Intimate Partner Violence (IPV) Screening and Intervention

The American College of Preventive Medicine Position Statement

Tanya M. Phares, DO, MPH, Suzanne Harrison, MD, Connie Mitchell, MD, MPH, Kevin Sherin, MD, MPH
Randall Freeman MD, MPH, Kate Lichtenberg, DO, MPH, Amer Shakil, MD, MPH

Introduction

The term "intimate partner violence" (IPV) describes physical, sexual, psychological, or economic harm by a current or former intimate partner or spouse. This type of abuse can occur regardless of gender or sexual orientation and does not require sexual intimacy (1). The term “domestic violence” is often used interchangeably with “intimate partner violence.” Physical injury is reported by half of victims of intimate partner violence, and professional medical treatment is sought by 4 in 10 of those victims (2). The main contribution to morbidity is from the mental health consequences of abuse (3). The health-related costs of IPV exceed $5.8 billion each year, with direct costs of medical and mental health care responsible for greater than two-thirds of this amount (4, 5).

Exposure to IPV has been associated with a higher prevalence of adverse health behaviors such as smoking or substance use disorder (6). Increased mental distress and low self-esteem, attributes often seen in patients impacted by violence and abuse, often result in a decreased attention to preventive health measures during medical encounters (7) . In addition, victims of IPV use emergency services more than primary care, regardless of whether they have health insurance (8).

Primary prevention, through identification of risk and protective factors, could allow intervention before violence occurs. However, further research is needed on primary prevention of intimate partner violence (9). The World Health Organizations promotes systematic primary prevention methods including multi-sectorial action and integration with existing programs such as those that address alcohol and substance abuse or reproductive health (9). Though the importance and need for continued research on primary prevention is

recognized, the primary focus of this paper is screening and intervention for intimate partner violence.

Although there is consensus among medical organizations to recommend screening for IPV, screening is most effective when done within a systems-based approach that supports clinicians to effectively diagnose and provide intervention to victims of IPV (10, 11). The prevalence, the impact on individual health, healthcare utilization and associated health related costs all support the need for an effective systems-based approach to screening, identification and intervention for IPV.

Incidence & Prevalence

The World Health Organization estimates that worldwide 15-71% of women have experienced intimate partner violence, and that it is the leading cause of morbidity and mortality among women of childbearing age (3). A national CDC survey found that 35.6% of women and 28.5% of men have experienced rape, physical violence or stalking by an intimate partner during their lifetime (12). Many victims of sexual violence, stalking, and intimate partner violence, experience victimization early in life. Over 71% of female victims and 58% of male victims first experience intimate partner violence before age 25, and over 23% of female victims and 14% of male victims are victimized before the age of 18 (13).

More than 1 in 3 female victims of intimate partner violence experienced physical violence, stalking or multiple forms of rape (14). Among adolescents surveyed, 9.6% experienced physical dating violence and 10.6% experienced sexual dating violence (15). In undergraduate students, females experience an annual 5.6% incidence of rape or attempted rape, usually by someone that they know (16). The 2011 National Intimate Partner and Sexual

Violence Survey estimated that in the U.S., 19.3% (>23 million) women and 1.7% (almost 2 million) men have been raped during their lifetime (13).

In the United States, the U.S. Centers for Disease Control and Prevention (CDC) estimates that 32.3% of multiracial women, 27.5% of American Indian/Alaska Native women, 21.2% of non-Hispanic black women, 20.5% of non-Hispanic white women, and 13.6% of Hispanic women have been raped during their lifetimes. Two to three times these percentages have experienced sexual violence other than rape (13). Of these racial/ethnic groups an estimated 11.4% of multiracial women, 9.6% of non-Hispanic white women, 8.8% of non-Hispanic black women and 6.2% of Hispanic women were raped by an intimate partner during their lifetimes (13). An estimated 26.8% of multiracial women, 17.4% of non-Hispanic black women, 17.1% of non-Hispanic white women, and 9.9% of Hispanic women experienced sexual violence other than rape by an intimate partner (13).

