



Complete Summary

GUIDELINE TITLE

National consensus guidelines on identifying and responding to domestic violence victimization in health care settings.

BIBLIOGRAPHIC SOURCE(S)

Family Violence Prevention Fund. National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. San Francisco (CA): Family Violence Prevention Fund; 2004 Feb 1. 70 p. [70 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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

SCOPE

DISEASE/CONDITION(S)

- Intimate partner violence (IPV) (a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation, and threats perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and aimed at establishing control by one partner over the other)
- Any condition resulting from intimate partner violence (IPV) (e.g., inflicted physical injury, chronic headaches, depression, sexual dysfunction, pelvic pain, chronic pain syndrome, substance abuse, chronic mental illness)

GUIDELINE CATEGORY

Counseling
Evaluation
Management
Prevention
Risk Assessment
Screening

CLINICAL SPECIALTY

Dentistry
Emergency Medicine
Family Practice
Geriatrics
Internal Medicine
Nursing
Obstetrics and Gynecology
Orthopedic Surgery
Pediatrics
Physical Medicine and Rehabilitation
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dentists
Emergency Medical Technicians/Paramedics
Health Care Providers
Nurses
Physical Therapists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

- To present recommendations on how inquiry for domestic violence victimization, assessment, documentation, intervention, and referrals should occur in multiple settings, and in various professional disciplines
- To review current findings regarding the prevalence and health impact of domestic violence, to present a rationale for regular and routine inquiry and response, and to underscore the importance of culturally competent practice in addressing domestic violence
- To outline the recommendations for identification and response
- To offer continuous quality improvement goals to help monitor the impact and implementation of abuse identification and response protocols

TARGET POPULATION

All female and male adolescent and adult patients exposed to or at risk of intimate partner violence (IPV)

INTERVENTIONS AND PRACTICES CONSIDERED

1. Routine patient inquiry about current and lifetime exposure to intimate partner violence (IPV)
2. Immediate safety assessment after disclosure and repeated and/or expanded assessments during follow-up appointments
3. Assessment of pattern and history of abuse
4. Providing validation and oral and written information on domestic violence and safety planning, responding to safety issues, making referrals to local resources
5. Reporting IPV to law enforcement or social service agencies depending on applicable statutes in each state and informing patient about any limits of confidentiality
6. Documentation of relevant history, results of physical examination, laboratory and other diagnostic procedures, interventions, and referrals; documentation of reasons for concerns and physical findings if patient does not disclose IPV victimization
7. Follow-up with a health care provider, social worker or domestic violence advocate

MAJOR OUTCOMES CONSIDERED

- Risk, incidence and prevalence of intimate partner violence (IPV)
- Morbidity and mortality related to IPV

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The developer conducted searches of Medline.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

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

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Family Violence Prevention Fund (FVPF) invited the Advisory Committee from the 1999 "Preventing Domestic Violence: Clinical Guidelines on Routine Screening" to be reviewers. Advisory Committee members worked assiduously to develop and revise the Guidelines. These recommendations reflect the combined decades of their experience in the field as well as results from current research.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Responses to intimate partner victims are most efficient and effective when coordinated in a multi-disciplinary manner and in collaboration with domestic violence (DV) advocates so that no single provider is responsible for the entire intervention. All providers in the settings listed in the original guideline document should be trained and achieve basic competence regarding how to identify and respond to intimate partner violence (IPV). Site-specific policies should be developed that clarify each provider's role in implementing specific elements of the protocol.

Inquiry

What should providers ask?

Ask patients about current and lifetime* exposure to IPV victimization, including direct questions about physical, emotional, and sexual abuse.

*Because of the long-term impact of abuse on a patient's health, we recommend integrating assessment for current and lifetime exposure into routine care. However, we acknowledge there will be times (particularly in emergency/urgent care) when assessment for lifetime exposure to abuse will not always be possible due to time constraints.

Who should be routinely asked about current and past IPV victimization?

