, or distress through verbal or non-verbal acts [75]. It is the second most common form of elder abuse that can take the form of verbal harassment, belittling, threatening, and scolding, which may be overt or subtle [75]. Frequently it is associated with financial and other forms of



abuse or may involve coercive control [73, 87]. Invariably, it involves humiliation and most often it takes the form of intimidation.

### ***Financial or material abuse***

Financial or material abuse or exploitation is emerging as the most prevalent form of elder abuse, defined as the illegal or improper use of an older adult's funds, property, or assets [75, 88, 97].

### ***Sexual abuse***

Sexual abuse is defined as the non-consensual sexual contact of any kind with an elderly person like incest, rape or other types of sexual coercion [75, 97]. Sexual abuse is probably the least common and most underestimated form of elder abuse because of society's denial of the sexuality of the elderly, thereby indirectly promoting the belief that when sexual abuse is identified the abuser is a stranger to the victim [73].

### ***Neglect***

Neglect is defined as the refusal or failure of a designated carer to meet the needs of a dependent old person or to fulfil any part of his/hers obligations or duties to an older adult [75, 87]. It may or may not involve a conscious and intentional attempt to inflict physical or emotional distress on the older person [97], which can have a profound effect on the older person and should not be underestimated [73]. It can be either intentional or unintentional (passive abuse). Unintentional abuse can be the result of the caregivers' lack of understanding of the needs of the elderly or of their lack of knowledge of how to carry out the required care.

## **Risk Factors for Elder Abuse**

Elder abuse can be inflicted by any person holding a position of trust (acquaintances, neighbours, professionals). The evidence about where abuse takes place indicates that almost two-thirds (64%) of all reports of abuse are related to the older person's own home. In the European region around 70% of the perpetrators of abuse are members of the family or of the close environment of the older person, the majority being their partners, followed by their children [82, 99].

Abuse of the elderly is influenced by individual aspects of the victim and the perpetrator, and also by individual, relational, communal and social risk factors. Risk factors for the care recipient mainly include social isolation and functional dependency, as well as

age over 74 years, cognitive impairment, female gender, physical disability, dementia and depression, memory problems, physical handicaps or substance abuse [77, 87]. Being abused earlier in life appears to be related to a higher risk of becoming a victim [86], while physical and mental impairment are the two most significant risk factors [101].

Risk factors for the caregiver include stress, caregiver burden, mood disorders, depression, difficult prior relationships, social isolation, while anxiety and feelings of burden are preventable risk factors for the family caregivers [77, 91]. Caregivers with a history of substance or alcohol abuse are at increased risk of perpetrating abusive behaviour. The same is true for those with mental impairment or those dependent on the elder and more specifically those living with the elder [91]. Tools have been developed to help detect elder abuse.. Among the validated tools for use with caregivers is the Caregiver Abuse Screen (CASE), which evaluates possible physical and/or psychological mistreatment and neglect perpetrated by the caregiver. It is well accepted by the interviewees because it does not generate the need for justification [93].

## **Recognition and Assessment of Elder Abuse**

Elder abuse, like other forms of abuse, is a complex problem, less evident in the ED than child and intimate partner abuse. It is often subtle, under-recognised and under-reported. The key to recognition by emergency personnel is the awareness of the potential for abuse and its suggestive signs and symptoms, which should lead to earlier diagnosis and improved outcomes [74].

### ***Consequences***

Elder abuse impacts negatively on the health of the victims, resulting in deterioration of the quality of life and existing medical conditions, depression, anxiety, dementia, and a mortality rate that can be up to three times higher than that of an age matched non abused population [83, 88, 94]. Also it has been associated with major adverse health outcomes, including a higher rate of hospital admissions and institutionalisation, lower survival rates and elevated social costs [78, 91]. There is evidence that shows that each year elder mistreatment is responsible for 30% of the homicide deaths in older people in the European Region [82]. Elder abuse has a significant impact not only on the victims, but also on many aspects of health care systems [79]. The USA Federal Interagency Forum (FIF) on Aging-Related Statistics reported that abused elderly are seen by a doctor 14 times in the period of a year [81].