Women are victimized predominately (94.7-99%) by men; however, men are victimized by both males (79.3%) and females (54.7-82.6%) depending on the form of sexual assault (13). Men also experience significant amounts of intimate partner violence. Although a comparatively few (0.5% of men nationwide) are estimated to suffer rape by an intimate partner, 18.2% of multiracial men, 14.8% of non-Hispanic black men, 13.5% of Hispanic men, and 7.6% of non-Hispanic white men experiencing sexual violence other than rape by an intimate partner (13).

Subpopulations, such as the U.S. military, experience higher than average rates of intimate partner violence and sexual assault. Stress due to military deployment or combat related health issues, such as Post-Traumatic Stress Disorder (PTSD), could be contributing factors (17, 18). Other subpopulations vulnerable to intimate partner violence include socioeconomically disadvantaged women (19) and women during pregnancy, preconception,

and postpartum periods (20) (17). Past and recent abuse has been associated with early cessation of breastfeeding (21). People who identify as lesbian, gay, bisexual or transgender are also at higher risk for intimate partner violence and sexual assault (22). Transgendered people suffer significantly greater odds of sexual assault, with black transgendered at increased odds relative to white transgendered(23). Women who have sex with women (WSW) experience intimate partner violence at a higher rate than heterosexual women (24, 25). In all groups, substance abuse is a significant contributing factor to both victimization and perpetration. (26).

For non-sexual physical violence, an estimated 51.7% of American Indian/Alaska Native women and 43% of men, 51.3% of multiracial women and 39.3% of men, 41.2% of non-Hispanic black women and 36.3% of men, 30.5% of non-Hispanic white women and 26.6% of men, 29.7% of Hispanic women and 27.1% of men, 15.3% of Asian or Pacific Islander women and 11.5% of men are victimized during their lifetime (13). Percentages of women and men who experience stalking are similarly high among both women and men, and perpetrated at high percentages by both women and men (13).

Data from the National Crime Victimization Survey showed that after enactment of the Violence Against Women Act (VAWA) in 1994, the rate of intimate partner violence dropped 64% between 1994 and 2010(27). As of 2007 the rate of intimate partner homicide of females decreased by 35% and the rate of intimate partner homicide of males decreased 46% (28).

Health consequences

The health consequences of violence in relationships can be both acute and chronic and have multiple sequelas. Intimate partner violence results in social, physical and psychological problems including family dissolution; adverse pregnancy outcomes; chronic pain and poor physical health such as asthma, irritable bowel syndrome, and diabetes; mental health

disorders (depression, post-traumatic stress disorder, anxiety); obesity; incarceration and death (13, 18, 29). Associated health risk behaviors include greater likelihood of smoking, engaging in heavy/binge drinking, and HIV behavior risk factors (30). In addition, survivors of IPV have an approximately 2-fold increase in the use of healthcare services (31).

While most clinicians recognize some injuries as suspicious for having been inflicted by another person (e.g., gunshot wounds, stabbings or neck contusions suggestive of strangulation), other injuries are more often explained as accidents (e.g., fractures, lacerations, contusions, ruptured tympanic membranes, burns and broken teeth) and therefore are less often considered suspicious for a history of abuse. IPV should be in the differential diagnosis especially for injuries to the mouth, face and neck of women.

Women in abusive relationships have increased rates of sexually transmitted infections, poor pregnancy outcomes and gynecologic symptoms (32-34). While this population is more likely to get sexual health screenings such as HIV testing, they are less likely to get screening tests such as pap tests or mammograms (35). Survivors report overall poor physical health and have an increased risk of developing a chronic disease (36). Chronic pain syndromes are common in survivors of abuse and there is an increased risk of developing coronary artery disease (37).

