Screening for Violence Against Women: What’s the Evidence?

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Objectives

• Review the scientific evidence regarding screening for violence against women

• Understand the
  – evidence regarding screening,
  – effectiveness of interventions, &
  – current screening guidelines (CTFPHC)

• Learn about an Ontario trial aimed at examining effectiveness of screening
Presentation Outline

• Background
• Correlates of abuse
• Identification of violence against women
  – Universal screening vs. case finding
• Interventions to reduce violence
  – Potential harms of interventions
• Conclusions
• Research agenda
• Selected resources
Background
Key Definitions

• Domestic violence against women
  - male to female intimate partner violence including physical, sexual, emotional, verbal and financial abuse

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

- Up to 1/3 of Canadian women report some form of physical or mental abuse during their lifetime
- 1 in 10-12 are abused in any given year
- Abused women at ↑ risk of
  - injury and death
  - emotional disorders: mood, eating, substance dependence, antisocial personality, depression, suicidality, PTSD
Impairment

- physical injuries
- anxiety, depression, & suicidality
- post-traumatic stress disorder
- substance abuse
- etc.

Plus for pregnant women:
- pre-term birth
- low birth weight
Correlates
Correlates of Abuse

“neither victims nor batterers fit a distinct personality or socioeconomic profile”

(Eisenstat & Bancroft, NEJM, 1999, p 886)
Meta-Analysis of Risk Indicators (in progress)

• To review the evidence for associations between intimate partner violence against women and characteristics of
  – men* (abusive vs. not abusive)
  – relationships (abusive vs. not abusive)
  – women (abused vs. not abused)

*there is very little data on risk indicators for violence in same sex couples therefore this was not included in the current review
Potential Indicators (initial list)

Characteristics of men:
• alcohol and/or drug use (esp binge drinking)
• unemployment
• history of witnessing and/or experiencing abuse or family conflict during childhood
• mental health status

Relationship characteristics:
• having children from a previous relationship
• presence of children in the home
• age difference between woman and male abuser
• type of union

Characteristics of women:
• Age, income/SES, education status, employment/welfare status¹
• pregnancy status
• having an unwanted pregnancy
• parity (children vs no children)
• somatization
• depression
• history of witnessing and/or experiencing abuse or family conflict during childhood

¹for socio-demographic factors, only data from representative samples are included
Correlates, cont.

Meta-analysis results to date:

• male abuser’s alcohol/drug abuse
• male abuser’s unemployment
• having children from a previous relationship
• depression or somatic complaints in abused woman
Correlates, cont.

Currently undergoing analysis:

• woman’s pregnancy, esp. having an unwanted pregnancy
• woman’s parity (children versus no children)
• presence of children in the home
• age difference between woman and male abuser
• history of witnessing and/or experiencing abuse or family conflict during childhood (man or woman)
• male abuser’s mental health status (esp. personality disorders)
• certain socio-demographic factors (*)
Correlates, cont.

Plus, for pregnant women:

- history of partner violence
- unwanted pregnancy
- increased parity
- number of stressful life events
Identification
Approach 1: Universal Screening

Ask all presenting women regardless of reason for seeking care.

Adult women

Universal Screening

Identification of women currently experiencing abuse (who disclose)

Potential harms of screening

Potential harms of intervention

Intermediate Outcomes
Social support
Safety behaviours
Use of resources
Others

Health Outcomes
Repeat violence
Physical health
Mental health
Screening for Violence

• Many screening tools are available for various settings, and for pregnant women
• They usually measure self-reported frequency, severity and type of abuse

Issues:
• Lifetime vs. current abuse
• Research instruments vs. clinical tools
Screening, cont.

Widely used tools include:
- Conflict Tactics Scale (CTS & CTS-2)
- Composite Abuse Scale (CAS)
- Partner Violence Screen (PVS)
- Index of Spouse Abuse (ISA)
- Woman Abuse Screening Tool (WAST)
- Abuse Assessment Screen (AAS) (pregnant women)
- etc.

Many perform reasonably well in identifying women who have been abused
Approach 2: Case Finding

Women presenting with specific signs/symptoms or risk indicators of abuse

Identification of women currently experiencing abuse (who disclose)

Intermediate Outcomes
- Social support
- Safety behaviours
- Use of resources
- Others

Health Outcomes
- Repeat violence
- Physical health
- Mental health

Asking about Abuse

Potential harms of screening

Intervention

Potential harms of intervention
Key Differences

• Universal screening
  - All women
  - Asymptomatic for abuse
  - No clinical “trigger” to ask

• Case finding
  - Women with clinical signs and symptoms
  - Clinical “trigger” for further asking and diagnostic assessment
Interventions

Primary Care Interventions

1. Counseling in the primary care setting
2. Referral of women to:
   - counseling
   - a safe place
   - community resources
3. Referral of batterers/couples to counseling
Primary Care Counseling

• No studies met inclusion criteria
Referral Interventions

Referral of Abused Women:
11 studies of 4 interventions for referral of abused women met inclusion criteria:

1. shelter effectiveness
2. post-shelter advocacy counseling
3. personal and vocational counseling
4. prenatal counseling
Referral Interventions, cont.

