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Intimate Partner Violence Screening and Intervention: The American College of Preventive Medicine Position Statement

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The purpose of this paper is to produce a position statement on intimate partner violence (IPV), a major sociomedical problem with recently updated evidence, systematic reviews, and U.S. Preventive Services Task Force guidelines. This position statement is a nonsystematic, rapid literature review on IPV incidence and prevalence, health consequences, diagnosis and intervention, domestic violence laws, current screening recommendations, barriers to screening, and interventions, focusing on women of childbearing age (15–45 years). The American College of Preventive Medicine (ACPM) recommends an integrated system of care approach to IPV for screening, identification, intervention, and ongoing clinical support. ACPM only recommends screening that is linked to ongoing clinical support for those at risk. ACPM recommends greater training of clinicians in IPV screening and interventions and offers health systems and research recommendations.

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BACKGROUND

The American College of Preventive Medicine (ACPM) routinely conducts reviews on important topics to update the College membership. The 2018 update of the U.S. Preventive Services Task Force (USPSTF) statement on intimate partner violence (IPV) provides the College the opportunity to conduct a rapid, updated, nonsystematic review of this critical topic for our members and for consideration by other specialties. The primary focus of this paper is the improvement of practices for addressing IPV among women of childbearing age (15–45 years), and screening and intervention with the provision of ongoing clinical support in health care and the community. This position statement uses a literature review to expand on the 2018 USPSTF guidelines, disseminate "promising or best practices," offer educational and training recommendations, provide policy recommendations for state and national organizations, offer recommendations for integrated health system delivery, and inform directions for future research.

INTRODUCTION

The term "IPV" describes physical, sexual, psychological, or economic harm by a current or former intimate partner, spouse, or dating partner.[1] This type of abuse can involve stalking, and can occur regardless of gender, sexual orientation, or whether there was a prior sexual relationship.[2,3] The historical term "domestic violence" is often used interchangeably with "IPV." Dating violence is synonymous. The primary focus of this paper is the secondary and tertiary prevention of IPV through healthcare screening and intervention for women of childbearing age (15–45 years).

Nearly 1 in 6 women (16%, or 19.1 million) and about 1 in 17 men (5.8%, or 6.4 million) in the U.S. were victims of stalking at some point in their lifetime.[4] In the U.S., approximately 1 in 4 women (24.4%, or 29.2 million) and nearly 1 in 10 men (10.6%, or 11.8 million) experience IPV during their lifetime.[4] The main contribution to morbidity is from the mental health consequences of abuse.[5] The health-related costs of IPV

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exceed $5.8 billion each year, with direct costs of medical and mental health care responsible for greater than two thirds of this amount.[6,7]

PRIMARY PREVENTION

Primary prevention, through the identification of risk and protective factors, allows interventions before violence occurs. The WHO promotes systematic primary prevention methods, including multisectorial action and integration with existing programs, such as those that address alcohol and substance abuse or reproductive health.[8,9] Though the importance and need for continued research on primary prevention is recognized by ACPM, it is beyond the scope of this work.[8]

SECONDARY AND TERTIARY PREVENTION

Secondary prevention through screening can identify and support those affected by violence. Tertiary prevention aims to prevent further injury or death owing to violence. There is lack of consensus at the global level on secondary prevention for IPV.[10]

In the U.S., and for the purposes of ACPM, there is wide consensus among American medical organizations to recommend routine screening for IPV in women of childbearing age. Screening with a systems-based approach that supports clinicians is the most effective in diagnosing and providing intervention to the victims of IPV.[11,12] 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 and Prevalence

Many victims of sexual violence, stalking, and IPV experience victimization early in life. More than 71% of the female victims and 58% of the male victims first experience IPV before age 25 years, and more than 23% of the female victims and 14% of the male victims are victimized before age 18 years.[13]

More than 1 in 3 female victims of IPV experienced physical violence, stalking, or multiple forms of rape.[14] Female undergraduate students experience an annual 5.6% incidence of rape or attempted rape, usually by someone that they know.[15] Among all the rapes reported by women, 51.1% are committed by a former or current intimate partner.[14]

Subpopulations such as the U.S. military experience higher than average rates of IPV and sexual assault. Stress because of military deployment or combat-related health issues, such as post-traumatic stress disorder, could be contributing factors.[16,17] Other subpopulations vulnerable to IPV include socioeconomically disadvantaged women[18] and women during pregnancy, preconception, and postpartum periods.[16,19] Past and recent abuse has been associated with the early cessation of breastfeeding.[20] People who identify as lesbian, gay, bisexual, or transgender are also at higher risk for IPV and sexual assault.[21]

Sexual violence impacts women across all races and ethnicities. Physical violence by an intimate partner over a lifetime is estimated to be experienced by 51.7% of American Indian/Alaska Native women, 51.3% of multiracial women, 41.2% of non-Hispanic black women, 30.5% of non-Hispanic white women, 29.7% of Hispanic women, and 15.3% of Asian or Pacific Islander women.[13]

