PUBLIC
RESOURCE GUIDE

Breaking the Silence™

Addressing Domestic Violence, Elder Abuse, and Neglect

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NO MORE

NPHI National Partnership for Healthcare and Hospice Innovation

About NPHI

The National Partnership for Healthcare and Hospice Innovation (NPHI) is a membership organization comprising 100+ not-for-profit, mission-driven hospice and palliative care providers. These members are dedicated to ensuring patients and their families have access to care that reflects their individual goals, values, and preferences. Representing providers from across the entire nation, NPHI and its members help design more innovative and effective models of care, advocate for comprehensive and community-integrated care customized to meet each person's unique needs, and build collaboration between national thought leaders, decision-makers, and other healthcare stakeholders to improve end-of-life care.

Learn more at **hospiceinnovations.org**.

About NO MORE

The NO MORE Foundation ("NO MORE") is dedicated to ending domestic and sexual violence by increasing awareness, inspiring action and fueling culture change. With more than 1,500 allied organizations and state, local, and international chapters, NO MORE sparks grassroots activism, encouraging everyone—women and men, youth and adults, from all walks of life—to be part of the solution. The Foundation creates and provides public awareness campaigns, educational resources and community organizing tools free of charge for anyone wanting to stop and prevent violence. First launched in 2013, NO MORE has brought together the largest coalition of advocacy groups, service providers, governmental agencies, major corporations, universities, communities and individuals, all under a common brand and a unifying symbol in support of a world free of violence.

Learn more at **NOMORE.org**

NPHI National Partnership for Healthcare and Hospice Innovation

NO MORE
TOGETHER WE CAN END DOMESTIC VIOLENCE & SEXUAL ASSAULT

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Key Abbreviations

Caregiver **(CG)**

Care Recipient **(CR)**

Domestic Violence **(DV)**

Elder Abuse **(EA)**

Neglect **(N)**

Social Determinants of Health **(SDOH)**

Social Isolation and Loneliness **(SIL)**

Addressing Domestic Violence, Elder Abuse, and Neglect

Cameron Muir, MD, FAAHPM
Chief Innovation Officer, NPHI

NPHI is committed to supporting our member programs to provide the highest quality care to patients and supporting their loved ones. While the COVID pandemic has highlighted the significant quality and safety benefits of caring for people living with advanced illness in their own place of residence, it has also brought more awareness and attention to the unique considerations of care in the home.

One of the emerging areas of great concern is what has been referred to as the "epidemic" of domestic violence (DV) and elder abuse/neglect (EA/N). Previously underappreciated and underreported, with more focus on care in the home, as well as increased education and awareness, cases of DV and EA/N have been found to be disturbingly frequent, and yet, still grossly underreported. In addition, there is a correlation between lower caregiver (CG) education as well as lower care recipient (CR) income with increased frequency of elder abuse and neglect. Thus, making NPHI's focus on social determinants of health (SDOH) and our broader Health Equity work even more integral to this issue.

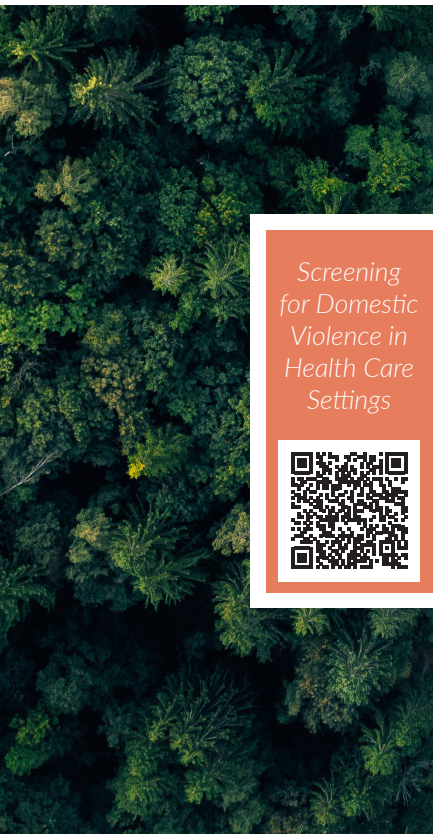
Finally, an additional area of focus for NPHI is on social isolation and loneliness (SIL), which can be an important element of elder abuse and neglect. Each of these related and overlapping areas (DV, EA/N, Health disparities, and SIL) have been demonstrated to contribute to increased health care costs and decreased quality. Furthermore, while often DV and EA/N are considered separately, it might be useful and important to consider them as almost a continuum from DV in "women of childbearing age" through to EA/N in the important population beyond childbearing age. Not only are the sociodemographic data similar for both the victim and the perpetrator, but as people live, these often sequential, multiple traumas can become both a pattern as well as a compounding of the traumatic injury (either physical and/or emotional) making both the identification, treatment and support significantly more important AND complex.