Both women and men report worsening mental health, with increased rates of depression and substance use (36) and diminished problem-solving skills (38). Abuse victims are more likely to develop PTSD, attempt suicide and abuse their children (33, 36). Post-concussive syndrome and mild traumatic brain injury may be co-morbid or contributing factors to sequalae such as anxiety or depression in IPV victims (39, 40)

Children exposed to violence in their early years have an increased rate of behavioral problems and mental health issues. About 50% of children exposed to IPV in the home are also physically abused (41). Physical ramifications include evidence of neglect, including malnutrition and poor dental hygiene. Mental health problems include depression, anxiety, substance abuse, attempted suicide, insecure attachment and under-stimulation causing diminished cognitive functioning. Behavioral issues include aggression, defiance, and violence toward peers, risky sexual behavior, and running away from home. (38, 42). Exposure to IPV in the family of origin increases learned helplessness and these individuals are therefore more likely to be victimized as adults (43). Runaway children with a prior history of abuse are more likely to be sexually exploited or trafficked (44). Children exposed to various forms of childhood trauma, collectively known as Adverse Childhood Experiences (ACEs) have increased rates of significant chronic physical and mental health conditions as adults, including higher mortality rates(45, 46). Physical or sexual dating violence can cause adolescents to miss school due to safety concerns, particularly among females (15).

Diagnosis and Intervention

The process of identifying and diagnosing IPV victimization should be differentiated from screening. Screening is the process of routine inquiry using an interactive dialog approach or a given standardized tool. IPV could also be identified when a clinician sees a pattern of injury or illness that is suggestive of IPV. Forming a diagnosis requires tailored and unique questions and specific diagnostic codes. Diagnostic codes for IPV include Adult Maltreatment (ICD-10 995.8), as well as modifier codes for types of abuse, causes or means of injury, and suspected or confirmed IPV. Consistent diagnosis and documentation on IPV is important so

that data is accurately collected. This will help in understanding the incidence, risk factors and associated injuries or illness.

Screening does not always lead to identification of IPV, intervention or referral (47). A study of police-identified women victims of IPV found that screening was done in 30% of visits and only 6% screened positive (48). Further studies reported that less than 25% of identified victims were provided referral for IPV services (49). Institutionally supported, system-level interventions are more successful than programs which only screen for IPV (10). The components associated with successful programs included effective protocols for screening, ongoing training, immediate access to support services and institutional support (10)

Once IPV is identified, systems-based approaches towards intervention with written procedures and consistent diagnostic classification have proven effective (50, 51). IPV interventions include danger assessment, safety planning, prevention options, and referral to violence intervention programs, social services or behavioral health professionals and compliance with reporting laws (52). Counseling has been shown to be effective in reducing IPV victimization (53) IPV advocates can provide support to victims, increasing screening, identification and more effectively facilitate referrals to community groups (47). Perpetrators are often referred to batterer intervention program (52). However, batterer intervention programs may only be available when a state-mandate exists for convicted perpetrators. There is limited research regarding recommendations for screening and referral of perpetrators.

Domestic Violence Laws

The first national observance for domestic violence was held in October 1981 as a "Day of Unity" organized by the National Coalition Against Domestic Violence. The first Domestic Violence Awareness Month was observed in October 1987, with commemorative legislation

first passed by the U.S. Congress in 1989 (54). The Violence Against Women Act (VAWA), enacted in 1994, created the United States Department of Justice's Office on Violence Against Women and provided resources for investigation and prosecution of violent crimes against women and funds shelters and support groups (55). The National Domestic Violence Hotline (800-799-SAFE) was also developed under the VAWA, which provides assistance to victims, families and health professionals who need help identifying local resources (28).

Since passing the Violence Against Women Act in 1994, Congress has reauthorized the Act every 5 years until 2012. In 2013 a new VAWA bill was passed with provisions for sex trafficking, Native Americans living on reservations, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals(55) Changes were made to the Gun Control Act in 1996, 1996, and 2005, making it a federal crime, in some cases, for domestic abusers to possess guns (56). However, most laws providing protection for Intimate Partner Violence are passed at the state level, and those laws vary considerably.

Forty-one states have established Domestic Violence Fatality Review teams (57). These vary in the members appointed, the scope of coverage (local, regional, or statewide), the recommendations developed, and the funding. The intent of these teams is to review fatality or near-fatality cases related to domestic violence. Some teams also review suicides, looking at the patterns related to domestic violence.

