UK National Screening Committee

Screening for Domestic Violence

External review against programme appraisal criteria for the UK National Screening Committee (UK NSC)

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The UK NSC advises Ministers and the NHS in all four UK countries about all aspects of screening policy. Its policies are reviewed on a 3 yearly cycle. Current policies can be found in the policy database at http://www.screening.nhs.uk/policies and the policy review process is described in detail at http://www.screening.nhs.uk/policyreview

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Summary

Screening for domestic violence is not recommended because there is insufficient evidence on the benefit of interventions. Comprehensive screening programmes can increase the level of screening (asking about domestic violence) undertaken, disclosure and identification but to date there is no evidence of reduction in level of such violence or positive health outcomes following screening. There are alternative methods that are equally successful in eliciting disclosure

1 Introduction

This paper uses evidence published up to September 2012 on screening for domestic violence, against the UK National Screening Committee (NSC) Criteria for appraising the viability, effectiveness and appropriateness of a screening programme[1].

The NSC policy not to screen for domestic violence was made in 2002 informed by a systematic review of the evidence[2, 3]. It was considered that although domestic violence is a common problem with major health consequences for women, implementation of a screening programme in healthcare settings could not be justified due to the lack of evidence of the benefit of specific interventions and on the potential harm from screening. A comprehensive review of the topic was undertaken by Feder as part of the Health Technology Assessment (HTA) Programme and the National Institute for Health Research (NIHR). The draft report was produced in 2007 and accepted for publication in 2008[4]. This review will outline the results of the HTA report and update it with more recent evidence.

For this update a literature review was carried out in April 2012 looking at English language literature published 01/01/2007 to 01/02/2012.

Domestic violence is threatening behaviour, violence, or abuse (psychological, physical, sexual, financial, or emotional) between adults who are relatives, partners, or ex-partners. It is a severe breach of human rights with profound health consequences, particularly for women who, compared with men, experience increased levels of sexual violence, more severe physical violence, and more coercive control from their partners. It is also increasingly recognised that children living in an environment of domestic violence can be severely damaged, even if they are not themselves assaulted.

2 The Condition

This review will use the term domestic violence as defined by Feder[4] as “partner violence”; which is physical, sexual or emotional abuse against women with coercive control of a woman by a man or woman partner who is, or was, in an intimate relationship with the woman

A variety of terms are in current use, which mean domestic violence perpetrated against an intimate partner. These are; ‘partner violence’, ‘intimate partner violence’ (IPV), ‘spouse abuse’, ‘partner abuse’ and ‘battering’. There is no international, or national, consensus about the most appropriate term to use for this form of domestic violence. Many experts in the field believe that ‘domestic violence’ is a misleading term because ‘domestic’ implies that the violence always happens within the home. Similarly, many see ‘IPV’ as

inappropriate, as there is nothing 'intimate' about an abusive relationship. This review is restricted to considering the case for screening for partner violence perpetrated against adult women. In September 2012 the UK government announced that the definition of domestic violence will be changed from March 2013 to include under 18 year olds and coercive control which recognises that patterns of behaviour and separate instances of control – including instances of intimidation, isolation, depriving victims of their financial independence or material possessions and regulating their everyday behaviour. This new definition, which is not a legal definition, will include "honour" based violence, female genital mutilation (FGM) and forced marriage. However, following Feder's HTA study, this review is based on evidence which does not encompass these areas and so is focused on adult women. Partner violence against men in heterosexual or same sex relationships is a social problem with potential long-term health consequences for male survivors. It is not the focus of this review as the prevalence of violence against women is more frequent and more severe, and women are three times more likely than men to sustain serious injury and five times more likely to fear for their lives.

2.1 The condition should be an important health problem

2 2. The epidemiology and natural history of the condition, including development from latent to declared disease, should be adequately understood and there should be a detectable risk factor, disease marker, latent period or early symptomatic stage

In the Department of Health 2010 communication information pack, 'Ending Violence Against Women and Children Campaign – Communications Information Pack', it is stated that one in four women have been affected by domestic violence and that two women are killed every week by a current or former male partner[5]. The police are said to be called every two minutes about an incident of domestic violence and that it accounts for 14% of all violent crime. The cost of providing increased public services (including health, legal and social services) and the lost economic output of women affected is at least £36.7 billion every year.

