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Cochrane in CORR®: Screening Women for Intimate Partner Violence in Healthcare Settings (Review)

Kim Madden MSc, Mohit Bhandari MD, PhD, FRCSC

Importance of the Topic

The orthopaedic surgeon's role in the identification and care of patients experiencing intimate partner violence (IPV) has gained considerable interest in the surgical community during the last few years. With the publication of the Prevalence

of Abuse and Intimate Partner Violence Surgical Evaluation (PRAISE) study [9] that determined the global prevalence of IPV in orthopaedic clinics, and a series of subsequent studies specifically focusing on IPV in orthopaedic settings [7, 11, 12], orthopaedic surgeons are becoming aware that IPV affects a staggering large number of the women whom they treat. One in six women in fracture

clinics has experienced IPV in the past year and one in 50 women present to fracture clinics with IPV-related injuries [9]. More than one in four women (28%) in IPV-therapy programs who have experienced abuse have musculoskeletal injuries requiring medical attention [2]. Since 45% of women who are killed by their intimate partner present to emergency departments within 2 years before their death [10], physicians and orthopaedic surgeons have an important opportunity to prevent further injuries and death for their patients.

In recent years, a number of IPV screening and assistance programs

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K. Madden MSc, M. Bhandari MD, PhD, FRCSC
Division of Orthopaedics, Department of Surgery, McMaster University, Hamilton, Ontario, Canada

K. Madden MSc (✉)
Center for Evidence-Based Orthopaedics, 293 Wellington Street North, Suite 110, Hamilton, ON L8L 8E7, Canada
e-mail: maddenk@mcmaster.ca

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have been implemented and tested in medical settings. These screening programs typically aim to ask every woman presenting for treatment a set of standardized questions to elicit disclosure of IPV. Assistance programs take this concept one step further by processes of referral, advocacy, or counseling once patients disclose IPV in order to reduce the health, social, economic and/or psychological consequences of IPV. Despite the availability of published randomized trials, recommendations about screening for IPV from health organizations have been conflicting [8, 13] and the value of screening is highly debated [4].

This Cochrane review evaluated the efficacy of screening programs for IPV in clinical settings. Based on evidence from 13 randomized trials (14,959 women) the authors concluded that there is insufficient evidence to recommend screening all women for IPV in clinical settings. It should be noted that the review did not evaluate IPV screening programs that also included a counseling, advocacy, or social services intervention. It should also be noted that, although domestic violence can affect men and women and is harmful to all persons affected, the review focuses only on interventions directed at women who have experienced IPV.

Upon Closer Inspection

While IPV screening programs demonstrated a considerable improvement in IPV identification, there were no major differences in referring patients to social services or counselling. The review also evaluated reduction of IPV, physical health, psychosocial health, and resource use. The authors were unable to pool these outcomes, but none showed significant differences between groups in individual trials. The authors concluded that these IPV screening programs that focus on identification of patients who have experienced IPV only are ineffective.

Although this meta-analysis was thorough and of high quality, identification and referral rates, the focus of the study, are not patient-important outcomes. Studies that evaluate the effects of patient-important outcomes such as physical and mental health outcomes would be more valuable in reporting efficacy of IPV interventions. Indeed, there was little data on outcomes that could be classified as patient-important. Additionally, patients in these studies were only asked about IPV once. It is important to ask patients about IPV multiple times during the course of their care, since patients may need to establish a relationship with the healthcare

professional before they feel ready to disclose [12]. This is part of the reason that orthopaedic surgeons have an advantage compared to emergency physicians when it comes to discussing IPV with patients.

It should also be noted that no trials were conducted in an orthopaedic setting (the PRAISE study was not interventional), so applicability to orthopaedic clinics is unclear. Further research is recommended evaluating interventions specifically for orthopaedic settings.

Take-home Messages

The conclusion from the authors that screening is ineffective does not mean that healthcare professionals should abandon the idea of identifying and helping patients who have experienced IPV. In fact, these findings highlight the fact that screening alone does not necessarily lead to improvements in any meaningful outcomes for patients, and perhaps a more rigorous “active” intervention is warranted. Trials evaluating IPV identification paired with referral or counselling services, which were not included in this review, demonstrate a positive impact on the lives of patients who have experienced IPV [5, 6]. We recommend that IPV interventions go beyond identification

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alone, and are evaluated based on patient-important outcomes such as reduction in IPV frequency and/or severity, or IPV-related health outcomes that directly impact a patient's health and well-being.

The American Academy of Orthopaedic Surgeons and other orthopaedic organizations have position statements that encourage orthopaedic surgeons to become familiar with IPV and their role in caring for abused women [1, 3].