Most states have specific mandatory reporting laws for abuse of adults that are separate and distinct from elder abuse, vulnerable adult abuse, and child abuse reporting laws. The reporting agency varies by state and may be to local police departments or public health agencies. In some states, this may apply only to injuries caused by weapons or in violation or criminal law, and in others, it may be specific to domestic violence (58). Civil Protection Orders

for domestic violence cover opposite sex partners in all states. Three states (Hawaii, Maine, Washington) and the District of Columbia specifically designate that same sex partners are included; two states (Louisiana, South Carolina) specifically exclude same sex partners; two states (Florida, Montana) have statutes that are silent on the issue; and the remaining states have statues that probably extend to same sex partners based on how those statutes have been construed or interpreted previously (Table 1) (59). There is wide variation between states in how statutes protect adult or teen dating partners (Table 1). The statutes are often silent or unclear in the case of teenagers (60).

Current screening guidelines

Healthcare providers play an integral part in caring for women and families experiencing intimate partner violence. A majority of victims (70-81%) reported that they would like their healthcare providers to screen them for IPV (61-63). Recommendations from other groups are summarized in Table 2.

In 2013, the United States Preventive Services Task Force (USPSTF) updated their recommended screening guideline for IPV, advising clinicians to screen all women of childbearing age for IPV and provide services for those who screen positive (64). In their review, the USPSTF examined 14 screening tools for IPV identification among adult women of childbearing age and elderly and vulnerable adults (65). Based on the reviewed studies, the six tools exhibiting the highest levels of sensitivity and specificity for identifying IPV are Hurt, Insult, Threaten, Scream (HITS); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire–Short Form (CTQ-SF); and Woman Abuse Screen Tool (WAST). The USPSTF concluded their review with a Grade B category rating, indicating

there is high certainty that there is a moderate net benefit for screening (65). More recent developments for IPV tools include the investigation of tools that assess stalking, including on college campuses (66-69). A comparison of screening tools can be found in Table 3. The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) also uphold the USPSTF guidelines (70). Similar to AAFP and ACP, The American Academy of Pediatrics (AAP) recommend a multifaceted approach, including physician education and skills in screening and intervention, knowledge of laws and collaboration with support organizations, (71, 72).

The American Congress of Obstetricians and Gynecologists (ACOG) recommends physicians screen all patients periodically for IPV, regardless of age. All patients should be screened during routine annual, family planning, and preconception visits. Among pregnant women, screening should occur at various times throughout the duration of the pregnancy, including the initial prenatal visit, at least once per trimester, and the postpartum checkup. ACOG also delineates various components to screening as described in Table 2 (73-75).

Clinician Education

Although any training at all has been found to make healthcare workers more likely to screen (76), there is no standard model for medical school and post-graduate education on IPV (77). IPV education during medical school and residency may help providers develop a foundation of knowledge and comfort level around screening, identifying and providing intervention for IPV. Medical school curriculum on IPV is inconsistent, with some medical students receiving little to no education (78). Compared to their counterparts, medical students who have received IPV education report more confidence and comfort interviewing patients and feel more prepared to address IPV (79), (78). Beyond primary care and across specialties,

residents continue to experience gaps in knowledge and training around IPV and report feeling unprepared to screen or counsel patients, resulting in low screening rates (80). Residents felt most unprepared on specific topics, such as risk assessment, creating a safety plan, providing resources and referrals and documentation (80).