Prevalence

Measuring the prevalence of partner violence is difficult because studies have different definitions, examine different populations in different contexts and use a variety of methods and questionnaires. Early studies mainly consider physical violence. Recent studies include emotional, sexual and physiological violence. The level of violence explored (of whatever type) also differs. The time frame of enquiry makes a significant difference. Asking about violence that happened over a year ago may produce under-reporting due to subjects' recall problems. However, not reporting over a sufficiently long period may also cause under-reporting as subjects may not have had adequate time to acknowledge or identify the violence. Longer term follow up is also problematic with high drop out rates. Prevalence may also change in a group over time especially in circumstances such as pregnancy. In a British longitudinal study in 2005 during and after pregnancy the prevalence increased during the

second half of pregnancy and post delivery[6]. However, the attrition rate was 45% suggesting that the results were below the real prevalence, especially as it was considered that those lost to follow up were more likely to be subject to violence. Prevalence studies require self-reporting by the subject which assumes a willingness to disclose. The causes of failure to disclose and thus under-reporting are numerous including; fear of the abuser finding out, not being allowed to participate in the study by the abuser and unwillingness to acknowledge the real situation. Prevalence studies also tend to under represent women in full time education or employment as they are often unable to attend the session. Therefore, it is only possible to quote prevalence ranges specific to the settings, time frames and study population.

Feder[4] reports that lifetime prevalence ranges from 13% to 31% in five community based samples (general population) and from 13% to 41% in eleven studies of women recruited in health service settings (clinical populations e.g. general practice, antenatal, emergency departments). Three studies in accident and emergency departments (A&E) identified a prevalence between 22 and 35 % [7- 9]. A&E studies report higher prevalence rates as victims of partner violence often attend for medical treatment resulting from their abusive experience. One year prevalence rates range from 4.2% to 6% in general population studies and, from 4% to 19.5% in clinical population studies. Prevalence in clinical populations tends to be higher in divorced or separated women; this could be because they are freer to report and/or because women subjected to IPV may leave their partners. Levels are higher in women aged 16 to 24 years and lower in women born outside of the UK[4].

Health impact

Partner violence has a significant impact on health. Again, it is difficult to compare the results of different studies due to variability in research tools, timescales, settings and study populations. The evidence is clear that partner violence can be a cause ofmental illness and substance misuse[10, 11]. Meta-analysis of eight studies on the impact of pregnancy found that only average birth weight and incidence of low birth weight were the result of domestic violence[12]. Domestic violence does have an impact on children causing a greater level of behavioural and mental health problems and diminished educational achievements[13-15]. Children living in an environment of IPV are more likely themselves to be abused. Partner violence also has been shown to increase gynaecological problems threefold[16]. Other conditions such as chronic pain and neurological symptoms[17], gastrointestinal disorders[18] and cardiovascular conditions[19] are also reported.

Conclusion

Domestic violence or partner violence results in important health problems with significant health implications for the victims and potentially for the children involved in the family unit.

2.3. All the cost-effective primary prevention interventions should have been implemented as far as practicable

Primary Care Organisations (PCOs) have a statutory duty to work with other local agencies to reduce crime under the Crime and Disorder Act (1998)[20]. The Department of Health advises general practices to; consider regular in-house training and the benefits of training to the whole team, establish links with named specialist workers at local domestic violence services, flag health records, consider the links between domestic violence and pregnancy, be aware of the risks to children and seek support for new initiatives at a strategic level[21, 22]. The UK Royal College of General Practitioners has identified domestic violence as one of its four new clinical priorities for 2011-2013[23]. Homicide reviews where domestic violence is involved have recommended the development and expansion of core training to address the dangers of the acceptance of domestic violence in some cultures. The report from the Taskforce on the Health Aspect of Violence Against Women and Girls (VAWG) subgroup (2009) states that when interacting with patients NHS staff should have, and apply, a clear understanding of risk factors for violence and abuse and of the consequences for health and wellbeing of violence and abuse[24].

