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ACADEMY ON VIOLENCE & ABUSE

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AVA Research Review

ADVANCING HEALTH EDUCATION & RESEARCH

Review Title: Assessing Cochrane Collaboration's conclusions regards screening women for IPV

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Article: O'Doherty L, Taft A, Hegarty K, Ramsay J, Davidson L, Feder G. Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis. BMJ 2014; 348:1-11

Article Summary:
Brief Overview:

Intimate partner violence (IPV) is common in the United States and can have a multitude of health consequences for victims. In 2004, the U.S. Preventative Services Task Force (USPSTF) found the evidence insufficient to support a screening for IPV based on existing research.[1] In 2013, the USPTF announced that they were now recommending screening women of reproductive age for IPV based on new evidence that screening methods for IPV were effective, interventions can reduce the violence and harms from IPV, and that the risk from screening or intervening is small.[2,3] Hence, the USPSTF concluded with moderate certainty that screening women for IPV has moderate benefit. Yet a Cochrane Collaboration review in 2013 reported that screening is likely to increase rates of identification but resulted in low rates of referrals and that there was an absence of evidence that screening improves long-term benefits for women.[4]

The article discussed here is the abridged version of the Cochrane Collaboration systemic review that was published in the British Medical Journal in 2013. The

purpose of this review is to explore how the Cochrane review may have arrived at a different recommendation than the 2013 USPSTF analysis that found screening for IPV victimization was beneficial.

Methods:

This study was a systematic review and meta-analysis of trials assessing effectiveness of IPV screening. Reviewed studies included randomized or quasi-randomized trials of screening programs for IPV involving women aged >16 years presenting at healthcare settings. Studies that included structured clinical interventions, such as advocacy or therapeutic interventions, after screening were excluded. A total of 11 trials (n=13,027) were identified and included in assessment. Study assessment, data abstraction, and quality assessment were conducted independently by two of the authors. Standardized estimation of risk ratios and 95% CI were calculated.

Aims/Hypotheses:

The objectives of the review were to determine if there was any evidence that IPV screening increases the number of women identified, increases likelihood of referrals of victims to specialist services, results in improved health benefits for victims, and causes any harm.

Relevant Findings:

In 6 pooled studies (n= 3564), screening increased the identification of IPV (RR 2.33, 95% CI 1.39 to 3.89), particularly in antenatal settings (4.26, 1.76-10.31). Based on 3 studies (n=1400), there was no evidence that screening increased referrals to IPV support services (2.67, 0.99 – 7.20). Only 2 studies measured experience of violence after screening (3-18 months after screening), and found a non-significant reduction in subsequent IPV associated with screening. One study measured negative consequences of screening and found that screening does not cause harm.

Authors' Conclusions:

The authors of this study report that while "screening is likely to increase identification of IPV in healthcare settings, rates of identification from screening were low relative to best estimates of prevalence of such violence." They also report that it is unclear if screening increases referrals to support agencies. As primary studies used in this analysis did not detect improved outcomes for women screened for IPV, they conclude that there is insufficient evidence to support screening in healthcare settings. The authors conclude that further research is needed to compare the effectiveness of screening versus case finding (i.e., asking about IPV if indicators of risk are present) and recommend assessing screening in combination with therapeutic intervention, with a specific recommendation for "testing the effectiveness of interventions for women who disclose abuse."

Potential Limitations:

The authors comment on a number of potential limitations including difficulty in assessing outcomes due to the many different ways outcomes were measured. They also comment on the potential under-reporting of IPV in some studies due to clinicians' unwillingness to document IPV in medical charts and women's unwillingness to disclose IPV in studies using audio-recordings. Additionally, the researchers comment on the difficulty of using a "referral" as an outcome measure, as referral may vary from being given a list of resources to more formal immediate referral to a social worker or other support services. Additionally, they comment on a lack of validated measures to assess for harm and for economic analysis.

Reviewer's Comments:

The conflicting recommendations by the Cochrane researchers and those from the USPSTF researchers highlight the difficulty in assessing IPV. IPV is a very complicated social issue that affects health in many variable ways. Medical research has typically focused on assessing effectiveness of specific interventions for specific diseases with specific outcomes. Measuring effectiveness of a medication to reduce blood pressure is fairly straightforward. Measuring effectiveness of interventions to address IPV is not so simple. The heterogeneity in IPV presentations (e.g., severity of abuse, emotional verse physical abuse, etc.), screening methods, interventions, and potential outcomes makes it difficult to compare and assess these different study findings. Hence, different researchers may come to different conclusions when looking at a subset of studies.

The main reason for the different conclusions is likely due to the reviewers from USPSTF and the Cochrane review using different studies to determine if screening for IPV resulted in improved outcomes for the victims. This appears to be due to the Cochrane researchers excluding studies that included interventions that went beyond simple referral to domestic violence services, while the USPSTF included studies that included more comprehensive interventions. The Cochrane researchers state they did this because this is more likely to represent real-world situations, where clinicians will not have comprehensive interventions readily available. Nonetheless, the basic premise to support screening for any issue is that there is an effective intervention. For example, USPSTF only recommends screening adults for depression when staff-assisted depression care supports are in place to assure effective treatment and follow-up.[5] Therefore, one could argue that any assessment for screening for IPV should consider the effectiveness of the intervention used post-screening.

Hence, when assessing outcomes after IPV screening, the researchers from the Cochrane review concluded there were no improved outcomes for women, and therefore insufficient evidence to support screening of IPV in health care settings. This is based on findings from just two studies that assessed outcomes after IPV screening, and those outcomes were specifically re-occurrences of IPV[6,7] and physical and mental health based on SF-12 Health Form.[7] To note, both studies did find a reduction of rates of IPV, but it was statistically non-significant between the intervention and control conditions. This is different from the USPSTF assessment[2] which based their recommendation on outcomes from 6 different randomized controlled trials that were not used in the Cochrane review. Those studies found that IPV screening, when combined with specific interventions, resulted in improved health outcomes, such as improved birth outcomes and reduced rates of IPV victimization.[2] Additionally, one of studies included in the Cochrane review assessed for reduction in IPV after only 3 months.[6] Given the complexity of IPV, it may be unrealistic to expect to see a change in such a short period of time. The studies used in the USPTF recommendations were of longer durations, including one study that tracked outcomes for 6 years.[8]

The Cochrane review concludes that screening does not increase rates of referral, but, similar to their assessment of health outcomes, is based on a small number of studies. Based on 3 studies, they state that screening does not increase referrals to domestic violence support services with

a risk ratio of 2.67 and 95% CI of 0.99 to 7.20. These results are very close to being statistically significant and are based on just 3 studies; hence, the lack of statistically significant findings may be due to small sample size.

The Cochrane Review, in its conclusion, states that the screening for IPV, based on existing evidence, does not improve outcomes for women. The USPSTF came to a different conclusion based on different evidence. These two organizations, the Cochrane Review and the USPSTF, are recognized for providing unbiased assessments of existing research, yet these different conclusions may lead to confusion among policy-makers. Hence, I feel the most important message from the Cochrane review should not be the statistical findings but their observations that there is a serious need for additional research that accounts for the complexity of IPV and that will focus on assessing the effectiveness of interventions for women who disclose IPV.

References:

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