Complete Summary

GUIDELINE TITLE

Screening for family and intimate partner violence: recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

Screening for family and intimate partner violence: recommendation statement. Ann Intern Med 2004 Mar 2;140(5):382-6. [46 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 51, Screening for family violence. p. 555-65.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Physical, sexual, emotional abuse or neglect associated with family or intimate partner violence

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Emergency Medical Technicians/Paramedics
Hospitals
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force (USPSTF) recommendations on screening for family and intimate partner violence based on the USPSTF´s examination of evidence specific to family and intimate partner violence
- To update the 1996 recommendations contained in the *Guide to Clinical Preventive Services*, second edition

TARGET POPULATION

Children, women and older adults seen in primary care settings

INTERVENTIONS AND PRACTICES CONSIDERED

Screening Techniques and Tools to Assess Family and Intimate Partner Violence

1. Techniques: self-administered questionnaires, clinical staff-directed interviews, and clinical observation
2. Tools:
    - Children: Hawaii Risk Indicators Screening Tool, Kempe Family Stress Inventory (KFI), Parenting Profile Assessment (PPA)
    - Women: The Partner Abuse Interview, Screening Questions for Domestic Violence, Domestic Abuse Assessment Questionnaire, Abuse Assessment Screen (AAS) for use in Pregnancy, Partner Violence Screen (PVS), The HITS (hurt, insult, threaten, scream) Scale, Emergency Department Domestic Violence Screening Questions, Women's Experience with Battering (WEB) Scale, Index of Spouse Abuse, Partner Abuse Scale: Physical (ISA-P), Woman Abuse Screening Tool (WAST), Domestic Violence Screening Tool
    - Older adults: Brief Abuse Screen for the Elderly (BASE), Hwalek-Sengstock Elder Abuse Screening Test (HSEAST), The Caregiver Abuse Screen (Reis-Nahmiash CASE)

Interventions to Reduce Harm in At-risk Patients

1. Children: nurse home visits providing parent education, support systems for the mother, and engagement of family members with other health and social services
2. Women: wallet cards (listing community resources), counseling, or outreach mentor

MAJOR OUTCOMES CONSIDERED

Key Question No. 1: Does screening for family violence reduce harm and premature death and disability?

Key Question No. 2: How well does screening identify current harm or risk for harm from family violence?

Key Question No. 3: What are the adverse effects of screening?

Key Questions No. 4: How well do interventions reduce harm from family violence?

Key Question No. 5: What are the adverse effects of intervention?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): Systematic evidence reviews were prepared by the Oregon Evidence-based Practice Center (EPC), Oregon Health & Science University for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Search Strategy

EPC staff developed an analytic framework with key questions and eligibility criteria to guide the literature searches.

Children

Relevant studies were identified from multiple searches of MEDLINE (1966 to December 2002), PsycINFO (1984 to December 2002), CINAHL (1982 to December 2002), ERIC (1989 to December 2002), and the Cochrane Controlled Trials Register. EPC staff reviewed references listed in a review of early childhood

home visitation for the prevention of violence for the U.S. Task Force on Community Prevention Service, the Prevention of Child Maltreatment Update from the Canadian Task Force on Preventive Health Care, and Violence in Families: Assessing Prevention and Treatment Programs. Additional articles were obtained by reviewing reference lists of pertinent studies, reviews, and editorials, and by consulting experts.

Women and Older Adults

Relevant studies were identified from multiple searches of MEDLINE® (1966 to December 2002), PsycINFO (1984 to December 2002), CINAHL (1982 to December 2002), Health & Psychosocial Instruments (1985 to December 2002), AARP Ageline (1978 to December 2002), and the Cochrane Controlled Trials Register. Additional articles were obtained by reviewing 2 recent systematic reviews, reference lists of pertinent studies, and by consulting experts.

Inclusion and Exclusion Criteria

Studies included in these reviews had English-language abstracts, were applicable to U.S. clinical practice, described abuse and neglect against children, women or elderly adults, were conducted in or linked to primary care (i.e., family practice, general internal medicine, pediatrics), obstetrics/gynecology, or emergency department settings, and included a physician or other health provider in the process of assessment or intervention. Studies about patients presenting with trauma were excluded. All eligible studies were reviewed, including those published prior to the 1996 USPSTF recommendation.

