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Priority Updates from the Research Literature from the Family Physicians Inquiries Network

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Time to routinely screen for intimate partner violence?

Yes, according to the USPSTF, which says a systematic review has tipped the scale in favor of regular screening.

PRACTICE CHANGER

Use a validated tool to screen women of childbearing age for intimate partner violence (IPV) and follow up with any woman with a positive screen.[1]

STRENGTH OF RECOMMENDATION

B: Based on a systematic review of 10 randomized controlled trials, 11 prospective cohort and cross-sectional studies, and 13 diagnostic accuracy studies.

Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the US Preventive Services Task Force Recommendation. *Ann Intern Med*. 2012;156:796-808.

ILLUSTRATIVE CASE

A healthy 27-year-old woman schedules a visit to discuss birth control options. Should you screen her for IPV and if so, what instrument should you use?

Each year in the United States, an estimated 5.3 million women ages 18 and older are affected by IPV, resulting in nearly 2 million injuries and more than $4 billion in direct medical and mental health costs.[2] In addition to the immediate effects, which include death as well as injuries from physical and sexual assault,[2] IPV has long-term consequences, such as chronic physical and mental illness and substance abuse.[3]

Too little evidence of benefit?

In 2011, the Institute of Medicine (IOM) recommended for the first time that all women of childbearing age be screened for IPV—and identified IPV screening as one of a number of preventive services that are important to women's health.[4] The IOM's recommendation is in line with positions held by the American Medical Association's National Advisory Council on Violence and Abuse[5] and the American College of Obstetrics and Gynecology.[6] These recommendations differ from that of the US Preventive Services Task Force (USPSTF), which determined in 2004 that there was insufficient evidence for or against screening women for IPV.[7] In issuing its "**I**" rating, the USPSTF cited a lack of studies evaluating the accuracy of screening tools for identifying IPV and a lack of evidence as to whether interventions lead to a reduction in harm.

The 2012 systemic review detailed below was undertaken on behalf of the USPSTF to assess the latest evidence and update its recommendation. The USPSTF and Agency for Healthcare Research and Quality (AHRQ) determined the focus and scope of the review.

STUDY SUMMARY

USPSTF issues a B recommendation for IPV screening

Thirty-four studies of women who sought care in either primary care settings or emergency departments (EDs) but had no complaints related to IPV were included in the review, which addressed 4 key questions.

Question 1: Does screening women for current, past, or increased risk of IPV reduce exposure to IPV, morbidity, or mortality?

No, according to one large RCT whose

ACKNOWLEDGEMENT
The PURLs Surveillance System is supported in part by Grant Number UL1RR024999 from the National Center For Research Resources, a Clinical Translational Science Award to the University of Chicago. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Center For Research Resources or the National Institutes of Health.

validity was compromised by high dropout rates. The researchers reviewed a multicenter RCT with 6743 participants ages 18 to 64 years to answer that question. (The study was deemed to be of fair quality because of the high percentage of dropouts from both the screened and unscreened groups.)

The women, recruited from primary care, acute care, and obstetrics and gynecology clinics in Canada, were randomly assigned to either screening with the Woman Abuse Screening Tool (WAST)—an 8-question, self-administered and validated tool—or no screening. Primary outcomes were exposure to abuse and quality of life in the 18 months after screening; secondary outcomes included both mental and physical ailments.

Those in the intervention group underwent screening before seeing their clinicians, who received the positive results before the patient encounter but were not told how, or whether, to respond. Women in both the screened and unscreened groups had access to IPV resources, including psychologists, social workers, crisis hotlines, sexual assault crisis centers, counseling services, and women's shelters, as well as physician visits. In addition, all participants completed a validated Composite Abuse Scale, a broader (30-question) self-administered measure of IPV, at the end of the visit. Those with positive scores were followed for 18 months.

At follow-up, women in both the screened and unscreened groups had accessed additional health care services. Both groups also had reduced IPV, posttraumatic stress disorder, depression, and alcohol problems, and improved quality of life and mental health. There was no statistical difference in outcomes between the groups.

