Intimate partner violence: the end of routine screening

Published Online
April 16, 2013
http://dx.doi.org/10.1016/S0140-6736(13)60584-X

See Online/Articles
http://dx.doi.org/10.1016/S0140-6736(13)60052-5

Intimate partner violence (IPV) is prevalent around the world, and was ranked 5th in terms of years of life lost owing to disability for women in the Global Burden of Disease Study 2010.[1] Prevention of IPV and its health consequences are thus public health priorities, and the idea that health professionals have an important role through identifying abused women and offering a structured intervention has been a widely held assumption for many years in different global settings.

Although many professional bodies have recommended identification of asymptomatic women through routine screening by health professionals, others including WHO, the Canadian Task Force,[2] and the UK's Health Technology Assessment Programme[3] have held back, concluding that there was insufficient evidence to support such a recommendation. The evidence base, however, has since grown. In *The Lancet*, Kelsey Hegarty and colleagues report findings from the WEAVE study, a large and rigorously designed randomised controlled trial of screening and counselling for women who had experienced IPV.[4] This study was done to assess a psychobehavioural intervention, but it began with the postal screening of nearly 20 000 women patients for fear of their partner in the previous 12 months. Those who responded and screened positive were invited for 30-min counselling sessions with their family doctor, or usual care depending on study group. 52 doctors (and their 272 female patients) were randomly allocated to either intervention or control. Primary outcomes were quality of life, the mental health SF12 instrument, and safety planning and behaviours. There was no difference between groups in any of the primary outcomes. This study, which was done in Australia, is the third such study to report outcomes from a high-income country, coming after a study done in the USA[5] and one done in Canada.[6] These large trials differed in their design, but their conclusions have resoundingly agreed that activities to identify asymptomatic abused women and offer different types of intervention do not improve women's health.

These sorts of interventions are attractive because they are simple and generally cost little, even if short counselling interventions are offered.[7] The identification of abused women, among general health-service users, through asking a simple question, or set of questions, is highly feasible.[7] Different intervention models thereafter have been recommended, but they usually encompass providing a leaflet, discussing safety, and referring women for further assistance to specialised services or counselling. The WEAVE study provides an example of a more intensive intervention.[4] The critical question, though, is whether this activity is worthwhile: any activity based on the identification of asymptomatic individuals has to result in improved health status of those screened. The evidence now indicates that it does not.

Yet the task of crafting an appropriate health sector response to IPV remains, and further research is needed to show how best to define such a response. The findings of the WEAVE trial, and those of the US and Canadian studies, do not show a lack of value in asking female patients about IPV in circumstances in which it might be directly associated with the presenting complaint or important for counselling or advice given. Indeed, IPV is a crucial causal factor underlying women's presenting problems in many parts of the health services, particularly mental health problems. Opening a discussion of problems in intimate relationships, including violence, is necessary to provide information for clinical care, and women might be more ready to address change in their lives that will result in the ending of IPV and abusive relationships when they recognise that they have related health problems. It should continue to be part of the clinical assessment of all women patients in these circumstances. In care and

Andrew Aitchison/In Pictures/Corbis

treatment services for HIV and sexually transmitted infections, relationship problems and partner violence can affect the nature of advice given and discussions around safer sexual practices, safe disclosure, and use of medication. High quality, individualised care can be provided only if health professionals understand whether HIV-positive women are in relationships marked by emotional, physical, or sexual violence, or highly controlling practices. Appropriate advice and intervention needs to be provided.

IPV and its health consequences should be prevented and addressed in health services. The time has come to conclude that routine identification of abused women and provision of a standard intervention is not the answer. We need to develop and test new directions for health-service responses. More substantive psycho-behavioural interventions might be of value in other contexts, for example when offered in antenatal services, where they have been shown to reduce IPV recurrence and improve maternal and infant outcomes.[8,9] This work needs to be developed and tested in other settings. The WEAVE study shows that uptake of counselling interventions is often disappointing, and research is needed to identify and overcome barriers. Future work could also take into account men's role in IPV. There has been little consideration of screening for IPV perpetration by men and offering men interventions to improve their relationship skills and stop their use of violence. The role of family health services in this deserves to be explored.

Rachel Jewkes
Gender and Health Research Unit, Medical Research Council, Pretoria 0001, South Africa
rjewkes@mrc.ac.za

I declare that I have no conflicts of interest.

1 Institute for Health Metrics and Evaluation. GBD 2010 leading causes and risks by region heat map. http://www.healthmetricsandevaluation.org/gbd/visualizations/gbd-2010-leading-causes-and-risks-region-heat-map (accessed April 10, 2013).

2 Wathen CN, MacMillan HL. Prevention of violence against women: recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2003; **169:** 582–84.

3 Feder G, Ramsay J, Dunne D, et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technol Assess* 2009; **13:** 1–347.

4 Hegarty K, O'Doherty L, Taft A, et al. Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial. *Lancet* 2013; published online April 16. http://dx.doi.org/10.1016/S0140-6736(13)60052-5.

5 Klevens J, Kee R, Trick W, et al. Effect of screening for partner violence on women's quality of life: a randomized controlled trial. *JAMA* 2012; **308:** 681–89.

6 MacMillan HL, Wathen CN, Jamieson E, et al. Screening for intimate partner violence in health care settings: a randomized trial. *JAMA* 2009; **302:** 493–501.

7 Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the US Preventive Services Task Force recommendation. *Ann Intern Med* 2012; **156:** 796–808.

8 Kiely M, El-Mohandes AA, El-Khorazaty MN, Blake SM, Gantz MG. An integrated intervention to reduce intimate partner violence in pregnancy: a randomized controlled trial. *Obstet Gynecol* 2010; **115:** 273–83.

9 Tiwari A, Leung WC, Leung TW, Humphreys J, Parker B, Ho PC. A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG* 2005; **112:** 1249–56.