- All adolescent and adult patients* regardless of cultural background
- Parents or caregivers of children in pediatric care

(Please see **Appendix A** and **Appendix B** in the original guideline document for setting-specific recommendations and for recommendations in child health settings, respectively).

*The majority of IPV perpetrators are male, so assessing all patients increases the likelihood of identifying perpetrators for victimization. We recommend routinely assessing men only if additional precautions can be taken to protect victims whose batterers claim to be abused. Training providers on perpetrator dynamics and the responses to lesbian, gay, transgender, bisexual, and heterosexual victims is critical, regardless of policies to assess all patients or women only.

(See **Appendix C** in the original guideline document **for** recommendations on assessing all patients for IPV).

How should inquiry for present and past IPV victimization occur?

Assessment should be:

- Conducted routinely, regardless of the presence or absence of indicators of abuse
- Conducted orally as part of a face-to-face health care encounter
- Included in written or computer based health questionnaires
- Direct and nonjudgmental using language that is culturally/linguistically appropriate
- Conducted in private: no friends, relatives (except children under 3), or caregivers should be present
- Confidential: prior to inquiry, patients should be informed of any reporting requirements or other limits to provider/patient confidentiality
- Assisted, if needed, by interpreters who have been trained to ask about abuse and who do not know the patient or the patient's partner, caregiver, friends, or family socially

When should inquiry for past and present IPV victimization occur?

- As part of the routine health history (e.g., social history/review of systems)
- As part of the standard health assessment (or at every encounter in urgent care)
- During every new patient encounter
- During periodic comprehensive health visits (assess for current IPV victimization only)
- During a visit for a new chief complaint (assess for current IPV victimization only)
- At every new intimate relationship (assess for current IPV victimization only)
- When signs and symptoms raise concerns or at other times at the provider's discretion

(Please see **Appendix D** in the original guideline document for suggested assessment questions and strategies).

When should inquiry not occur?

- If provider can not secure a private space in which to conduct inquiry
- If there are concerns that assessing the patient is unsafe for either patient or provider
- If provider is unable to secure an appropriate interpreter

If inquiry does not occur:

- Note in chart that inquiry was not completed and schedule a follow-up appointment (or if in an urgent care setting, refer patient to a primary care provider)
- Have posters, safety cards, and patient education materials about IPV available in exam or waiting rooms, bathrooms, or on discharge instructions

Health and Safety Assessment

The goals of the assessment are to a) create a supportive environment in which the patient can discuss the abuse and b) enable the provider to gather information about health problems associated with the abuse and c) assess the immediate and long-term health and safety needs for the patient in order to develop and implement a response.

When should assessment occur?

- Initial assessment should occur immediately after disclosure.
- Repeat and/or expanded assessments should occur during follow-up appointments.
- At least one follow-up appointment (or referral) should be offered after disclosure of current or past abuse with health care provider, social worker, or DV advocate.

What should assessment include?

For the patient who discloses current abuse, assessment should include at a minimum:

Assessment of immediate safety

- "Are you in immediate danger?"
- "Is your partner at the health facility now?"
- "Do you want to (or have to) go home with your partner?"
- "Do you have somewhere safe to go?"
- "Have there been threats or direct abuse of the children (if s/he has children)?"
- "Are you afraid your life may be in danger?"
- "Has the violence gotten worse or is it getting scarier? Is it happening more often?"
- "Has your partner used weapons, alcohol or drugs?"
- "Has your partner ever held you or your children against your will?"
- "Does your partner ever watch you closely, follow you, or stalk you?"
- "Has your partner ever threatened to kill you, him/herself, or your children?"

If the patient states that there has been an escalation in the frequency and/or severity of violence, that weapons have been used, or that there has been hostage taking, stalking, homicide or suicide threats, providers should conduct a homicide/suicide assessment.

(See **Appendix E** in the original guideline document for danger assessment and other assessment tools).

