EMERGENCY NURSES ASSOCIATION

Clinical Practice Guideline:
Intimate Partner Violence

For adult (18 and older) emergency department patients, how effective is screening and/or intervention for intimate partner violence?

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Background and Significance

Intimate Partner Violence (IPV) is a serious public health concern that can result in numerous long-term negative physical and psychological effects. The World Health Organization (WHO) describes IPV as behaviors that occur within an intimate relationship that cause physical, psychological, or sexual harm to those within the relationship (WHO, 2012). Intimate partner violence is now recognized as a global health and societal issue (WHO, 2013). Examples of IPV acts include physical violence (hitting, slapping, kicking, beating), sexual violence (forced/coerced sexual activity), psychological abuse (insults, belittling, intimidation, humiliation, harmful threats, threats to take away children), and controlling behaviors (isolating from friends and family, stalking, restricting access to resources such as finances, employment, education or medical care) (Nelson, Bougatsos, & Blazina, 2012).

Intimate partner violence may be directed against both men and women and occurs across all socioeconomic, religious, and cultural groups (WHO, 2012). Despite substantial evidence of heterogeneity among victims of IPV, the majority of studies investigating screening and interventions focus on women (Ahmad, Ali, Rehman, Talpur & Dhingra, 2017; Nelson et al., 2012). Facilitating disclosure of IPV from those who have experienced it requires careful attention among healthcare providers because an inability to recognize IPV may result in inadequate and/or inappropriate health interventions (Svavarsdóttir & Orlygsdóttir, 2015).

Nurses practicing in emergency departments (ED) are expected to recognize, assess, and intervene when patients present with suspected IPV (Nielson, 2018). Olive (2016) asserts that the identification of IPV by healthcare providers validates the client's experience and begins the process toward intervention. Routine IPV screening is recommended by The Joint Commission, the American Medical Association, the American Congress of Obstetricians and Gynecologists, the American Nurses Association, and the U.S. Preventive Services Task Force (USPSTF) (U.S. Department of Health and Human Services, 2013). However, the USPSTF has suggested that because of insufficient evidence for or against screening, caution should be used when screening patients for IPV (Rabin, Jennings, Campbell & Bair-Merritt, 2009).

Taft et al. (2013) investigated the effectiveness of screening for IPV within healthcare settings and concluded there was insufficient evidence to justify universal IPV screening. They also concluded that IPV screening does not appear to cause harm and may encourage survivors to disclose or recognize the abuse. The USPSTF and the Canadian Task Force on Preventive Health Care have also surmised there is insufficient evidence to support universal screening based on the limitations of screening approaches, the effectiveness of referral options, the paucity of evidence demonstrating a correlation between screening for IPV and positive health outcomes, and that there are few studies that evaluate the potential harm related to screening for IPV (Nelson, Nygren, & McInerney, 2004; Wathen, MacMillan, & Canadian Task Force on Preventive Health Care, 2003).

This Clinical Practice Guideline (CPG) focuses on the effectiveness of screening for IPV in the emergency department and the implementation of appropriate interventions.

Methods

This CPG is based on a thorough review and critical analysis of the literature following ENA's Requirements for the Development of Clinical Practice Guidelines. All articles and published abstracts relevant to the topic were identified via a comprehensive search of the following databases: PubMed, CINAHL, Web of Science, and the Cochrane Databases. Initial searches were conducted using a combination of the search terms "intimate partner violence", "domestic violence", "screening, interventions", "emergency department", and "emergency nursing". The literature search was limited to English language articles on human subjects published from 2000 to 2017. Meta-analyses, systematic reviews, and research articles from ED settings and non-ED settings, position statements, and clinical guidelines were reviewed. Clinical findings and levels of recommendation regarding patient management were made by the Clinical Practice Guideline Committee according to ENA's classification of levels of recommendation for practice (Table 1). The articles reviewed to formulate the recommendations in this CPG are described in Appendix 1.

Articles that met the following criteria were chosen to formulate the CPG: research studies, meta-analyses, systematic reviews, and existing guidelines relevant to the topic of IPV screening and interventions in the ED. Articles cited in meta-analyses or systematic reviews were not considered independently unless they addressed additional factors. Other types of reference articles and textbooks

also were reviewed and used to provide additional information. The CPG authors used standardized worksheets, including the Evaluation Table, to prepare tables of evidence, ranking each article in terms of the level of evidence, quality of evidence, and relevance and applicability to practice. Clinical findings and levels of recommendation regarding patient management were then made by the CPG Committee according to ENA's classification of levels of recommendation for practice, which include: Level A, High; Level B, Moderate; Level C, Weak; and Not recommended for practice (See Table 1).

Table 1. Levels of Recommendation for Practice

Level A Recommendations: High
• Reflects a high degree of clinical certainty • Based on availability of high quality level I, II, and/or III evidence rated using the Melnyk and Fineout-Overholt grading system (Melnyk & Fineout-Overholt, 2015) • Based on consistent and good quality evidence; has relevance and applicability to emergency nursing practice • Is beneficial
Level B Recommendations: Moderate
• Reflects moderate clinical certainty • Based on availability of Level III and/or Level IV and V evidence rated using the Melnyk and Fineout-Overholt grading system (Melnyk & Fineout-Overholt, 2015) • There are some minor inconsistencies in quality evidence; has relevance and applicability to emergency nursing practice • Is likely to be beneficial
Level C Recommendations: Weak
• Has limited or unknown effectiveness • Level V, VI, and/or VII evidence rated using the Melnyk and Fineout-Overholt grading system (Melnyk & Fineout-Overholt, 2015) - Based on consensus, usual practice, evidence, case series for studies of treatment or screening, anecdotal evidence, and/or opinion
Not Recommended for Practice
• No objective evidence or only anecdotal evidence available, or the supportive evidence is from poorly controlled or uncontrolled studies • Other indications for not recommending evidence for practice may include: ◦ Conflicting evidence ◦ Harmfulness has been demonstrated ◦ Cost or burden necessary for intervention exceeds anticipated benefit ◦ Does not have relevance or applicability to emergency nursing practice • There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. For example: ◦ Heterogeneity of results ◦ Uncertainty about effect magnitude and consequences ◦ Strength of prior beliefs ◦ Publication bias

Summary of Literature Review

Background information on the prevalence of IPV and IPV risk factors are discussed prior to the review of IPV screening and interventions.

IPV PREVALENCE

The occurrence of IPV varies internationally and is high in women seeking healthcare (Feder et al., 2011). Results from a systematic review of available global data from 81 countries indicated that 30.0% [95% confidence interval (CI) 27.8 to 32.3%] of women 15 years of age and older have experienced some form of physical and/or sexual IPV during their lifetime (Devries et al., 2013). Hugl-Wajek, Cairo, Shah and McCreary (2012) conducted a retrospective chart review of 1,550 female patients between 19 and 60 years of age who were interviewed by a domestic violence (DV) advocate at a Level I Trauma center in the United States, and found 75 patients were currently in relationships involving DV (4.8%, 95% CI 3.9–6.0%) and 351 patients had previously experienced DV (27.5%, 95% CI 25.3–29.8%).

RISK FACTORS

Several researchers and organizations (Table 2) have attempted to identify the risk factors associated with IPV. For example, Capaldi, Knoble, Shortt, and Kim (2012) performed a systematic review to identify a comprehensive set of risk factors for IPV. Most studies included in the review (N = 228) were cross-sectional designs (61% of adult studies and 55% of adolescent studies), often interviewing only one member of the dyad (78% of the adult studies and 95% of the adolescent studies). Capaldi et al. (2012) found IPV declines with age, men and women are both likely to perpetrate IPV, and there is a significant association between unemployment, increased financial stress, and IPV, as well as greater risks for minority groups. They also found a small but significant association between early child abuse or neglect and later IPV. Ellsberg, Jansen, Heise, Watts and Garcia-Moreno (2008) conducted a cross-sectional survey, enrolling 19,568 participants from 115 sites in 10 countries to explore the magnitude and characteristics of different forms of physical, sexual, and emotional violence in partnered women between 15 and 49 years of age. They found significant associations between a lifetime experience of physical or sexual violence by male partners and a wide range of self-reported physical and mental health issues.

Table 2. Causes and Risk Factors for Intimate Partner Violence

Individual Factors	
Men Who Commit Violence against Partners	**Women's Increased Likelihood of Experiencing IPV**
• Young age	• Low level of education
• Low level of education	• Exposure to violence between parents
• Witnessing or experiencing violence as a child	• Sexual abuse during childhood
• Harmful use of alcohol and drugs	• Acceptance of violence
• Personality disorders	• Exposure to other forms of prior abuse
• Acceptance of violence	
• Past history of abusing partners	
Relationship factors	
• Conflict or dissatisfaction in the relationship	
• Male dominance in the family	
• Economic stress	
• The male having multiple partners	
• Disparity in educational attainment – when the less-dominant partner has a higher level of education	

Community and Societal Factors
• Gender-inequitable social norms
• Weak legal sanctions against IPV within marriage
• Lack of women's civil rights
• Broad social acceptance of violence as a way to resolve conflict
• Poverty
• Low social and economic status of women
• Weak community sanctions against IPV
• Armed conflict and high levels of general violence in society
Examples of Norms and Beliefs that Support Violence Against Women
• A man has a right to assert power over a woman and is considered socially superior
• A man has a right to physically discipline a woman for "incorrect" behavior
• Physical violence is an acceptable way to resolve conflict in a relationship
• Sexual intercourse is a man's right in marriage
• A woman should tolerate violence in order to keep her family together
• There are times when a woman deserves to be beaten
• Sexual activity (including rape) is a marker of masculinity
• Girls are responsible for controlling a man's sexual urges

Source: World Health Organization (2012)

IPV AND SUBSTANCE ABUSE

Substance abuse may increase the likelihood of IPV. Chermack et al. (2014) investigated the characteristics and treatments of individuals in an urban ED who indicated having a substance use disorder (SUD) and a history of violence or victimization within the preceding 6 months. In this convenience sample (N = 1,441) the participants (62.1% male; mean age 32.2 years, SD 19–60) indicated they had an alcohol abuse disorder or had used cannabis, cocaine, stimulants, or opioids within the past 30 days. Participants were categorized as follows: 46.8% in the no-violence group, 17.3% in the partner-only violence group, 20.2% in non-partner violence (NPV) group, and 15.7% in both partner and non-partner violence group. Participants in the violence groups tended to be younger and more likely to consume alcohol. The prevalence of IPV and NPV in those with SUD was higher than other studies assessing IVP and NPV.

