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ASPE POLICY BRIEF

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

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SCREENING FOR DOMESTIC VIOLENCE IN HEALTH CARE SETTINGS

Background

In 2011 the Institute of Medicine (IOM) released, *Clinical Preventive Services for Women: Closing the Gaps*, an extensive report which identified eight key preventive services that would help ensure women's health and well-being. That same year the U.S. Department of Health and Human Services (HHS) adopted these recommendations in the *Women's Preventive Service Guidelines* (hereafter referred to as "the guidelines"). Under the Affordable Care Act, these services are generally covered in new health plans without requiring a co-payment, co-insurance, or deductible (Health Resources and Services Administration, 2012; The Patient Protection and Affordable Care Act, § 2713). One of the preventive services identified by the IOM and included in the guidelines is screening and counseling for "interpersonal and domestic violence." Additionally, the U.S. Preventive Services Task Force (USPSTF) released a recommendation in January 2013 calling for clinicians to "screen women of childbearing age for intimate partner violence" (U.S. Preventive Services Task Force, 2013). Given the new policies in support of screening for domestic violence in health care settings, the purpose of this brief is to present the state of practice and research regarding effective screening.

Reasons for Screening in Health Care Settings

Domestic violence is prevalent among women

According to the 2010 National Intimate Partner and Sexual Violence Survey (NISVS),[1] more than one in three women have experienced physical violence at the hands of an intimate partner, including a range of behaviors from slapping, pushing or shoving to severe acts such as being beaten, burned, or choked. An estimated 3.6 percent of women reported experiencing these behaviors in the 12 months prior to taking the survey. Roughly one in four women (24.3%) have experienced severe physical violence, which includes having been slammed against something, having been hit with something hard, or having been beaten (Black et al.,

ABOUT THIS POLICY BRIEF

This ASPE Policy Brief on screening and counseling for domestic violence in health care settings is intended for policy makers, health care practitioners, and other stakeholders.

The brief, written by Madeleine de Boinville, presents the state of practice and research surrounding domestic violence screening. The brief discusses reasons for screening in health care settings, the current prevalence of screening and reasons this prevalence is relatively low, existing evidence about screening, and next steps toward ensuring that screening becomes an effective preventive service.

Office of the Assistant Secretary for Planning and Evaluation

Office of Human Services Policy

U.S. Department of Health and Human Services

Washington, DC 20201

[1] The NISVS, fielded by the Centers for Disease Control and Prevention (CDC), is a nationally representative survey that collects information about experiences with sexual violence, stalking, and intimate partner violence among non-institutionalized English and/or Spanish speaking women and men aged 18 or older in the United States (Black et al., 2011).

2011). Additionally, nearly one in ten women in the United States (9.4%) have been raped by an intimate partner in her lifetime (Black et al., 2011).

DEFINITIONS

For the purposes of this brief:

Health Care Settings: Any location where health issues are addressed, including but not limited to emergency departments, patient treatment centers, and the offices of primary care clinicians and other health care practitioners.

Clinicians: Includes doctors, nurses, nurse practitioners, physician assistants, counselors, and other health care practitioners in a variety of health care settings.

Screening/Counseling: *Screening* may consist of a few short, open-ended questions asked by a clinician to the patient. It can also be facilitated by the use of forms or other assessment tools. *Counseling* may include provision of basic information, including on how a patient's health concerns may relate to violence, and referrals for additional assistance when patients disclose abuse.

Universal Screening: In this brief, universal screening is defined as a clinician screening every female patient through age 64 for domestic violence, as opposed to only screening certain patients because of risk factors or warning signs.

Domestic violence (DV) / Intimate partner violence (IPV) "physical violence, sexual violence, threats of physical or sexual violence, and psychological/ emotional violence. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy" (CDC, 2010).

Interpersonal violence is an overarching term that refers to "the intentional use of physical force or power, threatened or actual, against another person or against a group or community that results in, or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation." This type of violence includes family and intimate partner violence as well as violence between two unrelated individuals (World Health Organization, 2013).

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Intimate partner violence is associated with poor health outcomes

Intimate partner violence is associated with life-threatening injuries as well as other physical and mental health problems of both an immediate and long-term nature. In its most severe form, physical IPV can result in death or major injuries. According to the CDC's National Violent Death Reporting System, in 2003, 20 percent of homicides were directly associated with intimate partner conflict. For victims aged 40 to 44 years old, intimate partner violence was the most common form of violence resulting in death (Centers for Disease Control, 2006).

Physical violence can also result in less severe injuries, including bruises, black eyes, cuts, scratches, or swelling (Salber and Taliaferro, 2006). These types of physical injuries are commonly associated with abuse and may trigger clinicians to ask their patients about IPV (Salber and Taliaferro, 2006). Sexual abuse can result in injuries or infections, such as vaginal and anal tearing, bladder or vaginal infections, and sexually transmitted infections. These types of injuries may also cause a clinician to ask about abuse (Campbell and Lewandowski, 1997; Letourneau et al., 1999).

IPV is also associated with a number of long-term health impacts that may be more difficult for a health care provider to identify as resulting from abuse. Sustained exposure to violence is linked with central nervous system problems, including back pain, headaches, and seizures, as well as gastrointestinal problems (Coker, Smith, et al., 2000; Dillon et al., 2013). Sexual abuse is associated with higher risk of contracting sexually transmitted diseases, such as HIV/AIDS, either through forced unprotected sex or through the increased likelihood of risky sexual behavior (Hess et al., 2012; Mittal et al., 2012; Stockman et al., 2012).

The severe and prolonged stress caused by IPV can be detrimental to mental health as well. IPV is a major risk factor for depression, deliberate self-harm, and suicide (Jaquier et al., 2012; Pico-Alfonso et al., 2006; Van Dulmen et al., 2012). One study found that women who had experienced domestic violence were over twice as likely to suffer from depression than women who had never experienced abuse (Dienemann, et al., 2000). IPV is also correlated with alcohol and drug abuse. One study found that survivors of IPV were over nine times more likely to be dependent on alcohol than women who had not experienced abuse, and eight times more likely to have used illicit drugs in the past 12 months (Lipsky et al., 2005).