Studies about assessment were included if they evaluated the performance of verbal or written questionnaires or other assessment procedures such as physical examinations that were brief and applicable to the primary care setting. Included studies described the study sample, the screening instrument or procedure, the abuse or neglect outcome, and the collection of data. Outcomes included indicators of physical abuse, neglect, emotional abuse, and/or sexual abuse and any reported related health outcomes (i.e., depression).

Studies about interventions were included if they measured the effectiveness of an intervention in reducing harm from family and intimate partner violence compared with nonintervention or usual care groups. Studies that tested effectiveness of interventions to educate health care professionals about family violence or to increase screening rates in institutions were excluded. EPC staff also excluded studies about mandatory reporting laws, descriptions of programs, the accuracy of physician diagnosis and reporting of abuse, and physician factors related to reporting.

NUMBER OF SOURCE DOCUMENTS

Screening

- Children: 1,808 abstracts identified; 6 studies met eligibility criteria.
- Women: 806 abstracts identified; 14 met inclusion criteria.
- Elderly: 1,045 abstracts identified; 3 studies met modified inclusion criteria.

Interventions

- Children: 1,748 abstracts identified; 17 studies met inclusion criteria.
- Women: 667 abstracts identified; 2 met inclusion criteria.
- Elderly: 1,084 abstracts identified, 72 articles were retrieved for further review; however, none provided data about effective interventions.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): Systematic evidence reviews were prepared by the Oregon Evidence-based Practice Center (EPC), Oregon Health & Science University for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Study Abstraction

For each included study, EPC staff abstracted the study design, number of participants, setting, length and type of interventions, length of follow-up, outcomes, methods of outcome measurement, and study duration, among others. Two reviewers independently rated each study's quality using criteria specific to different study designs developed by the USPSTF. When reviewers disagreed, a final score was reached through consensus.

Preparation of the Systematic Evidence Reviews

EPC staff and Task Force members participated in the initial design of the study and reviewed interim analyses and the final manuscript. Additional reports were distributed for review to content experts and revised accordingly before preparation of the final document.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF´s 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians routinely provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians routinely provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve

health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole USPSTF before final recommendations are confirmed.

Recommendation of Others. Recommendations for screening for family and intimate partner violence from the following groups were discussed: the American Academy of Pediatrics, the American Medical Association, the Canadian Task Force on Preventive Health Care, the Centers for Disease Control and Prevention's Task Force on Community Preventive Services, the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF found insufficient evidence to recommend for or against routine screening of parents or guardians for the physical abuse or neglect of children, of women for intimate partner violence, or of older adults or their caregivers for elder abuse. **I recommendation.**

The USPSTF found no direct evidence that screening for family and intimate partner violence leads to decreased disability or premature death. The USPSTF found no existing studies that determine the accuracy of screening tools for identifying family and intimate partner violence among children, women, or older adults in the general population. The USPSTF found fair to good evidence that interventions reduce harm to children when child abuse or neglect has been assessed (see Clinical Considerations). The USPSTF found limited evidence as to whether interventions reduce harm to women, and no studies that examined the effectiveness of interventions in older adults. No studies have directly addressed the harms of screening and interventions for family and intimate partner violence. As a result, the USPSTF could not determine the balance between the benefits and harms of screening for family and intimate partner violence among children, women, or older adults.

Clinical Considerations

- The USPSTF did not review the evidence for the effectiveness of case-finding tools; however, all clinicians examining children and adults should be alert to physical and behavioral signs and symptoms associated with abuse or neglect. Patients in whom abuse is suspected should receive proper documentation of the incident and physical findings (e.g., photographs, body maps); treatment for physical injuries; arrangements for skilled counseling by a mental health professional; and the telephone numbers of local crisis centers, shelters, and protective service agencies.
- Victims of family violence are primarily children, female spouses/intimate partners, and older adults. Numerous risk factors for family violence have been identified, although some may be confounded by socioeconomic factors. Factors associated with child abuse or neglect include low income status, low maternal education, non-white race, large family size, young maternal age, single-parent household, parental psychiatric disturbances, and presence of a stepfather. Factors associated with intimate partner violence include young age, low income status, pregnancy, mental health problems, alcohol or substance use by victims or perpetrators, separated or divorced status, and history of childhood sexual and/or physical abuse. Factors associated with the abuse of older adults include increasing age, non-white race, low income status, functional impairment, cognitive disability, substance use, poor emotional state, low self-esteem, cohabitation, and lack of social support.