IPV AND PREGNANCY

Among pregnant women, IPV also affects the health and development of the unborn child. Cripe et al. (2010) conducted a randomized controlled trial with 220 women in Lima, Peru to describe the frequency and severity of IPV among pregnant women and to examine the outcomes of an empowerment intervention that included supportive counseling and education along with safety advice. Women who participated in the empowerment intervention adopted more safety behaviors including notifying family/friends and hiding the money and extra clothing that are often necessary to escape their situation. Although the adoption of these safety behaviors was not statistically different between the control and intervention groups, simply by asking a pregnant woman about IPV has the potential to empower the woman to seek preventative assistance.

Rivara et al. (2017) conducted an 11-year longitudinal cohort study of 760 children of mothers with no history of IPV and 631 children of mothers with a history of IPV. Results indicated that IPV towards the mothers lead to significantly greater use of primary care, specialty care, mental health, and pharmacy care by the children, even when the IPV ceased before their birth. If the IPV continued during their childhood, their utilization of the ED and primary care facilities was greatly increased, and they were 3 times more likely to use mental health services than children of mothers who did not experience IPV. These results support the need to address all persons affected by IPV.

IPV AND MEN

Research focused on men who have experienced IPV is minimal, and only one study met the inclusion criteria for this CPG. Mills, Avegno, and Haydel (2006) conducted a descriptive prospective verbal survey, using a convenience sample ($N = 55$, 75% African American) from a large urban teaching ED to describe the prevalence and characteristics of males who suffer from IPV, and to determine if current screening tools are accurate in men. The Hurt, Insult, Threatened with Harm (HITS) and the Partner Violence Screen (PVS) were not sensitive screening tools in men when compared with the Revised Conflict Tactics Scale (CTS-2) (considered the gold standard).

IPV SCREENING

There are many challenges and barriers to universal screening of patients presenting to the ED. O'Doherty et al. (2015) employed the following definitions: universal screening as asking standardized questions to all women who present to the healthcare organization; selective screening as questioning those in high risk groups such as pregnant women; routine inquiry as when all are asked about IPV, but the questions vary among the healthcare workers; and case-finding as asking IPV questions only when indications are present. Universal screening of women has the potential to prevent stigma and prejudice. However, based on low to moderate levels of evidence, the WHO (2013) recommends against universal screening. They suggest healthcare providers should be knowledgeable and trained to respond to a victim of IPV, and screen when their assessment reveals physical and psychological indictors are present.

It is important to note that screening for IPV is only the first step in the intervention process. Evidence exists that simple, direct questioning is an effective way for survivors to disclose IPV episodes, yet routine screening in healthcare facilities has not always been successful (Olive, 2007). The purpose of screening is to identify victims of IPV who are either currently involved in an IPV event or who have recently experienced IPV in order to offer interventions (O'Doherty et al., 2015).

MacMillan et al. (2009) conducted an RCT to examine the effectiveness of IPV screening and reporting of positive results to healthcare providers. They also examined whether or not screening women for IPV resulted in harmful consequences. Eligible women included those who presented for their own healthcare visit who were between 18–64 years of age and had been in a relationship with a man within the past 12 months. Attrition was high, however; those retained in the study had more education and lower scores on the screening tools. There was a small, non-significant reduction in IPV risk at 18 months for the screened versus non-screened women (OR 0.82; 95% CI 0.32–2.12). Additionally, 44% of screened women discussed IPV with their healthcare provider compared with 8% of non-screened women. The authors concluded there was no association between IPV screening and increased harm among either group of women.

Svavarsdóttir (2010) conducted a descriptive cross-sectional study intended to evaluate the effectiveness of a self-reported questionnaire and an interview to detect IPV within an ED and high-risk prenatal care clinic (HRPCC). Results indicated that women are more likely to disclose physical abuse in face-to-face interview; women in the ED would disclose emotional and sexual abuse when using a self-reported instrument; and women at the HRPCC would disclose emotional and sexual abuse regardless of the method used.

O'Campo, Kirst, Tsamis, Chambers and Ahmad (2011) conducted a systematic review on the initial steps of the IPV clinical management process including screening, risk assessment, and identification of IPV survivors. Twenty-three articles were reviewed, representing 17 different screening programs. These programs incorporated screening components at multiple levels, including the use of effective screening protocols, initial and ongoing training for healthcare providers, and providing immediate access or referral to support services along with institutional support. These programs that broadly incorporated multiple screening components were more effective in increasing IPV screening and disclosure/identification rates.

O'Doherty et al. (2015) conducted a systematic review to examine the evidence regarding the screening of women for IPV and whether there were any harmful effects such as an exacerbation of IPV. Eight studies met the inclusion criteria and involved a combined total of 10,074 participants from a variety of healthcare settings including the ED. The authors found screening identified more women who have experienced IPV. However, they did not find any evidence of an effect of other outcomes such as an increase in referrals, re-exposure to IPV, change in health status, or harmful effects 3–18 months after screening. They therefore concluded that there is insufficient evidence to justify screening in healthcare settings (O'Doherty et al., 2015).

IPV SCREENING TOOLS

The ED environment requires specialized IPV screening tools. Recent efforts in this area have focused on developing short, simple, and sensitive IPV screening tools for the detection of lifetime physical, sexual, emotional (and mental) abuse that comprises IPV.

Paranjape and Liebschutz (2003), using a convenience sample of women ($N = 75$) who were in a relationship (34% married), conducted a prospective survey and structured interviews with the intent to create a short, simple, and sensitive screening tool for detection of lifetime IPV. Using 43 dichotomous screening questions intended to cover the physical, sexual, and emotional aspects of IPV, followed by structured interviews, the authors found a 63% prevalence of lifetime IPV (47 of 75), with 15% (11 of 75) experiencing IPV within the preceding 12 months. They reported that three questions were very sensitive for the detection of IPV and these became the STaT questionnaire:

1. Have you ever been in a relationship where your partner has pushed or slapped you? (Sensitivity 87%, 95% CI 78–96; Specificity 96%, 95% CI 90–100)
2. Have you ever been in a relationship where your partner has thrown, broken, or punched things? (Sensitivity 83%, 95% CI 72–94; Specificity 82%, 95% CI 68–96)
3. Have you ever been in a relationship where your partner has threatened you with violence? (Sensitivity 79%, 95% CI 67–96; Specificity 96%, 95% CI 90–100) (Paranjape and Liebschutz, 2003, p. 236)

Rabin et al. (2009) conducted a systematic review to summarize IPV screening tools and the available psychometric data, and assess the quality of the studies. Thirty-three studies were included and 21 different screening tools evaluated. The most frequent IPV tools studied included the Hurt, Insult, Threaten, and Scream (HITS), Woman Abuse Screening Tool (WAST), Partner Violence Screen (PVS), and Abuse Assessment Screen (AAS). They concluded that, because of the small number of studies conducted in healthcare settings, additional reliability and validity testing is needed. Therefore, because of the complexity of IPV, there is no gold standard screening tool

Svavarsdóttir and Orlygsdóttir (2015) conducted a cross-sectional study to determine if the disclosure of abuse was different in women seen at the ED compared with those who were at a cafeteria or in a quiet reading room at a university. The Women Abuse Screening Tool (WAST) was the instrument used, and it was administered via one of three collection procedures: 1) self-report with paper/pencil ($n = 53$ at university sites, $n = 44$ at ED); 2) computer format ($n = 53$ at university sites, $n = 48$ at ED); 3) face-to-face interview ($n = 60$ at university sites, $n = 48$ at ED). No significant differences in reporting of IPV were identified based on the method of data collection. However, a higher proportion of women from the ED reported being a survivor of IPV (ED, 27.9%; US, 9.65%; $\chi^2 = 17.098$, $p < 0.001$). Women from the ED scored higher on WAST compared with the university sites (ED mean 14.46; university sites mean 12.67; $t = 2.385$, $p < 0.022$). Svavarsdóttir and Orlygsdóttir (2015) concluded that, although there were no differences found in the proportion of women who disclosed IPV via the paper-and-pencil format, the computerized format, or interviews, healthcare workers should choose a screening method that bests suits their environment.

Arkins, Begley, and Higgins (2016) sought to identify the best psychometrically tested screening tools to assess IPV in men and women in the mental health setting. They reviewed 36 studies and found that, of the 10 screening tools utilized, only four assessed all areas of IPV (physical, sexual, and psychological). Furthermore, only the Women Abuse Screen Tool (WAST), Abuse Assessment Screen (AAS), and the Humiliation, Afraid, Rape, Kick (HARK) screens were validated against a reference standard. The Women Abuse Screen Tool WAST) was evaluated in the ED and demonstrated sensitivity from 47% to 88% and specificity from 89% to 95.6%, and was found suitable to screen men for IPV. The Abuse Assessment Screen (AAS) was investigated in two ED studies with both men and women, and had a sensitivity of 93% and specificity of 55%. The Humiliation, Afraid, Rape, Kick (HARK) screen demonstrated an 81% sensitivity and 95% specificity, and covered all areas of IPV. The STaT was validated in the ED, and demonstrated a sensitivity of 80.6–83% and a specificity of 91.7%; STaT does not assess for sexual abuse or IPV in men, however.

Table 3. Comparison of IPV Screening Tools

Screening Tool	Full Name	Items	Type of Questions	Questions Covered			Where studied
				Physical	Sexual	Psychological	
AAS	Abuse Assessment Screen	4	Dichotomous	2	1	1	Prenatal Primary Care
CAS	Composite Abuse Scale	4	Dichotomous			3	Clinics
	Feldhaus partner violence screen	3	Dichotomous and open-ended	1	1	1	Emergency Department
HARK	Humiliation, Afraid, Rape, Kick	4	Dichotomous	2	1	1	General Practice
HITS	Hurt, Insulted, Threatened with Harm	4	Dichotomous	2		2	Family Practice Emergency Department HIV Clinics Men Hispanic Patients
OVAT	Ongoing Violence Assessment Tool	4	Dichotomous and Likert	1		3	Emergency Department
PAI	Partner Abuse Interview	11	Face-to-face interviews				Clinics
PVS	Partner Violence Screen	3	Dichotomous	1		2	Emergency Department
SAFE-T	Secure, Accepted, Family, Even Talk	5	Likert			5	Emergency Department
STaT	Slapped, Threatened, thrown, broken or punched Things	3	Dichotomous	3			Emergency Department
WEB	Women's Experience with Battering	10	Likert			10	Family Practice
VAWS	Violence Against Women Screen	7	Likert	2	1	4	Perinatal
WAST	Women Abuse Screening Tool	2+	Dichotomous			2	Family Practice

Adapted from Phelan (2007), Fulfer et al. (2007), Hussain et al. (2013)

COMPUTERIZED SCREENING

Computerized screening for IPV has been shown to be an effective, time-efficient, and acceptable screening method. For example, Trautman, McCarthy, Miller, Campbell, and Kelen (2007) conducted a quasi-experimental study to compare a computer-based method of screening for IPV with usual care in a Level I adult trauma academic medical center ED. They found the computer-based health survey with IPV questions identified more survivors of IPV compared with usual care only (17.8% difference; 95% CI 13.9 to 21.7%). Houry et al. (2008) conducted a prospective observational study with a convenience sample of 3,083 participants from a large urban university-affiliated ED to 1) investigate if disclosure of IPV on computer screening in ED has safety issues (security issues, partner interference); 2) determine if survivors of IPV had short-term safety problems at 1 and 3 months; 3) determine if providing resource information would result in contacting referrals or measures to improve safety. Results indicated there were no safety issues reported after using the computer screening. At the one-week follow-up, 15% of the participants reported contacting one resource, while at three months, 35% of the participants reported contacting a resource.