Some progress has been made to date. The Violence Against Women Act (VAWA) was enacted in 1994, creating the U.S. Department of Justice's Office on Violence Against Women. The VAWA also provided resources for investigation and prosecution of violent crimes against women, and funded shelter and support groups.[22] Data from the National Crime Victimization Survey showed that after enactment of the VAWA, the rate of IPV dropped 64% between 1994 and 2010 among people aged ≥12 years from a nationally representative sample of U.S. households.[23] Between 1993 and 2007, the rate of intimate partner homicide of female victims decreased by 35%, and the rate of intimate partner homicide of male victims decreased 46%.[24]

HEALTH CONSEQUENCES

Social, physical, and psychological problems result from IPV, including family dissolution, adverse pregnancy outcomes, poor physical health, mental health disorders, incarceration, and death.[13,17,25] Associated health risk behaviors include a greater likelihood of smoking and heavy/binge drinking.[26] Survivors of IPV have an approximately twofold increase in the use of healthcare services.[27] Exposure to IPV has been associated with a higher prevalence of adverse health behaviors, such as smoking or substance use disorder.[28]

Injuries owing to IPV often go undetected. Although most clinicians recognize some injuries as suspicious for having been inflicted by another person, other injuries are more often explained as accidents. 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.[29–31] Although this population is more likely to receive sexual health screenings, such as HIV testing, they are less likely to get screening tests, such as Pap tests or mammograms.[32] Abuse victims are more likely to develop post-traumatic stress disorder, attempt

suicide, and perpetrate unhealthy patterns of abuse.[30,33] Post-concussive syndrome and mild traumatic brain injury may be comorbid or contributing factors to sequelae, such as anxiety or depression in IPV victims.[34,35]

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 dialogue 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. Detailed diagnostic codes for IPV are supported by ICD-10-CM.[36] Consistent diagnosis and documentation on IPV is important, so that data are collected accurately. This will help in understanding the incidence, risk factors, and associated injuries or illness. The use of electronic health records can be useful in the capture of specific IPV diagnostic and treatment data.[36] The security of records poses a real concern where controlling partners may have authorized Health Insurance Portability and Accountability Act of 1996 consent or power of attorney. Clinicians should therefore review these records meticulously for more limited access.

Screening does not always lead to the identification of IPV, intervention, or referral.[37] A study of police-identified women victims of IPV found that screening was done in 30% of the visits, and only 6% screened positive.[38] Further studies reported that <25% of identified victims were provided referral for IPV services.[39] Institutionally supported, system-level interventions are more successful than programs that only screen for IPV.[11] The components associated with successful programs include effective protocols for screening, ongoing training, immediate access to support services, and institutional support.[11]

Once IPV is identified, systems-based approaches toward intervention with written procedures and consistent diagnostic classification have proven effective.[40,41] IPV interventions include danger assessment, safety planning, prevention options; referral to violence intervention programs, social services, or behavioral health professionals; and compliance with reporting laws.[42] Counseling has been shown to be effective in reducing IPV victimization.[43] IPV advocates can provide support to victims, increase screening, and identify and more effectively facilitate referrals to community groups.[37] The Danger and Safety Assessment is part of the Veterans Health Administration integrated model for IPV screening. Screening and response evaluation data from the Veterans Health Administration has shown that women who screen positive on brief danger assessments are more likely to receive timely psychosocial follow-up care in integrated health care.[44]

Perpetrators are often referred to batterer intervention programs.[42] However, batterer intervention programs may only be available when a state mandate exists for convicted perpetrators. There is limited research regarding the 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.[45] The National Domestic Violence Hotline (800–799-SAFE) was developed under the VAWA, which provides assistance to victims, families, and health professionals who need help identifying local resources.

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 people who identify as lesbian, gay, bisexual, transgender, and queer.[22] 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.[46] However, most laws providing protection for IPV are passed at the state level, and those laws vary considerably.

Forty-one states have established Domestic Violence Fatality Review teams.[47] These vary in the appointed members, scope of coverage (local, regional, or statewide), developed recommendations, and 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 the 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 local police departments or public health agencies. In some states, this may only apply to injuries caused by weapons or in violation of criminal law; whereas in others, it may be specific to domestic violence.[48] 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; 2 states (Louisiana, South Carolina) specifically exclude same-sex partners; 2 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).[49] There is wide variation between states in how statutes protect adult or teen dating partners (Table 1). The statutes are often silent or unclear for teenagers.[49]

CURRENT SCREENING GUIDELINES

Healthcare providers play an integral part in caring for women and families experiencing IPV. A majority of victims (70%–81%) reported that they would like their healthcare providers to screen them for IPV.[50–52] Screening recommendations from other groups are summarized in Table 2.