Assess the impact of the IPV (past or present) on the patient's health:

There are common health problems associated with current or past IPV victimization. Disclosure should prompt providers to consider these health care risks and assess:

- How the (current or past) IPV victimization affects the presenting health issue
- "Does your partner control your access to health care or how you care for yourself?"
- How the (current or past) IPV victimization relates to other associated health issues

(See **Appendix F** in the original guideline document for expanded assessment areas).

Assessment of the pattern and history of current abuse:

- "How long has the violence been going on?"
- "Have you ever been hospitalized because of the abuse?"
- "Can you tell me about your most serious event?"
- "Has your partner forced you to have sex, hurt you sexually, or forced you into sexual acts that made you uncomfortable?"
- "Have other family members, children, or pets been hurt by your partner?"
- "Does your partner control your activities, money, or children?"

For the patient that discloses past history of IPV victimization:

- "When did the abuse occur?"
- "Do you feel you are still at risk?"
- "Are you in contact with your ex-partner?" "Do you share children or custody?"
- "How do you think the abuse has affected you emotionally and physically?"

What to do if a patient says "no":

- Respect her/his response.
- Let the patient know that you are available should the situation ever change.
- Assess again at previously recommended intervals.
- If patient says "no" but you believe s/he may be at risk, discuss the specific risk factors and offer information and resources in exam and waiting rooms, or bathrooms.

(See **Appendix G** in the original guideline document for indicators of abuse that should prompt follow-up questions).

Interventions with Victims of IPV

Interventions will vary based on the severity of the abuse, the patient's decisions about what s/he wants for assistance at that time, and if the abuse is happening currently. It is important to let the patient know that you will help regardless of whether s/he decides to stay in or leave the abusive relationship. For all patients who disclose current abuse providers should:

Provide validation:

- Listen non-judgmentally.
- "I am concerned for your safety (and the safety of your children)."
- "You are not alone and help is available."
- "You don't deserve the abuse and it is not your fault."
- "Stopping the abuse is the responsibility of your partner, not you."

Provide information:

- "Domestic violence is common and happens in all kinds of relationships."
- "Violence tends to continue and often becomes more frequent and severe."
- "Abuse can impact your health in many ways."
- "You are not to blame, but exposure to violence in the home can emotionally and physically hurt your children or other dependent loved ones."

Respond to safety issues:

Offer the patient a brochure about safety planning and go over it with her/him.

(Please see **Appendix H** in the original guideline document for a sample safety plan).

- Review ideas about keeping information private and safe from the abuser.

- Offer the patient immediate and private access to an advocate in person or via phone.
- Offer to have a provider or advocate discuss safety then or at a later appointment.
- If the patient wants immediate police assistance, offer to place the call.
- Reinforce the patient's autonomy in making decisions regarding her/his safety.
- If there is significant risk of suicide, the patient should be kept safe in the health setting until emergency psychiatric evaluation can be obtained.

Make referrals to local resources:

- Describe any advocacy and support systems within the health care setting.
- Refer patient to advocacy and support services within the community.
- Refer patients to organizations that address their unique needs such as organizations with multiple language capacities, or those that specialize in working with specific populations (i.e., teen, elderly, disabled, deaf or hard of hearing, particular ethnic or cultural communities, or lesbian, gay, transgender, or bisexual clients)
- Offer a choice of available referrals including on-site advocates, social workers, local DV resources, or the National DV Hotline (800) 799-SAFE, TTY (800) 787-3224

For the patient who discloses past but not current IPV victimization:

- "Domestic violence is common and happens in all kinds of relationships."
- "Abuse can impact your health in many ways."
- "What happened to you may be related to health problems now."
- "How do you feel about this now? Is there anything I can do for you now?"
- If the patient feels the issue is still affecting them physically or emotionally, offer to set up an appointment to discuss it further with a primary care provider, mental health provider, social worker, or DV advocate, depending on the patient's needs.

(Please see **Appendix I** in the original guideline document for more detailed recommendations on interventions for patients with current and/or past experience with IPV).