Since the 2008 review[4] there has been one cluster, randomised control trial (RCT)[25], which reported in 2011. It looked at the effectiveness of a programme for training and support in UK based primary healthcare practices to increase the identification of women experiencing domestic violence and their referral to specialist advocacy services. This is called the IRIS model. GP practices in Hackney and Bristol were stratified by female doctors, postgraduate training status, number of patients and patient income. The 51 practices were randomised to intervention or control. The intervention included two practice-based training sessions, a prompt in the medical record to ask about abuse and a referral pathway to a named domestic violence advocacy service who also delivered training and further consultancy. The IRIS model was rooted in a close partnership with third-sector specialist agencies so linking primary care into an inter-sectoral response to violence against women.

Three times more women experiencing domestic violence were identified in the intervention practices than in the control practices. There was also a seven-fold increase in referrals of patients from the intervention practices. The Markov model showed a high probability of the staff-training intervention being cost-saving or cost-neutral and no adverse effects of the intervention were reported from the participating practices or from the specialist domestic violence agencies. However, of the 184 direct referrals to the specialist agencies, contact could not be made with 55 (30%), indicating the difficulties in moving from identification to intervention. The initial training had highlighted that many women would not want to pursue advocacy in the first instance (or ever) and that pressuring women was not appropriate and potentially dangerous. The study showed that such a programme can increase identification and referral and they suggest that “clinician behaviour relating to domestic violence can be changed”.

The authors conclude that; “our findings reduce the uncertainty about the benefit of training and support interventions in primary care settings for domestic violence and show that screening of women patients for domestic violence is not a necessary condition for improved identification and referral to advocacy services.” The IRIS model was not based on screening but showed a similar magnitude of effect in terms of identification of women experiencing violence.

In the UK, the model appears to be sustainable outside of a research context. In Hackney, where the IRIS programme was commissioned, in the year after the trial ended, 46 women were directly referred by clinicians in the intervention practices and 74 women registered in those practices contacted agencies of domestic violence through other routes. The IRIS model is now being implemented across eight different areas and being considered by further areas in England, Scotland and Wales.

Conclusion

There is an intervention which is thought to be cost effective that could be implemented in primary care to increase referral to specialist services.

3 The Test

3.1. There should be a simple, safe, precise and validated screening test.

The HTA review in 2008[4] considered 18 screening tools which were assessed in 15 validation studies with 10,289 participants. The high number of different screening tools indicates the difficulty in identifying one screening instrument. The tools ranged from a single question to a 30 item research inventory. Twelve tools were tested as index tools and eight as comparators with two, the Woman Abuse Screening Tool (WAST) and the Women's Experience with Battering Scale (WEB) serving in both capacities in different studies. Only 10 included sufficient data to calculate diagnostic accuracy. No screening tools were tested in the UK. Settings varied from general practice (six), accident and emergency departments (four), antenatal clinics (three), women's healthcare centres (two), women's homes (two), domestic violence refuges (two) and an urgent care centre within a hospital (one). Feder concluded that; "there are valid and reliable screening tools for partner violence against women that can be used in healthcare settings, fulfilling the NSC criterion, although the number of studies reporting validation and reliability for any one tool is small." The review concluded that the 'Hurts, Insults, Threatens and Screams at her' (HITS) scale showed the most diagnostic accuracy, concurrent validity and reliability and ranked above the other tools. However, they did caution about the need to recognise the use of different terms as the tool was developed in a US setting.

Judging a screening tool for screening of partner violence is not like considering a screening tool for a medical condition. Women who disclose to a clinician that they are victims of partner violence have already gone through a complex process of recognition of the problem and by disclosure they are willing to trust the clinician with information that may open them up to further violence and other difficult decisions. It is not clear when and why women choose to disclose abuse and what may trigger a response.

Conclusion

There are a wide range of candidate screening tools for identifying partner violence. Some of these are valid and appropriate according to specific circumstances. However none have

been tested in a UK healthcare setting. There is no one tool which can be said to be the sole screening tool for screening in the UK.

3.2. The distribution of test values in the target population should be known and a suitable cut-off level defined and agreed.

The HITS scale had the best predictive power (sensitivity ranged from 86% to 100%, specificity ranged from 86% to 99%), concurrent and construct validity (*r* ranged from 0.75 to 0.85, $p < 0.001$) and reliability (Cronbach's alpha ranged from 0.61 to 0.80). A cut-off of 5.5 maximised sensitivity (100%) and specificity (86%)[4].