Shelter Effectiveness:

The sole study (Berk et al., 1986) that attempted to evaluate the effectiveness of shelters in reducing violence was rated “poor”
Referral Interventions, cont.

Post-Shelter Advocacy Counseling:

Women receiving counseling reported:
- Less physical re-abuse (76% vs. 89%)
- Improved quality of life
- Increased use of social support
- Increased effectiveness in obtaining resources

(Sullivan & Bybee, 1999)
Referral Interventions, cont.

Personal/Vocational Counseling:
- Studies were rated “poor”

Prenatal counseling:
- Studies were rated “poor”
Batterer/Couple Interventions

• Overall, studies examining effectiveness of batterer or couple interventions in reducing violence against women are of variable quality, and their results are mixed

• A recent meta-analysis* concluded the same, indicating only a 5% effect for treatment beyond the effect of arrest.

The San Diego Navy Experiment

• RCT (n = 861 couples) with 12 mo follow-up
• compared 3 interventions to controls:
  – weekly groups for men
  – conjoint group (men and their partners)
  – rigorous monitoring plus monthly counseling
• Self-reports (men & women); arrest records
• No differences between groups on any of the measures

(Dunford, 2000)
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
Conclusions of systematic review
Conclusions

• Screening can identify women who are abused, but whether identification of women leads to intervention that prevents or reduces re-abuse has not been shown

• **Routine** screening is different from case-finding/diagnosis
Conclusions, cont.

• Shelters have not been adequately evaluated for their ability to reduce re-abuse, or the potential for leading to reprisal violence against women who have to return home

• Structured post-shelter advocacy counseling is effective in reducing re-abuse (fair evidence)

• The evidence for treating batterers or couples is mixed
Existing Guidelines

• Non-evidence based guidelines generally favor screening, based on the prevalence and consequences of abuse

• Evidence-based assessments find insufficient evidence to determine whether screening does more good than harm (e.g. USPSTF, CTFPHC; see also Ramsay et al., BMJ 2002; 325:314-327)
CTFPHC statement

• “There is insufficient evidence to recommend for or against routine universal screening for violence against either pregnant or non-pregnant women, however clinicians should be alert to signs and symptoms of potential abuse and may wish to ask about exposure to abuse during diagnostic evaluation of these patients”

   CMAJ 2003; 169: 583-4
Gaps in the Evidence

- What are the important outcomes for women who seek to escape violence?
- Does screening women and following them through interventions result in positive changes in important outcomes?
- Which interventions for women, men and couples result in positive changes in important outcomes, without undue harm?
- Do primary prevention strategies reduce the incidence of violence at a population level?
Current Research

If, When and How to Ask the Question(s): Assessing Screening Approaches to Identify Woman Abuse in Health Care Settings

Supported by the Ontario Women’s Health Council, Ontario Ministry of Health and Long-Term Care
Background

• Does screening in health settings do more good than harm?
• What screening approaches and tools work best in different health settings?
• Test effect of universal screening (+ usual care) vs. no screening (+ usual care)
Research Program

Phase 1 studies

RCT Testing screening methods

RCT Effectiveness of screening
Phase 1 studies

- Qualitative Focus groups
- Health Care Provider Survey
- Patterns of Screening for Woman Abuse in Public Health Practice
- Population Attitudes Towards Screening
- Meta-Analysis of Risk Indicators for WA
- Testing Screening Formats and Protocols
Objectives of “Testing Trial”

In four types of health care setting:

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 (Ontario, Canada)

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

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
Methods

• Women aged 18 – 64
• Both PVS and WAST administered in PP and 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
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)
Sample recruitment to date

Recorded by site coordinators
N = 11790

Eligible
N = 2326

Completed screen
N = 2202

Ineligible
Not pt 2848
Age 2821
Prev app 934
Other 2861

Refused
N = 124 (5.3%)
Next steps

- Complete data collection at all sites
- Analyze results by type of setting
- Compare PVS and WAST tools
  - Disclosure rates
  - Agreement with CAS
  - Missing data
  - Participant evaluation of tool
- Finish collection and analysis of staff feedback data
Screening Effectiveness Trial
Objective

• Using results of the “testing trial” to determine tools and approaches for each type of site, test the effectiveness of universal screening vs. no screening in
  – reducing violence and
  – improving quality of life for women
Trial Settings

- Emergency departments
- Family practices & community health centers
- Specialty clinics (Ob/Gyn & Women’s Health)
- Public health
RCT design

Universal screening (Screen + CAS)

Positive
100%

Negative
5%

Positive
100%

Negative
5%

No Screening (CAS only)

Positive
100%

Negative
5%

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

*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

• 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
Related Publications


Clinical Resources


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www.fhs.mcmaster.ca/vaw

Violence against women
Testing the effectiveness of screening

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.

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 at McMaster University.