There has emerged in recent years, consensus that the key to addressing both DV and EA/N involves, at least in part, screening of the person. Screening, however, can be particularly challenging for a myriad of reasons. For example, screening is difficult in people who are cognitively impaired due to dementia and other neuro-degenerative conditions. Thus, every effort to address these issues will help NPHI members to drive value (higher quality and lower costs) in each of their communities – especially for an aging population with increasing incidence of dementia and other neurodegenerative illnesses. There is evolving research and evidence that can help to guide us toward better, and even best, practices.

Center for Disease Control: Intimate Partner Violence

A Silent Epidemic

The CDC estimates the incidence of domestic violence (DV) is disturbingly high with more than 1 in 3 (33%) women and 1 in 4 (25%) men experiencing sexual assault, physical violence and/or stalking by an intimate partner. Furthermore, they estimate that 1 in 10 (10%) women have been sexually assaulted by an intimate partner and 1 in 4 (24.3%) have been physically assaulted, and even more chilling, in 2010, 1,095 women were murdered by an intimate partner. Furthermore, the financial cost of DV in 2003 alone for medical and mental health services and lost productivity was estimated to be approximately $8.3 billion dollars.



Screening for Domestic Violence in Health Care Settings

The magnitude of the DV public health crisis resulted in a policy brief to US HHS, based in large part on a review of the research released by the Institute of Medicine in 2011, "Clinical Preventive Services for Women: Closing the Gaps" and led to the 2013 report of the US Preventive Services Task Force (USPSTF) which called for clinicians to "screen women of childbearing age for intimate partner violence". In addition, as people age and become more frail and often dependent, the risk of elder abuse and neglect (EA/N) can become equally as problematic. The importance of health care workers being front line and often in private conversations with both patients and caregivers allows for the healthcare setting to be particularly helpful in identifying DV and EA/N. But there is clear evidence that more education and appropriate screening is needed.

Definitions and Prevalence of Elder Abuse

Definitions of 'Elder Abuse' and 'Abuse in Later Life' vary widely, hindering efforts by policy makers, researchers and practitioners to describe the extent of the problem and enact a coordinated response. For instance, VAW Net (NRCDV) describe Abuse in Later Life as the intersection of domestic violence, sexual abuse, and elder abuse, while The National Center on Elder Abuse highlights 'neglect and financial exploitation' as being key characteristics.

Furthermore, there is a discrepancy in age criteria among organizations. The National Clearinghouse on Abuse in Later Life (NCALL) defines abuse in later life relating to those over 50, while the National Institute on Aging states it is suffered by those over the age of 60. Disparities in definitions and data collection risks some survivors of elder abuse to exist in the margins between definitions, and remain invisible.

This resource adopts a specific stance for clarity and focus:

- We align with The Elder Justice Act's classification of an 'elder' as anyone aged 60 or older.
- Our discussion is guided by The World Health Organization's comprehensive definition of elder abuse:

  "The abuse of older people, also known as elder abuse, comprises a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person."

In the US, Elder Abuse, including neglect and exploitation, is experienced by about 10% of people aged 60 and older who live at home – though current estimates suggest that only 6% of cases are ever reported.

From 2002 to 2016, more than 643,000 older American adults were treated in the emergency department for nonfatal assaults and over 19,000 homicides occurred. Up to five million older Americans are abused every year, and the annual loss by victims of financial abuse is estimated to be at least $36.5 billion.

Nursing Home Abuse Guide Website

About Abuse of Older Persons

Get the Facts on Elder Abuse

World Health Organization

"Even if the proportion of victims of abuse of older people remains constant, the global number of victims will increase rapidly due to population ageing, growing to some 320 million victims by 2050." (World Health Organization)

Types of Abuse

Physical Abuse

Is the intentional use of physical harm or physical coercion that may result in bodily injury, physical pain, or impairment. Under the Older Americans Act, "physical harm" means bodily injury, impairment, or disease. Examples include:

- Hitting, beating, pushing, shaking, slapping, kicking, pinching, strangling, and burning;
- Throwing objects and furniture at the victim;
- Using unlawful, excessive, or unnecessary use of force like restraints, like tying the victim to a chair, locking them in a room or force-feeding;
- Over-medication or under-medication;
- With-holding medication or failing to get necessary health support.