Renker (2008) conducted an integrative review [2 randomized controlled trials (RCT), 1 quasi-experimental, 6 descriptive studies] to identify and analyze findings from research studies on computer screening for IPV. The prevalence of IPV was higher with computer-assisted self-interview (CASI) than with written or interview formats in all but one study, and the participants generally favored CASI. Ahmad et al. (2009) conducted an RCT to investigate the effectiveness of computerized screening for identification of patients at risk for IPV. Participants were randomized to the computerized screening (n = 140) or usual care (n = 146). The overall prevalence of IPV, as determined by an exit poll, was 22% (62 of 286 participants). Results indicated an 18% (25 of 139 participants) detection of IPV in the computerized screening group, and 9% (12 of 141 participants) in the usual care group (adjusted RR 2.0, 95%

CI 0.9 to 4.1). The authors concluded that computer-assisted screening improved the opportunities to discuss IPV and improved the detection of women at risk.

Rickert et al. (2009) conducted an RCT of three screening approaches to determine IPV disclosure rates and satisfaction with the screening process. Young women between the ages of 15 and 24 years of age ($N = 699$) were randomized into one of three groups: basic questions, healthy relationship questions, and bidirectional questions. Participants in the basic question group were asked three questions about IPV violence within the preceding 12 months and 2 questions about lifetime IPV. Participants in the healthy relationship question group were asked the same five questions from the basic question group along with two questions eliciting the degree of partner respect and how they would rate their partners' treatment of them. Women in the bidirectional question group were asked the five basic questions along with whether they were the perpetrator, if they were suspicious of their partners' fidelity, and if there were any physical violence in the relationship. Each participant completed the questionnaires using a computer. Trained healthcare providers were then asked to screen for IPV regardless of whether or not the participant disclosed it. No significant differences were found between the three groups based on demographic or reproductive health characteristics, suggesting that the randomization did not result in any bias. A significant difference was noted ($p < 0.03$) regarding the time to complete the medical histories, with a 7.7-minute average in the basic question group, 8.6 minutes in the healthy relationship question group, and 8.3 minutes in the bidirectional question group. They also found that the provider identified fewer survivors than the screening tools. In the total group, 31% indicated via the screening procedure that they had experienced IPV, but only 18% of the healthcare providers identified IPV during their screening. The authors also concluded that IPV tools can be easily incorporated in to the health history and that this screening process did not interrupt the clinic flow.

Klevens et al. (2012) conducted an RCT, enrolling participants from 10 primary healthcare centers to determine the effect of using computerized screening for partner violence plus provision of a partner violence resource list versus providing a partner violence resource list only versus a control group that did not receive any IPV screening on women's health in primary care settings. Of the women participating ($N = 2{,}708$), 9.9% ($n = 235$) reported experiencing violence in the past year. Sixty-five percent remembered receiving the list of resources, 32.9% shared the list with someone else, 6.3% used the list to contact services, and 4.4% contacted an agency providing IPV services. The authors concluded that, because the list of resources can be considered a resource, this study demonstrates that providing a list of resources at the time of screening does not result in significant health benefits.

Hussain et al. (2015) conducted a systematic review and meta-analysis to assess the rate of IPV disclosure in adult women, using three different screening tool administration methods: computer-assisted self-administered, self-administered written, and face-to-face interviews. Six studies met inclusion criteria. When comparing a self-administered computer-assisted screen versus a self-administered written screen, the odds of disclosing IPV were 23% greater with the computer-assisted screen (OR 1.23, 95% CI 0.092–1.64; $I^2 = 0\%$, $p = 0.16$). In addition, they found the odds of disclosing IPV did not differ whether self-administered written questionnaires or face-to-face interviews were conducted (OR 1.02, 95% CI 0.77–1.35; $I^2 = 49\%$). No differences were found in participant satisfaction with the different screening modalities. These results indicate that when IPV survivors use a computer-assisted self-administered screening tool they are more likely to disclose IPV than with face-to-face interviews or self-administered written tools.

Choo et al. (2016) employed a patient-centered mixed-methods approach to create and perfect the Brief Intervention for Substance Use and Partner Abuse for Females in the ED (BSAFER), a computer-based intervention for drug-using women reporting IPV in the ED. In this qualitative study, five themes were identified with supporting quotes. BSAFER was adapted from themes identified from the qualitative data. The program was beta-tested and reviewed by experts from the community for acceptability, feasibility, and relevance of intervention elements in the program. Changes were made based on recommendations. An open trial of BSAFER using 10 participants had overall positive responses. Only 5 (50%) completed a follow-up ("booster") call, which included a discussion of priorities, challenges to change, referral options, problem solving, and encouragement. These booster calls are an important part of the process because they add a human element and are participant-specific. Choo et al. (2015) investigated the women's attitudes to the use of computers to screen and intervene in drug and partner abuse. Using a convenience sample ($N = 17$), they identified that women did not have problems with the use of the computer tablet device and were comfortable giving information about abuse/drug use via the computer. However, they did not feel that interventions using the computer were personal and preferred intervention through human interaction.

SCREENING BARRIERS

There are many barriers to screening for IPV that contribute to inconsistent efforts by healthcare providers. These include a lack of training, inadequate experience, and the constraints (time and available resources) on providing emergency care (Hugl-Wajek et al., 2012). Screening for IPV requires asking direct questions about patients' experiences in such a manner as to demonstrate compassion and understanding while assuring a private setting so as others may not overhear the conversation.

Allard (2013) and Houry et al. (2008) identified common barriers to screening and potential strategies to overcome them.

Table 4. Potential Strategies for Addressing Barriers to Screening for IPV

Barriers	Strategies
• Lack of time to deal with screening results	• Training in how to respond and intervene
• Being unable to offer appropriate support and advice	• Multi-agency training on what services are available
• Not having the appropriate training to deal with disclosures	• An IPV policy that staff can access
• Being unable to meet patients' expectations of what you can do to help	• Access to an IPV advocate
• Patients' resistance to accepting help	• Standardized procedures for dealing with IPV
• Fear of offending the patient	• Directing patients to independent domestic IPV advisory services
• Patient non-disclosure	
• Lack of specific treatment protocols	

Adapted from Allard (2013), Houry et al. (2008)

Gerlach et al. (2007) conducted a prospective, cross-sectional study using a convenience sample of 2,853 participants (63% female) at an urban Level 1 trauma center to investigate whether the sex of the screener had an effect on self-reporting of IPV. Positive IPV screens were reported by 48 females (2.7%) and 21 males (2.0%). There was no significant association between the sex of the screener and the reporting of IPV for male (odds ratio 0.98, CI 0.35–2.72) or female (odds ratio 0.90, CI 0.45–1.82) participants. IPV prevalence was considerably lower in this sample, which could indicate that face-to-face may not be the most effective way to screen for IPV. These results may be skewed because they screened only from 7:00 am to midnight for an 8-week period. Beynon, Gutmanis, Tutty, Wathen, and MacMillan (2012) investigated the barriers and facilitators to asking questions about IPV. In a sample of nurses (n = 597) and physicians (n = 328), they found lack of time, behaviors typical of women living with abuse, lack of education, language/cultural barriers, and partner presence were top barriers, while education, community resources/professional support, and professional tools were listed as facilitators.

Gutmanis, Beynon, Tutty, Wathen, and McMillan (2007) used a survey mailed to physicians and nurses (N = 931; 60% nurses) intended to identify specific barriers and facilitators to routine questioning regarding IPV, and found that 50% had personal experience with IPV (themselves, friend, and/or relative). Among the barriers described by participants, eight themes emerged that affected routine IPV questioning (self-confidence, preparedness, comfort following disclosure, practitioner lack of control, professional supports, abuse inquiry, practice pressures, and practitioner consequences of asking). Training and professional experience were associated with increased comfort in IPV screening and intervention.

Nurses' Role in IPV Screening

Al-Natour, Qandil, and Gillespie (2016) investigated the role and practices of Jordanian nurses in screening for IPV. Through semi-structured interviews of a purposive sample of six female and six male nurses, four themes emerged: 1) IPV was not commonly screened for; 2) advantages and disadvantages of IPV screening were identified; 3) four sub-themes blocking screening included: a) lack of knowledge about IPV and screening practices; b) prioritizing medical care over safety and screening; c) unfamiliarity with policies and protocols; d) the conservative culture of Jordan; and 4) nurses felt happy and satisfied when screening occurred, helpless and guilty when it did not. Al-Natour et al. (2016) concluded that increasing awareness of the need for screening for IPV along with education and experience aids the practitioner in adopting IPV screening practices. Feder et al. (2011) tested the effectiveness of a program of training and support intended to improve the response of primary healthcare practices to domestic violence, focusing

on identification, appropriate initial response, and referrals to an advocacy program. There was a seven-fold difference between the training and support intervention group versus the no-training group. The number of patients identified who experienced IPV and the number of recorded referrals were substantially increased. In Finland, Husso et al. (2012), through a convenience sample of nurses, physicians, social workers, and psychologists (N = 30, 73% female) sought to explore professionals' processes of making sense of violence interventions and their organization's practices in this area. They found DV can be framed in 4 ways: 1) practical (where to refer); 2) medical (how to define in medical terms); 3) psychological (feelings and experiences of the patient); 4) individualistic frames (unique for each individual). With the expectation that nurses screen all women for IPV, lack of training and knowledge often leads to feelings of inadequacy and frustration that may result in a failure to obtain 100% screening for IPV.

Ahmad et al. (2017) conducted a rapid review of the literature to explore available IPV screening tools utilized in the ED and to investigate the impact of IPV screening in the ED. They included 12 studies related to IPV screening interventions and 12 studies that investigated the barriers to IPV screening. Results of this investigation indicated that routine or universal screening for IPV results in higher identification rates, and that women who screen positive are more likely to experience IPV in the following few months. Additionally, Ahmad et al. (2017) found that nurses and healthcare providers do screen patients with obvious signs of IPV and selectively screen others who do not present with obvious signs of IPV.

Healthcare providers are in a unique position to screen for IPV when victims present to the ED. However, IPV screening is fraught with numerous challenges including who to screen (selective verses universal screening) and what screening tool and method of screening to use (face-to-face, pen and pencil, computerized). Additionally, numerous barriers exist which adds to the complexity of this issue. To be beneficial to the victim of IPV, the provider's response to a patient's disclosure should be nonjudgmental, nondirective, and knowledgeable (Alvarez, Fedock, Grace and Campbell (2017).