IPV is associated with more subtle physical and mental health problems in addition to serious physical injuries.

Research indicates that the relationship between IPV and alcohol and drug abuse by the victim is complicated. Abuse may be more likely to occur when the victim is under the influence of alcohol or drugs (El-Bassel et al., 2005). However, survivors often "self-medicate" to cope with abuse, suggesting that identifying abuse as a root cause for alcohol and drug abuse may be useful in providing treatment (Campbell, 2002; El-Bassel et al., 2003; La Flair et al., 2012).

In addition to the direct linkage between IPV and physical and mental health problems, IPV can affect health outcomes in indirect ways. For example, the National Intimate Partner and Sexual Violence Survey reports that nearly 30 percent of women who have experienced any kind of violence, including physical violence, stalking, and/or rape, reported at least one major detrimental impact related to these experiences, such as being fearful or missing at least one day of work (Black et al., 2011; Kovac et al., 2003). The debilitative impact of abuse can potentially inhibit a woman's ability to attend medical appointments, adhere to medical treatment plans, or overcome other adverse behaviors such as smoking, substance abuse, or overeating (Salber and Taliaferro, 2006).

The debilitative impact of IPV can potentially inhibit ability to attend medical appointments, adhere to medical treatment plans, or overcome other adverse behaviors.

Furthermore, abuse can have intergenerational health effects. IPV can result in unintended pregnancies either through forced unprotected sex, risky sexual behavior associated with abuse, or through reproductive coercion, which occurs when one partner interferes with the other's method of birth control (Silverman et al., 2004). IPV that occurs during pregnancy is associated with preterm birth, low birth weight, and lower gestational age (Kovac et al., 2003; Shah and Shah, 2010). These health consequences may have negative effects on the cognitive and motor skill development of newborns (De Jesus et al., 2013; Hack and Fanaroff, 2000; Hutton et al., 1997). Moreover, children who witness domestic violence are at increased risk of experiencing emotional, physical, and sexual abuse themselves (Holt et al., 2008; Lewis-O'Connor et al., 2006; Peled et al., 1995). Witnessing IPV in childhood is one of 10 adverse childhood experiences linked to negative health outcomes across the life course, including depression, alcoholism, adolescent pregnancy, and suicide attempts (CDC, 2012). The numerous direct and indirect effects that IPV can have on short and long-term physical and mental health are frequently cited as justification for regular screening (American Medical Association, 1993; Family Violence Prevention Fund, 2004; Institute of Medicine, 2011; Salber and Taliaferro, 2006; U.S. Preventive Services Task Force, 2013).

Intimate partner violence is associated with high health care costs

In addition to the high cost of violence for society and for individuals who experience abuse, IPV is associated with high health care costs. In one study, researchers surveyed 3,333 randomly selected women ages 18 to 64 to assess their IPV history (Bonomi et al., 2009). The women, with their consent, were then linked with their health care records to determine usage of health services. The total adjusted health care costs for women who had disclosed physical abuse were 42 percent higher than for women who had never experienced abuse. Further, women who had disclosed types of abuse that were non-physical in nature had total annual health care costs 33 percent higher than those of women who had not experienced any form of abuse, suggesting that non-physical abuse can also be costly (Bonomi et al., 2009). The CDC estimated in 2003 that the costs of intimate partner rape, physical assault, and stalking exceeded $5.8 billion, with nearly $4.1 billion going directly for medical and mental health services (CDC, 2003).

Health care settings provide a unique opportunity for identification and intervention

Health care settings provide a unique opportunity for screening and intervention because of trusting relationships, confidentiality, and space away from the abuser.

Proponents of expanded screening note that screening in health care settings provides a unique opportunity to identify patterns of violence and prevent future harm (Family Violence Prevention Fund, 2004). Existing research on IPV and emergency room utilization suggests that there is potential for identification and intervention before violence escalates. For example, one study examining emergency department utilization by women who were ultimately killed by an intimate partner found that 44 percent of the women had sought help in an emergency department within the two years prior to their death (Wadman and Muelleman, 1999). Clinicians also usually see patients individually, giving patients the ability to talk to someone without the abuser present. Clinicians can also discuss abuse in the health care context, helping patients understand the implications of abuse for their health and well-being. In addition, patients may feel more comfortable disclosing abuse to a physician or health care provider with whom they have built a trusting relationship, and because of physician-patient confidentiality expectations (American Academy of Family Physicians, 2005). There are some cases where confidentiality will be limited. Some states have mandatory reporting laws, which obligate health care providers to disclose IPV to authorities. Explaining confidentiality to patients during screening requires a clear understanding of such laws.[2]

Major medical associations and organizations recommend routine screening

The Joint Commission on the Accreditation of Hospitals and Health Care Organizations, American Medical Association, American Congress of Obstetrician Gynecologists, American Nurses Association, and U.S. Preventive Services Task Force all recommend routine IPV screening.

There is growing consensus among major medical associations that asking women about their experiences with IPV is important for reducing its incidence and severity. Most recently, in 2013, the USPSTF released a recommendation stating that "clinicians 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" (U.S. Preventive Services Task Force, 2013). The USPSTF is an independent group of national experts in prevention that makes evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. Its recommendations are widely accepted in the medical community (Agency for Healthcare Research and Quality, 2007). This recommendation was significant in that it updated a 2004 USPSTF determination which at the time found insufficient evidence to conduct universal IPV screening.

Screening and counseling for domestic violence was first institutionalized in 1992 when the Joint Commission on the Accreditation of Hospitals and Health Care Organizations (JCAHO) mandated that emergency departments develop written protocols for identifying and treating survivors of domestic violence in order to receive hospital accreditation (Joint Commission, 2009). Since then, many health associations have supported screening across health care specialties. The American Medical Association (AMA), American Congress of Obstetrician Gynecologists (ACOG), and the American Nurses Association (ANA) all recommend routine universal screening. These recommendations support screening not only in hospitals, but in a variety of health care settings, and not just when physical signs of abuse are present (ACOG, 1995; AMA, 1993; ANA, 2000).