The USPSTF 2018 guideline recommends that clinicians screen all women of childbearing age for IPV and provide services for those who screen positive.[1] Multiple screening tools are available to screen women of childbearing age; however, the USPSTF did not find valid screening methods for men in the primary care setting without direct evidence of abuse.[1] The USPSTF concluded their review with a Grade B level of evidence category rating, indicating there is high certainty that there is a moderate net benefit for screening.[1] More recent developments for IPV tools include the investigation of tools that assess stalking, including on college campuses.[53–56] The American Academy of Family Physicians and the American College of Physicians also uphold the USPSTF guidelines.[57] Similarly, the American Academy of Pediatrics recommends a multifaceted approach, including physician education and skills in screening and intervention, knowledge of laws, and collaboration with support organizations.[58]

The American College of Obstetricians and Gynecologists 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. The American College of Obstetricians and Gynecologists also delineates various components to screening as described in Table 2.[59,60]

CLINICIAN EDUCATION

Although any training at all has been found to make healthcare workers more likely to screen,[61] there is no standard model for medical school and postgraduate education on IPV.[62] 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, and mandatory reporting laws. Medical school curriculum on IPV is inconsistent, with some medical students receiving little to no education.[63] Compared with their counterparts, medical students who have received IPV education report more confidence and comfort interviewing patients and feel more prepared to address IPV.[63,64] 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.[65] The residents felt most unprepared on specific topics, such as risk assessment, creating a safety plan, and providing resources, referrals, and documentation.[65]

The American Academy of Family Physicians recommends the following training curriculum in IPV for residency programs: epidemiology, risks and red flags for identifying IPV or sexual harassment, and resources available to assist affected women; components of the evaluation and treatment of victims of rape and sexual assault (including psychosocial and legal issues); and the ability to perform or refer women for IPV counseling.[57,66] The American College of Emergency Physicians recommends that medical schools and emergency medicine residency curricula include education and training on IPV to recognize, assess, and intervene.[67] The American Association of Pediatricians recommends that residency training programs incorporate education on IPV and its implications for child health into the curricula of pediatricians and pediatric subspecialists.[58] The American College of Obstetricians and Gynecologists and American College of Physicians do not make specific recommendations regarding medical or residency education and training.[60,68]

Only a handful of states require any type of continuing medical education training for physicians who may be the first point of contact for a victim of domestic abuse (Table 1). Connecticut requires 1 contact hour pertaining to domestic violence at least every 6 years.[69] Florida requires 2 contact hours every 3rd biennial renewal.[70] Kentucky requires a 3-hour course on domestic violence within the first 3 years of a license being granted, with no further contact hours required.[71] Texas requires 2 contact hours in medical ethics or professional responsibility every 2 years. This may include risk management, domestic abuse, or child abuse.[72] The literature is inconclusive on the contribution of continuing medical education training to changes in physician behavior, but there is evidence that assuring a system of

Table 1. State Regulations

State	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 16–17 years old	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

(*continued on next page*)

Table 1. State Regulations (*continued*)

State	Fatality review team	Mandatory reporting	Mandatory CME	Order of protection			
				Opposite-sex partner	Same-sex partner	Adult/Teen dating partner	Stalking
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 aged ≥16 years)	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

CME, continuing medical education; N, no; Y, yes.

support and victim response if IPV is identified can impact physician behaviors.[73,74]

BARRIERS

Barriers to screening for IPV exist at multiple levels within the medical system, and although they may vary depending on the health setting, they are largely systemic. The barriers include lack of training, attitudes and perception of healthcare providers, and logistic 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 in addressing such a sensitive and complex issue may be less likely to screen for IPV.[75,76] Lower screening rates have been reported in emergency departments.[61] A study by Rhodes et al.[39] found that providers in emergency departments frequently missed opportunities to identify and provide interventions for police-identified women victims of IPV. A lack of information about domestic violence has been reported as a significant barrier to IPV screening in the emergency department setting.[77] This is significant because the emergency department is a critical entry point and the authors of that study estimate that between 20% and 50% of all female patients in the emergency room 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.[78,79] Lack of training was identified as the most common barrier to screening among trauma nurses.[80] Another study noted clinician confusion over reporting laws and legal responsibilities, as well as logistic challenges owing to lack of time and privacy, concluding that nurses need clearer protocols and resources before screening.[81]

Personal barriers, including the attitudes and perceptions of the healthcare provider, may negatively affect the performance of IPV screening. A survey of physicians noted that less than half of surveyed physicians believed that IPV was an issue for their female patients.[82] Physician-perceived barriers vary with practice setting and specialty, with increased perceived barriers in a private practice and fewer perceived barriers by obstetricians and gynecologists.[75] Clinician personal discomfort, a feeling of powerlessness in the screening situation, or previous personal experience can inhibit in-depth screening in some case.[77] Preconceptions and a lack of awareness regarding IPV later in life may affect a provider's ability to identify abuse.[83] Some clinicians reported forgetfulness as a barrier to screening, which underscores the usefulness of simple chart reminders for increased screening.[61]

Survivors face barriers in the decision to disclose IPV. Factors that can influence disclosure include patient–provider connectedness and ambiguity in the role of the healthcare system to address violence.[84] Anticipatory stigma, the belief that one will be blamed and stigmatized for disclosing, has been found to be a barrier for survivors in disclosing abuse.[85] Furthermore, race may affect the willingness of victims to disclose IPV if there is perceived discordance between the provider and patient.[86]

Logistic barriers include a lack of space for privacy and safety needs and a lack of time for sensitive intervention. Lack of privacy has been reported by clinicians

Table 2. Screening Recommendations of Other Groups

Organization	Screening recommendation
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 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 the 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 the 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.