3.3. The test should be acceptable to the population

Feder in the HTA review[4] considered thirteen journal articles and one UK Home Office Report on the acceptability of screening for partner violence. These articles provided a total of 1393 participants. Informants, even those not willing to disclose abuse, considered screening beneficial as it raises awareness, reduces stigma and potentially enables women to disclose at a later date. Women preferred to disclose to a professional they already knew and where they felt listened to and in a non–judgmental environment. Women were concerned about potential negative repercussions such as legal involvement and were more likely to disclose if they were given a reason for screening. Preference for face- to-face screening or a written questionnaire varied but the use of a computer[26] to interrogate patients on their experiences in an Accident department in the US has been shown to increase disclosure. Some women also preferred talking to a woman professional. Overall the proportion of survey respondents who found screening by healthcare professionals acceptable varied between 35% and 99%. The majority of survey respondents and informants in the qualitative studies did find it acceptable even if it made them uncomfortable. In UK based studies, 20% of respondents did not support screening in a general practice context, and 40% thought women should seldom or never be asked about partner violence in an accident and emergency department[27]. Younger women, especially those aged 15 to 19 years were less likely to agree with screening for partner violence[28-30]. Witting and colleagues found that a higher proportion of respondents with lower education status supported partner violence screening[31]. There was no consistent difference in acceptability by abuse status, although several studies found that a lower proportion of women with a history of partner violence were in favour of screening compared with women without that history. There were no consistent differences in acceptability of screening by healthcare setting.

Conclusion

There is a reasonable level of acceptability of screening for domestic violence but it varies according to the healthcare setting and the individual's circumstances.

3.5. There should be an agreed policy on the further diagnostic investigation of individuals with a positive test result and on the choices available to those individuals

As the diagnosis of partner violence is based on subject disclosure there is no further investigation required to make the diagnosis. Any further investigation is related to identifying detrimental and treatable health impacts and referral to specialist services. Further investigation will depend on the patient circumstances including; level of disclosure, type of abuse, type of injury and victim circumstances, including the presence of children in the family, and expectations. This will be patient specific.

4. The Treatment

4.1. There should be an effective treatment or intervention for patients identified through early detection, with evidence of early treatment leading to better outcomes than late treatment

There are a range of possible interventions based both on the victim and the perpetrator, the type of violence and the setting.

Advocacy

A Cochrane review of ten randomised controlled trials of advocacy for intimate partner abuse up to July 2008[32] concluded that; "it is possible that intensive advocacy for women recruited in domestic violence shelters or refuges reduces physical abuse one to two years after the intervention but we do not know if it has a beneficial effect on their quality of life and mental health. Similarly, there is insufficient evidence to show if less intensive interventions in healthcare settings for women who still live with the perpetrators of violence are effective."
Feder made a similar conclusion but also considered that as most studies show some benefit from advocacy for some outcomes it is a legitimate referral option for healthcare professionals especially for women who have sought help from professional services. The outcomes for such women are reduction in abuse, increased social support and enhanced quality of life[4].
Continued severe abuse or re-victimisation was the outcome most resistant to advocacy especially in the short term.

A review of interventions published in 2010 by Casteel and Sadowski concluded that advocacy may reduce re-victimisation rates compared with no treatment, but it may have low levels of acceptability[33].

Cognitive therapy

A Cochrane review of cognitive therapy for abusive men published in 2011[34] reviewed six trials all from the USA and relatively small with the largest sample being 871 participants. They considered that the results of such studies are difficult to generalise as the baseline risk

of violence varies. Also, the motivation to comply with treatment differs and may be associated with court ordered treatment or because their wife has threatened to leave the marriage. The authors concluded that "the research evidence is insufficient to draw conclusions about the effectiveness of cognitive behavioural interventions for physically abusive men in reducing or eliminating male violence against female partners. This does not mean that there is evidence for no effect. We simply do not know whether the interventions help, whether they have no effect, or whether they are harmful."

The 2010 review by Casteel and Sadowski[33] concluded that cognitive trauma therapy may reduce post-traumatic stress disorder and depression compared with no treatment and cognitive behavioural counselling may reduce minor physical or sexual IPV, both minor and severe psychological IPV and depression compared with no counselling.