Reporting IPV to law enforcement or social service agencies:

Some states have requirements to report current victimization to law enforcement or social services. Providers should:

- Learn applicable statutes in your state (See **Appendix J** in the original guideline document for a summary of state laws).
- If you practice in a state with a mandated reporting law, inform patients about any limits of confidentiality prior to conducting assessment.

(See **Appendix B** in the original guideline document for a discussion of reporting requirements for child exposure to IPV).

Confidentiality procedures:

Inappropriate disclosure of health information may violate patient/provider confidentiality and threaten patient safety. Perpetrators who discover that a victim has sought care may retaliate with further violence. Employers, insurers, law enforcement agencies, and community members who discover abuse may discriminate against a victim or alert the perpetrator. It is imperative that policy, protocol, and practice surrounding the use and disclosure of health information regarding victims of IPV should respect patient confidentiality and autonomy and serve to improve the safety and health status of victims of IPV. The federal medical records privacy regulations issued in August 2002 (in effect April 14, 2003) have specific implications for victims of violence.

Prior to implementing a domestic violence program:

- Review relevant state privacy laws.
- Follow the federal regulations and privacy principles for victims of IPV.

(For a summary of new federal regulations, see **Appendix L** in the original guideline document).

Documentation

Documentation should be conducted by a health care provider who is authorized to record in the patient's medical record. Providers should document the patient's statements and avoid pejorative or judgmental documentation (e.g. write "patient declines services" rather than "patient refuses services," "patient states" rather than "patient alleges").

(See **Appendix B** in the original guideline document for recommendations on documentation in child health settings).

Document relevant history:

- Chief complaint or history of present illness
- Record details of the abuse and its relationship to the presenting problem.
- Document any concurrent medical problems that may be related to the abuse.
- For current IPV victims, document a summary of past and current abuse including:
 - Social history, including relationship to abuser and abusers name if possible
 - Patient's statement about what happened, not what lead up to the abuse (e.g., "boyfriend John Smith hit me in the face," not "patient arguing over money")
 - Include the date, time, and location of incidents where possible.
 - Patient's appearance and demeanor (e.g., "tearful, shirt ripped," not "distraught")
 - Any objects or weapons used in an assault (e.g., knife, iron, closed or open fist)
 - Patient's accounts of any threats made or other psychological abuse
 - Names or descriptions of any witnesses to the abuse

Document results of physical examination:

- Findings related to IPV, neurological, gynecological, mental status exam if indicated
- If there are injuries, (present or past) describe type, color, texture, size, and location.
- Use a body map and/or photographs to supplement written description.
- Obtain a consent form prior to photographing patient. Include a label and date.

(See **Appendix K** in the original guideline document for more on photo documentation and forensic evidence collection).

Document laboratory and other diagnostic procedures:

- Record the results of any lab tests, x-rays, or other diagnostic procedures and their relationship to the current or past abuse.

Document results of assessment, intervention, and referral:

- Record information pertaining to the patient's health and safety assessment including your assessment of potential for serious harm, suicide, and health impact of IPV.
- Document referrals made and options discussed.
- Document follow-up arrangements.

If patient does not disclose IPV victimization:

- Document that assessment was conducted and that the patient did not disclose abuse.
- If you suspect abuse, document your reasons for concerns (i.e., "physical findings are not congruent with history or description," "patient presents with indications of abuse.")

Follow-Up and Continuity of Care for Victims**At least one follow-up appointment (or referral) with a health care provider, social worker, or DV advocate should be offered after disclosure of current or past abuse:**

- "If you like, we can set up a follow-up appointment (or referral) to discuss this further."
- "Is there a number or address that is safe to use to contact you?"
- "Are there days/hours when we can reach you alone?"
- "Is it safe for us to make an appointment reminder call?"