AAFP, American Academy of Family Physicians; AAP, American Association of Pediatricians; ACEP, American College of Emergency Physicians; ACOG, American College of Obstetricians and Gynecologists; ACP, American College of Physicians; EMS, emergency medical services; USPSTF, U.S. Preventive Services Task Force.

in the emergency department setting[77] and may also contribute to the personal discomfort already inherent to the screening process.[79] Time constraints also present a barrier to IPV screening.[77,79] In addition to screening barriers, IPV identification is complicated by a variety of other factors—including fear of retaliation by the abuser, law enforcement/legal involvement, behaviors attributed to the abused women,[87] or the presence of a partner during screening.[88]

HEALTH SYSTEM CHANGES AND MODEL PRACTICES

Addressing barriers requires systems-based changes. McCaw and colleagues[74] 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: training for physicians, nurses, and clinical staff; clinic system change including administrative buy-in, quality strategies, and patient education; and clinic culture change, such that the healthcare system values and norms support identification, intervention, and treatment.[12] Models that aim to address such barriers include the Healthcare Can Change from Within model,[12,37] the evidence-based systems model implemented at Kaiser Permanente, Northern California,[89] and the comprehensive conceptual framework developed by O'Campo et al.[11] Improved IPV screening and intervention were demonstrated by the Change from Within model, through

enhanced provider education, training, community partnerships, and improved clinic policies.[12] The Veterans Health Administration offers a national integrated program for the early identification of IPV, danger assessment, and intervention—including home visits and continued supportive care.[90] This is seen as a model for integrated health systems nationally (L Bruce, Veterans Health Administration, personal communication 2019).

RECOMMENDATIONS FROM THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE

ACPM supports screening for IPV in women of childbearing age. More research should be done to determine the appropriate screening methods for other populations at risk for IPV, including men, the elderly, adolescents, and lesbian, gay, bisexual, transgender, and queer populations (which can also include women of childbearing age). Further research is needed on the screening and management of perpetrators of IPV. ACPM supports the development of standardized methodologies and best practices for screening, identification, diagnosis, intervention, and documentation of IPV for clinicians. Early intervention of IPV is important, and further research is needed on primary prevention.

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

ACPM recommends the following:

1. Medical education and training. All physicians should receive standardized evidence-based education and training on IPV screening, identification, diagnosis, intervention, and reporting laws, during medical school and residency.
2. National medical associations. National medical associations should 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 should require initial continuing medical education training on reporting requirements, as this can vary from state to state.
4. Local and regional health systems. Local and regional health systems should provide an infrastructure that enables the providers to screen, identify, diagnose, and intervene effectively in all healthcare settings where the victims of IPV may present. Health systems should develop patient messaging and education materials and provide private and safe environments for screening and caring for victims of IPV. Health systems should also develop the internal expertise of select staff and general training for all staff, collaborate with community organizations, identify resources, and develop referral patterns. Written procedures/protocols and quality improvement strategies should be created, with support and oversight from leadership to ensure capacity building.
5. Healthcare providers. Within a supportive system, healthcare providers should routinely screen for IPV in a private and safe environment using a nonjudgmental manner. Providers should be 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. ACPM statement presented here is consistent with recommendations from other organizations and additionally recommends systems-based approaches to IPV screening, identification, and intervention. Although ACPM supports improved education and training for healthcare providers, the application to clinical practice will be most effective in screening, diagnosing, and providing intervention for IPV through a systemic approach. ACPM further recommends that this systems-based approach be applied collaboratively across various levels of infrastructure that affect providers and their clinical practice. In addition, addressing IPV will require research to improve early screening and intervention, the development of best practices, and attention to at-risk subpopulations.

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REFERENCES

1. U.S. Preventive Services Task Force, Curry SJ, Krist AH, et al. Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults: U.S Preventive Services Task Force final recommendation statement. JAMA. 2018;320(16):1678–1687. https://doi.org/10.1001/jama.2018.14741.