Sexual Abuse

Is non-consensual sexual contact of any kind with an older adult. Examples include:

- Unwanted touching, sexual assault or battery, sexual harassment;
- Sexual interaction with elders who lack the capacity to give consent (rape);
- Forcing victim to watch sexual acts.

Emotional/Psychological Abuse

Is the infliction of anguish, pain, or distress through verbal or nonverbal acts.

Examples include:

- Verbal assaults, insults, threats, intimidation, humiliation, isolation, and harassment;
- Repeatedly ignoring the victim;
- Ridiculing cultural or personal beliefs;
- Treating an older person like an infant;
- Isolating an older person from their family, friends, or regular activities; and
- Blaming the older adult for everything that goes wrong.

Neglect

Is the refusal or failure of a caregiver to fulfill any part of a person's obligations or duties of care to an older person. The Elder Justice Act defines neglect as “the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder".

Examples include:

- Failing to provide for life necessities such as food, water, clothing, shelter, and medicine;
- Withholding access to healthcare, or not organizing appointments;
- Not assisting with personal hygiene, e.g. washing, wearing clean clothes etc.

Financial Abuse

Is the illegal, unauthorized, or improper use of an older person's resources for monetary or personal benefit, profit, or gain, or that results in depriving an older person of rightful access to, or use of, benefits, resources, belongings, or assets.

Examples include:

- Misusing or stealing an older person's money or possessions;
- Coercing or deceiving an older person into signing any document such as a contract or will;
- Improper use of conservatorship, guardianship, or power of attorney;
- Forging the victim's signature, cashing their checks without permission, taking benefits, changing names on will, insurance policy, deeds to house;
- Ignoring or avoiding an older adult's financial responsibilities, such as paying rent or mortgage, medical expenses or insurance, utility bills, or property taxes;
- Health care fraud: a form of financial abuse committed by health care providers, hospital staff, or other health care workers. It includes intentionally overcharging, billing twice for the same service, charging for care that wasn't provided, or falsifying Medicaid or Medicare claims.

Advice on where to report Financial Abuse can be found here:
https://www.justice.gov/elderjustice/find-help-or-report-abuse

Where to report Financial Abuse

National Elder Fraud Hotline
1-833-FRAUD-11 (833-372-8311)
10 a.m. - 6 p.m. Eastern Time
Monday - Friday

Abandonment

Is the desertion of an older person by an individual who has assumed responsibility for providing care for them, or who has physical custody of them. It can take place in hospital, in a nursing home, or other public place.

Some state statutes classify abandonment as a separate and unique form of elder abuse, whereas others categorize elder abandonment as a type of elder neglect.

Technology Abuse

Is also known as technology-facilitated abuse (TFA) or digital abuse, and refers to the misuse of technology to control, harass, intimidate, stalk, or harm an elder. *This behavior is often a form of verbal or emotional abuse conducted online* (NRCDV).

Examples include:

Taking advantage of the victim's lack of knowledge of technology:

- Abusing the victim for not responding to emails, calls, or texts, and/or not quickly enough;
- Ridiculing the victim's use of technology;
- Denying the victim access to online accounts.

Using technology to steal or deceive:

- Tracking or manipulating the victim's online bank accounts;
- Using technology to defraud the victim of assets, titles, or properties;
- Forcing the victim to make unwanted online purchases;
- Impersonating the victim online, by creating a social media account using the victim's name without his or her consent;
- Posting photos or stories of victim online without his or her consent.

Using Technology to scare and confuse the victim:

- Sending the victim disturbing or offensive information or website links;
- Making threats via email, text messages and social media;
- Changing settings on room temperature, making a computer talk or make sounds;
- Secretly changing the victim's device settings.

Using Technology to monitor and stalk the victim:

- Using spyware to track computer activity and/or to track the victim's location via GPS;
- Constantly contacts victim by calling or texting repeatedly or sending unwanted messages.

Using Technology to isolate the victim, compromising their safety and independence:

- Cutting off or limiting the victim's technology use and access;
- Making the victim feel stupid and incapable of understanding technology to limit their use;
- Controlling what the victim does and who he or she may contact online;
- Using technology to discredit the victim;
- Withholding, removing, or damaging technology or assistive devices;
- Misleading others (family, friends, caregivers, etc.) about victim's well-being by sending emails from the victim's account to suggest that everything is fine or intercepting the victim's email to keep him or her from telling friends or family about the abuse or from seeking help;
- Making all the decisions about technology;
- Using the age of the victim as an excuse for controlling or limiting access to technology;
- Withholding access to victim's online healthcare information.