INTERVENTIONS

It is important to note that, owing to the complexity and sensitive nature of IPV, conducting clinical research with people who have experienced IPV has many methodological challenges (Sprague et al., 2017). A person experiencing IPV may be anywhere on the change continuum. For example, some IPV victims may be contemplating leaving their relationship or have previously attempted to leave, while other victims may be experiencing IPV for the first time. It is essential that healthcare personnel be cognizant of these situations and offer appropriate interventions.

Edwardsen and Morse (2006) suggested that education, prevention, and early intervention may alleviate the potential psychological, physical, and economic burden survivors of IPV may experience. Knowing that approximately 84 to 95% of IPV is perpetrated against women, they investigated the educational impact of placing the Alternatives for Battered Women (ABW) and the Men's Education for Non-Violence pamphlets in a single occupancy restroom. Research assistants were trained to ask each person who exited the restroom if they wanted to participate in a research study. They found that 65/122 (53%) noticed the materials; 10/122 (8%) read the materials; 7/122 (6%) kept the materials; and 19/122 (16%) acknowledged they knew someone who could benefit from the materials. The results of this study indicate that providing resource information that individuals can access privately may be an important step in a multi-faceted approach to IPV intervention.

McFarlane, Groff, O'Brien and Watson (2006) conducted a randomized clinical trial of 319 women over a two-year period to test two interventions to determine if the number of threats of abuse, assaults, danger risks for homicide, and work harassment declined while adopted safety measures and use of community resources increased. The first intervention included an abuse assessment and a referral card. The second intervention included both the abuse assessment and referral card along with nursing case management services. Between baseline and 24 months, both groups saw significantly fewer threats of abuse, assaults, danger risks for homicide, and work harassment, and both groups practiced significantly more safety behaviors ($p < 0.001$). There was a significant decline in the use of community resources, however ($p < 0.001$). There were no significant differences between the groups.

Roberts (2007) conducted a grounded theory and ethnographic study in prison, police departments, and shelters for battered women to develop a 5-level classification schema or continuum of the duration and severity of IPV. The author asserted the importance of documenting the duration and intensity of IPV histories using a 5-level scale (Level 1, short-term; Level 2, intermediate; Level 3,

intermittent long-term; Level 4, chronic and predictable; Level 5, homicidal) because survivors of short-term or intermediate patterns of abusive behaviors may be more accepting of assistance than long-term survivors. Interventions can be geared to the type of abuse pattern detected. This scale is intended to be used by behavioral health, family counselors, and other mental health clinicians.

Power, Bahnisch, and McCarthy (2011) conducted a mixed-methods study to evaluate the impact of a domestic and family violence screening program. More specifically, they investigated whether the introduction of a screening tool increased referrals to the hospital's social work team. They concluded that the introduction of this screening program substantially increased referrals by 213%.

Nelson et al. (2012) conducted a systematic review of 33 studies to investigate evidence of the effectiveness of screening and interventions for women in healthcare settings that are effective in reducing IPV and other unfavorable health outcomes. The diagnostic accuracy of screening interventions and the adverse effects of IPV screenings and interventions were also addressed. Only one fair-quality RCT evaluated the effectiveness of IPV screening. The authors found 15 fair-to-good studies that evaluated 13 screening instruments, and six RCTs that evaluated interventions to reduce IPV. These results were largely consistent, indicating counseling interventions provided benefits. Additionally, the authors found that few studies reported adverse effects of screening and interventions.

Rhodes et al. (2015) conducted a randomized controlled trial utilizing a motivational intervention provided at the time of the patient's ED visit to determine if it would reduce IPV and heavy drinking. This study was conducted with 600 female patients between the ages of 18 and 64 years at two US academic urban EDs. They assessed whether the participants had engaged in heavy drinking or experienced IPV within the previous week. Participants in the experimental group received a 20- to 30-minute motivational intervention, whereas the control group received routine care. They found no significant differences between intervention group and the control group for IPV (OR 1.02; 95% CI 0.98–1.06) and heavy drinking (OR 0.99, 95% CI 0.96–1.03. These results do not support the use of a brief motivational intervention in women who drink heavily and experience IPV.

WHO GUIDELINES

The WHO (2013) offers guidelines that should be integrated into healthcare providers' practice. Below is a summary of the guidelines.

Table 5. Summary of the World Health Organization's Violence Against Women: Guidelines for Health Sector Response

Women-centered care	Healthcare providers should offer support that includes but is not limited to maintaining a non-judgmental attitude and empathetic listening, while providing privacy and confidentiality. Resources should be offered.
Identification and care for survivors of IPV	Healthcare providers should inquire about IPV when patients present with conditions suspected to have been caused by IPV in an effort to identify victims and offer appropriate care
Clinical care for survivors of sexual violence	Provide comprehensive care including initial treatment, emergency contraception, and STI and HIV prophylaxis along with a complete health history
Training of healthcare providers on intimate partner violence and sexual violence	Healthcare providers should be educated on IPV and sexual assault
Healthcare policy and provision	Policies and procedures should be written into existing healthcare services
Mandatory reporting of intimate partner violence	Mandatory reporting is not recommended; however, healthcare providers should offer IPV victims the opportunity to report the incidents if they choose

Adapted from: http://www.who.int/reproductivehealth/publications/violence/en/index.html

Healthcare providers have a unique opportunity to screen for and offer assistance to those who disclose they are victims of IPV. The majority of research on IPV is focused on identification of victims and providing assistance, with outcomes that are often inconclusive and conflicting (Sprague et al., 2017). The complexity of IPV makes designing policies and procedures to identify victims and offer assistance with outcomes more difficult. However, it has been demonstrated that healthcare providers should educate themselves on IPV and reflect on their own values and beliefs. Healthcare organizations should provide adequate support for the IPV victim and healthcare providers, including up-to-date policies and procedures, and access to community and institutional resources.

SUMMARY

The focus of this CPG is on the effectiveness of screening for IPV in the emergency department and the implementation of appropriate interventions. Controversy exists as to whether ED nurses should universally or randomly screen for IPV. It is clear, however, that because of the inflammatory nature of IPV, it is important for the screening, using whatever method individual institutions support, is completed in a private area. Each institution should have a comprehensive plan in place that includes screening procedures, screening tools, access to referral agencies on a 24/7 basis, and educational programs for all providers involved in IPV screening.

Description of Decision Options/Interventions and the Level of Recommendation

	Description of Decision Options/Interventions and the Level of Recommendation	
Screening	The Hurt, Insult, Threaten, and Scream (HITS), Woman Abuse Screening Tool (WAST), Partner Violence Screen (PVS), Abuse Assessment Screen (AAS), and the STaT screening tools can be used in clinical settings (Arkins et al., 2016; Rabin et al., 2009).	A
	IPV screening efforts may increase the identification of IPV survivors but the screening does not reduce the rate of IPV (Nelson et al., 2012; O'Doherty et al., 2015).	A
	Computerized screening is a safe, efficient, and effective way to screen for IPV in the ED (Ahmad et al., 2009; Choo et al., 2015; Choo et al, 2016; Houry et al., 2008; Hussain et al., 2015; Renker 2008; Rickert et al., 2009; Trautman et al., 2007).	B
	IPV screening tools can be used in the ED (Mills et al., 2006; Nelson et al., 2004; Paranjape & Liebschutz, 2003; Svavarsdóttir, 2010).	B
	Education and experience are necessary for healthcare providers to feel comfortable screening for IPV in healthcare settings (Al-Natour et al., 2016; Husso et al., 2012).	C
Interventions	A multifaceted approach to IPV in the ED, including screening, referrals, and interventions are necessary for an effective IPV program (Feder et al., 2011; McFarlane et al., 2006; Power et al., 2011)	A

Level A (High)	Based on consistent and good quality of evidence; has relevance and applicability to emergency nursing practice.
Level B (Moderate)	There are some minor inconsistencies in quality evidence; has relevance and applicability to emergency nursing practice.
Level C (Weak)	There is limited or low-quality patient-oriented evidence; has relevance and applicability to emergency nursing practice.
N/R	Not recommended based upon current evidence.
I/E	Insufficient evidence upon which to make a recommendation.
N/E	No evidence upon which to make a recommendation.

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Acknowledgments

ENA would like to acknowledge the following members of the 2018 IENR Advisory Council for their review:

Michael D. Moon, PhD, MSN, RN, CEN, CNS-CC, FAEN, Chairperson
Kathy Baker, PhD, RN, NE-BC
Paul R. Clark, PhD, MA, RN
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Developed: December 2018

Appendix 1: Evidence Table

Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
Ahmad, F., Hogg-Johnson, S., Stewart, D. E., Skinner, H. A., Glazier, R. H., & Levinson, W. (2009). Computer-assisted screening for intimate partner violence and control: A randomized trial. *Annals of Internal Medicine, 151*(2), 93–102. doi:10.7326/0003-4819-151-2-200907210-00124	The authors tested the effectiveness of computerized screening for identification of patients at risk for IPV. They hypothesized that using computers will create opportunities for women to discuss IPV with their providers.	RCT *N* = 293 Family practice clinic	79-question questionnaire inquiring about alcohol, tobacco, street drug use, sexually transmitted infections, road and home safety, depression, CV risks, sociodemographic factors. IPV questions were embedded.	18% detection of IVP in intervention group, 9% in control group. Computer-assisted screening improved the opportunities to discuss IPV and improved the detection of women at risk. Computer-assisted screening is generally an effective, time-efficient, and acceptable screening method.	I	II
Ahmad, I., Ali, P. A., Rehman, S., Talpur, A., & Dhingra, K. (2017). Intimate partner violence screening in emergency department: A rapid review of the literature. *Journal of Clinical Nursing, 26*(21–22), 3271–3285. doi:10.111/jocn.13706	The authors sought to explore available IPV screening tools utilized in the ED and investigate the impact of IVP screening in the ED.	Rapid review of the literature	12 studies related to IPV screening interventions were included along with 12 studies that investigated the barriers to IPV screening.	Routine or universal screening yields higher identification of IPV. Positive screens indicate IPV likely within the next few months. Healthcare workers need training. Lack of privacy, lack of resources, lack of time, and increased work pressure lead to lack of IPV screening.	I	V
Al-Natour, A., Qandil, A., & Gillespie, G. L. (2016). Nurses' roles in screening for intimate partner violence: A phenomenological study. *International Nursing Review, 63*(3), 422–428. doi:10.1111/inr.12302	To describe the role and practices of Jordanian nurses in screening for IPV	Descriptive Phenomenological 6 female, 6 male nurses University hospital in northern Jordan	Semi-structured interview guide	4 themes emerged 1) IPV was not commonly screened 2) Advantages and disadvantages for IPV screening were identified 3) 4 sub-themes blocking screening included: a) lack of knowledge about IPV and screening practices; b) prioritizing medical care over safety and screening; and c) unfamiliarity with policies and protocols; d) the conservative culture of Jordan 4) Nurses felt happy and satisfied when screening occurred, helpless and guilty when it did not	I	VI
Alvarez, C., Fedock, G., Grace, K. T., & Campbell, J. (2017). Provider screening and counseling for intimate partner violence: A systematic review of practices and influencing factors. *Trauma, Violence, & Abuse, 18*(5), 479–495. doi:10.1177/1524838016637080	The authors sought to review the research focused on providers' screening and counseling practices for individuals who have experienced IPV.	Systematic review, PRISMA guidelines		Healthcare workers are challenged when screening and responding to IPV. Personnel and systems support are needed to help healthcare workers screen and respond. There is a lack of organizational support.	I	I