2. Saltzman L, Fanslow JL, McMahon PM, et al. *Intimate Partner Violence Surveillance, Uniform Definitions and Recommended Data Elements*. Atlanta, GA: HHS, CDC, 2002.
3. Costa D, Hatzidimitriadou E, Ioannidi-Kapolou E, et al. Male and female physical intimate partner violence and socio-economic position: a cross-sectional international multicentre study in Europe. *Public Health*. 2016;139:44–52. https://doi.org/10.1016/j.puhe.2016.05.001.
4. Smith SG, Zhang X, Basile KC, et al. *National intimate partner and sexual violence survey: 2015 Data Brief -Updated Release*. Atlanta, GA: National Center for Injury Prevention and Control, CDC;2018.
5. Hegarty K. Domestic violence: the hidden epidemic associated with mental illness. *Br J Psychiatry*. 2011;198(3):169–170. https://doi.org/10.1192/bjp.bp.110.083758.
6. Max W, Rice DP, Finkelstein E, Bardwell RA, Leadbetter S. The economic toll of intimate partner violence against women in the United States. *Violence Vict*. 2004;19(3):259–272. https://doi.org/10.1891/vivi.19.3.259.65767.
7. National Center for Injury Prevention and Control. Costs of Intimate Partner Violence Against Women in the United States. Atlanta, GA: CDC, 2003.
8. Harvey A, Garcia-Moreno C, Butchart A. *Primary prevention of intimate-partner violence and sexual violence: background paper for WHO expert meeting May 2–3, 2007*. www.who.int/violence_injury_prevention/publications/violence/IPV-SV.pdf. Published 2007. Accessed July 3, 2019.
9. WHO. Responding to intimate partner violence and sexual violence against women. https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf;jsessionid=00E52F68E08FDA8EEBA3C0F28204A228?sequence=1 Published 2013. Accessed July 3, 2019.
10. O'Doherty LJ, Taft A, Hegarty K, et al. Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis. *BMJ*. 2014;348:g2913. https://doi.org/10.1136/bmj.g2913.
11. O'Campo P, Kirst M, Tsamis C, Chambers C, Ahmad F. Implementing successful intimate partner violence screening programs in health care settings: evidence generated from a realist-informed systematic review. *Soc Sci Med*. 2011;72(6):855–866. https://doi.org/10.1016/j.socscimed.2010.12.019.
12. Ambuel B, Hamberger LK, Guse CE, et al. Healthcare can change from within: sustained improvement in the healthcare response to intimate partner violence. *J Fam Violence*. 2013;28(8):833–847. https://doi.org/10.1007/s10896-013-9550-9.
13. Breiding MJ, Smith SG, Basile KC, et al. Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization—national Intimate Partner and Sexual Violence Survey, United States, 2011. *MMWR Surveill Summ*. 2014;63(8):1–18.
14. Black MC, Basile KC, Breiding MJ, et al. *National Intimate Partner Sexual Violence Survey 2010 summary report*. Atlanta, GA: National Center for Injury Prevention and Control, CDC; 2011.
15. Salazar LF, Vivolo-Kantor A, Hardin J, Berkowitz A. A web-based sexual violence bystander intervention for male college students: randomized controlled trial. *J Med Internet Res*. 2014;16(9):e203. https://doi.org/10.2196/jmir.3426.
16. Saltzman LE, Johnson CH, Gilbert BC, Goodwin MM. Physical abuse around the time of pregnancy: an examination of prevalence and risk factors in 16 states. *Matern Child Health J*. 2003;7(1):31–43. https://doi.org/10.1023/A:1022589501039.
17. Gierisch JM, Shapiro A, Grant NN, King HA, McDuffie JR, Williams JW. *Intimate Partner Violence: Prevalence Among U.S.* Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches. Washington, DC: Department of Veterans Affairs; 2013.
18. Bohn DK, Tebben JG, Campbell JC. Influences of income, education, age, and ethnicity on physical abuse before and during pregnancy. *J Obstet Gynecol Neonat Nurs*. 2004;33(5):561–571. https://doi.org/10.1177/0884217504269009.
19. Agrawal A, Ickovics J, Lewis JB, Magriples U, Kershaw TS. Postpartum intimate partner violence and health risks among young mothers in the United States: a prospective study. *Matern Child Health J*. 2014;18(8):1985–1992. https://doi.org/10.1007/s10995-014-1444-9.
20. Sorbo MF, Lukasse M, Brantsaeter AL, Grimstad H. Past and recent abuse is associated with early cessation of breast feeding: results from a large prospective cohort in Norway. *BMJ Open*. 2015;5(12):e009240. https://doi.org/10.1136/bmjopen-2015-009240.
21. Rothman EF, Exner D, Baughman AL. The prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States: a systematic review. *Trauma Violence Abus*. 2011;12(2):55–66. https://doi.org/10.1177/1524838010390707.
22. Modi MN, Palmer S, Armstrong A. The role of Violence Against Women Act in addressing intimate partner violence: a public health issue. *J Womens Health (Larchmt)*. 2014;23(3):253–259. https://doi.org/10.1089/jwh.2013.4387.
23. Catalano S. *Special Report: Intimate Partner Violence 1993–2010*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2015.
24. Catalano S, Smith E, Snyder H, et al. *Female Victims of Violence*. U.S. Department of Justice, Office of Justice Programs, 2009.
25. Davies R, Lehman E, Perry A, McCall-Hosenfeld JS. Association of intimate partner violence and health-care provider-identified obesity. *Women Health*. 2016;56(5):561–575. https://doi.org/10.1080/03630242.2015.1101741.
26. Breiding MJ, Smith SG, Breiding M, Black MC, Mahendra R. *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements*. Version 2.0. Atlanta, GA: CDC;2015.
27. Ulrich YC, Cain KC, Sugg NK, et al. Medical care utilization patterns in women with diagnosed domestic violence. *Am J Prev Med*. 2003;24(1):9–15. https://doi.org/10.1016/s0749-3797(02)00577-9.
28. McCall-Hosenfeld JS, Chuang CH, Weisman CS. Prospective association of intimate partner violence with receipt of clinical preventive services in women of reproductive age. *Womens Health Issues*. 2013;23(2):e109–e116. https://doi.org/10.1016/j.whi.2012.12.006.
29. Plichta SB. Intimate partner violence and physical health consequences: policy and practice implications. *J Interpers Violence*. 2004;19(11):1296–1323. https://doi.org/10.1177/0886260504269685.
30. Campbell JC. Health consequences of intimate partner violence. *Lancet*. 2002;359(9314):1331–1336. https://doi.org/10.1016/s0140-6736(02)08336-8.
31. Janssen PA, Holt VL, Sugg NK, et al. Intimate partner violence and adverse pregnancy outcomes: a population-based study. *Am J Obstet Gynecol*. 2003;188(5):1341–1347. https://doi.org/10.1067/mob.2003.274.
32. Brown MJ, Weitzen S, Lapane KL. Association between intimate partner violence and preventive screening among women. *J Womens Health*. 2002;22(11):947–952. https://doi.org/10.1089/jwh.2012.4222.
33. Coker AL, Davis KE, Arias I, et al. Physical and mental health effects of intimate partner violence for men and women. *Am J Prev Med*. 2002;23(4):260–268. https://doi.org/10.1016/S0749-3797(02)00514-7.
34. Davis A. Violence-related mild traumatic brain injury in women: identifying a triad of postinjury disorders. *J Trauma Nurs*. 2014;21(6):300–308. https://doi.org/10.1097/jtn.0000000000000086.
35. Kwako LE, Glass N, Campbell J, et al. Traumatic brain injury in intimate partner violence: a critical review of outcomes and mechanisms. *Trauma Violence Abus*. 2011;12(3):115–126. https://doi.org/10.1177/1524838011404251.
36. Miller E, McCaw B, Humphreys BL, Mitchell C. Integrating intimate partner violence assessment and intervention into healthcare in the United States: a systems approach. *J Womens Health (Larchmt)*. 2015;24(1):92–99. https://doi.org/10.1089/jwh.2014.4870.