See Tech Safety and Older Adults for further information (Download).

Tech Safety and Older Adults

Stalking

National Clearinghouse on Abuse in Later Life

Almost 30% of all stalking victims are aged 50 or older (National Clearinghouse on Abuse in Later Life (NCALL)). NCALL describe stalking as:

"A pattern of repeated, unwanted attention, harassment, and contact directed at a specific person that would cause a reasonable person to feel fear for their safety or the safety of others or suffer substantial emotional distress". Stalking behaviours include:

- Following or watching the victim in person;
- Using hidden cameras to watch and track the older person;
- Making unwanted appearances at locations where the older person regularly visits, like community halls, faith centers or health facilities;
- Constantly sending gifts, cards or notes which are unwanted and unrequested;
- Filing change of address forms to intercept the older person's mail.

See Stalking in Later Life for further information (Download).

Stalking in Later Life

Who Abuses?

Perpetrators of elder abuse have diverse nationalities, faiths, income levels, sexual orientations, and genders.

Family

Elder abuse is frequently caused by those known to, and trusted by older adults, such as children, spouses, partners, and other family members. The older victim often protects their relative rather than focusing on their own personal safety, and they may feel shame, guilt, and embarrassment because they are being abused by a family member.

Current or former intimate partners

An individual might have suffered years of abuse at the hands of their partner, which is continuing into the 'elder' phase of their relationship (i.e., over 60), or the person may marry in their 60s+ and find themselves with an abusive spouse. Alternatively, a former partner could be stalking the older person, or using technology to scare and disturb them.

Staff in Nursing Homes, Hospices, Assisted Living, and other facilities (non-relative caregivers)

Unfortunately, those who are paid to provide care, sometimes become abusers of their elderly patients. A 2020 study by The World Health Organization found that 66% of nursing home staff members admitted to abusing residents in the past year.

An example of abuse in a hospice would be a care aide who forms a close, personal bond or even a fabricated romantic relationship with the terminally ill patient with the explicit purpose of gaining control of their finances. Patients with dementia are especially vulnerable to this form of abuse. (Nursing Home Abuse Center)

Nursing Home Abuse Center

Strangers

An older person could suffer sexual assault or stalking perpetrated by a stranger.

Risk and Protective Factors

Common Characteristics and Risk Factors of Abusers

Although having a substance abuse issue or being abused in the past are common characteristics of elder abusers, they are not the reason for the abuse. Abusers choose to behave the way they do and are typically in complete control of their actions. The Centers for Disease Control and Prevention (CDC) has identified further factors that can contribute to the risk of becoming a perpetrator of elder abuse:

- Current physical or mental health problem.
- Experience of disruptive behavior or traumatic events.
- High levels of stress.
- Poor or inadequate preparation or training for caregiving responsibilities.
- Inadequate coping skills.
- Exposure to or witnessing abuse as a child.
- Social isolation.
- High financial and emotional dependence upon a vulnerable elder.
- Past family conflict.
- Lack of social support.
- Staffing problems and lack of qualified staff, and
- Staff burnout and stressful working conditions.

Common Characteristics and Risk Factors of Victims

Like abusers, victims of elder abuse are from diverse backgrounds, nationalities, faiths, income levels, sexual orientations, and genders. Some groups, however, suffer a higher rate of abuse than others:

- Elderly women are more likely to suffer from abuse than men, according to the National Institutes of Health (NIH) and the National Center on Elder Abuse (NCEA).

  This may be because women live longer than men, and the older a person is, the greater risk they have of becoming a victim. Additionally, more women are senior citizens than men, and women are more likely to be widowed than men (senior citizens who don't have a spouse are more likely to be victimised). Women are also targeted because they are seen as frailer, weaker, and more vulnerable than elderly men.

  The types of elder abuse experienced includes:

  - Physical abuse (71.4%)
  - Emotional abuse (76.3%)
  - Financial abuse (63%)
  - Neglect (60%)

- Veterans are also more likely to be victims, especially if they suffer from illnesses like PTSD which renders them more vulnerable.

Elder Abuse Statistics

Abuse in Later Life

The National Clearinghouse on Abuse in Later Life (NCALL) has identified the following factors that can contribute to the risk of becoming a victim of elder abuse:

- Poor physical or mental health
- Disability
- Financial dependence
- Social isolation, and prior exposure to trauma
- Gender

Risks can also include:

- Shared living arrangement
- Alcohol abuse by the older adult
- Aggressive behaviors displayed by a person with dementia.