### ***Identification and screening***

The identification of elder abuse by emergency medical services personnel is important as older patients are more likely to be transported to the emergency department by ambulance than younger adults [90]. In the ED, the evaluation of cases of elder abuse presents several challenges, as victims may conceal their circumstances or be unable to articulate them owing to cognitive impairment. Also, the burden of chronic illness in older people creates both false negative and false positive findings in the evaluation, while cultural and language barriers may hold up the disclosure of abuse [88].

### ***Assessment***

Primary assessment of abused older patients does not differ from that for other patients in the ED, and varies according to the type of abuse suspected. However, special attention should be given to detect these patients due to their poor prognosis. Emergency physicians must be prepared to recognise the signs and symptoms of these types of elder abuse, which should feature in their list of differential diagnoses [97]. Direct and indirect questions, which may be less threatening, can be used with the potential victim. In some cases, an assessment of cognition and mood will be needed for the evaluation to be complete. In the case of a suspected abuser the assessment should be conducted by an experienced practitioner [88].

The general signs for the specific forms of abuse are shown in Table 4. While each of them frequently may occur in the absence of elder abuse, their presence should prompt a consideration of abuse as a possible diagnosis.

**Table 4.** Manifestations of the different forms of elder abuse (adapted from [88]).

<b>Type of abuse</b>	<b>Manifestations</b>
<b>Physical abuse</b>	<ul style="list-style-type: none"><li>• abrasions, lacerations, bruises,</li><li>• fractures, dislocations,</li><li>• use of restraints,</li><li>• burns,</li><li>• depression, delirium with or without worsening of dementia or dementia-related behavioural problems</li><li>• poor hygiene</li><li>• bad nutritional status</li></ul>

	<ul style="list-style-type: none"> <li>• untreated injuries (organised hematoma over fracture site), or injuries in various stages of healing</li> <li>• drug overdose, overmedication, under-medication</li> </ul>
<b>Psychological or emotional abuse</b>	<ul style="list-style-type: none"> <li>• changes in behaviour, unusual behaviour,</li> <li>• depression, anxiety,</li> <li>• subtle signs of intimidation, such as deferring questions to a caregiver or potential abuser,</li> <li>• evidence of isolation of the victim from both previously trusted friends and family members,</li> <li>• withdrawn victim with violent mood fluctuations</li> </ul>
<b>Financial abuse</b>	<ul style="list-style-type: none"> <li>• victim lacks basic comfort, normally not outside their financial reach</li> <li>• unexplained worsening of chronic medical problems previously controlled,</li> <li>• non adherence to medication regimen or other treatment</li> <li>• malnutrition, weight loss, or both, without an obvious medical cause,</li> <li>• depression, anxiety</li> </ul>
<b>Sexual abuse</b>	<ul style="list-style-type: none"> <li>• bruising, abrasions, lacerations in the anogenital area or abdomen,</li> <li>• newly acquired sexually transmitted diseases, especially in nursing home residents</li> <li>• urinary tract infection</li> <li>• difficulty in walking or sitting,</li> <li>• torn, stained or bloody underclothing, pain or itching in genital area,</li> </ul>
<b>Neglect</b>	<ul style="list-style-type: none"> <li>• decubitus ulcers,</li> <li>• malnutrition, dehydration,</li> <li>• poor hygiene,</li> <li>• non adherence to medication regimen.</li> <li>• delirium with or without worsening of dementia or</li> </ul>

## **Interventions**

There have been no large, high-quality randomised, controlled studies of specific and discrete interventions in cases of elder abuse [88]. Interventions are best accomplished by using a team approach that involves the medical profession, social services, mental health, and legal professionals [74]. Emergency departments should develop protocols and guidelines for suspected elder abuse cases.

Possible interventions include case management when indicated, reporting and referral to support groups, prevention and education.

### ***Case management***

An elder patient indicating that they are being mistreated is to be considered as seriously as when one identifies a physical problem. Emergency physicians are in a unique position regarding the diagnosis and management of elder mistreatment. Because of the relative isolation of many elders who are mistreated, an unexpected visit to the ED may be the only opportunity for detection of abuse [76]. The most important tasks for the emergency physician are to recognise and identify elder abuse, to become familiar with resources for intervention that are available in the local community, and to refer the patient to those resources [88].

Successful treatment rarely involves the swift and definitive extrication of the victim of abuse from his or her predicament with a single intervention. The different forms of abuse require different interventions. A critical consideration in all cases of elder abuse is whether the victim has decision-making capacity to accept or refuse an intervention, because of the high prevalence of cognitive impairment from dementia [88].