Appendix 1: Evidence Table

Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
Arkins, B., Begley, C., & Higgins, A. (2016). Measures for screening for intimate partner violence: A systematic review. *Journal of Psychiatric and Mental Health Nursing, 23*(3–4), 217–235. doi:10.1111/jpm.12289	To identify the best psychometrically tested screening tools to assess IPV in men and women in the mental health setting	Systematic review		Findings: 10 screening tools, 3 assessed all areas of IPV. Women Abuse Screen Tool (WAST): evaluated in ED; sensitivity from 47% to 88%, specificity from 89% to 95.6%. Abuse Assessment Screen (AAS): included ED studies with both men and women (2 studies); sensitivity 93%, specificity 55% (low). Humiliation, Afraid, Rape, Kick (HARK): 81% sensitivity and 95% specificity; covers all areas of IPV. STaT: validated in ED; sensitivity 80.6 and 83%, specificity, 91.7%; does not measure sexual abuse or IPV in men.	I	I
Beynon, C. E., Gutmanis, I. A., Tutty, L. M., Wathen, C. N., & MacMillan, H. L. (2012). Why physicians and nurse ask (or don't) about partner violence: A qualitative analysis. *BMC Public Health, 12,* 473. doi:10.1186/1471-2458-12-473	The authors investigated the barriers and facilitators to asking questions about IPV.	Descriptive survey design	43 items, two open-ended $N = 931$, RNs 59.7%. 82.6% provided written comments	Tables list barriers (9) and facilitators (8) by total sample and RN/MD. Lack of time, behaviors attributed to women living with abuse, lack of education, language/cultural barriers, and partner presence were top barriers, while education, community resources/professional support, professional tools were listed as the facilitators.	II	VI
Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse,* 3(2), 231–280. doi:10.1891/1946-6560.3.2.e4	To provide a comprehensive compilation of the risk factors for IPV	Systematic review		Most studies were cross sectional, interviewing only one member of the dyad. IPV declines with age, men and women are both likely to perpetrate IPV, there is a significant association between IPV and unemployment, minority groups are at greater risk as are those under increased financial stress. A low to moderately significant association exists between child abuse and neglect and later IPV.	I	I

Appendix 1: Evidence Table

Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
Chermack, S. T., Murray, R., Kraus, S., Walton, M. A., Cunningham, R. M., Barry, K. L., . . . Blow, F. C. (2014). Characteristics and treatment interests among individuals with substance use disorders and a history of past six-month violence: Findings from an emergency department study. *Addictive Behaviors, 39*(1), 265–272. doi:10.1016/j.addbeh.2013.10.004	The authors investigated the clinical characteristics and treatment interests of individuals in a suburban ED who indicated a substance use disorder and a history of violence or victimization within the preceding 6 months.	Descriptive design Convenience sample Urban medical center	Conflict Tactics Scale Substance Abuse Outcomes Module The Addiction Severity Index	46.8% in no violence group, 17.3% in the partner only violence group, 20.2% in non-partner violence group, and 15.7% in both partner and non-partner violence group. Violence groups tended to be younger and used alcohol. The prevalence of IPV and NPV in those with SUD was higher than other studies assessing IVP and NPV within the previous year.	I	VI
Choo, E. K., Guthrie, K. M., Mello, M. J., Wetle, T. F., Ranney, M. L., Tapé, C., & Zlotnick, C. (2016). "I need to hear from women who have 'been there'": Developing a woman-focused intervention for drug use and partner violence in the emergency department. *Partner Abuse, 7*(2), 193–220. doi:10.1891/1946-6560.7.2.193	The authors sought to develop and refine a computer-based intervention for drug-using women in the ED reporting IPV.	Mixed methods Convenience sample Adult ED in a teaching hospital	Measures: Surveys, interviews, BSAFER statistical analysis for qualitative data	Five major themes identified with supporting quotes	I	VI
Choo, E. K., Ranney, M. L., Wetle, T. F., Morrow, K., Mello, M. J., Squires, D., . . . Zlotnick, C. (2015). Attitudes toward computer interventions for partner abuse and drug use among women in the emergency department. *Addictive Disorders & Their Treatment, 14*(2), 95–104. doi:10.1097/ADT.0000000000000057	To determine women's attitudes to use of computers to screen and intervene in drug and partner abuse	Qualitative design Convenience sample $N = 17$	Measures: iPad for completion of survey; semi-structured interviews 1 to 2 weeks after ED visit; reached saturation	Identified 4 themes with supporting quotes. Women were comfortable with giving information about abuse/drug use on the computer. Did not feel that interventions were personal, preferred human interaction for interventions. Women did not have problems with the use of the iPad	I	VI
Cripe, S. M., Sanchez, S. E., Sanchez, E., Ayala-Quintanilla, B., Hernandez-Alarcon, C., Gelaye, B., & Williams, M. A. (2010). Intimate partner violence during pregnancy: A pilot intervention program in Lima, Peru. *Journal of Interpersonal Violence, 25*(11), 2051–2076. doi:10.1177/0886260509354517	The authors sought to investigate the effectiveness of an empowerment intervention vs. standard of care for abused pregnant women.	RCT $N = 220$ Maternity hospital in Lima, Peru	Conflict Tactics Scale-Revised (CTS-2) Modified Safety Behavior checklist Short form health survey	Feasibility of conducting IPV interventions demonstrated	I	II
Edwardsen, E. A., & Morse, D. (2006). Intimate partner violence resource materials: Assessment of information distribution. *Journal of Interpersonal Violence, 21*(8), 971–981. doi:10.1177/0886260506290200	The authors investigated the impact of placing IPV information in a clinical setting.	Descriptive, cross-sectional study Convenience sample $N = 122$ Urban academic ED	Observational	65/122 noticed materials; 10/122 read materials; 7/122 kept materials; 19/122 said they knew someone who could benefit; 9/122 said some of the information was new to them.	I	VI

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Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet, 371*(9619), 1165–1172. doi:10.1016/S0140-6736(08)60522-X	The authors explored the magnitude and characteristics of different forms of physical, sexual, and emotional violence in women 15–49 years of age.	Cross-sectional survey design *N* = 19,568 from 115 sites in 10 countries		Significant associations exist between lifetime experience of physical or sexual violence by male partners and a wide range of self-reported physical and mental health issues in the women surveyed.	II	VI
Feder, G., Davies, R. A., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., ... Sharp, D. (2011). Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: A cluster randomized controlled trial. *The Lancet, 378*(9805), 1788–1795. doi:10.1016/S0140-6736(11)61179-3	The authors tested the effectiveness of a program of training and support intended to improve the response of primary healthcare practices to domestic violence. They focused on identification, appropriate initial response, and referrals to an advocacy program.	Cluster RCT of 51 healthcare practices in Hackney and Bristol, UK	Primary outcome was the number of referrals	There was a seven-fold difference between the training and support intervention group vs. no-training group. There was a substantially increased number of recorded referrals and the number of identifications of patients who had experienced IPV.	I	II
Gerlach, L. B., Datner, E. M., Hollander, J. E., Zogby, K. E., Robey, J. L., & Wiebe, D. J. (2007). Does sex matter? Effect of screener sex in intimate partner violence screening. *The American Journal of Emergency Medicine, 25*(9), 1047–1050. doi:10.1016/?j.ajem.2007.06.010	The authors investigated whether the sex of the screener had any influence on the self-reporting of IPV.	Prospective, cross-sectional study Convenience sample *N* = 2,853 Urban ED-Level 1 trauma center	IPV detected using a 4-item questionnaire adapted from the Abuse Assessment Scale to measure physical and psychological abuse during the preceding 6 months.	IPV-positive screens were reported by 48 females (2.7%) and 21 males (2.0%). There was no significant association between the sex of the screener and the report of IPV for males (odds ratio 0.98, CI 0.35–2.72) or females (odds ratio 0.90, CI 0.45–1.82).	II	VI
Gutmanis, I., Beynon, C., Tutty, L., Wathen, C. N., & MacMillan, H. L. (2007). Factors influencing identification of and response to intimate partner violence: A survey of physicians and nurses. *BMC Public Health, 7,* 12. doi:10.1186/1471-2458-7-12	The authors intended to identify specific barriers and facilitators with routine questioning regarding IPV.	Descriptive survey design *N* = 931	43-item questionnaire	50% of the sample had personal experience with IPV (themselves, friend, and/or relative). Eight constructs identified: preparedness, self-confidence, practitioner lack of control, comfort following disclosure, professional supports, practice pressures, abuse inquiry, and practitioner consequences of asking. Training and professional experience are associated with inquiring about IPV.	I	VI