Interventions during pregnancy.

For almost 30% of women who experience domestic violence, the first incident occurs in pregnancy[35]. Abuse during pregnancy is of particular interest because it is a threat to both mother and child health[36]. There are a number of interventions to prevent violence against pregnant mothers. A review by Sharps in 2008 suggested that perinatal home visiting programmes are likely to improve pregnancy and infant outcomes[37]. However, according to O'Reilly in 2010, despite healthcare professionals being in a unique position to identify and assist women during pregnancy evidence of the effectiveness of interventions during pregnancy remains inconclusive[38]. A further Cochrane review of interventions for preventing or reducing domestic violence against pregnant women is underway but as yet has not reported[39].

Interventions for mothers and children.

The HTA literature review by Feder[4] identified five studies (seven papers) evaluating the use of
interventions with children where there was also a degree of involvement of the mothers. Four of the studies were conducted in the USA and one in Canada. The interventions are quite different from each other, ranging from forgiveness therapy to expressive writing to cognitive trauma therapy. The studies were small and only three met the review quality criteria. The review concluded that; "the strength of evidence for effectiveness of interventions with children of abused women is currently insufficient."

Other interventions

The Sadowski review [33] also reported that:

- "career counselling plus critical consciousness awareness may increase a woman's confidence and awareness of the impact of IPV on her life compared with career counselling alone,

- although empowerment counselling seems to reduce trait anxiety, it does not seem to reduce current anxiety or depression or to improve self-esteem,
- peer support groups may improve psychological distress and decrease use of healthcare services compared with no intervention,
- nurse support and guidance is probably unlikely to be beneficial in IPV,
- safety planning may reduce the rate of subsequent abuse in the short term, but longer-term benefit is unknown."

Conclusion

There are a range of interventions for partner violence. There is a lack of clear evidence on the effectiveness of these interventions.

4.2. There should be agreed evidence- based policies covering which individuals should be offered treatment and the appropriate treatment to be offered

There is a lack of evidence on which individuals should be offered which intervention.

4.3. Clinical management of the condition and patient outcomes should be optimised in all healthcare providers prior to participation in a screening programme

There is no consistency on how services should be, and are provided in UK healthcare settings.

5. The Screening Programme

5.1. There should be evidence from high quality Randomised Controlled Trials that the screening programme is effective in reducing mortality or morbidity. Where screening is aimed solely at providing information to allow the person being screened to make an "informed choice" (eg. Down's syndrome, cystic fibrosis carrier screening), there must be evidence from high- quality trials that the test accurately measures risk.

The information that is provided about the test and its outcome must be of value and readily understood by the individual being screened

Feder in 2008 identified eight studies of interventions to implement screening with a total patient sample of 16,272 (one study did not report the number of participants) with publication dates ranging from 1998 to 2006[4]. The majority of studies were based in the USA. None were in the UK. Settings varied and included; family practice, community clinics, health maintenance organisations (HMOs), women's health clinics, and accident and

emergency departments. In one study nurses visited vulnerable women at home, seven were before-and-after studies with varying follow up periods (6 months to 2 years), and one a randomised controlled trial. None of the studies measured outcomes in relation to mortality or morbidity. The review concluded that; "despite the finding that interventions in primary care settings produced overall a trend for increased identification and other activities aimed at reducing morbidity and mortality, there is insufficient evidence of effectiveness. The most methodologically robust study showed least effect on identification rates."