### ***Reporting elder abuse***

The response of emergency personnel to cases of elder abuse should include communication with specialists in other disciplines including social workers, as well as law enforcement and protection services, European countries have different reporting rules for elder abuse, which vary with respect to who are considered mandated reporters and what actions require reporting. In 2010, the European Charter of Rights and Responsibilities of Older People in Need of Long-term Care and Assistance has become an EU-level reference

document and a guide with recommendations and concrete examples of interventions targeting European, national and local authorities, service providers, older people's organisations and potential victims [80, 82]. Some countries have developed programs to protect those considered legally "weak". In 2017, the WHO established an interactive platform for preventing violence, which includes information on prevalence, consequences, risk factors, prevention and response strategies [100]. Regardless of the importance of these initiatives as a first step to tackle this issue, these are not enough to address the discrepancies among European countries in the fight against elder abuse and safeguard the universal right to dignity and protection from abuse.

### ***Prevention***

The understanding of how and why elder abuse occurs is important for its prevention. Early recognition of warning signs in the ED and identification of elders at risk is key for early prevention, which is considered the best intervention [74]. To develop effective preventive programs it is essential to increase the understanding of its causes, and the ways to improve detection through training of all professionals involved.

### ***Training and awareness***

The increase of emergency personnel awareness through education is the best intervention [92]. Training can explore the complexities that surround elder abuse and thus facilitate its identification and management by emergency professionals. According to FIF, doctors are treating the victims of elder abuse, often without identifying it for what it really is [81]. The training of health care and social work professionals encourages them to report cases, thus becoming a major means of diminishing elder abuse [95]. It is worth noting that a US study on pre-hospital protocols on elder abuse identification concluded that the majority (60%) of the state wide EMS guidelines examined did not have any protocols on elder abuse, whereas almost 80% had protocols on child abuse [89]. In 2006, INPEA, in order to promote public awareness, chose June 15th to be the World Elder Abuse Awareness Day (WEAAD).

## **SECTION 4: Prehospital Emergency Care of Domestic Violence Victims**

*Jana Šeblová – Helen Askitopoulou*

In 2012, the American College of Emergency Physicians reaffirmed that domestic violence is a serious public health hazard that emergency medical services (EMS) personnel

will encounter [102]. Prehospital emergency personnel who initially assess ill and injured patients, often in their home environment, are uniquely positioned to identify, to report and to intervene for victims of domestic abuse and violence [102]. Also, while they provide acute care and transport, they may observe unusual or inappropriate interactions between the caregiver or family and the patient and detect an unsafe home environment.

### **EMS Detection and Recognition of Domestic Violence**

In the prehospital area, the detection and recognition of domestic violence begin at the level of medical dispatch during an emergency call. In such cases, while the trained call-takers and dispatchers activate the EMS team they should also communicate potential concerns to law enforcement personnel for the safety of both the potential victim and the rescue team. The dispatch centre should keep updated lists of specialised support and social services and telephone lines for the use of the victims of domestic violence. Subsequently, the archived records of the emergency call can serve as evidence for further investigations or judicial proceedings.

The presence of emergency medical staff on the scene is significant for the identification of potential victims and perpetrators in their domestic environment. EMS personnel may be particularly helpful in the detection of self-neglect or unsafe home environment, to which hospital-based personnel would not have access. They can use their access to patients' homes to screen older adults for mental health, environmental, and social problems, including elder abuse, while the transport in the ambulance can safely isolate the victim from the perpetrator [105]. EMS observations and concerns should be directly communicated to ED personnel, social workers, or relevant authorities for further investigation [104]. Ensuring that EMS concerns or suspicions are successfully relayed could be particularly important for these vulnerable patients. It is reported that such communication is reinforced by providing patient-related feedback to the EMS personnel afterwards [102].

### **Principles of Good Practice**

In prehospital emergency care, the basic principles of good practice in cases of domestic abuse and violence include [11]:

- specific protocols to guide the identification, initial assessment and management of all forms of domestic violence,

- protocols to handover and to communicate information to ED personnel and other authorities in a timely manner,
- accurate documentation of injuries and health problems, including the recorded emergency call, for use in legal proceedings,
- assessment of risk and safety planning,
- knowledge of supporting and contact social services, other relevant authorities and shelter facilities,
- practical education and training of the EMS personnel.