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Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
Houry, D., Kaslow, N. J., Kemball, R. S., McNutt, L. A., Cerulli, C., Straus, H., . . . Rhodes, K. V. (2008). Does screening in the emergency department hurt or help victims of intimate partner violence? *Annals of Emergency Medicine, 51*(4), 433–442. doi:10.1016/j.annemergmed.2007.11.019	The authors sought to determine if disclosure of IPV on computer screening in ED has safety issues, if IPV survivors had short-term safety problems at 1 and 3 months, and if resource information would result in contacting referrals or measures to improve safety.	Descriptive prospective observational study $N = 3,083$ Large urban university ED	Computerized screening	Findings: no safety issues reported after using the computer screening, no increase in 911 calls in 6 months following; at 1-week follow-up, 15% reported contacting one of the resources; at 3 months, 35% reported contacting a resource.	II	IV
Hugl-Wajek, J. A., Cairo, D., Shah, S., & McCreary, B. (2012). Detection of domestic violence by a domestic violence advocate in the ED. *The Journal of Emergency Medicine, 43*(5). 860–865. doi:10.1016/j.jemermed.2009.07.031	The authors sought to examine the incidence and lifetime prevalence of DV in patients presenting to the ED who were interviewed by a domestic violence advocate.	Retrospective chart review $N = 1,550$ Level 1 trauma center		DV relationship incidence 4.8% (95% CI 3.9–6.0%); lifetime prevalence 27.5% (95% CI 25.3–29.8%)	II	VI
Hussain, N., Sprague, S., Madden, K., Hussain, F. N., Pindiprolu, B., & Bhandari, M. (2015). A comparison of the types of screening tool administration methods used for the detection of intimate partner violence: A systematic review and meta-analysis. *Trauma, Violence, & Abuse, 16*(1), 60–69. doi:10.1177/1524838013515759	The authors sought to assess the rate of IPV disclosure in adult women using three different screening tool administration methods: computer-assisted self-administered screen, self-administered written screen, and face-to-face interview screen.	Systematic review and meta-analysis 6 RCTs		Findings: 37% higher rate of disclosing IPV when computer screen used compared with face-to-face screen (OR 0.63, 95% CI: [0.31, 1.30]; I2 = 37%, $p = 0.21$). Comparing computer vs. self-written screen here was a 23% higher rate of disclosure for the computer-assisted self-administered screen (OR 1.23, 95% CO: [0.082, 1.64])	I	I
Husso, M., Virkki, T., Notko, M., Holma, J., Laitila, A., & Mäntysaari, M. (2012). Making sense of domestic violence intervention in professional health care. *Health & Social Care in the Community, 20*(4), 347–355. doi:10.1111/j.1365-2524.2011.01034.x	The authors sought to explore professionals' processes of making sense of violence interventions and how they engaged violence interventions.	Qualitative focus groups Convenience sample Finland	Focus groups: 1) How do you make sense of violence? 2) How does this connect to the challenges and possibilities of violence interventions at work? 3) How are the problems encountered in violence interventions related to institutional practices?	DV can be framed in 4 ways: 1) practical (where to refer); 2) medical (how to define in medical terms); 3) psychological (feelings and experiences of the patient); 4) individualistic frames (unique for each individual). Lack of training and knowledge often leads to feelings of inadequacy and frustration.	II	VI

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Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
Klevens, J., Kee, R., Trick, W., Garcia, D., Angulo, F. R., Jones, R., & Sadowski, L. S. (2012). Effect of screening for partner violence on women's quality of life: A randomized controlled trial. *JAMA, 308*(7), 681–689. doi:10.1001/jama.2012.6434	The authors investigated the effect of a computerized screening for partner violence plus providing an IPV resource list vs. provision of a partner violence list only vs. standard of care on women's health.	3-arm RCT Convenience sample Primary care setting	A-CASI Screening Tool, Quality of Life tool. Days lost from work or housework because of IPV. Mean number of hospitalizations and emergency department or ambulatory care visits.	QOL index 44–52 among all, no statistical difference. Days lost from work because of IPV: 0.7 (95% CI 0.5–0.8); days lost from housework: 2.0 (95% CI 1.8–2.2). Mean number of hospitalizations: 0.2 (95% CI 0–0.3). Emergency department visits 0.3 (95% CI 0.2–0.4). Ambulatory care visits: 5.7 (95% CI 4.1–7.2). No significant statistical differences between groups. Remembered receiving list of resources: 65% (1574/2364). Shared the list with someone: 32.9% (519/1574). Utilized the list to contact services: 6.3% (106/2362). Contacted an agency providing services: 4.4% (106/2362). Reported experiencing violence in the preceding year: 9.9% (235/2362).	I	II
MacMillan, H. L., Wathen, C. N., Jamieson, E., Boyle, M. H., Shannon, H. S., Ford-Gilboe, M., ... McNutt, L. A. (2009). Screening for intimate partner violence in health care settings: A randomized trial. *JAMA, 302*(5), 493–501. doi:10.1001/jama.2009.1089	The authors sought to examine the effectiveness if IPV screening and communicating the results to the medical staff	RCT *N* = 3271 women who were screened before their healthcare visit, N = 3472 women who were screened after their healthcare visit	Women Abuse Screening Tool (WAST), Composite Abuse Scale (CAS), World Health Organization Quality of Life (WHOQOL) Brief Instrument	11% of women screened positive on 1 instrument – 84% were positive on the WAST and negative on the CAS. Self-report immediately after their healthcare visit, 44% of screened women and 8 % of non-screened women discussed violence with their healthcare provider	I	II

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Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
McFarlane, J. M., Groff, J. Y., O'Brien, J. A., & Watson, K. (2006) Secondary prevention of intimate partner violence: A randomized controlled trial. *Nursing Research 55*(1), 52–61. doi:10.1097/00006199-200601000-00007	The authors sought to test two interventions to determine if the number of threats of abuse, assaults, danger risks for homicide, and work harassment declined while adopted safety measures, and use of community resources increased.	RCT $N = 360$ Primary care clinics and two women, infants, and children clinics in a large urban area	Safety Behavior Checklist, Community Resources Checklist, Severity of Violence Against Women Scale, Danger Assessment Scale, Employment Harassment Questionnaire	Between baseline and 24 months, scores for both groups of women showed fewer threats of abuse, assaults, danger risks for homicide, work harassment, and both practiced more safety behaviors ($p < 001$). However, there was a significant decline in the use of community resources ($p < 0.001$). These findings support the notion that abuse assessment and referral is sufficient to reduce reported levels of violence.	I	II
Mills, T. J., Avegno, J. L., & Haydel, M. J. (2006). Male victims of partner violence: Prevalence and accuracy of screening tools. *The Journal of Emergency Medicine, 31*(4), 447–452. doi:10.1016/j.jemermed.2005.12.029	To describe the prevalence and characteristics of males who suffer from IPV and to determine if current screening tools are accurate in men	Descriptive prospective survey design Convenience sample Large urban teaching ED	HITS ("Hurt/Insult/Threaten/Scream"), Partner Violence Screen (PVS), Revised Conflict Tactics Scale (CTS-2).	The HITS and the PVS were not sensitive screening tools when compared with the CTS-2 (considered the gold standard).	II	VI
Nelson, H. D., Bougatsos, C., & Blazina, I. (2012). Screening women for intimate partner violence: A systematic review to update the U.S. Preventive Services Task Force recommendation. *Annals of Emergency Medicine, 156*(11), 796–808. doi:10.7326/0003-4819-156-11-201206050-00447	The authors sought to review the evidence of the effectiveness of screening and interventions for women in healthcare settings.	Systematic review of 33 studies		Screening: several IPV screening tools have fair-to-good internal consistency, and some validated with longer instruments. None have been evaluated against measurable IPV outcomes. Few intervention studies are available, most focus on pregnant women, limiting interpretation	I	I
Nelson, H. D., Nygren, P., & McInerney, Y. (2004). Screening for family and intimate partner violence (Systematic evidence review number 28). Retrieved from the Agency for Healthcare Research and Quality (US) website: https://www.ahrq.gov/downloads/pub/?prevent/pdfser/famviolser.pdf	The authors sought to examine the evidence on the performance of screening procedures and interventions in primary care settings for IPV on children, women, and elderly adults.	Systematic review		Only one fair-quality RCT evaluated the effectiveness of IPV screening. 15 fair to good studies evaluated 13 screening instruments. 6 RCT evaluated interventions to reduce IPV and the results were largely consistent indicating counseling interventions provided benefits. Few studies reported adverse effects of screening and interventions	I	I

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Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
O'Campo, P., Kirst, M., Tsamis, C., Chambers, C., & Ahmad, F. (2011). Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review. *Social Science & Medicine, 72*(6), 855–866. doi:10.1016/j.socscimed.2010.12.019	The authors focused their review on the initial steps of the IPV clinical management process, which includes screening, risk assessment and identification of IPV victims.	Systematic review	23 articles were included, 17 screening programs were represented	Programs incorporating many screening components at multiple levels along with institutional support were more effective. The use of effective screening protocols, initial and ongoing training, and providing immediate access or referral to support services were more effective.	I	V
O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L. L., Feder, G., & Taft, A. (2015). Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews,* (7):CD007007. doi:10.1002/14651858.CD007007.pub3	The authors sought to examine the evidence regarding the screening of women for IPV and if there are any harmful effects.	Systematic review		Screening demonstrated an increase in the identification of women who had experienced IPV. However, there is insufficient evidence to justify screening in healthcare settings. No evidence was found that screening decreased IPV.	I	I
Paranjape, A., & Liebschutz, J. (2003). STaT: A three-question screen for intimate partner violence. *Journal of Women's Health, 12*(3), 233–239. doi:10.1089/154099903321667573	The authors aimed to create a short, simple, and sensitive IPV screening tool for detection of lifetime IPV.	Prospective survey design Convenience sample *N* = 72 Urban teaching hospital	Conflict Tactics Scale (CTS), Index of Spouse Abuse (ISA).	63% prevalence of lifetime IPV (47 of 75), previous 12 months was 15% (11 of 75). Three questions were very sensitive for the detection of IPV	II	VI
Power, C., Bahnisch, L., & McCarthy, D. (2011). Social work in the emergency department—Implementation of a domestic and family violence screening program. *Australian Social Work, 64*(4), 537–554. doi:10.1080/0312407X.2011.606909	The authors sought to evaluate the impact of a domestic and family violence program.	Mixed method design Convenience sample *N* = 37 South Australian ED	Measures: chart audit of referrals to social work and presenting diagnoses (compared 3 months before and 3 months after implementation of screening program), Surveyed medical and nursing staff (included Likert scale and comment section) to obtain staff perception of program.	Findings: 1) Referrals increased by 32 (213%) after implementation (only included hours 8–4). 2) Presenting diagnoses (*n* = 57): 4 (7%) domestic/family violence; 21 (36.8%) assault-related injuries; 5(8.8%) physical injuries/conditions; 27 (47.4%) mental health issues 3) Medical staff survey: effective in identification of domestic violence (*M* = 3.8, *SD* = 0.64); impact mildly effective (*M* = 3.2, *SD* = 0.9); increase in identifications with tool (*M* = 3.2, *SD* = 1.0). Comments: one-hour staff training not sufficient for confidence in use of tool.	II	I

