Does screening women for partner violence meet criteria for a screening programme?

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

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Executive summary

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Executive summary

Background

Partner violence against women is physical, sexual or emotional abuse with coercive control of a woman by a man or woman partner or ex-partner. It is a common problem, with a detrimental effect on health and well-being. Although there is a consensus that health services need to respond to partner violence, there is uncertainty whether screening for partner violence in health-care settings is effective and appropriate.

Objectives

This review has two specific aims:

- To identify, appraise and synthesise research across a range of study designs that are relevant to selected UK National Screening Committee (NSC) criteria for a screening programme in relation to partner violence.
- To make a judgment on whether current evidence is sufficient for fulfilment of selected NSC criteria for the implementation of screening for partner violence in health-care settings.

The research questions

There are seven review questions (linked to key NSC criteria):

- Question I: What is the prevalence of partner violence against women and what are its health consequences? (NSC criterion 1)
- Question II: Are screening tools valid and reliable? (NSC criteria 5 and 6)
- Question III: Is screening for partner violence acceptable to women? (NSC criterion 7)
- Question IV: Are interventions effective once partner violence is disclosed in a health-care setting? (NSC criteria 10 and 15)
- Question V: Can mortality or morbidity be reduced following screening? (NSC criterion 13)
- Question VI: Is a partner violence screening programme acceptable to health professionals and the public? (NSC criterion 14)
- Question VII: Is screening for partner violence cost-effective? (NSC criterion 16)

Methods

Data sources

Fourteen electronic databases from their respective start dates to 31 December 2006.

Study selection

Different sets of inclusion/exclusion criteria were required for the seven review questions. All criteria were applied independently by two reviewers, and disagreements were adjudicated by a third reviewer.

Data extraction and assessment of quality

Data were extracted onto electronic forms and ordered into summary tables including the results of quality appraisal. These tables formed the basis of our narrative synthesis of the primary studies. The quality of the primary studies was assessed using published appraisal tools in accord with the different review questions and the study designs: STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) for observational studies; QUADAS (Quality Assessment of Diagnostic Accuracy Studies) for diagnostic accuracy studies; CASP (Critical Appraisal Skills Programme) for qualitative studies and reviews; USPSTF (United States Preventative Services Task Force) criteria for intervention studies; and the Jadad score for randomised controlled trials.

Data synthesis

We grouped the findings of the surveys, diagnostic accuracy and intervention studies and qualitatively analysed differences between outcomes in relation to study quality, setting (country, type of health-care facility), populations (if available, ethnicity, socioeconomic status, method of identification/disclosure) and, in the case of intervention studies, the nature of the intervention. For review questions III and VI we combined the findings of qualitative and quantitative studies. We also used the results from qualitative studies of survivors of partner violence to comment on the scope of our review. We systematically considered each of the selected NSC criteria against the review evidence.

Results

- Question I: The prevalence in the UK of partner violence against women and the magnitude of health sequelae vary with study design and population. In samples drawn from the general population, lifetime prevalence ranged from 13% to 31%, and in samples from clinical populations it ranged from 13% to 35%. One-year prevalence ranged from 4.2% to 6% in the general population studies. Even the lower estimates for prevalence, morbidity and mortality show that partner violence against women is a major public health problem and potentially an appropriate condition for screening and intervention.
- Question II: Several short screening tools are relatively valid and reliable for use in health-care settings. The HITS (Hurts, Insults, Threatens and Screams) 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), with a suitable cut-off score.
- Question III: Most women patients considered screening acceptable (range 35–99%), although they identified potential harms, particularly with regard to stigmatisation and breach of confidentiality. Informants thought that, besides identifying women experiencing partner violence, the aims of screening should also include information giving and signalling willingness for clinicians to talk about partner violence.
- Question IV: Effect sizes for post-traumatic stress disorder (PTSD) ranged from 0.10 (an individual psychological intervention) to 1.23 (an individual psychological intervention); depression ranged from 0.16 (an individual psychological intervention) to 1.77 (an individual psychological intervention); self-esteem ranged from 0.10 (an individual psychological intervention) to 2.55 (an individual psychological intervention); and physical abuse ranged from 0.02 (advocacy) to 0.48 (advocacy). The evidence for effectiveness of advocacy is growing, particularly for women who have actively sought help or are in a refuge. The two studies of advocacy interventions in women identified through screening in health-care services were based in antenatal clinics. Psychological interventions and work with survivors and their children may be effective, but not necessarily for women identified through screening.
- Question V: There were no trials of screening programmes measuring morbidity and mortality. The proxy outcome measure of referral rates ranged widely from a difference of 4% to 67% between control and intervention sites. The proxy outcome measure of identification showed little change, ranging from 25% to 3% between control and intervention sites. Studies using proxy outcome measures generally had weak designs and execution.
- Question VI: There was heterogeneity in the outcomes of qualitative and survey studies about the acceptability to health-care professionals of partner violence screening. The acceptability of partner violence screening among health-care professionals ranged widely from 15% to 95%, but overall the evidence showed that this NSC criterion is not met.
- Question VII: There were no cost-effectiveness studies of partner violence screening interventions. A Markov model of a pilot intervention to increase identification of survivors of partner violence in general practice found that such an intervention was potentially cost-effective.

