



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

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# AVA Research Review

## ADVANCING HEALTH EDUCATION & RESEARCH

**Review Title:** Screening Women for Intimate Partner Violence

**Reviewer:** Gene Feder, MD FRCGP, professor of primary health care, University of Bristol, United Kingdom

#### **Articles:**

1. Nelson HD, 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* 2012; 156 (11): 1-13.

2. Klevens J, Kee R, Trick W, Garcia D, Angulo FR, Jones R et al. Effect of screening for partner violence on women's quality of life: a randomized controlled trial. *JAMA* 2012; 308(7):681-689.

#### **Article Summary:**

*Brief Overview:*

How best to identify women patients experiencing IPV is a perennial debate internationally, with policies advocating universal screening in all health care settings not being supported by systematic reviews of research trials, including one conducted by Heidi Nelson and colleagues in 2004 for the US Preventive Services Task Force which concluded there was insufficient evidence to support a policy of universal screening. Below we summarize the update of that review and a recent randomised controlled trial of IPV screening by Joanne Klevens and colleagues.

#### ***Aims of the Nelson article:***

This systematic review evaluates new (January 2002 to January 2012) evidence on (i) the effectiveness of screening and of interventions for women in health care settings on IPV and related health outcomes, (ii) on the diagnostic accuracy of

screening instruments, and (iii) on the potential adverse effects of screening and interventions.

***Relevant findings:***

The only screening versus usual care trial – judged “fair quality by the reviewers” - showed no difference in recurrence of IPV nor in health outcomes. Fifteen fair and good quality studies of screening instruments (questionnaires) found six that were accurate. Four out of six fair and good quality trials of interventions (counselling, mentoring or nurse management) after women are identified through screening, found reduced IPV, improved birth outcomes for pregnant women, and reduced pregnancy coercion and unsafe relationships for women in family-planning clinics.

***Authors' conclusions:***

(i) screening could reduce IPV and improve health outcomes (while acknowledging the limitations of “effectiveness trials”); (ii) some screening instruments accurately identify women experiencing IPV in health care settings; (iii) screening has “minimal adverse effects”.

***Potential limitations of the Nelson findings:***

The biggest limitation of this systematic review is the virtual absence of studies comparing screening to usual care

(although human subjects protections from IRBs may have limited the availability of that comparison), and none that compared screening to active case finding by trained clinicians. Restriction of the study inclusion to research conducted in the US “or similar populations that received services and interventions applicable to medical practice in the United States” is a limitation with regards to health care policy in other countries and health economies. The restriction of the search to studies published after 2002 is a potential limitation, although the previous review by the authors found only two low quality trials before 2002 of interventions post-screening. Similarly, restriction to English language reports is a potential limitation, although at present there are no known screening or intervention trials published in other languages.

***Aims of the Klevens article:***

Reporting a three-armed randomized controlled trial testing the effect of a screening program in 10 urban primary care settings in Illinois. The majority of the 2700 participants of African American (55%) or Latina (37%) origin with relatively low educational status (57% high school education or less). The first group were screened with a 3-question computer

delivered tool and then recorded information encouraging access to appropriate services and an information sheet for women in abusive relationships and contacts for general health and social resources. In the second group all the women received the information sheet without screening, including contact details for local IPV support services and a list of general and social resources. The third group of women received only the list of general health and social resources.

***Relevant findings:***

At one year follow up there were no differences in measured outcomes between the groups, including physical and mental health quality of life; time off work in the past month, use of IPV services and recurrence of IPV.

***Potential limitations of the Klevens findings:***

The key limitation is the low intensity of the intervention (recorded verbal and written information about services). Subjects in the screening group were only screened once. While it is possible that there may be a beneficial health outcome to women’s health if the health system more fully incorporated this type of screening with multiple health encounters (increasing the intensity of the intervention),

this has yet to be demonstrated in rigorous research efforts.

**Reviewer's Summary:**

The conclusion of Nelson and colleagues' systematic review, that screening women for IPV in health care settings may benefit them, particularly in terms of reducing IPV recurrence is demonstrated within specific populations of women (i.e. low income pregnant women seeking health care), but not in all healthcare settings. They did identify potentially successful interventions (i.e. mentoring) which may hold promise to address IPV. The high recruitment rate (82% of eligible patients) and low attrition (12% loss to follow up), gives the Klevens trial high external validity (generalizability), at least for urban primary care populations in the US. If this were one of a number of trials comparing screening vs. usual care in health care settings, then it might not change the conclusions of the systematic review. But it is only the second trial of its kind, joining the Canadian screening trial by Harriet MacMillan and colleagues in primary care, emergent care and obstetrics and gynaecology clinics, which also did not find benefit for the screening group.

**Reviewer's comments:**

The debate over universal IPV screening in health care settings continues. Up until the recent review by Nelson and colleagues, systematic reviews - using various study eligibility criteria - have concluded that there is insufficient evidence for the effectiveness of universal IPV screening and some uncertainty about safety. Despite that conclusion, there has been continuing political pressure on health care policy makers to implement universal screening, culminating in the Institute of Medicine and the American College of Obstetricians and Gynaecologists recommending universal IPV screening in 2012. The Nelson review, "an update for the U.S. Preventive Services Task Force recommendation on screening women for IPV", informs this debate, but perhaps not in the direction the authors conclude. There are three key questions which need consideration. First, do the findings of two trials directly testing the benefit of screening, and finding no benefit, trump four trials of interventions for women who were identified by screening? Note that the Klevens trial was published after the Nelson review, so could not have been included. Second, is the attention we are focusing on regarding the means of identifying women experiencing IPV distracting

us from the task of developing and testing interventions post-disclosure that decrease recurrence, increase safety and improve mental health and quality of life outcomes for survivors and their children? Third, is the ambivalence of health care providers about screening for IPV, which may undermine a top-down policy of screening, actually a sensible position in light of the current evidence? My answers to these questions, from my perspective as a family physician and IPV researcher are: yes, yes and yes. My caveat about both the Klevens (and Macmillan) trials is the weakness of the post-disclosure interventions. But there is something peculiar about implementing a policy of screening that has been tested in two negative trials, on the basis of successful interventions for women disclosing IPV, when the method of identification of participants is not intrinsic to those interventions. The positive trials are not tests of screening per se. There are other successful IPV interventions for women identified through other means, such as residence in a shelter. There are also training and support interventions in health care settings that increase identification and referral to specialist IPV services that are based on clinical inquiry or case finding.

***The priority for health care services in the US and internationally should be training of clinicians to ask about IPV (or to respond appropriately to disclosures via screening instruments), to provide immediate and ongoing support to their patients who disclose, and refer to colleagues or other services that can provide evidence-based interventions to improve the safety and other outcomes for their patients. The method of identification is of secondary importance.***

The growing evidence about accuracy of (some) screening instruments and limited adverse effects of screening, when measured, may persuade individual health care institutions to implement IPV screening as a policy, particularly in perinatal settings where post-screening interventions appear effective. After all, there is no evidence that IPV screening has less benefit than other means of identification in health care settings, so if the opportunity costs are bearable and the clinicians can be persuaded, there is no compelling argument against that decision. What is not justified is a national or international policy on universal screening for IPV. We need to shift the focus from studies of identification methods and re-direct our research and development efforts to effective training for

clinicians and effective interventions for patients identified in health care settings. Finally, we have to develop effective care pathways between health care providers and specialist IPV services, the latter often provided by voluntary or 3rd sector organisations that are particularly vulnerable to funding cuts in these cold economic times.