[2] For more information on mandatory reporting laws, see the National Health Resource Center on Domestic Violence at http://www.futureswithoutviolence.org/content/features/detail/790/.

Prevalence of Screening

Research indicates that the prevalence of screening for intimate partner violence differs across health care specialties and is, overall, relatively low. One study synthesized the literature regarding screening rates from 1992 to 2005, finding that 3 to 41 percent of physicians reported routine screening for intimate partner abuse (Stayton and Duncan, 2005).[3] Physicians caring for pregnant patients reported routine screening 11 to 39 percent of the time. Another study, conducted in 2002, examined screening practices among a large sample composed of family practitioners, gynecologists, and emergency medicine physicians. It found that 6 percent of clinicians always screened their patients for domestic violence, while 10 percent had never screened a patient (Elliott, et al., 2002).

> Despite recommendations, screening prevalence is relatively low across health care specialties.

Despite the evidence that women experiencing violence often seek help in emergency departments, research indicates that women are commonly not asked about IPV when treated there. A 2006 study examining emergency department utilization by women who had been identified by police as victims of IPV found that only one-third of them were asked when treated if their injury was a result of violence (Kothari and Rhodes, 2006). Research also indicates that not every clinician is equally likely to screen. In general, clinicians are more likely to screen patients regularly if they have received training on the subject (Stayton and Duncan, 2005), are female (Jaffee et al., 2005), are younger (Stayton and Duncan, 2005), and/or are nurses rather than physicians (Stayton and Duncan, 2005).

The practice environment in which clinicians work also appears to play a role in predicting the likelihood of screening. For example, a study looking at the prevalence of screening across health care settings found that the highest rates occurred in settings where clinicians were prompted to screen (Stayton and Duncan, 2005). Kaiser Permanente, the largest nonprofit health plan in the United States, implemented an electronic medical record system to integrate IPV screening into everyday care, which resulted in a 600 percent increase in IPV identification from 2000 to 2011 in Kaiser Permanente's Northern California region (Decker et al., 2012). The use of such system prompts may be increasingly relevant as more clinicians implement electronic health information technology that requires clinicians to respond to certain fields in client health records (Rhodes, 2012). Finally, research has also found increases in screening rates associated with "environmental enablers," such as posters, pamphlets, on-site social workers, and reminder stickers on charts, as well as staff training (Stayton and Duncan, 2005).

Reasons for Relatively Low Screening Prevalence

Clinician-reported barriers to screening

Several studies have focused on identifying what obstacles, both real and perceived, clinicians face in conducting regular IPV screening. Sprague et al. conducted a meta-analysis of this research in 2012, identifying 22 studies that surveyed clinicians about barriers to IPV screening. The three most common barriers included time constraints (cited in 82 percent—or 18 out of 22—of the studies reviewed); lack of knowledge, education, or training on the issue (cited in 68 percent of studies); and inadequate follow-up resources and support staff (63 percent of studies). Clinicians also reported discomfort discussing IPV, concerns for their personal safety, and apprehension about misdiagnosis. Half of the reviewed studies reported that the health care provider feared invading their patients' privacy or offending them. Several reviewed studies (46 percent) also reported that health care providers did not think it was their role to screen for IPV or felt that they had more pressing issues to address (Sprague et al., 2012).

[3] Among the studies included in the Stayton and Duncan article, the date the study was conducted was not correlated with the reported prevalence of screening. In other words, according to the article, screening is not becoming more or less common.

Medical community views on screening frequency, context, and focus

There is debate within the medical community over what the appropriate frequency and conditions of screening should be given clinicians' limited time and resources. One question is whether asking about IPV should be done through a "case finding" approach or through universal screening (Wathen and McMillan, 2012). Case finding involves evaluating whether the patient has specific symptoms associated with IPV, such as cuts, bruises, or broken bones. It also considers whether something in the patient's history or status indicates that she is at greater risk. For example, IPV occurs across socioeconomic statuses, but the risk is higher if the patient is from a lower socioeconomic status (Rennison and Welchans, 2000; U.S. Department of Justice, 2004) or has a history of drug or substance abuse (McCloskey et al., 2005). These physical symptoms or other warning signs would signal to the clinician that additional questioning about IPV may be necessary.

Universal screening, on the other hand, involves a standardized assessment of all patients, regardless of their reasons for seeking medical attention or patient history (Wathen and McMillan, 2012). For example "The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings," developed in 1999 by Futures without Violence (formerly the Family Violence Prevention Fund), recommends that screening occur regularly including as part of routine health histories and during every new patient encounter.[4]

These guidelines, recommending screening frequently, regardless of risk factors or warning signs, demonstrate a universal screening approach. The USPSTF recommendation takes a modified universal screening approach, stating that all women should be screened regardless of risk factors, but it places an age restriction, limiting the recommendation to women of childbearing age, and does not specify in what conditions screening should occur. The IOM recommendation does not provide guidance on when and how often screening should occur or within which contexts.

Existing Evidence on Screening and Intervention

The 2013 USPSTF recommendation supporting screening of all women of childbearing age for intimate partner violence was based on the 2012 Annals of Internal Medicine's "Systematic Review of Evidence to Update the 2004 U.S. Preventive Services Task Force Recommendation" (Nelson et al. 2012). That review of 36 studies about IPV screening in health care settings concluded that there are effective screening tools, that screening tools do not cause significant harm, and that some interventions, primarily for pregnant or post-partum women, have had positive results.[5]

The review examined 15 studies that evaluated 13 existing screening instruments. Six screening instruments were found to be highly accurate, including: the Hurt, Insult, Threaten, and Scream (HITS) instrument; the Ongoing Violence Assessment Tool (OVAT); the Slapped, Threatened, and Throw (STaT) instrument; the Humiliation, Afraid, Rape, Kick (HARK) instrument; the Women Abuse Screening Tool (WAST); and the Partner Violence Screen (PVS) (Nelson et al., 2012). Fourteen studies included in the review determined that screening patients for IPV did not result in adverse outcomes (Nelson et al., 2012).