To provide effective care for victims of domestic abuse and violence, EMS personnel should use intervention protocols of proven efficacy, such as the S.I.G.N.A.L program that has been field tested in several European countries [104]. These protocols should also include provisions to optimise care and safety for patients who refuse transport as well as to manage potential hazards in the home environment [102].

Education of EMS personnel should encompass practical training in communication, crisis intervention, the evaluation and management of victims of domestic violence. The training should include recognition of victims of domestic abuse and violence in all its forms, risk assessment in individual cases, understanding of the patterns of abuse and how this affects care, scene safety, preservation of evidence, and documentation requirements. Training should also include the communication of such information without loss of critical issues during the handover between EMS and ED staff [102]. Core components of training to educate EMS personnel on the dynamics of domestic violence and how to speak non-judgmentally have been described. Also, a free online training on domestic violence of EMS personnel has been offered for use as part of ongoing education to enhance the EMS response to victims [103].

Emergency response and trauma systems are a critical health-services component of comprehensive approaches to violence prevention and management [7].



## SECTION 5. Risk Management

*Bernard Foëx*

### **Duty to the Victim**

*“Patients need good doctors. Good doctors make the care of their patients their first concern”*. So begins the UK GMC’s guidance on Professionalism in Action [106]. On this basis, the Emergency Physician’s duty to the victim of domestic violence should be no different to his/her duty to any patient presenting to the Emergency Department. Physical injuries should be managed as expertly as injuries caused in any other way. All health care professionals should have an awareness of the possibility of domestic violence (and also about non-physical forms of abuse) and have a duty to ask about the possibility. Emergency Departments should provide a safe and private environment for victims of domestic violence where appropriate treatment can be delivered and disclosure of what has happened is facilitated. ED personnel have a duty to provide information about support services and to refer the victims of domestic violence to appropriate support services if that is what the victim wishes.

In the UK, ED personnel should discuss with the victim the fact that domestic violence is a criminal offence and that it can be reported to the police (see Appendix for the legal requirements in other European countries). There may be circumstances (see below) when the crime needs to be reported, whether the victim wants to or not. ED personnel have a duty to check whether anyone else is at risk, such as children or dependent adults.

### **The Duty of Confidentiality and Duty to Report**

Confidentiality is a cornerstone of medical ethics and of the doctor-patient relationship. It comes under the umbrella of the principle of patient autonomy. It is also enshrined in the right to privacy under Article 8 of the European Convention on Human Rights [107]. Patients, even if they are victims of domestic violence still have a right to confidentiality. As competent adults, they have the right to make their own decisions in the matter of disclosure to the police or other agencies.

Health professionals must understand that reporting domestic violence may be a very difficult and sometimes dangerous process for the victim. Victims themselves should be able to decide for themselves if and when they report their domestic violence to the police or other

agencies. This will usually demand careful preparations to ensure the safety of the victim and any children or other dependents.

In the UK, the GMC in its recent guidance on *confidentiality* acknowledges that “Doctors have a duty of confidentiality to their patients, but they also have a wider duty to protect and promote the health of patients and the public” [108]. This has clear implications in the context of patients with infectious diseases or of patients who may present a risk to others by virtue of their illness or intoxication, for example, in relation to driving motor vehicles. The GMC guidance goes on to suggest that “You should ask for a patient’s consent to disclose information for the protection of others unless it is not safe or practicable to do so, or the information is required by law. You should consider any reasons given for refusal.” In the case of a patient who is the victim of domestic violence this guidance may be of limited value, especially if there is no one else at risk. The legal requirements for exceptions to the doctors’ duty of confidentiality in other European countries are shown in the Appendix.

## Reporting Domestic Violence

The management of a patient who presents with injuries due to domestic violence raises a number of legal and ethical issues for the physician regarding the legal responsibility to report the act of violence to law enforcement agencies [110]. In the following circumstances disclosure of personal information is permitted:

- With patient’s consent, which may be either implicit in relation to the patient’s direct medical care, such as the referral to a specialist team for management of injuries, or explicit.
- When a patient lacks capacity and disclosure is considered to be of overall benefit to the patient.
- When disclosure is required by law.
- When disclosure is in the public interest.