37. Hamberger LK, Rhodes K, Brown J. Screening and intervention for intimate partner violence in healthcare settings: creating sustainable system-level programs. *J Womens Health (Larchmt).* 2015;24(1):86–91. https://doi.org/10.1089/jwh.2014.4861.
38. Kothari CL, Rhodes KV. Missed opportunities: emergency department visits by police-identified victims of intimate partner violence. *Ann Emerg Med.* 2006;47(2):190–199. https://doi.org/10.1016/j.annemergmed.2005.10.016.
39. Rhodes KV, Kothari CL, Dichter M, et al. Intimate partner violence identification and response: time for a change in strategy. *J Gen Intern Med.* 2011;26(8):894–899. https://doi.org/10.1007/s11606-011-1662-4.
40. Olive P. Classificatory multiplicity: intimate partner violence diagnosis in emergency department consultations. *J Clin Nurs.* 2017;26(15–16):2229–2243. https://doi.org/10.1111/jocn.13673.
41. Leppakoski T, Paavilainen E. Interventions for women exposed to acute intimate partner violence: emergency professionals' perspective. *J Clin Nurs.* 2013;22(15–16):2273–2285. https://doi.org/10.1111/j.1365-2702.2012.04202.x.
42. Chen PH, Jacobs A, Rovi SL. Intimate partner violence: counseling, community resources, and legal issues for IPV victims and perpetrators. *FP Essent.* 2013;412:18–23.
43. Kiely M, El-Mohandes AA, El-Khorazaty MN, Blake SM, Gantz MG. An integrated intervention to reduce intimate partner violence in pregnancy: a randomized controlled trial. *Obstet Gynecol.* 2010;115(2):273–283. https://doi.org/10.1097/aog.0b013e3181cbd482.
44. Iverson KM, Sorrentino AE, Bellamy SL, et al. Adoption, penetration, and effectiveness of a secondary risk screener for intimate partner violence: evidence to inform screening practices in integrated care settings. *Gen Hosp Psychiatry.* 2018;51:79–84. https://doi.org/10.1016/j.genhosppsych.2018.01.002.
45. National Resource Center on Domestic Violence. Domestic violence awareness month history. Adapted from *the 1996 Domestic Violence Awareness Month Resource Manual* of the National Coalition Against Domestic Violence. http://www.nrcdv.org/dvam/DVAM-history. Accessed June 22, 2016.
46. U.S. Attorneys. Northern District of Georgia. Federal domestic violence. U.S. Department of Justice, 2016. www.justice.gov/usao-ndga/victim-witness-assistance/federal-domestic-violence. Updated 2015. Accessed 23 July 2019.
47. Websdale N. *National domestic violence fatality review initiative*. http://ndvfri.org/review-teams/. Published 2016. Accessed September 25, 2016.
48. Durbow N, Lizdas KC, O'Flaherty A, Marjavi A. Compendium of state statutes and policies on domestic violence and health care. *The Family Violence Prevention Fund.* 2010.
49. American Bar Association Commission on Domestic & Sexual Violence. Civil protection orders: domestic violence. 2016. www.americanbar.org/groups/domestic_violence/Initiatives/statutory_summary_charts/. Accessed July 18, 2019.
50. Parsons L, Goodwin MM, Petersen R. Violence against women and reproductive health: toward defining a role for reproductive health care services. *Matern Child Health J.* 2000;4(2):135–140. https://doi.org/10.1023/A:1009578406219.
51. Parker B, McFarlane J, Soeken K. Abuse during pregnancy: effects on maternal complications and birth weight in adult and teenage women. *Obstet Gynecol.* 1994;84(3):323–328.
52. McFarlane J, Parker B, Soeken K. Physical abuse, smoking, and substance use during pregnancy: prevalence, interrelationships, and effects on birth weight. *J Obstet Gynecol Neonat Nurs.* 1996;25(4):313–320. https://doi.org/10.1111/j.1552-6909.1996.tb02577.x.
53. McEwan TE, Pathe Ogloff JR. Advances in stalking risk assessment. *Behav Sci Law.* 2011;29(2):180–201. https://doi.org/10.1002/bsl.973.
54. McEwan TE, Shea DE, Daffern M, et al. The reliability and predictive validity of the Stalking Risk Profile. *Assessment.* 2018;25(2):259–276. https://doi.org/10.1177/1073191116653470.