MacMillan et al published results of an RCT in 2009[40]. The study was undertaken in Ontario Canada but was supported by a data monitoring committee chaired by Feder a UK based primary care professor. The objective was to determine the effectiveness of IPV screening and the communication of positive results to clinicians. It was conducted in emergency departments, family practices, and obstetrics/gynaecology clinics in Ontario, Canada, among 6743 English-speaking female patients aged 18 to 64 years who presented between July 2005 and December 2006. The participants had to be able to be seen individually, and be well enough to participate. In the screened group (n=3271) women self-completed the Woman Abuse Screening Tool (WAST). If a woman screened positive, this information was given to her clinician before the healthcare visit. Subsequent discussions and/or referrals were at the discretion of the treating clinician. The non-screened group (n=3472) self-completed the WAST after their visit. Women disclosing IPV in the past year were interviewed initially and every 6 months for 18 months regarding any further IPV, their quality of life, health outcomes and potential harms of screening. Crucial in the results of this study was the high loss to follow-up, 43% (148/347) of screened women and 41% (148/360) of non-screened women did not complete the full set of interviews. 30% of this loss was after the first visit. Loss to follow up in both groups was higher in less educated women and women not married; both factors associated with higher mobility and a higher risk of violence. At 18 months (n = 411), the observed recurrence of IPV among screened vs non-screened women was 46% vs 53% (modelled odds ratio, 0.82; 95% confidence interval, 0.32-2.12). Screened vs non-screened women exhibited about a 0.2-SD greater improvement in quality-of-life scores (modelled score difference at 18 months, 3.74; 95% confidence interval, 0.47-7.00). However, when multiple imputations were used to account for sample loss, the differences between groups were reduced and quality-of-life differences were no longer significant. Screened women did not use services more than non-screened women. Screened women reported no harms of screening.

The study concluded that; "although sample attrition urges cautious interpretation, the results of this trial do not provide sufficient evidence to support IPV screening in health care settings. Evaluation of services for women after identification of IPV remains a priority." The authors are unable to explain the high loss to follow up but suggested that it may have been due to women not wishing to, or unable to, take up services. Women who disclose partner violence but are not willing or not able, to address it and seek an alternative are described as passive refusers. The result is that a high pick up rate from screening may not result in victims going on to treatment nor a reduction in violence. The authors also suggest that the reduced levels of violence over time in both groups may have been because the cases were identified at the height of the violent period and the reduction was due to time not

identification or intervention. The researchers considered that the study was not replicable as there was a high level of well- trained research staff involved providing additional staff training as well as one to one support to the women when filling in the questionnaire. They considered that routine health services would not be able to have such a high level of input. A three arm blinded RCT[41] in 10 primary health care centres in Cook County, Illinois enrolled 2727 eligible women from May 2009-April 2010 re-interviewing them a 1 year. 2708 were randomized (99%), and 2364 (87%) were re-contacted 1 year later. Participants were; predominantly African American or Latina (92%), had a high-school education or less (57%), uninsured (57%) and an average age of 30 years. The three interventions were: Partner Violence Screen plus list of local resources if positive (909 persons), resource list only (893 persons), and no screen or list (898 persons). A quality of life questionnaire was used to assess physical and mental health outcomes. There was no difference found between the three groups using the quality of life tool nor in terms of: days unable to work or complete housework, number of hospitalisations, emergency department, or ambulatory care visits, proportion who contacted a partner violence agency, or recurrence of partner violence. The study concludes that there is no evidence for screening for partner violence.

A review of screening published in 2011 by O'Campo[42,] "Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review", looked solely at the outcomes of numbers screened and numbers of women identified. Their rationale was that screening for intimate violence is complex and to review screening in terms of violence reduction is too complex with a "myriad of mediating factors between screening and a change or reduction in violence." They only looked at universal screening in healthcare settings where there was an evaluation of screening as the intervention. They determined that a good screening programme required screening protocols, institutional support, training of staff and immediate access to referral for further treatment. They considered that successful programmes, that is those that implemented a screening programme and had a raised uptake and increased identification, deliver if; the providers of the screening provide the intervention, the screeners are trained and comfortable with asking about intimate violence and if adequate resources and time is available. It was acknowledged that there may be other ways of increasing identification. A second stage of the work is underway. This is a realist-informed scoping review on the referrals offered to victims of IPV after identification by health care providers.

A review prepared by the Canadian research group (Oregon Evidence-based Practice Center) for the US Preventive Service Task Force looking at Screening Women for Intimate Partner Violence and Elderly and Vulnerable Adults for Abuse reported in May 2012[43]. This was as an update of the previous 2004 evidence report on screening for IPV and abuse of elders and vulnerable persons for the U.S. Preventive Services Task Force (USPSTF)[44]. Evidence was identified by searching Medline, the Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews up to January 2012. They concluded that;

- a trial of screening showed reductions in IPV recurrence and improvement in related outcomes for both screening and comparison groups,
- trials of IPV interventions for pregnant women and young mothers showed

improved outcomes for the intervention versus usual care groups,

- several instruments have been developed for IPV screening.