### ***Disclosure with the patient’s consent***

Patients should be encouraged to report incidents of domestic violence with the caveats discussed above. If they are unwilling to do so the doctor should establish whether the patient has the capacity to make a decision regarding disclosure (a Presumption of Capacity, under UK Law). If the patient does have the capacity and decides not to report the domestic violence then the doctor should find out the reasons for this decision and warn the

patient of the risks of not sharing this information, for example with social services or the police.

In Scotland and Wales, there is a legal requirement to disclose information about adults who are known or are considered to be at risk of, or have suffered, abuse or neglect, whether or not they have the capacity. This is not the case in England and other European countries (see Appendix).

### ***Disclosure about patients who lack capacity***

If a patient lacks capacity then disclosure of personal information may be justified if it is of overall benefit to the patient. In general, patients who lack capacity should be supported and encouraged to be involved in decisions regarding their care. When deciding what is of overall benefit for any patient who lacks capacity health professionals should take into account any known preferences and feelings of the patient and adopt a course of action that is least restrictive of the patient's rights and freedom of action.

### ***Disclosure required by law***

There may be specific situations where the law requires a breach of confidentiality, to report specific conditions to local authorities for further action for patient and community safety. Knowledge of mandatory reporting laws is integral to the practice of emergency medicine and part of the multitasking role required of emergency physicians [111]. For example reporting of communicable diseases, loss of fitness to drive, or motor vehicle accidents is required in the UK. In Scotland and Wales, there is a legal requirement to disclose information about adults who are known or are considered to be at risk of, or have suffered, abuse or neglect, whether or not they have capacity. The legal requirements for mandatory reporting in other European countries are shown in the Appendix.

### ***Disclosure in the public interest***

The exceptions to the duty of confidentiality are:

- when children are at risk,
- when the public is at risk,
- when a serious offence has been committed.

Some of these may apply in the case of domestic violence. In some cases, there will be no general risk to the public. The risk may be to the one victim, but the risk may be of

escalating violence. Child abuse and elder abuse mandatory reporting laws are intended to protect the safety of a vulnerable population and notions of confidentiality and informed consent may not be an issue. In addition, critics point out that most child abuse is neglect from underprivileged families without resources and may not reflect negligent or ill-intended guardians [111].

In the UK, the GMC has offered guidelines on the reporting of gunshot and knife crimes. This guidance concludes that the police should usually be informed of patients presenting with gunshot wounds [109]. The guidance suggests the same for knife wounds but acknowledges that *“There may ... be other circumstances in which you consider that contacting the police is not proportionate. For example, this might be the case if you consider that no one other than the patient is at risk of harm and that contacting the police might cause the patient harm or distress, or might damage their trust in you or in doctors generally.”* This may be particularly pertinent in the case of domestic violence. The key principle should be that any breach of confidentiality should be proportionate. The legal requirements for exceptions to the duty of confidentiality in other European countries are shown in the Appendix.

### **Duty to Report and Confidentiality in the Case of the *Perpetrator of Domestic Violence***

The situation will be rather different if the patient is the perpetrator of domestic violence. In principle, this patient is owed the same duty of confidentiality. However, maintaining confidentiality is likely to leave others at risk of future harm. Reporting the perpetrator of domestic violence is likely to fall into the category of “disclosure in the public interest”, where:

- failure to disclose information may put someone other than the patient at risk of death or serious harm, however, the physician should not usually disclose information against the wishes of an adult patient who has capacity if the patient is the only person at risk of harm,
- disclosure is likely to help in the prevention, detection or prosecution of a serious crime.

As stated above the key principle is that any breach of confidentiality should be proportionate.

## SECTION 6: Education and Training of ED Personnel

*Marc Sabbe*

When encountering domestic violence, it is very important, besides the initial detection, also to take the right actions, as violence may have long-lasting physical and psychological negative effects. Emergency Physicians are central to the identification, support and referral of victims of domestic violence. In the UK, the National Institute for Health and Care Excellence in 2014 recommended that training in domestic violence and abuse should be part of the medical undergraduate curriculum [9]. However, there is considerable variation in what education medical students receive on domestic violence in the UK, USA, Canada and Australia [118]. Teaching about abuse and violence is often not included in undergraduate medical curricula or is inadequately covered [118]. In 2013, the WHO landmark guidelines made recommendations that in-service training in interpersonal violence and sexual assault should be implemented in primary healthcare education [123, 125]. The need for sufficient training of students and residents in all specialities was recognised in the early 2000s [115]. During the past decade, there has been increased interest in providing training for healthcare practitioners in order to improve their ability to identify and respond to abuse [128]. The American College of Emergency Physicians has recommended that besides medical schools, emergency medical services and emergency medicine residency curricula should include education and training in the recognition, assessment, and evidence-based interventions in cases of child maltreatment, intimate partner violence, elder abuse and neglect [48]. In Europe, better education of doctors in how to respond to domestic abuse and violence is needed. Additionally, training specifically for ED personnel is needed.