The review also looked at evidence related to interventions. An intervention is the response provided by the clinician or by a different service provider after a women discloses abuse through the screening process. The review included six studies that showed evidence that an intervention had a positive effect

[4] From "The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings" written by Futures Without Violence in 1999, and revised in 2004. The guidelines can be accessed at: http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf.

[5] For a listing of studies and more detail on the evidence thresholds used to assess them, see Nelson et al., 2012.

on reducing exposure to IPV, physical or mental harms, or mortality (Blair-Merritt et al., 2010; El-Mohandes et al., 2011; Kiely et al., 2010; McFarlane et al., 2006; Miller et al., 2011; Taft et al., 2009). Five of these six studies conducted interventions that targeted pregnant and postpartum women, and found modest improvements, including fewer episodes of IPV, reduction in reproductive coercion, and improved child gestational age and birth weight (Blair-Merritt et al., 2010; El-Mohandes et al., 2011; Kiely et al., 2010; Miller et al., 2011; Taft et al., 2009). One of the six studies assessed an intervention targeted to women in urban primary care public clinics and tested the difference between two intervention approaches (providing a wallet-sized referral card versus a 20-minute nurse case management session). The study found that both groups experienced a reduction in the number of threats of abuse, assaults, risks for homicide, and events of work harassment, and there was no statistically significant difference between the two interventions (McFarlane et al., 2006).

The systematic review also found one study that addressed the question of whether screening for IPV, without a follow-up intervention, reduced exposure to IPV, physical or mental harms, or mortality. Comparing outcomes for screened and non-screened women, the study found there was no statistically significant difference (MacMillan et al., 2009).

While the review provided sufficient evidence for the USPSTF to recommend universal IPV screening for all women of childbearing age, further research remains to be done to identify the most effective approaches to screening and to understand better the relationship between screening, intervention, and women's health outcomes.

Next Steps

The implementation of the *Women's Preventive Services Guidelines*—and the release of the 2013 U.S. Preventive Services Task Force recommendation—create new opportunities for identifying women experiencing IPV through the increased use of screening by health care providers. The National Health Resource Center on Domestic Violence, funded by HHS, has produced materials to explain the importance of IPV screening to health care providers in an effort to increase screening use.

Additional research could help policy makers and practitioners understand more fully how IPV screening and counseling can most effectively contribute to positive health outcomes. Several areas of research could be particularly helpful. First, evidence is needed to identify effective screening and assessment tools and the best methods of administration. The theoretical basis for improving health outcomes through screening starts when the patient discloses abuse to the clinician, so research to determine what types of questions and methods of inquiry enable patients to feel comfortable enough to discuss abuse would be useful. In addition, further study of the use of electronic health records and prompts could provide valuable information about how to effectively integrate screening into clinicians' usual routine.

Further, the field could benefit from well-conducted research identifying effective ways of making referrals and of facilitating patients' connection to services. Since additional services may be required to reduce a patients' exposure to violence, it is essential for clinicians to make referrals in a way that results in patient follow-through and use of the services.

Finally, research is needed to develop and evaluate effective post-screening interventions. Intimate partner violence has real short and long term direct and indirect negative consequences for physical and mental health. Screening for intimate partner violence has potential to improve health outcomes for women especially when tied to effective and evidence-based interventions that help women prevent or reduce their exposure to violence, when possible. Further research is needed to identify these interventions and the strategies clinicians can use to connect their patients with these interventions.

References

Agency for Healthcare Research and Quality. "Evaluation of the U.S. Preventive Services Task Force: Final Report." December 2007. Accessed 3 March 2013 from http://www.ahrq.gov/research/findings/final-reports/uspstf/index.html#contents

American Academy of Family Physicians. "Family and Intimate Partner Violence and Abuse." 2012. Accessed 12 December 2012 from http://www.aafp.org/online/en/home/policy/policies/f/familyandintimatepartner-violenceandabuse.html.

American Academy of Family Physicians. "Violence Position Paper: AAFP policy and advocacy statement." American Academy of Family Physicians. 2005. Accessed 10 February 2013 from http://www.aafp.org/online/en/home/policy/policies/v/violencepositionpaper.html.

American Congress of Obstetricians and Gynecologists. "Domestic Violence: ACOG Technical Bulletin No. 209" 1995. Accessed 10 February 2013 from http://www.ncbi.nlm.nih.gov/pubmed/8635639

American Medical Association. "American Medical Association Diagnostic and Treatment Guidelines on Domestic Violence." Arch Family Medicine Vol. 1, No. 1. 1992. Accessed 31 October 2012 from http://triggered.edina.clockss.org.ezproxyhhs.nihlibrary.nih.gov/ServeContent?url=http percent3A percent2F percent2Farchfami.ama-assn.org percent2Fcgi percent2Freprint percent2F1 percent2F1 percent2F39

American Nurses Association. "Position Statement on Violence Against Women."American Nurses Association. 2000. Accessed 10 February 2013 from http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Violence-Against-Women.html.

Bauer, Heidi M., Paul Gibson, Maria Hernandez, Charlotte Kent, Jeffrey Klausner, and Gail Bolan. "Intimate Partner Violence and High-Risk Sexual Behaviors Among Female Patients with Sexual Transmitted Diseases." Sexually Transmitted Diseases. Vol. 29 No. 7 pp. 411-416. Accessed 30 October 2012 from http://p9003-nihlibrarysfx.nih.gov.ezproxyhhs.nihlibrary.nih.gov/sfx_local/img/ajaxtabs/transparentpixel.png

Black, Michele C., Kathleen C. Basile, Matthew J. Breiding, Sharon G. Smith, Mikel L. Walters, Melissa T. Merrick, Jieru Chen, and Mark R. Stevens. "The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report." Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2011. Accessed 18 October 2012 at http://www.cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf

Blair-Merritt, Megan H., Jacky M. Jennings, Rusan Chen, Lori Burrell, Elizabeth McFarlane, Loretta Fuddy, and Anne K. Duggan. "Reducing Maternal Intimate Partner Violence After the Birth of a Child: A Randomized Controlled Trial of the Hawaii Healthy Start Home Visitation Program." Arch Pediatric Adolescent Medicine. Vol. 164 No. 1 PP 16-23. 2010. Accessed 4 November 2012 from http://archpedi.jamanetwork.com.ezproxyhhs.nihlibrary.nih.gov/article.aspx?articleid=382648.