The AAFP recommends the following training curriculum in IPV for residency programs: 1) epidemiology, risks and red flags for identifying IPV or sexual harassment, and resources available to assist affected women; 2) components of the evaluation and treatment of victims of rape and sexual assault (including psychosocial and legal issues); and 3) the ability to perform or refer women for IPV counseling (81, 82). The American College of Emergency Physicians (ACEP) recommends that medical schools and emergency medicine residency curricula include education and training on IPV to recognize, assess and intervene (83). The American Association of Pediatricians (AAP) recommends that residency training programs incorporate education on IPV and its implications for child health into the curricula of pediatricians and pediatric subspecialists (72). The American College of Obstetricians and Gynecologists (ACOG) and American College of Physician (ACP) do not make specific recommendations regard medical or residency education and training (75, 84)

Only a handful of states require any type of continuing medical education (CME) training for physicians who may be the first point of contact a victim of domestic abuse (Table1). Connecticut requires one contact hour pertaining to domestic violence at least every 6 years (85). Florida requires two contact hours every third biennial renewal (86). Kentucky requires a three hour course on domestic violence within the first three years of a license being granted, with no further contact hours required (87). Texas requires two contact hours in Medical Ethics and/or Professional Responsibility every two years. This may include risk management,

domestic abuse, or child abuse (88). The literature is inconclusive on the contribution of CME training to changes in physician behavior but there is evidence that assuring a system of support and victim response if IPV is identified can impact physician behaviors. (89, 90)

Barriers

Barriers to screening for intimate partner violence exist at multiple levels within the medical system, and though they may vary depending on the health setting, they are largely systemic. Barriers include lack of training, beliefs and perceptions, and logistical barriers.

Lack of sufficient training among healthcare providers is the most frequently reported barrier and is ubiquitous in results reported in the literature concerning IPV screening. Providers lacking confidence for addressing such a sensitive and complex issue may be less likely to screen for IPV (91, 92). Lower screening rates have been reported in Emergency Departments (76). A study by Rhodes et al., found that providers in Emergency Departments frequently missed opportunities to identify and provide interventions for police-identified women victims of IPV (49). A lack of information about domestic violence has been reported as a significant barrier to IPV screening in the Emergency Department (ED) setting (93). This is significant since the ED is a critical entry point and the authors of that study estimate that between 20% and 50% of all female patients in the ER are victims of domestic violence. There is a need for increased education and better training for orthopedic surgeons and providers in fracture clinics, who also may encounter victims of IPV (94, 95). Lack of training was identified as the most common barrier to screening among trauma nurses (96). Another study noted nurses' confusion over reporting laws and legal responsibilities as well as logistical challenges due to lack of time and privacy, concluding that nurses need clearer protocols and resources before screening (97).

In addition to lack of knowledge, personal barriers exist including the attitudes and perceptions of the healthcare provider that may negatively affect the performance of IPV screening. A survey of physicians note that less than half of physicians surveyed believed that IPV was an issue for their female patients (98). A study by Jaffee (91) reports the prevalence of physician-perceived barriers and notes the correlation with the type of setting (increased perceived barriers in a private practice) and with the specialty (OB/GYNs reported fewer perceived barriers). ED nurses reported personal discomfort and a feeling of powerlessness in the screening situation and that previous personal experience may have prevented more in-depth screening in some case (93). Preconceptions and lack of awareness regarding intimate partner violence later in life may effect a provider's ability to identify abuse (99). Some providers reported forgetfulness as a barrier to screening, which underscores the usefulness of simple chart reminders for increased screening (76). Furthermore, race may affect the willingness of victims to disclose intimate partner violence if there is perceived discordance between provider and patient. (100).

Logistical barriers include lack of space for privacy and safety needs and lack of time for sensitive intervention. Lack of privacy has been reported by nurses in the ED setting (93), and may also contribute to the personal discomfort already inherent to the screening process (95). Time constraints also present a barrier to IPV screening (93, 95). In addition to screening barriers, IPV identification is complicated by a variety of other factors. These include fear of retaliation by the abuser or law enforcement/legal involvement behaviors attributed to (101) the abused women, or the presence of a partner during screening (102).