### **Training on Awareness of Violence**

The ability of emergency personnel to be aware of and recognise domestic violence and abuse depends on education and training. The main benefit of training is an increased willingness of staff to ask relevant questions about abuse in a way that makes it easier for the victim to disclose it [2, 9]. The learning objectives of training programmes should include at least the situations in which violence should be suspected and how to deliver appropriate first-line support for the victims [123]. There should be a focus on knowledge, but also on the skills to investigate and respond appropriately, while ensuring the safety and confidentiality of victims [116]. According to a systematic review, training programmes that improved

knowledge, attitudes and clinical competence in dealing with child abuse included the involvement of specialist domestic violence practitioners and interactive discussion [122, 124].

As ED personnel always work in teams, training of physicians, nurses and other staff should preferably be integrated into a multidisciplinary educational programme, while additional training for team leaders should be recommended. Child abuse, IPV and elder abuse should be addressed in the same educational program [123, 128]. The use of booster sessions, follow-up and supervision after the training is also important, as brief educational sessions only improve knowledge but do not influence behaviour towards domestic violence [114, 121, 123, 124, 128].

### **Education on how to Identify and Support Victims**

Evidence exists that training in domestic violence, alongside other changes in the system of care, may be beneficial in improving the identification, and possibly even the outcomes, for the victims of violence [125]. The main issues to which the ED personnel should have structured training are [54, 116]:

- how to identify victims of domestic violence,
- how to investigate and respond appropriately,
- how to ensure the safety and confidentiality of the victims,
- how to support the victims,
- awareness of available resources and whom to consult for further care and referrals.

Identification of victims of violence starts with asking patients about violence and abuse. A positive answer mandates an appropriate response. One of the many barriers for healthcare providers to ask about or screen for violence in the emergency department is a lack of knowledge of appropriate care after identification [112, 125]. In this respect, the training for ED personnel should include all aspects of the response to abuse, including documentation, intervention and referral [123, 128]. The inclusion of a specific protocol and access to resources for patients and/or healthcare providers in training also proves to be more effective [122, 124,]. In a systematic review comparing six studies on child abuse, the use of a standardised checklist proved to be an effective aid in consideration and documentation of non-accidental injury [117]. Decisional flowcharts for suspected physical abuse had the same effect, increasing documentation of non-accidental physical injury by 69.5% [117]

Training should also be focused on empathetic listening, gaining rapport, understanding and validating the feelings of victims, helping them to feel comfortable in discussing abuse and knowing when and how to ask about violence [116]. Communicational and clinical skills in identification are extremely important, as victims often present with vague and rather indistinct symptoms, such as psychological conditions [119, 127]. Addressing the possibility of interpersonal violence and exploring emotions and possible readiness for change is often difficult and intimidating for inexperienced healthcare personnel, so they should be well-trained. An important aspect that should be addressed in training concerns the trainee's beliefs and emotions about abuse and violence, as these may interfere with the ability to ask questions and support victims of abuse [112, 120].

### **Training Levels & Strategies on Domestic Violence**

EDs should set up initial and on-going training on the dynamics of domestic violence and abuse to increase ED personnel knowledge, attitudes and clinical competence in dealing with all forms of domestic violence. The different levels of training for the different groups of professionals, recommended by the NICE guidelines, can be adapted to the training of ED staff [9].