Their conclusions concerning the reduction in IPV and improved outcomes were primarily based on the MacMillan RCT[25] discussed above.

This Canadian review was published in the Annals of Internal Medicine[45] with a conclusion that "screening instruments designed for healthcare settings can accurately identify women experiencing IPV. Screening women for IPV could reduce IPV and improve health outcomes depending on the population screened and outcome measured, although effectiveness trials have important limitations. Screening has minimal adverse effects, but some women experience discomfort, loss of privacy, emotional distress, and concerns about further abuse."

Feder and MacMillan questioned these conclusions[46] saying that they did not think that the trial had provided evidence for the effectiveness of screening in comparison to other methods of identifying survivors of IPV, such as clinical enquiry or case finding. They felt that the trial results had been misinterpreted and that the recommendation to screen was perpetuating an over-emphasis on screening and identifying women, when when there is continuing uncertainty on an effective and safe intervention after women have disclosed.

In 2004 The USPSFT determined that[44]; "The USPSTF found insufficient evidence to recommend for or against routine screening of parents or guardians for the physical abuse or neglect of children, of women for intimate partner violence, or of older adults or their caregivers for elder abuse." Based on the evidence of the Canadian review the policy was updated in 2012. The new recommendation is out for consultation until July 10th 2012. The recommendations are[47]: "The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services." This recommendation applies to women who do not have signs or symptoms of abuse. The recommendation at 11/12/2012 remained an update in progress.

5.2. There should be evidence that the complete screening programme (test, diagnostic procedures, treatment/ intervention) is clinically, socially and ethically acceptable to health professionals and the public.

Feder[4] identified ten quantitative articles and one UK Home Office report reporting the attitudes of healthcare professionals towards screening for partner violence. Four studies were
conducted in the USA, three in the UK, two in Sweden and two in Australasia. They explored attitudes in midwives, nurses, physicians and other professionals. The total number of recruited healthcare professionals was 446, ranging between 8 and 124 per study. Twenty qualitative studies were reviewed; eleven in the USA, five the UK, one each in Pakistan, Kuwait, Northern Ireland and Belgium. Two studies were self-report postal questionnaires, one an online self-report questionnaire, and the others face-to-face interviews or self-completed questionnaires. They involved; physicians, midwives, nurses, medical students, and mixed healthcare professionals. Response rates were between 17% and 100%, and the

number of recruited healthcare professionals ranged between 27 and 976, with a total of 4553 respondents. The conclusions were that there was a wider variation in the acceptability of partner violence screening among healthcare professionals than among women with many surveys showing that a majority of clinicians do not find it acceptable. Those studies that also measured screening behaviour and found an even smaller proportion of healthcare professionals actually performing screening, even in the USA where this is policy in many healthcare settings. Scepticism about the benefit of screening was expressed and in contrast to the views of women, there was little mention of potential benefits beyond eliciting disclosure. From the qualitative studies it was found that even when healthcare professionals considered screening acceptable they were wary due to lack of training and additional resources to deal with referrals after disclosure.

As reported above in 3.3 there is a mixed response from women on the acceptability of screening. The majority agree with screening or routine questioning about partner violence, but there is variation, not explained by study quality, abuse status, setting or demographic factors. Feder reported that[4] in interviews and focus groups, women said that they
found screening beneficial, even if they are not yet ready to disclose abuse. Informants perceived screening as a method of raising awareness rather than eliciting disclosure of abuse. Women who were not ready to disclose abuse still found screening beneficial as it helped to remove the stigma attached to partner violence, raised awareness of partner violence, gave them a sense of validation and let them know there is somewhere they can go if they need help when they are ready to disclose. Although women may not disclose abuse immediately, screening may facilitate disclosure later when they feel more comfortable with the health-care professional, or when their circumstances change and they feel the need to get help. Generally, informants found screening acceptable with certain caveats, such as the manner of asking and the type of abuse they experienced. However, the low levels of take up of services after disclosure suggest that a screening programme that includes treatment is less acceptable.