Addressing barriers requires systems-based changes. McCaw (90) successfully demonstrated a significant increase in screening in a managed care setting using a systems

model approach. Three elements have previously been identified for successful IPV prevention implementation. These include (1) training for physicians, nurses and clinical staff; (2) clinic system change including administrative buy-in, quality strategies and patient education; and (3) clinic culture change such that the healthcare system values and norms support identification, intervention and treatment (11). Models that aim to address such barriers include the Healthcare Can Change from Within Model (HCCW)(11, 47), the evidence-based systems model implemented at Kaiser Permanente, Northern California (103), and the comprehensive conceptual framework developed by O'Campo et al (10). Improved intimate partner violence screening and intervention were demonstrated by the Change from Within model, through enhanced provider education, training, community partnerships and improved clinic policies (11).

Recommendations from the American College of Preventive Medicine

The American College of Preventive Medicine (ACPM) supports screening for IPV in women of childbearing age. More research should be done to determine appropriate screening methods for other populations at risk for IPV including the elderly, adolescents, and the LGBT populations. Further research is needed on screening and management of perpetrators of IPV. The ACPM supports development of standardized methodologies and best practices for screening, identification, diagnosis, intervention, and documentation of IPV. Early intervention of intimate partner violence is important and further research is needed on primary prevention

Systems-based approaches should be uniquely implemented at various levels of healthcare, including medical education residency training, state medical boards, national medical associations, and within local and regional health systems.

The ACPM recommends the following:

1) Medical education and training: All physicians receive standardized evidence – based education and training on IPV screening, identification, diagnosis and intervention during medical school and residency.
2) National medical associations: National medical associations provide continuing medical education including education on billing, coding, documentation, and reporting, to build on the foundation developed during training.
3) State medical boards: State medical boards require initial CME training on reporting requirements as this can vary from state to state.
4) Local and regional health systems: Local and regional health systems provide an infrastructure that enables providers to screen, identify, diagnose and intervene effectively in all healthcare settings where victims of IPV may present.
    a. Develop patient messaging and education materials, and provide private and safe environments for screening and caring for victims of IPV
    b. Develop internal expertise of select staff and general training for all staff; collaborate with community organizations, identify resources and develop referral patterns
    c. Develop written procedures/protocols and quality improvement strategies, with support and oversight from leadership to ensure capacity building.
5) Healthcare Providers: Within a supportive system, healthcare providers routinely screen for IPV in a private and safe environment using a nonjudgmental manner. Providers are knowledgeable of local reporting laws, and follow established processes to provide an intervention including assessment of safety and an effective referral process.

6) Research recommendation: Further research is needed to develop standard guidelines and the development of "best practices" for clinicians and institutions to follow.

Rationale/conclusion

This article reviews the literature on IPV incidence and prevalence, health consequences, diagnosis and intervention, domestic violence laws, current screening recommendations and barriers to screening and intervention. The ACPM statement presented here is consistent with recommendations from other organizations and additionally recommends systems-based approaches to IPV screening, identity and intervention. Although ACPM supports improved education and training for healthcare providers, the application to clinical practice will be most effective within a systemic approach to IPV. The ACPM further recommends that this systems-based approach be applied uniquely and collaboratively across various levels of infrastructure that affect providers and their clinical practice. In addition, addressing intimate partner violence will require research to improve early screening and intervention, the development of best practices and attention to at risk sub-populations. The role of social determinants of health, exposure to violence and opportunities in early childhood development should also be considered in future research.