- **Level 1:** ED frontline staff, like receptionists, should be trained online or by distance learning to respond to a disclosure of domestic violence and abuse sensitively and in a way that ensures people's safety.
- **Level 2:** ED personnel, like ambulance staff, emergency nurses and emergency physicians should be retrained during continuing professional development to ask about domestic violence and abuse, to be able to assess the victim's immediate safety and to offer referral to specialist services.
- **Level 3:** ED staff, like social workers, should be trained to provide an initial response that includes risk identification and assessment, safety planning, referrals to specialist support services and aid to the police investigation.
- **Level 4:** Domestic violence advocates, counsellors or support workers should be trained to give expert advice and support to victims of domestic violence and abuse.
- **Level 5:** Emergency medicine trainees should be trained before qualification in the identification and assessment of all forms of domestic violence and abuse.

It is difficult to determine the most effective educational strategy, as the educational interventions and the outcome measures vary among studies. The use of modern interactive techniques can be very helpful in training, but whilst the use of computers, videos, etc. might have a positive impact, there is no real evidence suggesting that the success of education depends on these elements [123]. Several studies have found a correlation between the use of an online component in training and the impact on the knowledge of trainees [122, 128]. A recent systematic review has demonstrated that experiential learning in interactive workshops had a positive effect on attitudes and behaviour towards domestic abuse by physicians [128]. In addition, training interventions may use a wide variety of interactive techniques, such as role-playing, group discussions and simulations, among others [116]. However, the literature remains inconclusive about the best approach to education for healthcare practitioners in domestic abuse, and most studies vary widely in the educational approach used and the measured outcome. It is clear that more research is needed to gain more insight into the optimal duration and methods of training [115, 122].

## **Disclaimers**

The EuSEM Ethics Committee recognises that the individual circumstances, the facilities of Emergency Departments and the availability of staff all vary considerably across Europe and these recommendations cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and well-being resides with the treating clinician.

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## Appendix. Legislation regarding domestic violence and abuse in Europe<sup>1</sup>

<i>EUSEM Countries</i>	<b>Physician's duty to the victim to report offence to the police</b>	<b>Victim's consent for the physician's breach of the duty of confidentiality in relation to domestic abuse &amp; violence</b>	<b>Mandatory reporting laws about adults at risk of, or who have suffered, abuse or neglect</b>	<b>Council of Europe 2011 Treaty on preventing and combating violence against women</b>
Albania	<b>YES</b>	<b>NO</b>	<i>NO, but there are internal protocols that mandate reporting</i>	<i>Signed and ratified</i>
Austria	<b>YES</b>	<b>NO</b>	<i>NO, does not exist in Austria</i>	<i>Signed and ratified</i>
Belgium	<i>NO, if the victim is adult, obligatory if it is child abuse or neglect</i>	<i>YES, in case of a patient able to give consent himself</i>	<b>NO</b>	<i>Signed and ratified</i>
Bulgaria	<i>YES, the physician in duty must report to police in all cases of violence or physical injury to children and in cases with damage for adults</i>	<i>YES, in case that the patient is able to give consent himself</i>	<i>NO, the introduction of such legislative act is in the process of public discussion by the end of 2018</i>	<i>Signed, NOT ratified</i>
Czech Republic	<i>NO, if the victim is adult Obligatory if it is a child abuse or neglect</i>	<i>YES, victim's consent is mandatory, with the exception of murder or attempt or severe injury (obligatory reported criminal acts in respective legislation)</i>	<i>NO, no similar laws in CR</i>	<i>Signed, NOT ratified</i>
Croatia	<i>YES, the physician in duty must report to police, in all cases of violence or physical injury to children and adults</i>	<b>NO</b>	<i>YES, law on protection of domestic violence</i>	<i>Signed, NOT ratified</i>
Denmark	<i>NO, any suspicion of child abuse and/or maltreatment shall be reported to the social authorities</i>	<i>YES, with the exception of severe crime, ie murder or attempt, violence with severe injuries,</i>	<b>NO</b>	<i>Signed and ratified</i>