At every follow up visit with patients currently in abusive relationships:

- Review the medical record and ask about current and past episodes of IPV.
- Communicate concern and assess both safety and coping or survival strategies:

- "I am still concerned for your health and safety."
- "Have you sought counseling, a support group, or other assistance?"
- "Has there been any escalation in the severity or frequency of the abuse?"
- "Have you developed or used a safety plan?"
- "Told any family or friends about the abuse?"
- "Have you talked with your children about the abuse and what to do to stay safe?"
- Reiterate options to the patient (individual safety planning, talking with friends or family, advocacy services and support groups, transitional/temporary housing, etc.)

For current and previous victims of IPV:

- Ensure that patient has a connection to a primary care provider.
- Coordinate and monitor an integrated care plan with community-based experts as needed, or other health care specialists, trained social workers, or mental health care providers as needed.

(For more information on addressing short and long term mental health effects of IPV victims see the American Medical Association's [AMA's] Diagnostic and Treatment Guidelines on Mental Health Effects of Family Violence referenced in **Appendix N** of the original guideline document).

If patient does not disclose current or past IPV victimization:

- Document that assessment was conducted and that the patient did not disclose abuse.
- If you suspect abuse, document your reasons for concern (i.e., "physical findings are not congruent w/ history or description," "patient presents with indicators of violence.")

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Improved identification and management of victims of intimate partner violence(IPV)
- Regular, face-to-face screening of women by skilled health care providers markedly increases the identification of victims of IPV, as well as those who

are at risk for verbal, physical, and sexual abuse. Routine inquiry of all patients, as opposed to indicator-based assessment, increases opportunities for both identification and effective interventions, validates IPV as a central and legitimate health care issue, and enables providers to assist both victims and their children. When victims or children exposed to IPV are identified early, providers may be able to break the isolation and coordinate with domestic violence (DV) advocates to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Expert opinion suggests that such interventions in adult health settings may lead to reduced morbidity and mortality.

- Assessment for exposure to lifetime abuse has major implications for primary prevention and early intervention to end the cycle of violence.

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Systems should be in place that help providers implement clinical recommendations, such as ensuring that educational materials for patients are always available, that providers have training and tools they need, and that site-specific quality improvement goals for the intimate partner violence (IPV) program are developed. Site-specific goals assist providers in evaluating the quality of their IPV protocol. These goals can be set for compliance with the assessment and response protocols or for the number of patients providers expect to identify and assist in their practice. Both provider compliance and identification rates will vary depending on patient population, availability of resources in the health care setting and community, as well as other issues.

Goals for Compliance with IPV Protocols

Research shows that provider compliance with IPV protocols increases significantly with administrative support, including adequate staffing and training time and by offering provider tools. Over time, systems see significant improvements in provider compliance with the IPV protocols. Based on research and practical clinical experience, reasonable goals for provider compliance are:

- Thirty percent of providers comply with protocol (with minimal administrative support and monitoring) in the first year of the program.
- Seventy percent of providers comply with protocol (with strong administrative support and monitoring after the program is in place.)

Quality Improvement Goals for Identification Based on Setting-specific Prevalence Data

Understanding local IPV data or other available setting-specific prevalence data can help providers establish goals to reach as many victims as possible. Providers or administrators are encouraged to compare their identification rates with the

research on prevalence of IPV to work towards these improved identification goals. When a comprehensive and well designed assessment and response program is in place, identification rates can reflect national prevalence data fairly closely. Measuring provider skills, knowledge level, and satisfaction with the program will also provide valuable information that can be used to continually improve identification rates and response to victims. Success should not be based on disclosure alone, and there are many reasons why a patient may or may not disclose abuse. Evaluating patient satisfaction and improved health and safety behaviors in addition to measuring identification rates is strongly recommended.

Implementation Measures

Random sample medical record reviews, whether done just for the purpose of improving IPV assessment performance or whether folded into other quality documentation activities such as Health Plan Employer Data and Information Set (HEDIS) reporting, can provide valuable information about provider compliance with the IPV protocol. If the sample size is large enough, it is also possible that information from chart review can be used to estimate the number of patients being identified and referred at the level of a medical group (this is not applicable to individual physicians because of small sample size). Reviewing a random selection of medical records of each provider is recommended to evaluate documentation of assessment, intervention, and follow-up as outlined in the consensus guidelines.