Table 1. State Regulations

	Fatality Review Team	Mandatory Reporting	Mandatory CME	Order of Protection			
				Opposite Sex Partner	Same Sex Partner	Adult/Teen Dating Partner	Stalking
Alabama	Y			Y	Probably	Y/N	Y
Alaska	Y	Y		Y	Probably	Y/Y	Y
Arizona	Y	Y		Y	Probably	Y/N	Y
Arkansas		Y		Y	Probably	Y/N	Y
California	Y	Y		Y	Probably	Y/Y	Y
Colorado		Y		Y	Probably	Y/Y	Y
Connecticut		Y	Y	Y	Probably	Y/Y	Y
Delaware	Y	Y		Y	Probably	Y/Y	Y
District of Columbia	Y	Y		Y	Y	Y/Y	Y
Florida		Y	Y	Y	Statute Silent	Y/Statute Silent	Y
Georgia		Y		Y	Probably	N/N (Unless Partners Lived Together	Y
Hawaii	Y	Y		Y	Y	Y/N	Y
Idaho		Y		Y	Probably	Y/Y	Y
Illinois		Y		Y	Probably	Y/Y	Y
Indiana	Y	Y		Y	Probably	Y/Y	Y
Iowa	Y	Y		Y	Probably	Y/Unclear	Y
Kansas		Y		Y	Probably	Y/Unclear	Y
Kentucky	Y	Y	Y	Y	Probably	N/N	Y
Louisiana		Y		Y	N	Y/Y	Y
Maine		Y		Y	Y	Y/Y	Y
Maryland	Y	Y		Y	Probably	N/N	Y
Massachusetts		Y		Y	Maybe	Y/Y	Y
Michigan	Y	Y		Y	Maybe	Y/Y	Y
Minnesota	Y	Y		Y	Probably	Y/Sometimes	Y
Mississippi		Y		Y	Probably	Y/Unclear	Y
Missouri		Y		Y	Probably	Y/Unclear	Y
Montana	Y	Y		Y	Statute Silent	Y (If Opposite Sex)/Unclear	Y
Nebraska		Y		Y	Probably	Y/Unclear	Y
Nevada	Y	Y		Y	Probably	Y/Y	Y
New Hampshire	Y	Y		Y	Maybe	Y/Y	Y
New Jersey	Y	Y		Y	Probably	Y/Y	Y
New Mexico	Y			Y	Probably	Y/Y	Y

New York		Y		Y	Probably	Y/Unclear	Y
North Carolina	Y	Y		Y	Maybe	Y (If Opposite Sex)/Unclear	Y
North Dakota		Y		Y	Maybe	Y/Unclear	Y
Ohio		Y		Y	Probably	N/N	Y
Oklahoma	Y	Y		Y	Probably	Y/Y if 16 or 17 yo	Y
Oregon	Y	Y		Y	Probably	Y/Unclear	Y
Pennsylvania		Y		Y	Probably	Y/Unclear	Y
Rhode Island		Y		Y	Probably	Y/Y	Y
South Carolina		Y		Y	N	N/N (Unless Partners Lived Together	Y
South Dakota		Y		Y	Probably	N/N	Y
Tennessee	Y	Y		Y	Probably	Y/Y	Y
Texas	Y	Y	Y	Y	Probably	Y/N	Y
Utah		Y		Y	Probably	N/N	Y
Vermont	Y	Y		Y	Probably	Y/Y	Y
Virginia	Y	Y		Y	Probably	N/N	Y
Washington	Y	Y		Y	Y	Y/Y (If both are 16 yo or older)	Y
West Virginia	Y	Y		Y	Probably	Y/N	Y
Wisconsin		Y		Y	Probably	Y/N	Y
Wyoming				Y	Probably	Y/N	Y
American Samoa				Y	Probably	Y/Y	Y
Northern Mariana Islands				Y	Probably	Y/Y	Y
Puerto Rico				Y	Probably	Y/Unclear	Y
Virgin Islands				Y	Maybe	Y/Unclear	Y