<sup>1</sup> According to the answers of the national representatives

		<p><i>sexual abuse or any violence against children.</i></p> <p><i>However, also in case of severe crime it should be attempted to get victims consent first</i></p>		
Estonia	NA <sup>2</sup>	NA	NA	Signed and ratified
Finland	NA	NA	NA	Signed and ratified
France	<p><b>NO</b>, if it is an adult who is victim of violence. The physician must ask to the patient if he/she is OK to warn the police officer. <b>YES</b>, if it is a child (&lt; 18 yrs).</p>	<b>YES</b>	<b>NO</b>	Signed and ratified
Georgia	NA	NA	NA	Signed and ratified
Germany	<p><b>NO</b>, if the victim is adult capable of expressing his/her will</p> <p><b>Yes</b>, (in severe cases) if the victim is underage</p>	<p><b>YES</b>, the victim's consent is mandatory, with the <b>EXCEPTIONS</b> of</p> <p>a) underage persons</p> <p>b) adults in very severe cases with danger of recurrence</p>	<p><b>NO</b>, mandatory reporting laws, to protect the victim's will not to disclose</p>	Signed and ratified
Greece	<p><b>NO</b>, obligation for the physician in the relevant laws, (Yes for teachers for child abuse)</p>	<p><b>YES</b>, for testimony before a civil court,</p> <p><b>NO</b>, for testimony before a criminal court</p>	<p><b>YES</b>, acts of domestic violence are prosecuted <i>ex officio</i>, regardless of complaints by the victims</p>	Signed, <b>NOT</b> ratified
Hungary	<p><b>NO</b>, obligation by law for the physician to report to the police</p>	<p><b>YES</b>, except in those cases, when the police / district attorney / criminal judge requests the physician's opinion / testimony</p>	<p><b>NO</b>, if this event does not threaten the victim's life and the victim's movement is not restricted by the perpetrator</p>	Signed, <b>NOT</b> ratified
Iceland	NA	NA	NA	Signed, <b>NOT</b> ratified
Ireland	<b>NO</b>	<b>YES</b>	<b>NO</b>	Signed, <b>NOT</b>

<sup>2</sup> NA = not answered

				<i>ratified</i>
Israel	NA	NA	NA	Signed, NOT ratified
Italy	<b>YES</b> , the physician in duty must report Justice Authority (police, Carabinieri or the Judge directly) in all cases of violence or physical injury to children and adults. In adults there is "ex officio prosecution" if prognosis is >21 days, otherwise only upon lawsuit by the victim. For children is always ex officio	<b>NO</b> , for Justice authority report. In this case is considered as a transmission of "professional secret" that both are obliged to keep confidential <b>YES</b> , for all other stakeholders like social workers or psychologists. <b>YES</b> , for any other person	<b>NO</b> , the introduction of such legislative act is in discussion.  In each region there is an activity specific on that with protocols of intent with justice authority	Signed and ratified
Latvia	NA	NA	NA	Signed, NOT ratified
Lithuania	NA	NA	NA	Signed, NOT ratified
Malta	<b>YES</b> , if the injury is grievous	<b>YES</b> , but may be over-ridden if the injury is grievous if the victim refuses to give consent	<b>NO</b>	Signed and ratified
Netherlands	<b>Yes</b> , only if risk of severe injuries or death	<b>Yes</b> , adults must give consent  <b>NO</b> , consent needed for children	<b>NO</b>	Signed and ratified
Norway	NA	NA	NA	Signed, NOT ratified
Poland	NA	NA	NA	Signed and ratified
Portugal	NA	NA	NA	Signed and ratified
Romania	NA	NA	NA	Signed and ratified
Serbia	NA	NA	NA	Signed and ratified
Slovakia	<b>YES</b> , health care providers should report to the police, prosecution office and office of labour, social affairs and family	<b>NO</b>	<b>YES</b> , for adults with reduced capacity	Signed, NOT ratified
Spain	<b>YES</b> , if suspected a	<b>YES</b>	<b>YES</b>	Signed and

	<i>criminal act</i>			<i>ratified</i>
Sweden	<b>Yes</b> , if the suspected crime will be punished with more than 2 years in prison	<b>No</b> , If suspected crime might give more than 2 years in prison we have to report, if not, we are not allowed	<b>No</b>	Signed and ratified
Switzerland	<b>YES</b> , if life-threatening	<b>YES</b> , with the exception of murder or attempt, or severe injury	<b>NO</b>	Signed and ratified
Turkey	<b>YES</b> , the physician in duty must report to law enforcement in all cases of violence or physical injury to children and adults.	<b>NO</b> , victim's consent is not required for notification to law enforcement officials	<b>YES</b>	Signed and ratified
UK	<b>YES</b> , in relation to gunshot and knife injuries	<b>Yes</b>	<b>YES</b> , in Scotland and Wales, <b>NO</b> , in England	Signed, <b>NOT</b> ratified, no entry into force