- Several instruments to screen parents for child abuse have been studied, but their ability to predict child abuse or neglect is limited. Instruments to screen for intimate partner violence have also been developed, and although some have demonstrated good internal consistency (e.g., the HITS [Hurt, Insulted, Threatened, Screamed at] instrument, the Partner Abuse Interview, and the Women's Experience with Battering [WEB] Scale), none have been validated against measurable outcomes. Only a few screening instruments (the Caregiver Abuse Screen [CASE] and the Hwalek-Sengstock Elder Abuse Screening Test [HSEAST]) have been developed to identify potential older victims of abuse or their abusive caretakers. Both of these tools correlated well with previously validated instruments when administered in the community, but have not been tested in the primary care clinical setting.
- Home visit programs directed at high-risk mothers (identified on the basis of sociodemographic risk factors) have improved developmental outcomes and decreased the incidence of child abuse and neglect, as well as decreased rates of maternal criminal activity and drug use.

Definitions:

Strength of Recommendations

The Task Force grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians routinely provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians routinely provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

Strength of Evidence

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Accuracy of Clinical Screening Instruments

- All instruments designed to screen for child abuse and neglect were directed at parents, particularly pregnant mothers. Limited evidence suggests that these instruments had fairly high sensitivity but low specificity for identifying future child maltreatment when administered in the study populations, particularly when self-administered questionnaires were provided to pregnant mothers in a 2-step method such as the Hawaii Risk Indicators Screening Tool followed by the Kempe Family Stress Inventory. These questionnaires have not been widely tested in different populations.
- Newer brief instruments designed to identify women who are victims of intimate partner violence in primary care settings compare well with lengthier, previously validated instruments. Studies indicate that self-administered questionnaires elicit more positive responses than interviewer-administered questionnaires in emergency department settings, but the opposite was true in a Planned Parenthood clinic. No studies have evaluated the performance of screening instruments using verified outcomes of reported intimate partner abuse, although self-reported abuse may be a more accurately measured outcome than some verified outcomes (i.e., police or social services reports).
- The U.S. Preventive Services Task Force (USPSTF) found few screening instruments for the detection of older adults who are the potential victims of abuse or their caretakers. None of the instruments available have been widely validated.

Efficacy of Interventions

- The USPSTF reviewed the evidence for the efficacy of interventions with children, women, and older adults in reducing harmful outcomes of family and intimate partner violence. The intervention trials identified "high-risk" women and children based on various inclusion criteria that have not been validated, including sociodemographic characteristics, maternal substance use, low infant birth weight, and homelessness. A randomized controlled trial with 15 years of follow-up indicated that nurse home visit programs (i.e., the Nurse Family Partnership program) during the prenatal and 2-year postpartum periods for low-income, first-time mothers can improve the short-term and long-term outcomes of child abuse and neglect. When compared with the nonintervention group, the home visit group had improved outcomes, including decreased reports of child maltreatment, child injuries/toxic ingestions and emergency department visits, and maternal criminal activity and drug use. Several trials utilizing nurse home visits for varying lengths of time and with various program components for pregnant and postpartum mothers support these findings, although the outcomes in these studies were short-term measures of child abuse and related factors.
- There were 2 studies of interventions to decrease intimate partner violence in women; both studies, which only recruited pregnant women, showed a trend (not statistically significant) in women reporting decreased violence after brief counseling or outreach interventions. There are no studies of interventions initiated in the primary care setting with health outcomes for older children, women who are not pregnant, or older adults.

