



# The College of Emergency Medicine

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## CLINICAL EFFECTIVENESS COMMITTEE

# Guideline for the recognition and management of domestic violence in Emergency Departments

### Summary of recommendations

1. There should be written information about local domestic abuse services available in the emergency department. Posters in the waiting room and leaflets in the women's toilets may encourage disclosure. Level 5 evidence
2. There is insufficient evidence to advocate screening all women for domestic abuse, but clinicians should be prepared to ask simple direct questions, if there is any clinical suspicion. Level 2 evidence
3. Any concerns about child welfare should lead to the prompt activation of local child protection services. Level 5 evidence
4. Emergency Department medical and nursing staff should undergo domestic violence training. Level 4 evidence
5. A representative from the emergency department should attend local Multi-Agency Risk Assessment Conferences (MARACs). Level 3 Evidence
6. The contact details of the MARAC co-ordinator and the local independent Domestic Violence co-ordinator should be available to all emergency department staff. Level 5 evidence

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## **Scope**

This guideline is to assist clinicians caring for adult patients in emergency departments who have suffered or are continuing to suffer domestic abuse.

## **Reason for development**

To improve patient care.

## **Definition**

The Department of Health has provided a widely accepted definition of domestic abuse. 'Domestic violence refers to a wide range of physical, sexual, emotional and financial abuse between partners / ex-partners – whether or not they are co-habiting.' Both men and women can suffer abuse, though more women suffer abuse and this tends to be more severe. The terms 'Domestic abuse' and 'Domestic Violence' are used interchangeably. Though emergency physicians tend to focus on physical assault as the most obvious manifestation of abuse, the majority of abused patients report greater morbidity from the sexual and emotional abuse.

## **Health Consequences of Domestic Abuse**

There are significant and strong associations between domestic abuse and many illnesses, notably psychiatric complaints; depression, self-harm and drug and alcohol misuse. Other strong associations exist with termination of pregnancy, sexually transmitted diseases and medically unexplained symptoms.

## **Recognition of Domestic Abuse**

Domestic abuse is frequently not disclosed, it is estimated that a woman will suffer 20 assaults before disclosure. Opportunities for **confidential** disclosure should be considered. Posters in the waiting room and leaflets in the women's toilets may encourage disclosure and should be encouraged. Most women will not disclose abuse unless directly asked. Simple, direct questions such as 'We know violence at home is a problem for many people, is there someone who is hurting you at home?' are usually acceptable and effective. There is insufficient evidence to advocate screening all women for domestic abuse, but clinicians should be prepared to ask if there is any clinical suspicion.

## **The role of the emergency department**

Up to 12% of emergency department attendances are due to domestic violence and 30% of domestic abuse commences during pregnancy. Emergency department staff are often in a good position to identify cases.

## **What to do when a patient discloses domestic abuse**

The patient should be believed. Enquiry about the extent and severity of the abuse should be made in a non-judgemental manner. An assessment should be made of the victim's immediate safety. Specific inquiry should identify whether there are any children living with the victim or perpetrator. Injuries, if present, should be photographed. If an Independent Domestic Violence Advocate (IDVA) is available immediately then they will make adequate records, but if not, as much information as possible should be recorded at the time of disclosure.

Contact with the police and outside agencies should be offered from the safety of the emergency department. Information about local shelters and support agencies should be available in written form and handed to the patient.

Failure to involve outside help is common and may frustrate medical and nursing staff, who believe that there has to be immediate action to be effective. This is not true. Victims leave an abusive relationship when they feel ready, not when medical staff feel they should.

The risks to children growing up in an abusive household are greatly increased. Any concerns about child welfare should lead to the prompt activation of local child safeguarding procedures.

### **Training**

Emergency Department medical and nursing staff should undergo domestic violence training. These are usually organised by the Community Safety Department of the local council. The main benefit of training is an increased willingness to ask about domestic abuse.

### **Multi Agency Risk Assessment Conferences**

Multi Agency Risk Assessment Conferences (MARACS) reduce the risk of serious harm or homicide for a victim of domestic abuse. (Level 4 evidence) These are usually chaired by the Police, organised by the MARAC Coordinator and attended by the local independent domestic violence advocate (IDVA) service, Social Services, Housing representatives, Probation, Education, Mental Health, drug and alcohol services, health representatives and Children and Family Court Advisory and Support Services (CAFCASS) Neither the victim or the perpetrator attend the MARAC.

A senior, experienced representative from the Emergency Department should attend the MARAC; Data about a victim can be shared at the MARAC under the Data Protection Act, the Human Rights Act and Caldicott Guidelines.

Data about the perpetrator's emergency department attendances is often requested; the decision to share this data should be made on a case by case basis and should be based on an assessment of whether there is likely to be a serious arrestable offence. This is nearly always the case. If a decision is made to share data about a perpetrator, then a record of this should be kept separate from the perpetrator's notes e.g. by filing the MARAC notes, circulated post meeting by the MARAC coordinator. A MARAC Toolkit for emergency departments can be found on the co-ordinated action against domestic abuse website:

[http://www.caada.org.uk/practitioner\\_resources/TOOLKIT - A&E final version 09.pdf](http://www.caada.org.uk/practitioner_resources/TOOLKIT - A&E final version 09.pdf)

## REFERENCES:

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- 2) Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. *BMJ* 2002; 325(7359):314.
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**Review**

Usually within three years or sooner if important information becomes available.

**Disclaimers**

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline 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 wellbeing resides with the treating clinician.

**Research Recommendations**

None identified.

**Audit standards**

There should be a documentation and audit system in place within a system of clinical governance.

**Key words for search**

Domestic abuse, Domestic Violence, MARAC

## **Appendix 1**

### **Methodology**

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

### **Evidence Levels**

1. Evidence from at least one systematic review of multiple well designed randomised control trials
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting
3. Evidence from well designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies
4. Evidence from well designed non experimental studies from more than one centre or research group
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.