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Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
Rabin, R. F., Jennings, J. M., Campbell, J. C., & Bair-Merritt, M. H. (2009). Intimate partner violence screening tools: A systematic review. *American Journal of Preventive Medicine, 36*(5), 439–445. doi:10.1016/j.amepre.2009.01.024	The authors sought to summarize the available IPV screening tools and psychometric data/quality of studies.	Systematic review	Study quality judged by USPSTF criteria for diagnostic studies.	Most studied IPV tools: Hurt, INsult, Threaten, and Scream (HITS) sensitivity 30–100%, specificity 86–99%); Woman Abuse Screening Tool (WAST) sensitivity 47%, specificity 96%); Partner Violence Screen (PVS) sensitivity 35–71%, specificity 80–94%); Abuse Assessment Screen (AAS) sensitivity 93–94%, specificity 55–99%). Study quality: Excellent, 2; good, 14; Fair,15; Poor, 2. 21 tools: 16 assessed physical violence, 5 did not; 11/21 assessed emotional abuse; 15/21 (71%) assessed threats or fear. 7/21 assessed sexual abuse.	I	I
Renker, P. R. (2008). Breaking the barriers: The promise of computer-assisted screening for intimate partner violence. *Journal of Midwifery & Women's Health, 53*(6), 496–503. doi:10.1016/j.jmwh.2008.07.017	The authors sought to identify and analyze findings from research studies on computer screening for IPV.	Integrative review		Findings: higher prevalence of IPV identified by computer-assisted self-interview (CASI) than by written or interview formats in all but one study. Women generally favored CASI. Percent of providers that responded to computer prompts by discussing IPV was < 1% to 4%.	I	V
Rhodes, K. V., Rodgers, M., Sommers, M., Hanlon, A., Chittams, J., Doyle, A., . . . Crits-Christoph, P. (2015). Brief motivational intervention for intimate partner violence and heavy drinking in the emergency department: *A randomized clinical trial. JAMA,, 314*(5), 466–477. doi:10.1001/jama.2015.8369	The authors investigated whether a brief motivational intervention provided at the time of an ED visit influenced IPV and EtOH intake.	RCT Convenience sample *N* = 600 Two academic urban medical center EDs	Intervention: 20–30-minute motivational intervention (all interventions were recorded) and 3 month follow-up phone call. Assessment group was assessed as intervention group (weekly assessment for 12 weeks; follow-up phone calls at 3, 6, and 12 months)	Outcomes measured: 1. heavy drinking in past week; 2. episodes of IPV. No significant differences between intervention group and the assessed control group for IPV (OR 1.02, 95% CI 0.98–1.06) or heavy drinking (OR 0.99, 95% CI 0.96–1.03).	I	II

Appendix 1: Evidence Table

Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
Rickert, V. I., Davison, L. L., Breitbart, V., Jones, K., Palmetto, N. P., Rottenberg, L., . . . Stevens, L. (2009). A randomized trial of screening for relationship violence in young women. *Journal of Adolescent Health, 45(*2), 163–170. doi:10.1016/j.jadohealth.2008.12.012	The authors investigated the use of a computer-based screening to assess patient and provider satisfaction with three different IPV screening tools incorporated into a health history.	RCT Convenience sample *N* = 699 Reproductive healthcare setting		1. Provider identified fewer survivors than screening tools. 2. Time to complete tools: basic, 7.7 min; healthy relationship, 8.6 min; bidirectional, 8.3 min. 3. No significant differences in identifying IPV. 4. None of the tools resulted in increased identification. 5. Can be easily incorporated into the health history	I	II
Roberts, A. R. (2007). Domestic violence continuum, forensic assessment and crisis intervention. *Families in Society, 88*(1), 42–54. doi:10.1606/1044-3894.3591	To develop a 5-level classificatory schema or continuum of the duration and severity of IPV	Grounded theory and ethnography Setting was prison, police departments, and shelters for battered women *N* = 501		Level 1 = short term, Level 2 = intermediate, Level 3 = intermittent long-term Level 4 = chronic and predictable Level 5 = homicidal. Interventions can be geared to the type of abuse pattern detected.	I	VI
Svavarsdóttir, E. K. (2010). Detecting intimate partner abuse within clinical settings: Self-report or an interview. *Scandinavian Journal of Caring Sciences, 24*(2), 224–232. doi:10.1111/j.1471-6712.2009.00709.x	The author sought to evaluate the effectiveness of a self-reporting questionnaire and an interview in detecting IPV in an ED and a high-risk prenatal care clinic.	Descriptive cross-sectional design Convenience sample *N* = 208 University hospital and high-risk prenatal care clinic (HRPCC) in Reykjavik	Women Abuse Screening Tool (WAST) and the Evaluation Interview Frame for Nurses and Midwives regarding Women Abuse, Screening, and First Response	Women are more likely to disclose physical abuse in face-to-face interview; women in ED would disclose emotional and sexual abuse when using self-reported instrument; women at HRPCC would disclose emotional and sexual abuse regardless of method used.	I	VI

Appendix 1: Evidence Table

Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
Svavarsdóttir, E. K., & Orlygsdóttir, B. (2015). Disclosure of intimate partner violence in current marital/partner relationships among female university students and among women at an emergency department. *Journal of Forensic Nursing, 11*(2), 84–92. doi:10.1097/JFN.0000000000000061	To determine if the disclosure of abuse was different if seen at emergency department compared with a university site (US) (reading area or cafeteria).	Descriptive cross-sectional design Convenience sample $N = 306$ University of Iceland and ED waiting room	Women Abuse Screening Tool (WAST)	No significant difference in frequency of disclosure based on method of data collection at either site; significant differences between sites in terms of women's age, health, and educational background. Significantly higher proportion at ED were not Icelandic and separated from partner/husband within preceding 6 months. Higher proportion at ED reported being survivors of IPV (ED = 27.9%; US = 9.65; $\chi^2 = 17.098$, $p < 0.000$). Women at ED scored higher on WAST total scale compared with US (ED mean = 14.46, US mean = 12.67; $t = 2.385$, $p < 0.022$).	I	VI
Trautman, D. E., McCarthy, M. L., Miller, N., Campbell, J. C., & Kelen, G. D. (2007). Intimate partner violence and emergency department screening: Computerized screening versus usual care. *Annals of Emergency Medicine, 49*(4), 526–534. doi:10.1016/?j.annemergmed.2006.11.022	To compare computer-based method of screening for IPV with usual care in ED	Quasi-experimental Convenience sample For the three study periods: $N = 361$, $N = 441$, and $N = 233$ Adult ED of a university hospital Level 1 trauma center	1st study period [computerized health survey (CHS) only]: $N = 361$; 2nd study period (CHS + IPV questions): $N = 411$; 3rd study period (CHS only): $N = 233$	Findings: Completion of CHS along with IPV questions identified more positives compared with usual care only (+17.85% difference, 95% CI 13.9–21.7%). Referral to social worker more likely with CHS + IPV questions (+9.7% difference, 95% CI 6.7%–12.7%), but 77% of subjects classified as positive by CHS were not referred. Conclusion: Computer-based screening more effective than usual care for identification of IPV.	I	VI

Reference	Research Purpose Questions/Hypothesis	Design/Sample Setting	Variables/Measures Analysis	Findings/Implications	Quality of Evidence	Level of Evidence
World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women: *WHO clinical and policy guidelines.* Retrieved from http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/	The authors investigated the literature focusing on the identification of and clinical guidelines for persons who have experienced IPV.			Six findings: 1) Women-centered care; 2) Identification and care for survivors; 3) Clinical care for survivors; 4) Training for healthcare workers; 5) Health care policies and provisions; 6) Reporting of IPV	I	I

GRADING THE QUALITY OF THE EVIDENCE

I. Acceptable Quality: No concerns

II. Limitations in Quality: Minor flaws or inconsistencies in the evidence

III. Major Limitations in Quality: Many flaws and inconsistencies in the evidence

IV. Not Acceptable: Major flaws in the evidence

GRADING THE LEVELS OF THE EVIDENCE (MELNYK & FINEOUT-OVERHOLT, 2015)

I. Evidence from a systematic review or meta-analysis of all relevant, randomized, controlled trials or evidence-based clinical practice guidelines based on systematic reviews of RCTs