Barriers to Disclosing Abuse

Barriers to seeking help vary - and some are shared by victims throughout their lives, such as fear, shame and intimidation. Barriers specific to older survivors include:

Cultural Values	Older people might not recognize their experience as domestic violence or may choose to stay in an abusive relationship due to cultural pressures.
Awareness Restrictions	Older people may have less information about the support available to them or feel that the services don't meet their needs.
Loss of Independence	When an abusing spouse or partner is also the caregiver, older people may fear that reporting the abuse will leave them without the ability to remain independent or that they will be forced to leave their home.
Ageism	Ageist notions about an older people's capacity to comprehend abuse, and to make informed decisions about what to do, can impede an older survivor's access to healing and safety.
Discrimination	Victims from African American, rural, and tribal (and other) minority communities may have suffered instances of race-based or racial prejudice and other forms of discrimination, their whole life. These negative behaviours can display in a variety of ways, including institutionally, communally, and interpersonally, and can lead to distrust and suspicion of figures in authority and a reluctance to disclose abuse.

For more information, see:
Increasing Access to Healing Services and Just Outcomes for Older African American Crime Survivors: A Toolkit for Enhancing Critical Knowledge and Informing Action within the Crime Victim Assistance Field,

The Tribal Resource Tool - A searchable directory of services available for all American Indians and Alaska Natives (AI/AN) survivors of crime and abuse in Indian Country.

Recognizing the Signs of Abuse

Physical

- Bruises, black eyes, welts, lacerations, and rope marks;
- Dehydration, malnutrition, untreated bed sores, and poor personal hygiene;
- Bone fractures, broken bones, and skull fractures;
- Open wounds, cuts, punctures, untreated injuries in various stages of healing;
- Sprains, dislocations, and internal injuries/bleeding;
- Broken eyeglasses/frames, cell phones, or other items of importance to the victim;
- Physical signs of being subjected to punishment, and signs of being restrained;
- An older adult's sudden change in behavior; and
- The caregiver's refusal to allow visitors to see the older adult alone.

Sexual

- Bruises around the breasts or genital area;
- Unexplained sexually transmitted infection or genital infections;
- Unexplained vaginal or anal bleeding;
- Difficulty walking or sitting;
- Torn, stained, or bloody underclothing.

Emotional/Psychological

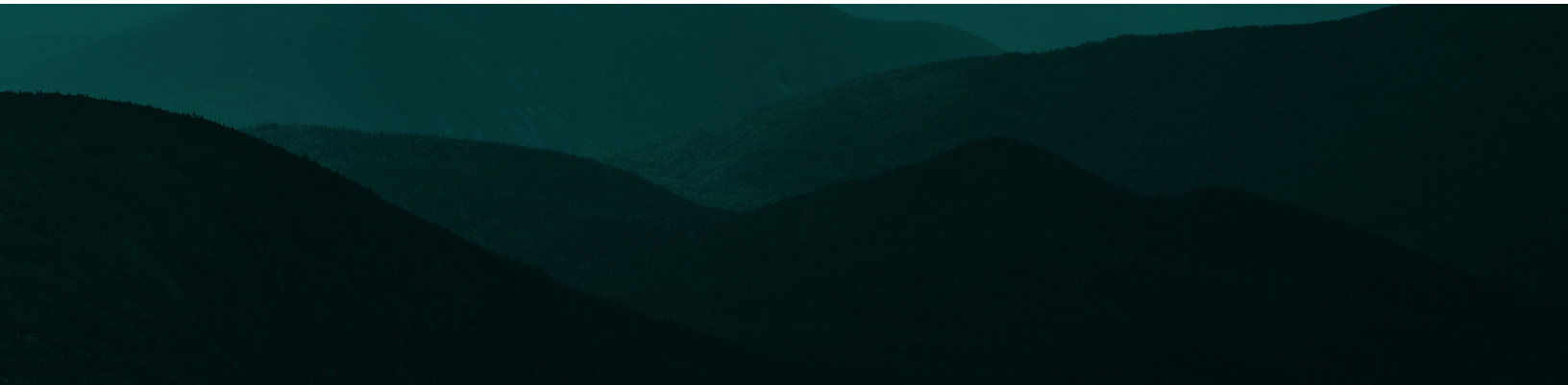
- Anxiety, depression, and low self-esteem;
- Being emotionally upset or agitated;
- Being extremely withdrawn and non-communicative or non-responsive;
- Unusual behavior usually attributed to dementia (e.g., sucking, biting, rocking).

