ACADEMY ON VIOLENCE & ABUSE

ADVANCING HEALTH EDUCATION & RESEARCH

AVA Research Reviews provides AVA members with recent published, peer-reviewed articles in a broad array of violence and abuse topics. The goal is to highlight and disseminate violence and abuse research in a timely fashion, and to enhance healthcare providers' practice by fostering the educational mission of AVA

AVA Research Review

ADVANCING HEALTH EDUCATION & RESEARCH

Review Title: Intimate Partner Violence Screening and Counseling in a Primary Care Setting: A Cluster Randomized Controlled Trial and Commentary

Reviewers: Kimberly A. Randell, MD, MSc – Children's Mercy Hospitals & Clinics, Kansas City, MO and Mario Cruz, MD – St. Christopher's Hospital for Children, Philadelphia, PA

Article(s): Hegarty, K., O'Doherty, L., Taft, A., Chondros, P., Brown, P., Valpied, J., et al. (2013). Screening and counseling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial. Lancet, 382, 249-258.

Associated Commentary: Jewkes, R. (2013). Intimate partner violence: the end of routine screening. Lancet, 382, 190-191.

Article Summary:
Brief Overview:

Despite the widely acknowledged adverse health consequences of intimate partner violence (IPV), controversy exists regarding the effectiveness of IPV interventions for women experiencing abuse. To address this gap, Hegarty, et al. evaluated the effectiveness of a primary care intervention using a cluster randomized trial of family physicians and their IPV positive female patients. Physicians were the randomization unit. Those in the intervention arm (n = 25) received 8 hours of Healthy Relationships Training to equip them to deliver a brief IPV counseling intervention based on the patient-centered Psychosocial Readiness Model. Physicians in both the intervention and control (usual care n = 27) arms received a basic IPV education pack and continuing education credits. To recruit patients, over 20,000

Australian females were mailed a health and lifestyle survey. Those who returned the survey (28% response rate), screened positive for "fear of their partner" (12.7% positive), and met other inclusion criteria were invited to participate in the study. Patients allocated to the intervention group (n = 137) were invited by letter to participate in one to six IPV counseling sessions from their family physician. Patients in the control arm (n=135) received usual care if they saw their physician during the study period. All patients received a list of IPV resources with the mailed survey. Follow up with women in both arms occurred via mailed survey at 6 and 12 months after the counseling invitation.

Study Aims/Hypotheses:

This study aimed to determine if brief family physician-provided IPV counseling of women with a positive IPV screen resulted in improvements in quality of life and mental health and increased safety planning , safety-related behaviors and physician screening for IPV.

Relevant Findings:

Although level of significance values are not presented, there appears to be several differences at baseline between the intervention and control groups, including marital status (28% vs. 38%) and living with children (54% vs. 69). Those lost to follow up were less likely to be married or in a relationship, live with their partner, have children < 18 years old, have a pension as their main income source or ever have had a safety plan. They were also more likely to have anxiety and depression.

Of the women in the intervention arm, half (n=67) women attended one or more counseling sessions (median of one visit, range 1-6). Although they received three reminder calls, 29 women had not attended counseling at 6 months. Forty-one (29.9%) women refused to participate. Thirty-nine women in the intervention arm and 35women in the control arm were lost to follow up at 12 months.

Using intention-to-treat analysis, no between-group differences were detected in quality of life, safety planning or behaviors, or global mental health (measured by the Short Form 12) at 12 months. Physical health improved among women in the intervention arm at 6 months ($p= 0.01$) but not at 12 months. Women in the intervention arm had fewer depressive symptoms (on the Hospital Anxiety and Depression Scale) at 12 months ($p = 0.006$) and increased physician inquiry regarding the woman's and her children's safety at 6 months ($p = 0.002$, $p = 0.008$) and 12 months ($p= 0.07$, $p= 0.06$). There were no differences between groups regarding anxiety symptoms or comfort to discuss fear with their physician at 6 and 12 months.

The majority of women in both arms agreed they were glad to have participated in the trial. At 12 months, 57% of women in the intervention arm perceived their quality of life as improved, compared to 47% of women in the control arm. For those women reporting partner awareness of trial participation, negative (e.g. anger, restricted freedom) and positive partner behaviors as a result of participating in the trial did not differ between groups.