Table 2. Screening Recommendations of other groups

Agency or organization	Recommendations
USPSTF	Clinicians should screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services (Grade B Recommendation). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (Grade I recommendation).
ACOG	Physicians should screen all women for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup), offer ongoing support, and review available prevention and referral options. Screen for IPV in a private and safe setting with the woman alone and not with her partner, friends, family, or caregiver. Use professional language interpreters and not someone associated with the patient. At the beginning of the assessment, offer a framing statement to show that screening is done universally and not because IPV is suspected. Also, inform patients of the confidentiality of the discussion and exactly what state law mandates that a physician must disclose. Incorporate screening for IPV into the routine medical history by integrating questions into intake forms so that all patients are screened whether or not abuse is suspected. Establish and maintain relationships with community resources for women affected by IPV. Keep printed take-home resource materials such as safety procedures, hotline numbers, and referral information in privately accessible areas such as restrooms and examination rooms. Posters and other educational materials displayed in the office also can be helpful.
AAFP	Physicians should discuss IPV and family violence with their patients in a routine, nonjudgmental manner. Disclose the limits of confidentiality, Inquire about violence and assess immediate safety, Offer support and harm reduction, offer supported referral. Provide primary prevention through patient education about healthy relationships.
ACEP	Training in the evaluation and management of victims of domestic violence should be incorporated into the initial and continuing education of EMS personnel. This training should include the recognition of victims and their injuries, an understanding of the patterns of abuse and how this affects care, scene safety, preservation of evidence, and documentation requirements.
ACP	Individual internists are encouraged to take as many of the following steps as possible to reduce for their patients the prevalence and recurrence of--as well as pain and suffering caused by--family violence; become aware and knowledgeable about the diagnosis and treatment of family violence; become familiar with applicable abuse reporting laws and other legal requirements as well as appropriate procedures for dealing with and referring suspected cases of abuse; work independently or with local medical societies or other community groups to participate in violence-prevention activities and/or develop resources--such as battered women shelters--in one's community; and encourage and participate in research on family violence.
AAP	Residency training programs and CME program leaders are encouraged to incorporate education on IPV and its implications for child health into the curricula of pediatricians and pediatric subspecialists. Pediatricians should remain alert to the signs and symptoms of exposure to IPV in caregivers and children and should consider attempts to identify evidence of IPV either by targeted screening of high-risk families or universal screening. When caregivers are asked about IPV, it is ideal to have a plan in place to respond to affirmative screens. Pediatricians are encouraged to intervene in a sensitive and skillful manner and attempt to maximize the safety of caretakers and child victims. Pediatricians should be cognizant of applicable IPV laws in their state, particularly as they relate to reporting abuse or concerns of children exposed to IPV. Pediatricians are encouraged to support local and national multidisciplinary efforts to recognize, treat, and prevent IPV.

Table 3. Comparison of Screening Tools

Scale	Description	Scoring	Sensitivity	Specificity	PV+	PV-	Gender neutral?	Notes
HITS	Self-report or clinician-administered survey	4 questions, 5 point frequency scale (min score of 4, max score of 20: IPV at >11)	96	91	70.2	0.87	yes	
WAST	Measures physical, sexual, and emotional abuse in prior 12 months	8 questions, 3 level responses, 0-16 responses (>4 score= IPV)	83	75	42.2	4.82	No, female only	
PVS	Clinician-administered about past violence and personal safety perception	3 questions	35-71	80-94			Yes	Developed for emergency room use
AAS	Designed for clinician administered interviews; any positive response is considered a positive screen	5 questions, scoring 0-5	32-61	98-99			No, pregnant women only	
WAST-SF	See WAST	2 questions					No, women only	
OAS/ OVAT	OVAT assesses current abuse	5/ 4 questions, 0-5 and 0-4 points					yes	
STaT	Self-report survey	3 questions, 0-3 points					yes	
HARK	Self-report survey adapted from AAS	4 questions, 0-4 point scoring						
MCTQ-SF	Self-report instrument for adults that assesses domestic violence in childhood; positive response if any answer except "never" is given	28 questions					Yes	
CAS	Measures 4 facets of IPV in past 12 months (severe combined abuse, emotional abuse, physical abuse, harassment)	30 questions, 4 subscales, 0-150 points					No, female only	

CTS2	Self-report or interview, half pertains to respondents behavior and half pertains to partner's behaviors	78 questions (can use a short form of the 3 original questions form CTS1) 7 point frequency scale (min score 15, max score 105)			79-95		yes	Taken as gold standard by many; High level of consistency and validity
WEB	Measure of women's exposure to violence	10 questions	86	91	67.8	3.2	No, female only	
ISA	Measures 11 types of physical abuse and 19 types of nonphysical abuse by male partner	30 questions, 0-100 points	90.7	92.2	72	2.15	No, female only	

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