Neglect

- Dehydration, malnutrition, untreated bed sores, and poor personal hygiene;
- Unattended or untreated health problems;
- Unsafe living conditions like improper wiring or no heat;
- Unclean living conditions, like soiled bedding, faecal/urine smell, or dirty clothes;
- Become withdrawn or act agitated or violent, or show signs of trauma such as rocking back and forth;
- Have unexplained pressure marks, bruises, burns, cuts, or scars;
- Poor personal care, looking messy, with unwashed hair, bedsores, or poor dental hygiene;
- Lack necessary health care items like glasses, a walker, dentures, or hearing aid.

Financial

- Unexplained withdrawal of large sums of money by a person accompanying the older adult;
- The inclusion of additional names on their bank signature card;
- Abrupt changes in their will or other financial documents;
- Unexplained disappearance of funds or valuable possessions;
- Unpaid bills despite having adequate financial resources;
- Unexplained sudden transfer of assets to a family member or someone outside the family;
- Paying for the provision of services that are not necessary for them.



What Medical/Clinical Professionals Can Do

Next steps when there is suspected abuse:

- If you think someone is in urgent danger, call 911.
- Staff members in nursing homes are required, both by law and internal policies at nursing homes and assisted living facilities, to report abuse and neglect. If you are a mandatory reporter, let patients know if you will be contacting law enforcement.
- Check your state's reporting requirements
- You can report abuse by contacting:

- **911**
- **National Adult Protective Services Association** – to find your local support.
- **The National Center on Elder Abuse** provides guidance on how to report abuse, where to get help, and state laws that deal with abuse and neglect. Visit the Center online or call **855-500-3537** for more information.
- **The National Long-Term Care Ombudsman Resource Center** advocate for the needs of people who live in assisted living facilities, board and care homes, and nursing homes. They are trained to help resolve problems. Find a long-term care ombudsman in your state online or by calling **202-332-2275**.

How to react to a disclosure:

- Believe what the older person is telling you;
- Listen carefully - they may describe the abuse without mentioning words like 'domestic violence' or 'rape';
- Reinforce that the abuse is not their fault;
- Ask them what they would like to do, and what their priorities are;
- Support their decisions;
- With their permission, contact appropriate support organizations who can help with risk assessment and safety planning.

Elder Assessment Instrument (EAI)

Elder Abuse Resource: Safety Plan

Screen patients for domestic violence and elder abuse/neglect:

This is a review of many screening tools for DV for which there is no consensus about the "best" single tool:

Elder Abuse Screening Tools for Healthcare Professionals

This is a training slide deck that reviews the topics of:

- The Public Health Crisis of Domestic Violence
- Conditions and Injuries Related to Domestic Violence
- The Role of Medical Professionals and Screening
- The Basics of Screening Patients for Domestic Violence
- Case Scenarios
- Keeping Families Safe

Screening Training Slide

Know your Community Resources

Provide information to patients on these services and allow them to call when, and if, they are ready.

Helplines

Your local Domestic Violence Helpline can be found here; see 'Support Options' below for further resources.

Shelters

A place of temporary refuge and support for victims escaping violent or abusive situations. You can find local shelters here.

Injunctions

Court orders that require a party to do, or refrain from doing, specific acts – see Womens Law for more information.

Crisis Intervention

Emergency psychological care to assist individuals in a crisis situation to restore balance to their biopsychosocial functioning.

Advocacy

Provide a range of supportive services to help individuals involved in domestic abuse situations to become self-sufficient.

Safety Plan

This is a list of actions on how to leave an abuser safely, and should be carried out with a DV professional. If this is impossible, The Hotline provides guidance on how to create your own.