Bonomi, Amy E., Melicall L. Anderson, Fredrick P. Rivara, and Robert S. Thompson. "Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence." Health Services Research Vol. 44 No. 3 March 2009. Accessed 1 November 2012 from http://onlinelibrary.wiley.com.ezproxyhhs.nihlibrary.nih.gov/doi/10.1111/j.1475-6773.2009.00955.x/pdf

Campbell, Jacquelyn C. "Health Consequences of Intimate Partner Violence." The Lancet. Vol. 359 April 2002. Accessed 4 November 2012 from http://www-ncbi-nlm-nih-gov.ezproxyhhs.nihlibrary.nih.gov/pubmed/11965295.

Campbell, Jacquelyn C. and Linda A. Lewandowski. "Mental and Physical Health Effects of Intimate Partner Violence on Women and Children." Psychiatric Clinics of North America Vol. 20, No. 2. June 1997. Accessed 20 October 2012 from http://www.sciencedirect.com.ezproxyhhs.nihlibrary.nih.gov/science/article/pii/S0193953X05703178

Catalano, Shannan, Erica Smith, Howard Snyder, and Michael Rand. "Female Victims of Violence." Bureau of Justice Statistics Selected Findings. Washington: Bureau of Justice Statistics, Office of Justice Programs, Department of Justice, 2009. Accessed 30 October 2012 from http://bjs.ojp.usdoj.gov/index.cfm?ty=tp&tid=971Center for Disease Control and Prevention. "Youth Violence: Definitions." Atlanta: Injury Center: Violence Prevention, Center for Disease Control and Prevention, 2011. Accessed 30 October 2012 at http://www.cdc.gov/violenceprevention/youthviolence/definitions.html

Centers for Disease Control and Prevention. "Adverse Childhood Experiences: Major Findings." 2012. Accessed 21 January 2013 from http://www.cdc.gov/ace/findings.htm.

Centers for Disease Control and Prevention. "Costs of Intimate Partner Violence Against Women in the United States." Atlanta: Center for Disease Control and Prevention, U.S. Department of Health and Human Services, 2003. Accessed 30 October 2012 from http://www.cdc.gov/ncipc/pub-res/ipv_cost/ipvbook-final-feb18.pdf

Centers for Disease Control and Prevention. "Intimate Partner Violence: Definitions." Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. 2010. Accessed 4 November 2012 from http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/definitions.html.

Centers for Disease Control and Prevention. "Homicides and Suicides—National Violent Death Reporting System, United States, 2003-2004." 2006. Accessed August 2013 from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5526a1.htm.

Coker, A., P. Smith, L. Bethea, M. King, R. McKeown. "Physical Health Consequences of Physical and Psychological Intimate Partner Violence." Archives of Family Medicine. Vol. 9. 2000. Accessed 30 October 2012 from http://www.clockss.org.ezproxyhhs.nihlibrary.nih.gov/clockss/Archives_of_Family_Medicine

Davis, J. W. "Domestic Violence: The 'Rule of Thumb': 2008 Western Trauma Association Presidential Address." The Journal of Trauma and Acute Care Surgery Vol. 65, No. 5. Nov. 2008, pp 969-74. Accessed 18 October 2012 from http://www.ncbi.nlm.nih.gov/pubmed/19001960

Decker, Michele R., Shannon Frattaroli, Brigid McCaw, Ann L. Coker, Phyllis Sharps, Wendy G. Lane, Mahua Mandal, Kelli Hirsch, Donna M. Strobino, Wendy L. Bennett, Jacquelyn Campbell, and Andrea Gielen. "Transforming the Healthcare Response to Intimate Partner Violence and Taking Best Practices to Scale." Journal of Women's Health. Vol. 21, No. 12. 2012. Accessed 14 April 2013 from http://online.liebertpub.com.ezproxyhhs.nihlibrary.nih.gov/doi/pdfplus/10.1089/jwh.2012.4058.

De Jesus, Lilia C., Athina Pappas, Seetha Shankaran, Lei Li, Abhik Das, Edward F. Bell, Barbara J. Stoll, Abbot R. Laptook, Michele C. Walsh, Ellen C. Hale, Nancy S. Newman, Rebecca Bara, and Rosemary D. Higgins. "Outcomes of Small for Gestational Age Infants Born at < 27 Weeks Gestation." The Journal of Pediatrics. Vol. 163 No. 1. July 2013. Accessed 1 April 2013 from http://www.jpeds.com/article/S0022-3476%2813%2900009-7/abstract.

Dienemann J., E. Boyle, D. Baker, W. Resnick, N. Wiederhorn, and J. Campbell. "Intimate Partner Abuse Among Women Diagnosed with Depression." Issues in Mental Health Nursing Vol. 21 No. 5 Aug. 2000 pp. 499-513. Accessed 30 October 2012 from http://www-ncbi-nlm-nih- gov.ezproxyhhs.nihlibrary.nih.gov/pubmed/11261074

Dillon, Gina, Rafat Hussain, Deborah Loxton, and Saifur Rahman. "Mental and Physical Health and Intimate Partner Violence Against Women: A Review of the Literature." International Journal of Family Medicine. 2013. Accessed 4 March 2013 from http://www.hindawi.com.ezproxyhhs.nihlibrary.nih.gov/journals/ijfm/2013/313909/.