Conclusion

Clinicians internationally and in the UK do not consider partner violence screening in healthcare settings acceptable.

Generally, women find being asked about domestic violence acceptable but with certain caveats, such as the manner of asking and the type of abuse they have experienced.

5.3. The benefit from the screening programme should outweigh the physical and psychological harm (caused by the test, diagnostic procedures and treatment).

The MacMillan RCT[40] specifically considered harm (reprisal violence, psychological distress, family disruption and risk of a child being removed from a mother's care following child protective services involvement) caused by screening. There was no indication that IPV screening was associated with short-term (maximum eighteen months) harm among abused

or non-abused women. The tool used had not undergone extensive validation prior to its use; however, the primary outcomes confirmed that screening did not lead to reprisal violence or decreased quality of life for screened women compared with non-screened women. An observational study of emergency department patients in 2008 who screened positive for IPV also indicated no safety concerns in the emergency department after undergoing screening[47]; although the follow-up period of one week was short and only 51% (random sample of the original study group) of the sample was interviewed.

Conclusion

There is limited evidence that screening for IPV does not cause harm.

5.6. The opportunity cost of the screening programme (including testing, diagnosis and treatment, administration, training and quality assurance) should be economically balanced in relation to expenditure on medical care as a whole (i.e. value for money). Assessment against these criteria should have regard to evidence from cost benefit and/or cost effectiveness analyses and have regard to the effective use of available resource.

Feder[4] was unable to identify any cost effectiveness studies of screening. A cost-effectiveness model of a pilot[25] trial of a primary care intervention that resulted in increased enquiry about partner violence by clinicians supported the hypothesis that this type of intervention could be cost-effective.

Conclusion

There is some evidence that increasing identification if associated with an effective intervention is cost-effective but not on whether screening is the most cost effective way to achieve increased identification.

5.7. All other options for managing the condition should have been considered (e.g. improving treatment, providing other services), to ensure that no more cost- effective intervention could be introduced or current interventions increased within the resources available.

There is insufficient economic evidence.

5.8. There should be a plan for managing and monitoring the screening programme and an agreed set of quality assurance standards.

No such standards are available but would be developed if a screening programme was developed.

5.9. Adequate staffing and facilities for testing, diagnosis, treatment and programme management should be available prior to the

commencement of the screening programme.

This area was not systematically reviewed. However, a Department of Health report[49] published in 2010; "Responding to violence against women and children – the role of the NHS. The report of the Taskforce on the Health Aspects of Violence Against Women and Children" stated that "the many NHS practitioners who deal with violence and abuse as part of their daily clinical practice understand the role that violence and abuse play in causing ill-health and distress. Despite this, we have not seen the same rigorous and systematic approach to this agenda as has been applied to other areas of NHS work such as diabetes or stroke services. This is an area where urgent action is needed. It is a disgrace that so little has been done by the NHS so far. I urge the Government not only to accept the report but also to implement the recommendations as a matter of urgency." The report recommended increased training, better collaboration, processes and policies, better oversight by the commissioners and a national steering group.

Conclusion

Reports suggest he present services for domestic violence are not at an optimum level of delivery.

5. 10. Evidence-based information, explaining the consequences of testing, investigation and treatment, should be made available to potential participants to assist them in making an informed choice.

This is not available.

6. Conclusions

There is insufficient evidence for the introduction of population screening programme for domestic violence. Intimate partner violence is a common and important issue with significant implications for the health of individuals and their families and also the health, social and legal services. Screening for partner violence does not meet the NSC criteria in the UK. Screening may increase the identification of such violence but it is not the only way to increase identification and does not improve the uptake of services. Other methods of increasing referrals appear to be as effective. There is a lack of evidence on effective interventions for those who do identify themselves.

6.1. Implications for policy

Intimate partner violence is a common and important issue with significant implications for health. However, screening for partner violence does not meet the NSC criteria in the UK. Screening may increase the identification of such violence but it is not the only way to increase identification and does not improve the uptake of services. Other methods of increasing referrals appear to be as effective. There is a lack of evidence on effective interventions for those who do identify themselves.

6.2. Implications for research

Further research is required to identify what interventions are most effective for perpetrators and recipients of intimate partner violence in reducing violence and the health implications.

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