Law Enforcement

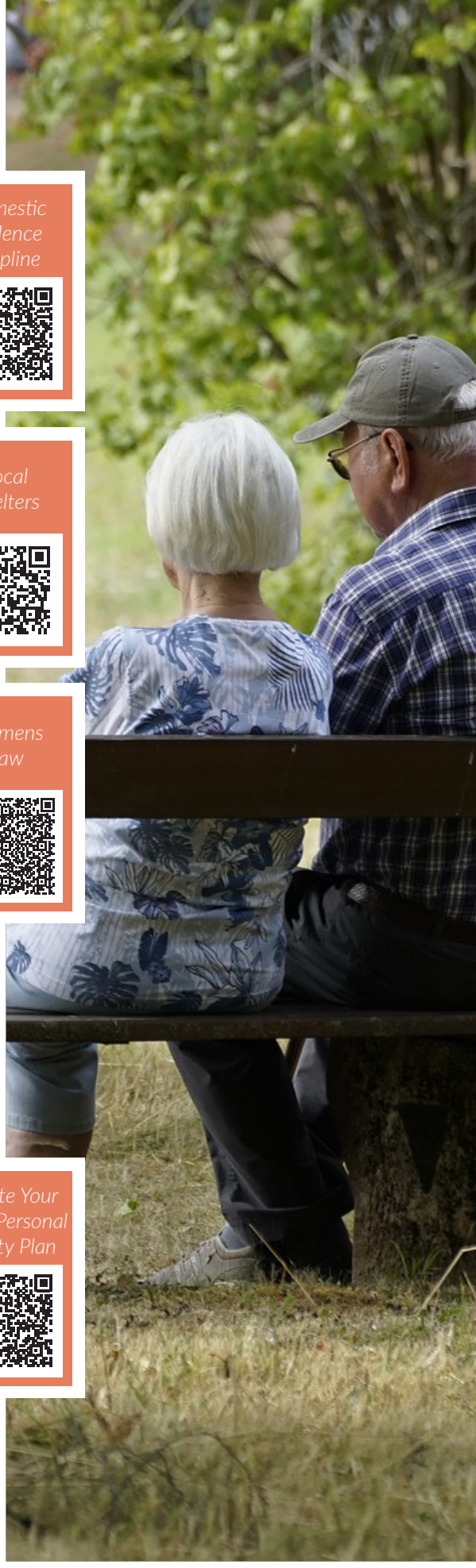
Some victims may seek the assistance of law enforcement.

Domestic Violence Helpline

Local Shelters

Womens Law

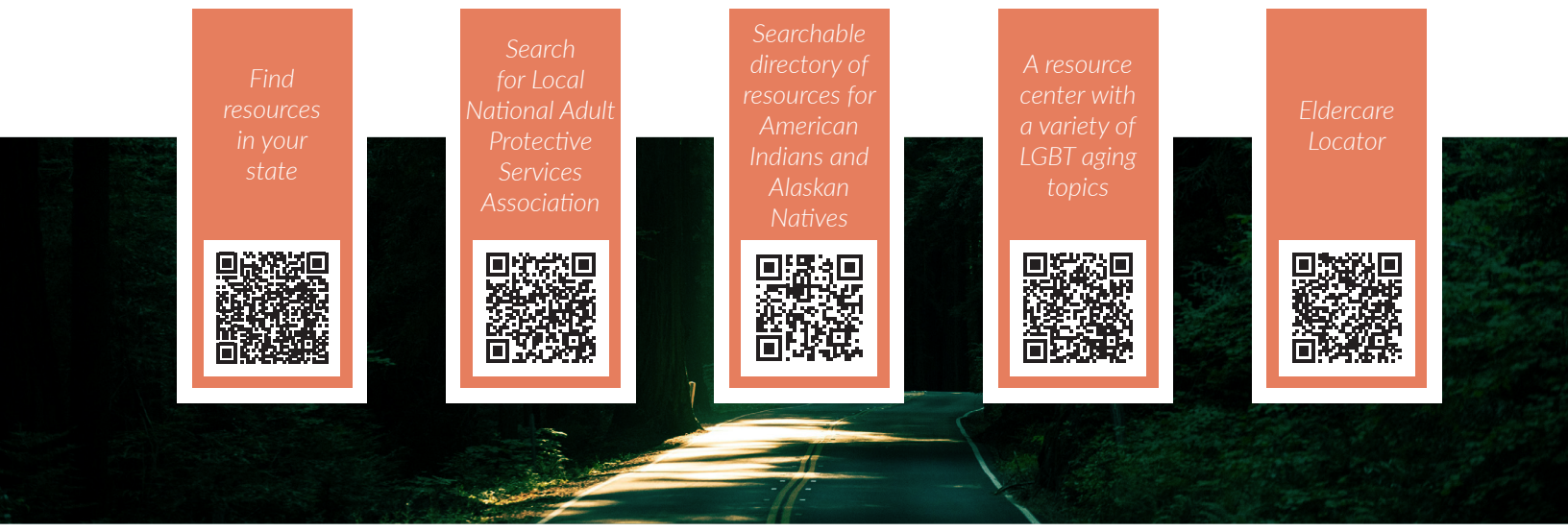
Create Your Own Personal Safety Plan



Helplines

National Domestic Violence Hotline (the Hotline)	1.800. 799.SAFE (7233) Text "START" to 88788
National Elder Fraud Hotline	833-FRAUD-11 or 833-372-8311
National Adult Protective Services Association	202-370-6292
Victim Connect Hotline	855-4-VICTIM or 855-484-2846