II. Evidence obtained from at least one properly designed, randomized, controlled trial

III. Evidence obtained from well-designed controlled trials without randomization

IV. Evidence obtained from well-designed case control and cohort studies

V. Evidence from systematic reviews of descriptive and qualitative studies

VI. Evidence from a single descriptive or qualitative study

VII. Evidence from opinion of authorities and/or reports of expert committees

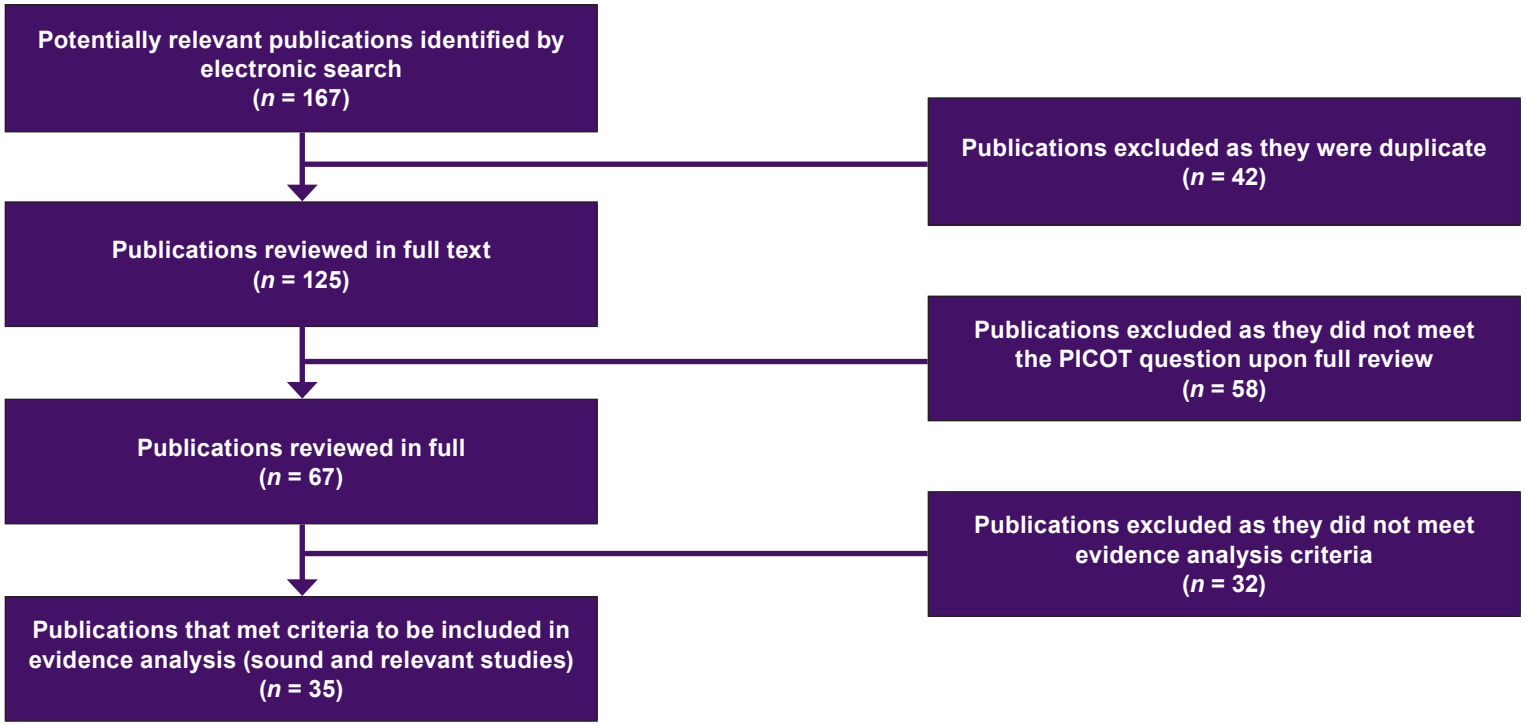
Appendix 2: Other Resources Table

Reference	Description	Conclusions
Allard, C. (2013). Caring for people who experience domestic abuse. *Emergency Nurse, 21*(2), 12–16. doi:10.7748/en2013.05.21.2.12.e1145	To identify and discuss the challenges nurses face in identifying and treating IPV with suggestions on improving the identification and support of survivors.	Lists barriers to screening and strategies to overcome them
Beach, S. R., Carpenter, C. R., Rosen, T., Sharps, P., & Gelles, R. (2016). Screening and detection of elder abuse: Research opportunities and lessons learned from emergency geriatric care, intimate partner violence, and child abuse. *Journal of Elder Abuse & Neglect, 28*(4–5), 185–216. doi:10.1080/08946566.2016.1229241	The authors provide an overview of elder abuse screening and discuss the screening processes in geriatric care including IPV.	Meaningful intervention is the first step in detecting elder abuse including IPV.
Choo, E. K., & Houry, D. E. (2015). Managing intimate partner violence in the emergency department. *Annals of Emergency Medicine, 65*, 447–451. doi:10.1016/j.annemergmed.2014.11.004	The authors discuss the importance of screening for IPV in the ED.	Lists identification and management actions including screening, response to a positive screening, assessing immediate safety concerns, initial steps the survivor can take, documentation, referrals, and special populations. Had several tables with relevant information.
Choo, E. K., Gottlieb, A. S., DeLuca, M., Tape, C., Colwell, L., & Zlotnick, C. (2015). Systematic review of ED-based intimate partner violence intervention research. *Western Journal of Emergency Medicine, 16*(7), 1037–1042. doi:10.5811/westjem.2015.10.27586	Assessment reactivity research is lacking in the ED. The authors therefore attempted to identify ED-based studies showing consistent evidence of improvement that would substantiate the presence of assessment reactivity.	Few clinical trials have been conducted that investigate the effect of screening and/or interventions for IPV on the outcomes for women's health.
Choo, E. K., Zlotnick, C., Strong, D. R., Squires, D. D., Tapé, C., & Mello, M. J. (2016). B-SAFER: A web-based intervention for drug use and intimate partner violence demonstrates feasibility and acceptability among women in the emergency department. *Substance Abuse, 37*(3), 444–449. doi:10.1080/08897077.2015.1134755	An investigation of the feasibility and acceptability of a computer-based program (BSAFER) and telephone booster for women who use drugs and experience IPV.	BSAFER was found to be feasible for use in the emergency setting with women who used drugs and experienced IPV.
Fulfer, J. L., Tyler, J. J., Choi, N. J. S., Young, J. A., Verhulst, S. J., Kovach, R., & Dorsey, J. K. (2007). Using indirect questions to detect intimate partner violence: The SAFE-T questionnaire. *Journal of Interpersonal Violence, 22*(2), 238–249. doi:10.1177/0886260506295814	The authors aimed to develop a brief screening tool to be used with IPV survivors.	The SAFE-T instrument is a valid, reliable, and easily remembered tool for ED personnel to use to screen for IPV.
Hamberger, L. K., Rhodes, K., & Brown, J. (2015). Screening and intervention for intimate partner violence in healthcare settings: Creating sustainable system-level programs. *Journal of Women's Health, 24*(1), 86–91. doi:10.1089/jwh.2014.4861	The authors based their review on presentations at an HHS-sponsored IPV screening and counseling research symposium in 2013.	Discusses system-level interventions and a model to overcome these barriers.
Leppäkoski, T., & Paavilainen, E. (2013). Interventions for women exposed to acute intimate partner violence: Emergency professionals' perspective. *Journal of Clinical Nursing, 22*(15–16), 2273–2285. doi:10.1111/j.1365-2702.2012.04202.x	The authors sought to examine interventions and practices emergency department professionals use when encountering IPV survivors.	Continued IPV education is needed to assure healthcare practitioners are well versed in the current laws and their duties and responsibilities.
Mason, M. J., Campbell, L., Zaharakis, N., Foster, R., & Richards, S. (2014). Levels of teen dating violence and substance use in an urban emergency department. *Journal of Developmental and Behavioral Pediatrics, 35*(9), 576–581. doi:10.1097/DBP.0000000000000095	The authors sought to determine the prevalence and any associations between levels of dating violence and substance abuse in an urban Level 1 pediatric trauma center.	The authors concluded that urban teens who are dating and have experienced psychological violence are at twice the risk for using drugs and alcohol as those who have experienced physical violence.
McGarry, J., & Nairn, S. (2015). An exploration of the perceptions of emergency department nursing staff towards the role of a domestic abuse specialist: A qualitative study. *International Emergency Nursing, 23*(2), 65–70. doi:10.1016/j.ienj.2014.06.003	The authors explored the perceptions of ED staff regarding the utilization of a domestic abuse nurse specialist	Three themes emerged: time constraints (taking things face on); education and training (a very visible service); professional and personal support (somewhere to go). The domestic abuse nurse specialist role was highly valued in terms of having the time to spend with patients.

Appendix 2: Other Resources Table

Reference	Description	Conclusions
Messing, J. T., Ward-Lasher, A., Thaller, J., & Bagwell-Gray, M. E. (2015). The state of intimate partner violence intervention: Progress and continuing challenges. *Social Work, 60*(4), 305–313. doi:10.1093/sw/swv027	The authors examined the current state of IPV intervention and the progress made in the last four decades along with addressing the continuing challenges	Discussed the Violence Against Women Act of 1994, state-level laws and policies, social services for survivors, challenges facing services for victim-survivors, and offender treatment.
Phelan, M. B. (2007). Screening for intimate partner violence in medical settings. *Trauma, Violence & Abuse, 8*(2), 199–213. doi:10.1177/1524838007301221	The author sought to review the literature on screening interventions and the impact of U.S. Preventive Services Task Force (USPSTF) recommendations.	The author concluded that the role and process of universal IPV screening in the healthcare industry will remain controversial until the most effective screening processes are identified.
Rhodes, K. V., Houry, D., Cerulli, C., Straus, H., Kaslow, N. J., & McNutt, L. A. (2009). Intimate partner violence and comorbid mental health conditions among urban male patients. *Annals of Family Medicine, 7*(1), 47–55. doi:10.1370/afm.936	The authors explored the association of IPV and comorbid conditions.	
Rhodes, K. V., Kothari, C. L., Dichter, M., Cerulli, C., Wiley, J., & Marcus, S. (2011). Intimate partner violence identification and response: Time for a change in strategy. *Journal of General Internal Medicine, 26*(8), 894–899. doi:10.1007/s11606-011-1662-4	The authors examined ED cases to explore the identification and response of IPV within a known population of abused women.	The authors found: 1) Survivors of IPV identified in the ED experienced more severe injuries; 2) Most ED visits were for medical complaints; and 3) Self-Identification of IPV was routinely transported to the ED by police.
Ritchie, M., Nelson, K., & Wills, R. (2009). Family violence intervention within an emergency department: Achieving change requires multifaceted processes to maximize safety. *Journal of Emergency Nursing, 35*(2), 97–104. doi:10.1016/j.jen.2008.05.004	The authors explored the experiences of ED nurses after routine screening for IPV to establish the impact on practice and identify barriers and enablers to screening.	The authors found: 1) Organizational barriers such as long delays between education and implementation, lack of privacy, and separating women from family to interview; 2) Personal barriers including a) Level of comfort with interviewing; b) Fear of a yes answer, and c) Forgetting
Rivara, F. P., Anderson, M. L., Fishman, P., Bonomi, A. E., Reid, R. J., Carrell, D., & Thompson, R. S. (2007). Intimate partner violence and health care costs and utilization for children living in the home. *Pediatrics, 120*(6), 1270–1277.	The authors sought to determine if there were differences in health care costs and utilization for the children whose mothers experienced IPV compared with those who did not.	Results indicated that children living in homes who were exposed to IPV had significantly greater use of ED and primary care visits including a 15% higher primary healthcare cost. They also found that healthcare costs for women exposed to IPV continue to be elevated even long after the IPV ceases. They also stated that interventions are needed that address all persons affected by IPV.
Sawyer, S., Coles, J., Williams, A., & Williams, B. (2016). A systematic review of intimate partner violence educational interventions delivered to allied health care practitioners. *Medical Education, 50*(11), 1107–1121. doi:10.1111/medu.13108	The authors sought to examine the current evidence for IPV healthcare provider education to inform future educational interventions.	Improvements in knowledge, attitudes, skills, and behaviors are associated with educational opportunities.
Sims, C., Sabra, D., Bergey, M. R., Grill, E., Sarani, B., Pascual, J., … Datner, E. (2011). Detecting intimate partner violence: More than trauma team education is needed. *Journal of the American College of Surgeons, 212*(5), 867–872. doi:10.1016/j.jamcollsurg.2011.01.003	The authors examined the incidence of IPV in the trauma population of a Level 1 trauma center and the impact of an IPV educational program for trauma residents.	IPV documented on 39.9% of charts prior to educational intervention, 46.1% after educational intervention – results were not statistically significant. IPV screening is far from universal. IPV was not investigated nearly as much as social habits (alcohol, tobacco, and drug use).
Taft, A., O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L., & Feder, G. (2015). Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews,* (7): CD007007. doi:10.1002/14651858.CD007007.pub3	The authors investigated the effectiveness of screening for IPV within healthcare settings for identification and referrals to support agencies along with the health outcomes.	The authors found no evidence IPV screening increased referrals, nor was there any significant reduction of abuse. Screening was found to increase IPV identification yet there was inadequate evidence of a long-term benefit.
U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2013). *Screening for domestic violence in health care settings.* Retrieved from https://aspe.hhs.gov/system/files/pdf/76931/pb_screeningDomestic.pdf	Evaluates current evidence on screening in health care	Provides a description of reasons for screening, potential barriers to screening, existing evidence, and next steps.

Appendix 3: Study Selection Flowchart and Inclusion/Exclusion Criteria



Inclusion Criteria	Exclusion Criteria
Studies published in English	Studies not published in English
Studies involving human subjects	Non-human studies
January 2005 - February 2017	Studies not in the timeframe listed
Studies addressing the PICOT question	Studies not addressing the PICOT questions

The following databases were searched: Medline, PubMed, CINAHL, The Cochrane Library, British Medical Journal, and the National Guideline Clearinghouse.

Search terms included: intimate partner violence, domestic violence screening, emergency department, interventions, and outpatient setting using a variety of search combinations.