Authors' Conclusions:

The authors reached the following conclusions: 1) Family doctors should be trained to ask about the safety of women and children, as well as provide supportive counseling for women experiencing abuse; 2) Study findings do not support the use of a mailed survey to identify women experiencing abuse; and 3) The study does not support screening for IPV in healthcare settings.

Potential Limitations:

The authors note the Hawthorne effect from completion of baseline surveys may have attenuated the intervention effect. Intervention effect attenuation may also have resulted from provision of the IPV education pack and continuing education credits to physicians in both the intervention and usual care arms of the trial. Additionally, all participants were screened for IPV and received resources. Therefore, the study could not answer a critical question, "Do women experiencing IPV who are screened and referred for services do better than those who are never identified and never receive resources?" As no assurance of fidelity to the counseling model was described, it is unclear if the intervention was delivered as planned. It is also unclear how physician competence with the intervention was determined. The intervention utilized motivational interviewing techniques, which may require considerable education and practice before competency is achieved.

Although the intention-to-treat analysis provides a "real-world" evaluation of intervention effectiveness, this may have resulted in a lesser intervention effect given 51% of women in the treatment arm did not utilize the intervention. The authors did not comment on the efficacy of the intervention for the limited number of women who participated in counseling.

Study findings may not be generalizable to the broad population of women experiencing IPV as the study population was English-speaking, Australian women with relatively high levels of education and employment. Additionally, physicians self-selected to participate and may have had a particular interest in addressing the issue of IPV.

Reviewers' Comment:

Hegarty, et al. may have underestimated the real and potential impact of their intervention. Additionally, we disagree with the conclusions of Jewkes' accompanying commentary which suggests that: 1) It is time to end universal IPV assessment in healthcare settings, and 2) IPV assessment should be limited to particular settings (e.g. obstetric clinics) and clinical situations.

Jewkes' commentary may have over-reached in concluding that this study's findings support the end of universal IPV screening in health care settings. First, this study did not evaluate screening in health care settings; rather the screening was performed via mail using a single IPV screening question that has not been previously validated. Thus the study population may not represent IPV victims identified in a health care setting by a validated screening instrument.

Although very limited (participants attended a mean of only one counseling session), the study intervention was associated with a reduction in depressive symptoms in 17% of participants (adjusted OR= 0.4, p =.006). An intervention with such significant clinical and statistical impact on depressive symptoms has the potential to improve women's health, although likely over a longer period of time than measured by this study.

Approximately half of the studies' participants lived with children; however, the outcomes for these children were not assessed. A brief intervention resulting in decreased maternal depression may have a significant positive impact on the health and resiliency of IPV-exposed children given the impact of maternal depression on outcomes for children exposed to IPV. An assessment of pediatric outcomes, as well as other secondary outcomes

(such as financial well-being), should be made prior to making firm conclusions about the effectiveness of this intervention.

Also limiting our ability to draw definitive conclusions from this article is the finding that half of the intervention group did not utilize the intervention as designed. While reminder phone calls were made, other barriers may have prevented women from attending counseling sessions (e.g., child care needs, obligations to work, control tactics by the abusive partner). Future iterations of this intervention should aim to facilitate patient compliance by identifying and providing solutions to these well-known barriers.

IPV is a complex problem requiring a wide array of resources, of which counseling is only one. Women experiencing IPV may also require legal, financial, housing and childcare related resources, among others. It is possible that an intervention linking women to these additional resources may result in a larger impact on quality of life, safety planning and behaviors, mental health and continuation of abuse.

Reviewers' Summary:

Hegarty et al. make an important contribution to the field with a rigorous evaluation of IPV assessment and intervention. This primary care IPV intervention resulted in a clinically significant reduction in depressive symptoms and therefore has the potential over time to improve the health, well-being and resiliency of both women experiencing IPV and their children. However, due to a number of important study limitations, it would be premature to make firm conclusions about the overall effectiveness of primary care IPV interventions. Further research is needed to determine means of increasing uptake of IPV resources and interventions, to continue to refine and improve IPV resources and interventions, and to examine the impact of IPV interventions on pediatric, as well as adult outcomes. Based on the study design and nature of the screening method, this study does not support the conclusion of the accompanying commentary that universal IPV assessment in healthcare settings should cease.