Records should provide information on assessment including:

- Percent of patients seen who were assessed for IPV during the last year
- Percent of patients assessed who disclosed that they were victims of abuse
- Percent of providers who complied with assessment protocols

For patients who assessed positive for current or past IPV, record should indicate that the following was conducted:

- Immediate safety and initial danger
- Abuse history (severity and extent)
- Impact of abuse on health issues and presence of related health care issues
- For those who answered yes to initial danger assessment questions, a suicide and homicide assessment was conducted

For patients disclosing abuse, records should indicate that intervention and treatment plans were offered including:

- Verbal and/or written information about safety planning (current victims only)
- An option to talk with an advocate in person or on the phone (current victims only)
- Verbal and/or written information about abuse and its impact on health
- Referrals to culturally and linguistically appropriate services
- A review of discharge instructions and a scheduled follow-up appointment or care plan with mental health, social worker or community-based service provider

If patient did not disclose abuse but provider is concerned, records should indicate:

- Verbal and written information about IPV and referrals were offered
- Prompts for specific follow-up questions to occur at the patient's next visit

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Chart Documentation/Checklists/Forms
Foreign Language Translations
Patient Resources
Pocket Guide/Reference Cards
Quick Reference Guides/Physician Guides
Resources
Slide Presentation
Staff Training/Competency Material
Tool Kits
Wall Poster

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

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

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

DATE RELEASED

2004 Feb 1

GUIDELINE DEVELOPER(S)

Family Violence Prevention Fund - Private Nonprofit Organization

SOURCE(S) OF FUNDING

Family Violence Prevention Fund

GUIDELINE COMMITTEE

National Advisory Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

National Advisory Committee Members: Elaine Alpert, MD, MPH, Boston University School of Public Health, Massachusetts; Jacquelyn C. Campbell, PhD, RN, FAAN, Johns Hopkins University, Maryland; Linda Chamberlain, PhD, MPH, Alaska Family Violence Prevention Project, Alaska; Anne L. Ganley, PhD, University of Washington, Washington; Leigh Kimberg, MD, Maxine Hall Health Center, California; Margaret M. McNamara, MD, University of California, San Francisco, California; Terri E. Pease, PhD, ServiceNet, Massachusetts; Patricia R. Salber, MD, Physicians for a Violence-free Society, California; Carole Warshaw, MD, Hospital Crisis Intervention Project, Illinois; Deborah Zilmer, MD, American Academy of Orthopaedic Surgeons

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Family Violence Prevention Fund Web site](#).

Print copies: Available from The Family Violence Prevention Fund, 383 Rhode Island Street, Suite 304, San Francisco, CA 94103-5133

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Family Violence Prevention Fund. National health care standards campaign on family violence. Model practices from 15 states. San Francisco (CA): Family Violence Prevention Fund; 2004 Feb

- Family Violence Prevention Fund. Making the connection: domestic violence and public health. San Francisco (CA): Family Violence Prevention Fund

Electronic copies: Electronic copies: Available in Portable Document Format (PDF) from the [Family Violence Prevention Fund Web site](#).

Additional implementation tools, including implementation measures, a physician quick reference guide for setting-specific clinical response to victims of domestic violence, suggested assessment questions and strategies, validated abuse and danger assessment tools, sample safety plan and discharge instructions, and a catalogue of training and education materials, including trainer's manuals, resource kits, pocket reference cards, videos, and posters, are included in the [original guideline document](#). Many of these materials are also available from the [Family Violence Prevention Fund Web site](#).

PATIENT RESOURCES

Various patient resources, including brochures and safety cards in a variety of languages, are available from the catalogue of training and education materials included in the [original guideline document](#). Many of these materials are also available from the [Family Violence Prevention Fund Web site](#).

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

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