POTENTIAL HARMS

No studies have directly addressed the harms of screening and intervention for family and intimate partner violence. False-positive test results, most common in low-risk populations, may compromise the clinician-patient relationship. Additional possible harms of screening may include loss of contact with established support systems, psychological distress, and an escalation of abuse. However, none of these potential harms has been studied.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The U.S. Preventive Services Task Force recommendations are independent of the U.S. government. They do not represent the views of the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Screening for family and intimate partner violence: recommendation statement. Ann Intern Med 2004 Mar 2;140(5):382-6. [46 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2004 Mar 2)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

*Task Force Members**: Alfred O. Berg, MD, MPH, Chair, USPSTF (Professor and Chair, Department of Family Medicine, University of Washington, Seattle, WA); Janet D. Allan, PhD, RN, CS, Vice-chair, USPSTF (Dean, School of Nursing, University of Maryland Baltimore, Baltimore, MD); Paul Frame, MD (Tri-County Family Medicine, Cohocton, NY, and Clinical Professor of Family Medicine, University of Rochester, Rochester, NY); Charles J. Homer, MD, MPH (Executive Director, National Initiative for Children's Healthcare Quality, Boston, MA); Mark S. Johnson, MD, MPH (Professor of Family Medicine, University of Medicine and Dentistry of New Jersey-New Jersey Medical School, Newark, NJ); Jonathan D. Klein, MD, MPH (Associate Professor, Department of Pediatrics, University of Rochester School of Medicine, Rochester, NY); Tracy A. Lieu, MD, MPH (Associate Professor, Department of Ambulatory Care and Prevention, Harvard Pilgrim Health Care and Harvard Medical School, Boston, MA); C. Tracy Orleans, PhD (Senior Scientist, The Robert Wood Johnson Foundation, Princeton, NJ); Jeffrey F. Peipert, MD, MPH (Director of Research, Women and Infants' Hospital, Providence, RI); Nola J. Pender, PhD, RN (Professor Emeritus, University of Michigan, Ann Arbor, MI); Albert L. Siu, MD, MSPH (Professor of Medicine, Chief of Division of General Internal Medicine, Mount Sinai School of Medicine, New York, NY); Steven M. Teutsch, MD, MPH (Senior Director, Outcomes Research and Management, Merck & Company, Inc., West Point, PA); Carolyn Westhoff, MD, MSc (Professor of Obstetrics and Gynecology and Professor of Public Health, Columbia University, New York, NY); and Steven H. Woolf, MD, MPH (Professor, Department of Family Practice and Department of Preventive and Community Medicine and Director of Research Department of Family Practice, Virginia Commonwealth University, Fairfax, VA)

**Members of the Task Force at the time this recommendation was finalized.* For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 51, Screening for family violence. p. 555-65.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Also available from the Annals of Internal Medicine Online.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Nelson H, Nygren P, McInerney Y, Klein J. Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med 2004;140(1)387-396.

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Also available from the Annals of Internal Medicine Online.

- Nelson H, Nygren P, Klein J. Screening children for family violence: a review of the evidence for the U.S. Preventive Services Task Force. Ann Fam Med. In press.

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

- Nelson HD, Nygren P, Qazi Y. Screening for Family and Intimate Partner Violence. Rockville (MD); Agency for Healthcare Research and Quality; 2004 Mar (Systematic Evidence Review No. 28).

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

The following are also available:

- The guide to clinical preventive services, 2006. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2006. 228 p. Electronic copies available from the AHRQ Web site.
- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2002 May. 189 p. Electronic copies available from the AHRQ Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Electronic Preventive Services Selector (ePSS), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following are available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

- Screening for family violence: recommendations from the U.S. Preventive Services Task Force. Summary for patients. Ann Intern Med 2004 Mar 2;140(1):70I

  Electronic copies: Available from the Annals of Internal Medicine Online.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on February 23, 2004. The information was verified by the guideline developer on March 1, 2004.

COPYRIGHT STATEMENT

Requests regarding copyright should be sent to: Gerri M. Dyer, Electronic Dissemination Advisor, Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research), Center for Health Information Dissemination, Suite 501, Executive Office Center, 2101 East Jefferson Street, Rockville, MD 20852; Facsimile: 301-594-2286; E-mail: gdyer@ahrq.gov.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

© 1998-2008 National Guideline Clearinghouse

Date Modified: 10/6/2008