55. McEwan TE, Strand S, MacKenzie R, James D. *Screening assessment for stalking and harassment (SASH).* www.stalkingriskprofile.com/stalking-risk-profile/sash. Published 2015. Accessed September 26, 2016.
56. McNamara C, Marsil DF. The prevalence of stalking among college students: the disparity between research and self-identified victimization. *J Am Coll Health.* 2012;60(2):168–174. https://doi.org/10.1080/07448481.2011.584335.
57. American Academy of Family Physicians. Women's Health: Recommended Curriculum Guidelines for Family Medicine Residents. Published 2012.
58. Thackeray JD, Hibbard R, Dowd MD. Intimate partner violence: the role of the pediatrician. Pediatrics. *Pediatrics.* 2010;125(5):1094–1100. https://doi.org/10.1542/peds.2010-0451.
59. American College of Obstetricians and Gynecologists. Screening Tools-Domestic Violence. Published 2014.
60. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 518: Intimate partner violence. *Obstet Gynecol.* 2012;119(2 Pt): 412–417. https://doi.org/10.1097/aog.0b013e318249ff74.
61. Elliott L, Nerney M, Jones T, Friedmann PD. Barriers to screening for domestic violence. *J Gen Intern Med.* 2002;17(2):112–116. https://doi.org/10.1046/j.1525-1497.2002.10233.x.
62. Hamberger LK. Preparing the next generation of physicians: medical school and residency-based intimate partner violence curriculum and evaluation. *Trauma Violence Abus.* 2007;8(2):214–225. https://doi.org/10.1177/1524838007301163.
63. Connor PD, Nouer SS, Mackey SN, Banet MS, Tipton NG. Intimate partner violence education for medical students: toward a comprehensive curriculum revision. *South Med J.* 2012;105(4):211–215. https://doi.org/10.1097/smj.0b013e31824f8b01.
64. Aluko OE, Beck KH, Howard DE. Medical students' beliefs about screening for intimate partner violence: a qualitative study. *Health Promot Pract.* 2015;16(4):540–549. https://doi.org/10.1177/1524839915571183.
65. LaPlante LM, Gopalan P, Glance J. Addressing intimate partner violence: reducing barriers and improving residents' attitudes, knowledge, and practices. *Acad Psychiatry.* 2016;40(5):825–828. https://doi.org/10.1007/s40596-016-0529-8.
66. Cronholm PF, Fogarty CT, Ambuel B, Harrison SL. Intimate partner violence. *Am Fam Phys.* 2011;83(10):1165–1172.
67. American College of Emergency Physicians. Domestic family violence. www.acep.org/imports/clinical-and-practice-management/resources/violence/domestic-family-violence/. Published 2017. Accessed July 7, 2019.
68. Hoxmeier JC, Flay BR, Acock AC. Control, norms, and attitudes: differences between students who do and do not intervene as bystanders to sexual assault. *J Interpers Violence.* 2018;33(15):2379–2401. https://doi.org/10.1177/0886260515625503.
69. Connecticut State Department of Public Health. Continuing medical education. www.ct.gov/dph/cwp/view.asp?a=3121&q=389490&dphNav_GID=1821. Accessed June 1, 2016.
70. Florida Department of State Board of Medicine. Continuing education for biennial renewal. www.flrules.org/gateway/RuleNo.asp?title=LICENSERENEWALANDREACTIVATION;CONTINUINGEDUCATION&ID=64B8-13.005. Accessed June 1, 2016.
71. Kentucky Board of Medicine. Continuing education requirements. https://kbml.ky.gov/cme/Documents/CME%20Domestic%20Violence.pdf. Accessed July 18, 2019.
72. Texas Medical Board. Continuing medical education for MDs/DOs. www.tmb.state.tx.us/page/resources-cme-for-md-dos. Accessed June 1, 2016.
73. Zaher E, Keogh K, Ratnapalan S. Effect of domestic violence training: systematic review of randomized controlled trials. *Can Fam Phys.* 2014;60(7):618–624.
74. McCaw B, Berman WH, Syme SL, Hunkeler EF. Beyond screening for domestic violence: a systems model approach in a managed care setting. *Am J Prev Med.* 2001;21(3):170–176. https://doi.org/10.1016/s0749-3797(01)00347-6.