Question 2: How effective are the screening techniques?

The efficacy of at least 5 tools has been demonstrated. Fifteen diagnostic accuracy studies, using cross-sectional and prospective data, evaluated a total of 13 screening instruments.

Five of the 13 screening tools—the face-to-face Hurt, Insult, Threaten, and Scream (HITS) tool, the self-administered Ongoing Violence Assessment Tool (OVAT), the face-to-face Slapped, Threatened and Throw (STaT) instrument, the self-administered Humiliation, Afraid, Rape, Kick (HARK) tool, and the WAST—were at least 80% sensitive and 50% specific in identifying IPV in asymptomatic women.

Question 3: How well do the interventions reduce exposure to IPV, morbidity, or mortality in women with positive screens?

Interventions improve outcomes, according to several studies. One good-quality RCT comparing prenatal behavioral counseling by psychologists or social workers with usual care found that the intervention led to decreased IPV up to 10 weeks' postpartum and improved birth outcomes. These included a reduction in preterm births, increased mean gestational age, and decreased rates of very low birth weight, although the difference for very low birth weight was not statistically significant.

One fair-quality trial comparing home visitation by paraprofessionals with usual care for postpartum women led to lower rates of IPV for those in the home visitation group 3 years after the intervention.

Another study compared a counseling intervention with usual care for women who had reported recent IPV. The intervention led to a decrease in pregnancy coercion—being physically or verbally threatened with pregnancy or prevented from using contraception—and an increase in the likelihood of ending an unsafe relationship.

Two trials evaluating counseling vs wallet-sized referral cards and nurse management vs usual care during pregnancy showed improved outcomes in both the intervention and control groups, with no statistically significant difference between them.

Question 4: What are the adverse effects of screening for IPV and interventions to reduce harm?

There are few—if any—adverse effects, according to 3 RCTs and several descriptive studies. The RCTs found no adverse effects of screening or IPV interventions. Descriptive studies showed low levels of harm among a wide range of study populations and a variety of methods. However, some women experienced loss of privacy, emotional distress, and concerns about further abuse.

CONTINUED

At least 3 screening instruments for intimate partner violence are suitable for use in primary care.

WHAT'S NEW

B recommendation is finalized

Given the relative safety of screening, the potential benefits of interventions for women who have positive screens, and the availability of accurate screening instruments, the USPSTF disseminated a draft recommendation that health care providers screen all women between 14 and 46 years old for IPV. At presstime in late January, the recommendation was finalized.[8]

CAVEATS

Universal screening questions remain

While the findings from this systematic review led the USPSTF to upgrade its recommendation for IPV screening from an **I** (insufficient evidence) to a **B** (moderate to substantial benefit of screening), additional high-quality studies are needed to definitively reveal the benefit of screening.

The validity of the large multicenter RCT that found no benefit from IPV screening was compromised by high dropout rates and, potentially, by the fact that women in the control group had access to materials that increased IPV awareness. Overall, the trials included in this systematic review ranged from fair to good quality and had relatively high and differential rates of loss to follow-up, enrollment of dissimilar groups, and concern for the Hawthorne effect (in which participants change their behavior simply as a result of being involved in a study).

What's more, some trials used narrowly defined populations, which could limit applicability. And, while some earlier studies had found higher rates of IPV disclosure using self-administered instruments compared with face-to-face questioning, more research is needed to identify the optimal screening method.[9]

CHALLENGES TO IMPLEMENTATION

The right screen—and reliable follow-up

Five of the screening instruments used in studies included in this systematic review accurately identified women with past or present IPV. Three of these are suitable for use in primary care:

- HARK, a self-administered screen available at www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562/table/T1
- HITS, a face-to-face screen
- WAST, a self-administered screen (more information about these screens is available at http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf).

After deciding which instrument to use, family physicians still must determine how to incorporate screening into a busy practice.

Finally, physicians should not screen for IPV until reliable procedures and resources for follow-up of patients who screen positive have been identified. Resources are readily available through local and national hotline numbers. The number of the National Domestic Violence Hotline is 800-799-SAFE. **JFP**

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