Personnel in orthopaedic clinics can do five simple things to help the women whom they treat who may be experiencing IPV, even without establishing a formal screening and intervention program [1].

1. Be aware that IPV affects about one in six of the women whom you treat.
2. If you feel comfortable asking your patients about IPV, here is a suggested method: "Because violence is so common in many women's lives, and because there is help available for women being abused, I now ask every patient about domestic violence." Follow with three validated questions: (1) Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? (2) Do you feel safe in your current relationship? (3) Is there a partner from a previous relationship who is making you feel unsafe now? [3].
3. If a patient discloses IPV, be supportive and validate her disclosure; tell her that the abuse is not her fault.
4. Become familiar with local resources, including hospital/clinic social services and community-based resources. For example, call the National Domestic Violence Hotline (1-800-799-SAFE) in the United States or visit sheltersafe.ca in Canada.
5. If reporting is not mandatory in your jurisdiction and no children are at risk, always ensure that you have the patient's permission to contact outside services like police or shelters.

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Appendix

[Intervention Review]

Screening women for intimate partner violence in healthcare settings

Lorna O'Doherty^{1,2}, Kelsey Hegarty², Jean Ramsay³, Leslie L Davidson⁴, Gene Feder⁵, Angela Taft⁶

¹Centre for Research in Psychology, Behaviour and Achievement, Coventry University, Coventry, UK. ²Department of General Practice, The University of Melbourne, Melbourne, Australia. ³Centre for Primary Care and Public Health, Barts and The London School of Medicine and Dentistry, Queen Mary University of London, London, UK. ⁴Department of Epidemiology, Mailman School of Public Health, Columbia University, New York, NY, USA. ⁵Centre for Academic Primary Care, School of Social and Community Medicine, University of Bristol, Bristol, UK. ⁶Mother and Child Health Research, La Trobe University, Victoria, Australia

Contact address: Lorna O'Doherty, Centre for Research in Psychology, Behaviour and Achievement, Coventry University, Priory Street, Coventry, CV1 5FB, UK. lorna.odoherty@coventry.ac.uk. lornajaneodoherty@hotmail.com.

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ABSTRACT

Background

Intimate partner violence (IPV) damages individuals, their children, communities, and the wider economic and social fabric of society. Some governments and professional organisations recommend screening all women for IPV rather than asking only women with symptoms (case-finding). Here, we examine the evidence for whether screening benefits women and has no deleterious effects.

Objectives

To assess the effectiveness of screening for IPV conducted within healthcare settings on identification, referral, re-exposure to violence, and health outcomes for women, and to determine if screening causes any harm.

Search methods

On 17 February 2015, we searched CENTRAL, Ovid MEDLINE, Embase, CINAHL, six other databases, and two trial registers. We also searched the reference lists of included articles and the websites of relevant organisations.

Selection criteria

Randomised or quasi-randomised controlled trials assessing the effectiveness of IPV screening where healthcare professionals either directly screened women face-to-face or were informed of the results of screening questionnaires, as compared with usual care (which could include screening that did not involve a healthcare professional).

Data collection and analysis

Two authors independently assessed the risk of bias in the trials and undertook data extraction. For binary outcomes, we calculated a standardised estimation of the odds ratio (OR). For continuous data, either a mean difference (MD) or standardised mean difference (SMD) was calculated. All are presented with a 95% confidence interval (CI).

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Main results

We included 13 trials that recruited 14,959 women from diverse healthcare settings (antenatal clinics, women's health clinics, emergency departments, primary care) predominantly located in high-income countries and urban settings. The majority of studies minimised selection bias; performance bias was the greatest threat to validity. The overall quality of the body of evidence was low to moderate, mainly due to heterogeneity, risk of bias, and imprecision.

We excluded five of 13 studies from the primary analysis as they either did not report identification data, or the way in which they did was not consistent with clinical identification by healthcare providers. In the remaining eight studies ($n = 10,074$), screening increased clinical identification of victims/survivors (OR 2.95, 95% CI 1.79 to 4.87, moderate quality evidence).

Subgroup analyses suggested increases in identification in antenatal care (OR 4.53, 95% CI 1.82 to 11.27, two studies, $n = 663$, moderate quality evidence); maternal health services (OR 2.36, 95% CI 1.14 to 4.87, one study, $n = 829$, moderate quality evidence); and emergency departments (OR 2.72, 95% CI 1.03 to 7.19, three studies, $n = 2608$, moderate quality evidence); but not in hospital-based primary care (OR 1.53, 95% CI 0.79 to 2.94, one study, $n = 293$, moderate quality evidence).