75. Jaffee KD, Epling JW, Grant W, Ghandour RM, Callendar E. Physician-identified barriers to intimate partner violence screening. *J Womens Health (Larchmt).* 2005;14(8):713–720. https://doi.org/10.1089/jwh.2005.14.713.
76. Pagels P, Kindratt TB, Reyna G, et al. Establishing the need for family medicine training in intimate partner violence screening. *J Commun Health.* 2015;40(3):508–514. https://doi.org/10.1007/s10900-014-9964-1.
77. Davis RE, Harsh KE. Confronting barriers to universal screening for domestic violence. *J Prof Nurs.* 2001;17(6):313–320. https://doi.org/10.1053/jpnu.2001.28181.
78. Gotlib Conn L, Young A, Rotstein OD, Schemitsch E. "I've never asked one question." Understanding the barriers among orthopedic surgery residents to screening female patients for intimate partner violence. *Can J Surg.* 2014;57(6):371–378. https://doi.org/10.1503/cjs.000714.
79. Sprague S, Madden K, Simunovic N, et al. Barriers to screening for intimate partner violence. *Women Health.* 2012;52(6):587–605. https://doi.org/10.1080/03630242.2012.690840.
80. DeBoer MI, Kothari R, Kothari C, Koestner AL, Rohs T Jr. What are barriers to nurses screening for intimate partner violence? *J Trauma Nurs.* 2013;20(3):155–160. https://doi.org/10.1097/jtn.0b013e3182a171b1.
81. Furniss K, McCaffrey M, Parnell V, Rovi S. Nurses and barriers to screening for intimate partner violence. *MCN Am J Matern Child Nurs.* 2007;32(4):238–243. https://doi.org/10.1097/01.nmc.0000281964.45905.89.
82. Reid SA, Glasser M. Primary care physicians' recognition of and attitudes toward domestic violence. *Acad Med.* 1997;72(1):51–53.
83. Brossoie N, Roberto KA. Community professionals' response to intimate partner violence against rural older women. *J Elder Abus Negl.* 2015;27(4–5):470–488. https://doi.org/10.1080/08946566.2015.1095664.
84. Williams JR, Gonzalez-Guarda RM, Halstead V, Martinez J, Joseph L. Disclosing gender-based violence during health care visits: a patient-centered approach. *J Interpers Violence.* In press. Online July 27, 2017. https://doi.org/10.1177/0886260517720733.
85. Kennedy AC, Prock KA. "I still feel like I am not normal": a review of the role of stigma and stigmatization among female survivors of child sexual abuse, sexual assault, and intimate partner violence. *Trauma Violence Abus.* 2018;19(5):512–527. https://doi.org/10.1177/1524838016673601.
86. Samples TC, Woods A, Davis TA, et al. Race of interviewer effect on disclosures of suicidal low-income African American women. *J Black Psychol.* 2014;40(1):27–46. https://doi.org/10.1177/0095798412469228.
87. Rodriguez MA, Bauer HM, McLoughlin E, Grumbach K. Screening and intervention for intimate partner abuse: practices and attitudes of primary care physicians. *JAMA.* 1999;282(5):468–474. https://doi.org/10.1001/jama.282.5.468.
88. Beynon CE, Gutmanis IA, Tutty LM, Wathen CN, MacMillan HL. Why physicians and nurses ask (or don't) about partner violence: a qualitative analysis. *BMC Public Health.* 2012;12:473. https://doi.org/10.1186/1471-2458-12-473.
89. Young-Wolff K, Kotz K, McCaw B. Transforming the health care response to intimate partner violence, addressing "wicked problems". *JAMA.* 2016;315(23):2517–2518. https://doi.org/10.1001/jama.2016.4837.
90. Veterans Health Administration. Intimate Partner Violence Assistance Program, 2018 Program Summary. Washington, DC: VA Care Management and Social Work, U.S. Department of Veterans Affairs; 2019.