Conclusions

Implications for health care

Currently there is insufficient evidence to implement a screening programme for partner violence against women either in health services generally or in specific clinical settings. It may be inappropriate to judge a policy of routine enquiry about partner violence by the NSC criteria, particularly as women perceive other valid purposes of screening besides identification. Even if the scope of routine enquiry is wider than screening, it is debatable whether that policy would be justified within health services.

Recommendations for research

1. Trials of system-level interventions to improve the response of health services to survivors of partner violence. These may incorporate routine or selective enquiry and, potentially, could compare differences in outcomes between the two policies.
2. Trials of psychological and advocacy interventions after disclosure, in health-care settings, of partner violence. Such trials would measure quality of life, mental health and further abuse.

3. Trials to test theoretically explicit interventions to help understanding of what works (or does not work) for whom, when and in what contexts.
4. Qualitative studies exploring what women want from interventions after disclosure of partner violence.
5. Cohort studies measuring risk factors, resilience factors and the trajectory of partner violence through the life course.
6. Longitudinal studies measuring the long-term prognosis for survivors of partner violence after their identification in health-care settings.

Programmes addressing these six research questions need to have the resources and expertise to include participants from majority and ethnic minority communities in the UK.

Publication

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The Health Technology Assessment (HTA) Programme, part of the National Institute for Health Research (NIHR), was set up in 1993. It produces high-quality research information on the effectiveness, costs and broader impact of health technologies for those who use, manage and provide care in the NHS. 'Health technologies' are broadly defined as all interventions used to promote health, prevent and treat disease, and improve rehabilitation and long-term care.

The research findings from the HTA Programme directly influence decision-making bodies such as the National Institute for Health and Clinical Excellence (NICE) and the National Screening Committee (NSC). HTA findings also help to improve the quality of clinical practice in the NHS indirectly in that they form a key component of the 'National Knowledge Service'.

The HTA Programme is needs led in that it fills gaps in the evidence needed by the NHS. There are three routes to the start of projects.

First is the commissioned route. Suggestions for research are actively sought from people working in the NHS, from the public and consumer groups and from professional bodies such as royal colleges and NHS trusts. These suggestions are carefully prioritised by panels of independent experts (including NHS service users). The HTA Programme then commissions the research by competitive tender.

Second, the HTA Programme provides grants for clinical trials for researchers who identify research questions. These are assessed for importance to patients and the NHS, and scientific rigour.

Third, through its Technology Assessment Report (TAR) call-off contract, the HTA Programme commissions bespoke reports, principally for NICE, but also for other policy-makers. TARs bring together evidence on the value of specific technologies.

Some HTA research projects, including TARs, may take only months, others need several years. They can cost from as little as £40,000 to over £1 million, and may involve synthesising existing evidence, undertaking a trial, or other research collecting new data to answer a research problem.

The final reports from HTA projects are peer reviewed by a number of independent expert referees before publication in the widely read journal series *Health Technology Assessment*.

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Reports are published in the HTA journal series if (1) they have resulted from work for the HTA Programme, and (2) they are of a sufficiently high scientific quality as assessed by the referees and editors.

Reviews in *Health Technology Assessment* are termed 'systematic' when the account of the search, appraisal and synthesis methods (to minimise biases and random errors) would, in theory, permit the replication of the review by others.

The research reported in this issue of the journal was commissioned by the HTA Programme as project number 05/09/07. The contractual start date was in January 2006. The draft report began editorial review in May 2007 and was accepted for publication in June 2008. As the funder, by devising a commissioning brief, the HTA Programme specified the research question and study design. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HTA editors and publisher have tried to ensure the accuracy of the authors' report and would like to thank the referees for their constructive comments on the draft document. However, they do not accept liability for damages or losses arising from material published in this report.

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