Find Local Resources



For advice and further information

National Center on Elder Abuse	ncea-info@aoa.hhs.gov 855-500-3537	
Consumer Financial Protection Bureau Office for Older Americans	olderamericans@cfpb.gov 855-411-2372	
American Bar Association	Find resources to learn about and respond to elder abuse	
Victim Law/OJP	A comprehensive list of legal programs with descriptions	
Nursing Home Abuse Center	877-388-5974	
Resource Library	From VAWnet (NRCDV)	
The National Center on Law and Elder Rights (NCLER)		

The Go-To Experts

There are three medical centers in the US, at the very least, that have dedicated significant resources to both DV and EA/N:

DV Med Training

The Florida State University (FSU) College of Social Work's Institute for Family Violence Studies (IFVS)

Answers In Aging And Abuse

The University of Southern California's (USC) Keck School of Medicine's National Center on Elder Abuse

Center of Excellence on Elder Abuse

The University of California, Irvine (UCI) Center for Excellence in Elder Abuse and Neglect (CEEAN)

Furthermore, FSU IFVS has established National Prevention Toolkit on Domestic Violence for Medical Professionals

NPHI has begun important work in collaboration with the global non-profit, NO MORE, which is "dedicated to ending domestic violence and sexual assault by increasing awareness, inspiring action and fueling culture change".

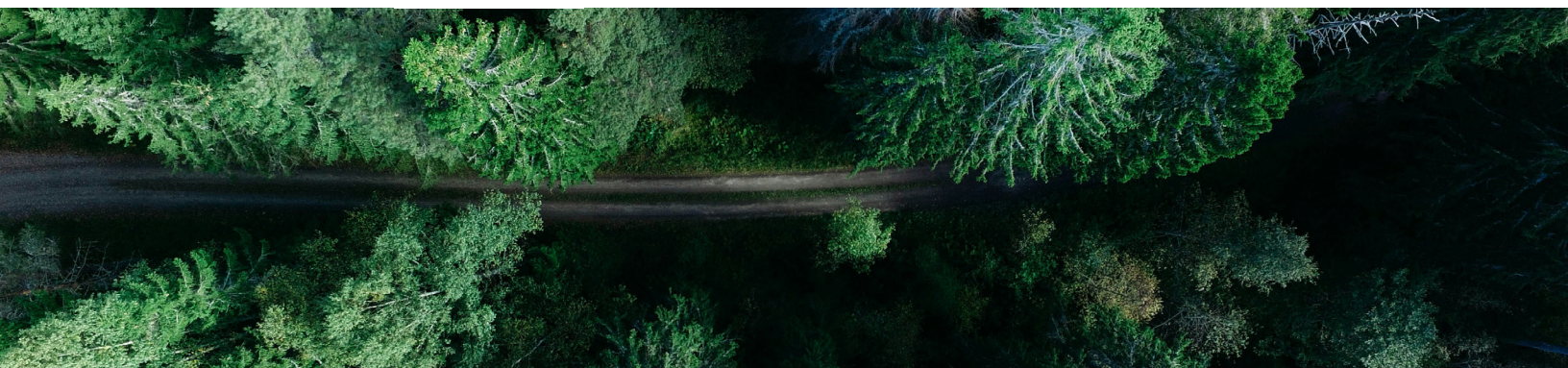
NO MORE

A Final Word for Medical Providers & Caregivers

Finally, as we continue our work in caring for patients and families, we must recognize that, whether domestic abuse (DV), typically thought of in women of childbearing age, or elder abuse and neglect (EA/N) in the older populations, each of these experiences result in trauma to the person – and often multiple traumas over the course of a lifetime. It is estimated that 70% of adults in the US have experienced trauma at some point in their lives. The importance and recognition of trauma-informed therapy has nearly paralleled the rise in education, screening, and awareness of DV and EA/N with a primary focus on reducing symptoms of post-traumatic stress disorder (PTSD), depression, and anxiety primarily through cognitive behavioral therapy.

DV and EA/N are common and yet still under-detected leading to tremendous suffering, PTSD-type symptoms, and even death. The essential steps needed are to educate health care professionals on the signs and symptoms of DV and EA/N, to initiate standard screening for both DV and EA/N as well as SDOH, and to know the community support and resources to both reduce social isolation and to refer to community services and, in many cases, help individuals to obtain trauma-informed therapy.

Trauma Informed Interventions



Important Notes

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