Elliott, Lorrie, Michael Nerney, Theresa Jones, and Peter Friedmann. "Barriers to Screening for Domestic Violence." J Gen Internal Medicine Vol. 17 Feb. 2002. Accessed 30 October 2012 from http://www.springerlink.com.ezproxyhhs.nihlibrary.nih.gov/content/b3256k12583712p0/

El-Bassel, Nabila, Louisa Gilbert, Elwin Wu, Hyun Go, and Jennifer Hill. "Relationship Between Drug Abuse and Intimate Partner Violence: A Longitudinal Study Among Women Receiving Methadone." American Journal of Public Health. Vol. 93 No. 3 March 2005 pp. 465-470. Accessed 18 October 2012 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449203/

El-Mohandes, Ayman A. E., Michele Kiely, Marie G. Gantz, and M. Nabil El-Khorazaty. "Very Preterm Birth is Reduced in Women Receiving an Integrated Behavioral Intervention: A Randomized Controlled Trial." Maternal and Child Health Journal. Vol. 15 No. 1 January 2011. Accessed 4 November 2012 from http://www.ncbi.nlm.nih.gov/pubmed/20082130.

Family Violence Prevention Fund. "National Consensus Guidelines On Identifying and Responding to Domestic Violence Victimization in Health Care Settings." San Francisco: The Family Violence Prevention Fund, 2004. Accessed 30 October 2012 from http://www.futureswithoutviolence.org/userfiles/file/Health care/consensus.pdf

Frank, Erica, Lisa Elon, Linda E. Saltzman, Debra Houry, Pamela McMahon, Joyce Doyle. "Clinical and Personal Intimate Partner Violence Training Experiences of U.S. Medical Students." Journal of Women's Health Vol. 15, No. 9, 2006. Accessed 1 November 2012 from http://online.liebertpub.com.ezproxyhhs.nihlibrary.nih.gov/doi/pdf/10.1089/jwh.2006.15.1071

Hack, Maureen and Avroy A. Fanaroff. "Outcomes of children of extremely low birthweight and gestational age in the 1990s." Seminars in Neonatology . Vol. 5 No. 2. May 2000. Accessed 1 April 2013 from http://www.journals.elsevierhealth.com/periodicals/ysiny/article/S1084-2756%2899%2990001-5/abstract.

Health Resources and Services Administration. "Women's Preventive Services: Required Health Plan Coverage Guidelines." Rockville: Health Resource and Services Administration, U.S. Department of Health and Human Services, 2012. Accessed 18 October 2012 at http://www.hrsa.gov/womensguidelines/

Hess, Kristen L., Marjan Javanbakht, Joelle Brown, Robert Weiss, Paul Hsu, and Pamina Gorbach. "Intimate Partner Violence and Sexually Transmitted Infections Among Young Adult Women." Sexually Transmitted Diseases Vol. 39 No. 5 PP. 366-71 May 2012. Accessed 4 November 2012 from http://www.ncbi.nlm.nih.gov/pubmed/22504601

Holt, Stephanie, Helen Buckley, and Sadhbh Whelan. "The impact of exposure to domestic violence on children and young people: A review of the literature." Child Abuse & Neglect. Vol. 32 No. 8 August 2008 pp 797-810. Accessed 10 February 2013 from http://www.sciencedirect.com.ezproxyhhs.nihlibrary.nih.gov/science/article/pii/S0145213408001348.

Hutton, Jane L., Peter O D Pharoah, Richard W I Cooke, Richard C Stevenson. "Differential effects of preterm birth and small gestational age on cognitive and motor development." Archives of Disease in Childhood. Vol. 76 PP. F75-F81. 1997. Accessed 31 October 2012 from http://fn.bmj.com.ezproxyhhs.nihlibrary.nih.gov/content/76/2/F75.full.pdf+html

Institute of Medicine. "Clinical Preventive Services for Women: Closing the Gaps." Washington: The National Academies Press, 2011. Accessed 31 October 2012 from http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx#

Jaffe, P. and M. Sudermann. "Child Witness of Women Abuse: Research and Community Responses." Understanding Partner Violence: Prevalence, Causes, Consequences, and Solutions in Families in Focus Services, Vol. II. Minneapolis: National Council on Family Relations, 1995.

Jaffee, Kim D., John W. Epling, William Grant, Reem M. Ghandour, Elizabeth Callendar. "Physician-Identified Barriers to Intimate Partner Violence Screening." Journal of Women's Health Vol. 14 No. 8, 2005. Accessed 30 October 2012 from http://online.liebertpub.com.ezproxyhhs.nihlibrary.nih.gov/doi/abs/10.1089/jwh.2005.14.713

Jaquier, Veronique, Julianne C. Hellmuth, Tami P. Sullivan. "Posttraumatic stress and depression symptoms as correlates of deliberate self-harm among community women experiencing intimate partner violence." Psychiatry Research. Vol. 206 No. 1. March 2013. Accessed 1 April 2013 http://www.deepdyve.com/lp/elsevier/posttraumatic-stress-and-depression-symptoms-as-correlates-of-7dNceZfWYO.

Joint Commission on Accreditation of Health care Organizations. "Standard PC.01.02.09." Accreditation Participation Requirements. 2009. Accessed 30 October 2012 from http://www.canainc.org/compendium/pdfs/D percent201. percent20JC percent20Standards percent202010.pdf

Kiely, Michele, Ayman A.E. El-Mohandes, M. El-Khorazaty, and Marie G. Gantz. "An Integrated Intervention to reduce Intimate Partner Violence in Pregnancy: A Randomized Trial." Obstet Gynecology Vol. 115 No. 2 Pt. 1 PP 273-283 February 2010. Accessed 4 November 2012 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2917915/.

Kothari, C.L. and K.V. Rhodes. "Missed opportunities: emergency department visits by police-identified victims of intimate partner violence." Annals of Emergency Medicine Vol. 47 No. 2 pp. 190-9. Feb. 2006. Accessed 6 November 2012 from http://www-ncbi-nlm-nih-gov.ezproxyhhs.nihlibrary.nih.gov/pubmed/16431233

Kovac, S. H., Klapow, J. C., Kroenke, K., Spitzer, R. L., and Williams, J. B. "Differing symptoms of abused versus nonabused women in obstetric-gynecology settings." American Journal of Obstetrics and Gynecology. Vol. 188 No. 3. 2003.

