Screening for Intimate Partner Violence: What’s the Evidence?

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Objectives

• To provide an overview of the Violence Against Women (VAW) research program on effectiveness of screening for VAW in health care settings

• To provide results of the “testing trial” of approaches to screening in various health care settings
Presentation Outline

• Background
  - Universal screening vs. case finding
  - Current evidence
• International context
• VAW research program
  - Overview
  - “Testing trial”
• Selected resources
Background
Universal Screening

“standardized assessment of patients, regardless of their reasons for seeking medical attention” (Cole, JAMA 2000, 284; p. 551)

- Many screening tools are available for various settings, and for pregnant women
- They usually measure self-reported frequency, severity and type of abuse (lifetime or current)
- Many perform reasonably well in identifying women who have been abused
Case Finding

• Ask women presenting with specific signs, symptoms or risk indicators of abuse
  - injuries consistent with abuse
  - unexplained depression, somatic complaints, etc.
• Also called the “diagnostic method”
• Part of good clinical care
Key Differences

• Universal screening
  - All women
  - Asymptomatic for abuse
  - No clinical indication to ask

• Case finding
  - Women with clinical signs and symptoms
  - Clinical indication for further asking and diagnostic assessment
Evidence to date

• Three recent evidence syntheses* found that most interventions have not been adequately evaluated to determine if they reduce violence or improve life quality
• There is no evidence evaluating onsite health care services for abused women
• There is fair evidence for a specific program of post-shelter advocacy counseling

* US Preventive Services Task Force, Canadian Task Force on Preventive Health Care; Ramsay et al., BMJ 2002; 325:314-327)
Potential Harms

No studies of either screening or interventions to reduce violence have evaluated the potential harms that might arise from intervening, including:

- Involvement of child protection agency in a way that puts children and women at greater risk
- Reprisal violence against women who seek or obtain relief from abuse
- Other forms of emotional, financial or other hardship resulting from seeking help
International context

- Evaluating the Effectiveness of Intimate Partner Screenings Expert Panel Meeting Feb 15, 2005 organized by CDC

- Follow-up letter to that meeting outlined conclusion that RCT design is best way to determine effectiveness of screening for intimate partner violence
VAW Research Program

Funded by the Ontario Women’s Health Council
VAW Research Team

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Research program

Phase 1 studies

RCT of Screening Methods

Screening Effectiveness RCT

- Focus groups with abused and non-abused women
- Health care provider survey
- Public health screening
- Population attitudes towards screening
- Meta-analysis of risk indicators
Overall Objective

Answer the question:

Does universal screening for VAW in health settings do more good than harm?

By testing the effectiveness of universal screening vs. no screening in:
- reducing violence and improving life quality
- balanced against potential harms
Trial of Screening Methods ("Testing Trial")

In four types of health care setting, test:

1. The best of three screening methods
   - Paper-pencil (PP)
   - Face-face (FF) with health care provider
   - Computerized (C) (tablet PC)

2. The better of two screening tools
   - Partner Violence Screen (PVS)
   - Woman Abuse Screening Tool (WAST)
Settings

Acute care:
• Norfolk General Hospital Emergency Department (Simcoe)
• Cambridge Memorial Hospital Emergency Department

Primary care:
• Carlisle Medical Centre (Hamilton)
• Victoria Family Medical Centre (London)
Settings, cont.

Specialty care:
• London HSC Obstetrics Clinic
• Hamilton HSC Obstetrics & Gynecology Colposcopy Clinic

Community:
• Hamilton Public Health Unit, Parent and Child Branch
  - Public Health Nurse home visits
Measures

- Partner Violence Screen (PVS) 3 items
- Woman Abuse Screening Tool (WAST) 8 items
- Composite Abuse Scale (CAS) “gold standard” 30 items
- Participant evaluation of PVS and WAST (8 items, after each tool)
- Participant evaluation of screening method (3 items)
Methods

• Women aged 18 – 64
• PVS & WAST administered in PP & C; one or the other in FF
• All self-completed CAS
• Administration method randomized by day (and shift, in ED)
• Randomly ordered: PVS or WAST first
• Target sample size: 246 per group per care type* (2214 total)

*Not including Public Health
Results
Final Sample

Recorded by site coordinators
N = 13862

Eligible
N = 2642

Completed screen
N = 2500

Ineligible = 11220
- Not pt = 3648
- Age = 3351
- Prev app = 986
- Other = 2019
- Missed = 1216

Refused
N = 142 (5.4%)
Disclosure rates by method & tool

Percent

CAS  PVS  WAST

Computer FF  PP

0  749  802  825  733  412  828  750  418  841

10.9  10.6  10.1  11.2  8.7  11.4  10.0  10.5  6.9

13
Missing data* by method & tool

*such that positive/negative status cannot be determined
Evaluation by participants

Mean 1 - 5

Easy
- Computer: 729
- FTF: 805
- PP: 836

Like it
- Computer: 726
- FTF: 803
- PP: 834

Private
- Computer: 723
- FTF: 803
- PP: 834

Evaluation by participants
Summary of Key Findings

• Face-to-face screening least preferred by women
• Prevalence of abuse disclosure of ~10% is somewhat lower than anticipated for clinical settings
• Screening tools get at different aspects of abuse, therefore variability in sensitivity and specificity
• Public health nurse home visits are not “screening” opportunities
Implications for Main RCT

- WAST delivered paper & pencil
- 10% prevalence rate means screening thousands of women to identify and follow hundreds who have been abused in past 1 year
- Public health setting reconsidered - exclude nurse home visits (qualitative research underway to explore what happens in this context)
Screening Effectiveness RCT
RCT design

Follow up
Baseline* 3m** 6m 9m 12m 15m 18m

Universal screening
- Positive: 100%
- Negative: <5%

No Screening
- Positive: 100%
- Negative

*Baseline within 7 days of screen
**"mini" phone interview at 3, 9, 15 m
Outcomes

• **Primary**
  - Reduction in repeat violence
  - Improvement in quality of life
  - Potential harms of screening*

• **Secondary**
  - Health measures (physical and mental)
  - Health service utilization
  - Social support, use of information, specific strategies and safety behaviours
  - Women’s perceptions re: screening & follow-up

*Since no standardized approaches to measuring harms of screening and intervention exist, we have developed and are testing an instrument to measure this*
Related Publications


Clinical Resources


Acknowledgments

- Ontario Women’s Health Council

- Canadian Institutes of Health Research New Emerging Team Program (Institutes for Gender & Health, Aging, Human Development, Child & Youth Health, Neurosciences, Mental Health, & Addiction and Population & Public Health)
If, When and How to Ask the Questions: Assessing Screening Approaches to Identifying Woman Abuse in Health Care Settings.

This is an integrated, multi-disciplinary program of research which looks at the effectiveness of screening in reducing violence and improving the quality of life for women and their children. There are a number of individual projects to address these objectives.

It is funded by the Ontario Women’s Health Council, and began in March 2003.

The program is headquartered at the Offord Centre for Child Studies, Department of Psychiatry & Behavioural Neurosciences at McMaster University.