Only two studies ($n = 1298$) measured referrals to domestic violence support services following clinical identification. We detected no evidence of an effect on referrals (OR 2.24, 95% CI 0.64 to 7.86, low quality evidence).

Four of 13 studies ($n = 2765$) investigated prevalence (excluded from main analysis as rates were not clinically recorded); detection of IPV did not differ between face-to-face screening and computer/written-based assessment (OR 1.12, 95% CI 0.53 to 2.36, moderate quality evidence).

Only two studies measured women's experience of violence (three to 18 months after screening) and found no evidence that screening decreased IPV.

Only one study reported on women's health with no differences observable at 18 months.

Although no study reported adverse effects from screening interventions, harm outcomes were only measured immediately afterwards and only one study reported outcomes at three months.

There was insufficient evidence on which to judge whether screening increases uptake of specialist services, and no studies included an economic evaluation.

Authors' conclusions

The evidence shows that screening increases the identification of women experiencing IPV in healthcare settings. Overall, however, rates were low relative to best estimates of prevalence of IPV in women seeking healthcare. Pregnant women in antenatal settings may be more likely to disclose IPV when screened, however, rigorous research is needed to confirm this. There was no evidence of an effect for other outcomes (referral, re-exposure to violence, health measures, harm arising from screening). Thus, while screening increases identification, there is insufficient evidence to justify screening in healthcare settings. Furthermore, there remains a need for studies comparing universal screening to case-finding (with or without advocacy or therapeutic interventions) for women's long-term wellbeing in order to inform IPV identification policies in healthcare settings.

PLAIN LANGUAGE SUMMARY

Screening women for intimate partner violence in healthcare settings

Background

We carried out this review to find out if asking (screening) all women attending healthcare settings about their experience of domestic violence from a current or previous partner helps to recognise abused women so that they may be provided with a supportive response and referred on to support services. We were also interested to know if this would reduce further violence in their lives, improve their health, and not cause them any harm compared to women's usual healthcare.

Women who have experienced physical, psychological, or sexual violence from a partner or ex-partner suffer poor health, problems with pregnancy, and early death. Their children and families can also suffer. Abused women often attend healthcare settings. Some people have argued that healthcare professionals should routinely ask all women about domestic violence. They argue that 'screening' might encourage women who would not otherwise do so, to disclose abuse, or to recognise their own experience as 'abuse'. In turn,

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this would enable the healthcare professional to provide immediate support or refer them to specialist help, or both. Some governments and health organisations recommend screening all women for domestic violence. Others argue that such screening should be targeted to high-risk groups, such as pregnant women attending antenatal clinics.

Study characteristics

We examined research up to 17 February 2015. We included research studies that had women over 16 years of age attending any healthcare setting. Our search generated 12,369 studies and we eventually included 13 studies that met the criteria described above. In all, 14,959 women had agreed to be in those studies. Studies were in different healthcare settings (antenatal clinics, women's health/maternity services, emergency departments, and primary care centres). They were conducted in mainly urban settings, in high-income countries with domestic violence legislation and developed support services to which healthcare professionals could refer. Each of the included studies was funded by an external source. The majority of the funding came from government departments and research councils, with a small number of grants/support coming from trusts and universities.

Key results and quality of the evidence

Eight studies with 10,074 women looked at whether healthcare professionals asked about abuse, discussed it, and/or documented abuse in participating women's records. There was a twofold increase in the number of women identified in this way compared to the comparison group. The quality of this evidence was moderate. We looked at smaller groups within the overall group, and found, for example, that pregnant women were four times as likely to be identified by a screening intervention as pregnant women in a comparison group. We did not see an increase in referral behaviours of healthcare professionals but only two studies measured referrals in the same way and there were some shortcomings to these studies. We could not tell if screening increased uptake of specialist services and no studies examined if it is cost-effective to screen. We also looked to see if different methods were better at picking up abuse, for example, you might expect that women would be more willing to disclose to a computer, but we did not find one method to be better than another. We found an absence overall of studies examining the recurrence of violence (only two studies looked at this, and saw no effect) and women's health (only one study looked at this, and found no difference 18 months later). Finally, many studies included some short-term assessment of adverse outcomes, but reported none.

There is a mismatch between the increased numbers of women picked up through screening by healthcare professionals and the high numbers of women attending healthcare settings actually affected by domestic violence. We would need more evidence to show screening actually increases referring and women's engagement with support services, and/or reduces violence and positively impacts on their health and wellbeing. On this basis, we concluded that there is insufficient evidence to recommend asking all women about abuse in healthcare settings. It may be more effective at this time to train healthcare professionals to ask women who show signs of abuse or those in high-risk groups, and provide them with a supportive response and information, and plan with them for their safety.

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