La Flair, Lareina N., Catherine P. Bradshaw, Carla L. Storr, Kerry M. Green, Anika H. Alvanzo, and Rosa M. Crum. "Intimate Partner Violence and Patterns of Alcohol Abuse and Dependence Criteria Among Women: A Latent Class Analysis." Journal of Studies on Alcohol and Drugs. May 2012. Accessed 10 February 2013 from http://www.jsad.com.ezproxyhhs.nihlibrary.nih.gov/jsad/downloadarticle/Intimate_Partner_Violence_and_Patterns_of_Alcohol_Abuse_and_Dependence_Crit/5013.pdf

Letourneau, E. J., M. Holmes, and J. Chasedunn-Roark. "Gynecologic Health Consequences to Victims of Interpersonal Violence." Womens Health Issues. Vol. 9. No. 2. 1999. Accessed 10 February 2013 from http://www.whijournal.com/article/S1049-3867%2898%2900031-0/abstract.

Lewis-O'Conner, Annie, Phyllis W. Sharps, Janice Humphreys, Faye A.Gary, and Jacquelyn Campbell. "Children Exposed to Intimate Partner Violence." Children Exposed to Violence. Edited by Margaret M. Feerick and Gerald B. Silverman. Baltimore: Paul H. Brookes Publishing Co. 2006.

Lipsky, Sherry, Raul Caetano, Craig A. Field, and Gregory L. Larkin. "Psychosocial and Substance-use Risk Factors for Intimate Partner Violence." Drug and Alcohol Dependence Vol. 78 No. 1 PP 39-47 April 2005. Accessed 4 November 2012 from http://www.sciencedirect.com.ezproxyhhs.nihlibrary.nih.gov/science/article/pii/S0376871604002637#

MacMillan, Harriet L., C. Nadine Wathen, Michael H. Boyle, Harry S. Shannon, Marilyn Ford-Gilboe, Andrew Worster, Barbara Lent, Jeffrey H. Coben, Jacquelyn C. Campbell, and Louise-Anne McNutt. "Screening for Intimate Partner Violence in Health Care Settings." American Medical Association. 2009. Accessed 30 December 2012 from http://www.ncbi.nlm.nih.gov/pubmed/19654384.

McCloskey, Laura A., Erika Lichter, Michael L. Ganz, Corrine M. Williams, Megan R. Gerber, Robert Sege, Thomas Stair, and Barbara Herbert. "Intimate Partner Violence and Patient Screening Across Medical Specialties." Academic Emergency Medicine. Vol. 12 No. 8. August 2005. Accessed 10 November 2012 from http://onlinelibrary.wiley.com/doi/10.1197/j.aem.2005.03.529/abstract;jsessionid=F59375252C338D7181F559C1A03D3B96.d03t01.

McFarlane, Judith M., Janet Y. Groff, Jennifer A. O'Brein, and Kathy Watson. "Secondary Prevention of Intimate Partner Violence: A Randomized Controlled Trial." Nursing Research. Vol. 55 No. 1 February 2006 pp52-61. Accessed 10 February 2013 from http://www.ncbi.nlm.nih.gov/pubmed/16439929

Michael C. and Robert L. Muelleman. "Domestic Violence Homicides: ED use before Victimization." The American Journal of Emergency Medicine. Vol. 17, No. 7 Nov. 1999. Accessed 21 January 2013 from http://www.sciencedirect.com.ezproxyhhs.nihlibrary.nih.gov/science/article/pii/S0735675799901614

Miller, Elizabeth, Michele R. Decker, Heather L. McCauley, Daniel J. Tancredi, Rebecca R. Levenson, Jeffrey Waldman, Phyllis Schoenwald, Jay G. Silverman. "A Family planning clinic partner violence intervention to reduce risk associated with reproductive coercion." Contraception. Vol. 83 No. 3 PP. 274-280 March 2011. Accessed 4 November 2012 from http://www-ncbi-nlm-nih-gov.ezproxyhhs.nihlibrary.nih.gov/pmc/articles/PMC3052939/.

Mittal, M., T.E. Senn, and M.P. Carey. "Intimate Partner Violence and Condom Use Among Women: Does the Information-Motivation-Behavioral Skills Model Explain Sexual Risk Behavior?" AIDS and Behavior. Vol. 16 No. 4. May 2012. Accessed 4 November 2012 from https://www.ncbi.nlm.nih.gov/m/pubmed/21484278/?i=10&from=/20069447/related&filter=loattrfree%20full%20text.

Nelson, Heidi D., Christina Bougatsos, and Ian Blazina. "Screening Women for Intimate Partner Violence: A Systematic Review to Update the 2004 *U.S. Preventive Services Task Force Recommendation*." Annals of Internal Medicine. Vol. 156 No. 11 June 2012. Accessed 4 November 2012 from http://www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderart.pdf

Nudelman, Janet, Nancy Durborow, Marya Grambs, and Patrick Letellier. "Best Practices: Innovative Domestic Violence Programs in Health Care Settings." Family Violence Prevention Fund, U.S. Department of Health and Human Services. 1997.

The Patient Protection and Affordable Care Act. Public Law No. 111-148, § 2713 (2010).

Peled, Einat, Peter G. Jaffe, Jeffrey L. Edleson. Ending the Cycle of Violence. Thousand Oaks: Sage Publications Inc., 1995.

Pico-Alfonso, Maria, M. Isabel Garcia-Linares, Nuria Celda-Navarro, Concepcion Blasco-Ros, Enrique Echeburua, and Manuela Martinez. "The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide." Journal of Women's Health. Vol. 15. November 2006. Accessed 1 April 2013 from http://empower-daphne.psy.unipd.it/userfiles/file/pdf/Pico-Alfonso%20M_%20-%202006.pdf.

Rennison, Callie Marie and Sarah Welchans. "Bureau of Justice Statistics Special Report: Intimate Partner Violence." U.S. Department of Justice, Office of Justice Programs. May 2000. NCJ 178247. Accessed 7 March 2013 from http://www.popcenter.org/problems/domestic_violence/PDFs/Rennison&Welchans_2000.pdf.

