Universal screening for intimate partner violence may provide only modest benefits

August 4 2009

New research suggests that universal intimate partner violence (IPV) screening in health care settings does not result in significant changes in subsequent reports of IPV or quality of life, according to a study in the August 5 issue of *JAMA,* a theme issue on violence and human rights.

There is a lack of consensus on the issue of screening women for IPV in health care settings. Proponents support screening because of the high prevalence of IPV and associated impairment and the availability of feasible screening techniques. But organizations such as the U.S. Preventive Services Task Force and the Canadian Task Force on Preventive Health Care have concluded that insufficient evidence exists to recommend for or against universal screening - mainly due to lack of interventions that have been proven effective for women exposed to violence and referred from health care settings. "Nevertheless, clinicians and health care organizations are being encouraged to implement IPV screening. Numerous professional societies recommend routine IPV evaluation, assessment, and/or screening as a part of standard patient care, and the standards of the Joint Commission require that hospitals have objective criteria for identifying and assessing possible victims of abuse and neglect," the authors write.

Harriet L. MacMillan, M.D., M.Sc., F.R.C.P.C., of McMaster University, Hamilton, Ontario, Canada, and colleagues examined the effectiveness of IPV screening and communication of a positive screening result to clinicians in health care settings, compared with no screening, in reducing subsequent violence and improving quality of life.

The randomized controlled trial was conducted in 11 emergency departments, 12 family practices, and 3 obstetrics/gynecology clinics in Ontario, Canada, among 6,743 female patients, age 18 to 64 years.

Women in the screened group (n = 3,271; 347 positive for abuse) self-completed the Woman Abuse Screening Tool (WAST); if a woman screened positive, this information was given to her clinician before the health care visit. Subsequent discussions and/or referrals were at the discretion of the treating clinician. The nonscreened group (n = 3,472; 360 positive for abuse) self-completed the WAST and other measures after their visit. Women who disclosed past-year IPV were interviewed at the start of the study and every 6 months until 18 months regarding subsequent incidents of IPV and quality of life, as well as several health outcomes and potential harms of screening. The number of women who did not complete the study was high: 43 percent of screened women, and 41 percent of nonscreened women, and data analysis accounted for these losses.

The study found that:

- All women in the trial showed reductions in exposure to violence across time - these reductions were not, however, associated with screening.

- At 18 months, observed recurrence of IPV among screened vs. nonscreened women was 46 percent vs. 53 percent (not statistically significant).

- Women in the screened vs. nonscreened groups showed higher improvement in quality of life and depression, but these differences were small and not statistically significant when the analysis accounted for women lost to follow-up. There were no

differences in other health outcomes.

- Screened and control group women had no differences in the frequency of using violence-related health and social services.
- Many women must be screened to identify one woman who discloses abuse.
- There were no harms of screening as implemented in this trial.

The authors suggest that one possible explanation for the lack of effectiveness of screening was "If it is true that study participation conferred benefits, the fact that both groups were interviewed using the same methods at the same intervals would have reduced the likelihood of detecting differences between groups. Screening itself—asking about IPV exposure—may have offered little benefit."

They add that even though screening may provide some small benefits on some outcomes, "It is critical to balance the number and magnitude of potential benefits of universal screening with the human, opportunity, and resource costs required." In this trial, trained research assistants conducted the screening in each health care setting and clinicians were only notified when a screen was positive. All sites consented to participate, and training regarding IPV was provided to them.

"We conclude, although sample attrition urges cautious interpretation, that these results do not provide sufficient evidence to support universal IPV screening in health care settings in the absence of an effective intervention to prevent or reduce IPV, especially in the context of the resources required to conduct screening and to deal with the number of women identified by the screening tool," the authors write. "Further research is essential to determine whether these findings are replicated in other settings and samples." They add that evidence regarding effective

interventions to assist women who disclose abuse in health care settings is urgently required.

More information: *JAMA*. 2009;302[5]:493-501.

Source: JAMA and Archives Journals (news : web)