Rhodes, Karin Verlaine. "Taking a Fresh Look at Routine Screening for Intimate Partner Violence: What Can We Do About What We Know?" Mayo Clinic Proceedings. Vol. 87 No. 5. May 2012. Accessed 10 November 2013 from http://www.mayoclinicproceedings.org/article/S0025-6196(12)00295-9/abstract.

Salber, Patricia R. and Ellen Taliaferro. The Physician's Guide to Intimate Partner Violence: A Reference for all Health Care Professionals. California: Volcano Press, 2006.

Shah, Prakesh S. and Jyotsna Shah. "Maternal Exposure of Domestic Violence and Pregnancy and Birth Outcomes; a Systematic Review and Meta-Analyses." Journal of Women's Health. Vol. 19, No. 11. Nov 2010 pp 2017-31. Accessed 30 October 2012 from http://online.liebertpub.com.ezproxyhhs.nihlibrary.nih.gov/doi/abs/10.1089/jwh.2010.2051

Silverman, Jay G., Anita Raj, Karen Clements. "Dating Violence and Associated Sexual Risk and Pregnancy Among Adolescent Girls in the United States." American Academy of Pediatrics Vol. 114 No. 2 Aug. 2004. Accessed 30 October 2012 from http://pediatrics.aappublications.org.ezproxyhhs.nihlibrary.nih.gov/content/114/2/e220.long

Simmons, Adelle and Laura Skopec. "47 Million Women will Have Guaranteed Access to Women's Preventive Services With Zero Cost-Sharing Under the Affordable Care Act." The Office of the Assistant Secretary for Planning and Evaluation. July 2012. Accessed 25 March 2013 from http://aspe.hhs.gov/health/reports/2012/WomensPreventiveServicesACA/ib.shtml.

Sprague, Shella, Kim Madden, Nicole Simunovic, Katelyn Godin, Ngan K. Pham, Mohit Bhandari, and J.C. Goslings. "Barriers to Screening for Intimate Partner Violence." Women and Health, Vol. 52 No. 6, 2012. Accessed 4 November 2012 from http://www-ncbi-nlm-nih-gov.ezproxyhhs.nihlibrary.nih.gov/pubmed/22860705

Stayton, Catherine D., and Mary M. Duncan. "Mutable Influences on Intimate Partner Abuse in Health Care Settings: A Synthesis of the Literature." Trauma, Violence, and Abuse Vol. 6 No. 4, Oct. 2005. Accessed 30 October 2012 from http://tva.sagepub.com.ezproxyhhs.nihlibrary.nih.gov/content/6/4/271.full.pdf+html

Stockman, Jamila K., Marguerite B. Lucea, and Jacquelyn C. Campbell. "Forced Sexual Initiation, sexual intimate partner violence and HIV risk in women: A global review of the literature." AIDS and Behavior. Vol. 17 No. 3. March 2013. Accessed 1 April 2013 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3586980/.

Taft, Angela J., Rhonda Small, Kelsey L. Hegarty, Lyndsey F. Watson, Lisa Gold, and Judith A. Lumley. "Mothers' AdvocateS in the Community (MOSAIC) –nonprofessional mentor support to reduce intimate partner violence and depression in mothers: a cluster randomized trial in primary care." BMC Public Health. Vol. 11No. 178 March 2011. Accessed 10 February 2013 from

U.S. Department of Justice. "When Violence Hits Home: How Economics and Neighborhood Play a Role." September 2004. Accessed 10 November 2012 from https://www.ncjrs.gov/pdffiles1/nij/205004.pdf.

U.S. Department of Health and Human Services. "Grandfathered Health Plans." 2012. Accessed 21 January 2013 from http://www.healthcare.gov/law/features/rights/grandfathered-plans/index.html.

U.S. Preventive Services Task Force. "Screening for Family and Intimate Partner Violence: Recommendation Statement." Rockville, MD: U.S. Preventive Services Task Force, 2004. Accessed 18 October 2012 at http://www.uspreventiveservicestaskforce.org/3rduspstf/famviolence/famviolrs.pdf .

U.S. Preventive Services Task Force. "Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults" U.S. Preventive Services Task Force, 2013. Accessed 10 February 2013 from http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Violence-Against-Women.html

Van Dulmen, Manfred H. M., Katherine M. Klipfel, Andrea D. Mata, Katherine C. Schinka, Shannon E. Claxton, Monica H. Swahn, and Robert M. Bossarte. "Cross-Lagged Effects Between Intimate Partner Violence Victimization and Suicidality From Adolescence Into Adulthood." Journal of Adolescent Health. Vol. 51 No. 5 November 2012. Accessed 1 April 2013 from http://www.jahonline.org/article/S1054-139X%2812%2900097-3/abstract.

Wadman, MC and Muelleman, RL. "Domestic Violence Homicides: ED Use Before Victimization." The American Journal of Emergency Medicine. Vol. 17 No. 7 November 1999. Accessed 10 November 2012 from http://www.ncbi.nlm.nih.gov/pubmed/10597091.

Wathen, Nadine and Harriet MacMillan. "Partner Violence Screening and Women's Quality of Life." Letters.Journal of American Medical Association. Vol. 308. No. 22. December 2012. Accessed 10 February 2013 from http://jama.jamanetwork.com.ezproxyhhs.nihlibrary.nih.gov/article.aspx?articleid=1484502 .

Woods, Stephanie J., Rasalie J. Hall, Jacquelyn C. Campbell, and Danielle M. Angott. "Physical Health and Posttraumatic Stress Disorder Symptoms in Women Experiencing Intimate Partner Violence." Journal of Midwifery & Women's Health Vol. 53, No. 6. Dec. 2008, pp 538-546. Accessed 18 October 2012 from http://www.sciencedirect.com.ezproxyhhs.nihlibrary.nih.gov/science/article/pii/S1526952308002493#bib3

World Health Organization. "Definition and typology of violence." 2013. Accessed 3 March 2013 from http://www.who.int/violenceprevention/approach/definition/en/.

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