

Screening for Family and Intimate Partner Violence: Recommendation Statement

U.S. Preventive Services Task Force*

This statement summarizes the U.S. Preventive Services Task Force (USPSTF) recommendations on screening for family and intimate partner violence, based on the USPSTF's examination of evidence specific to family and intimate partner violence, and updates the 1996 recommendations on this topic. In 1996, the USPSTF found insufficient evidence to recommend for or against the use of specific instruments to detect domestic violence (a grade C recommendation, according to 1996 grade definitions). The USPSTF now uses an explicit process in which the balance of benefits and harms is determined exclusively by the quality and magnitude of the evidence. As a result, current letter grades are based on different criteria from those in 1996. The complete information on which this statement is based, including evidence tables and references, is available in the accompanying article in this issue and in the summary of the evidence and systematic evidence

review on the USPSTF Web site (www.preventiveservices.ahrq.gov) and through the National Guideline Clearinghouse (www.guideline.gov). The USPSTF recommendation, the accompanying summary article, and the complete systematic evidence review are available through the USPSTF Web site (www.preventiveservices.ahrq.gov). The summary article and the USPSTF recommendation statement are available in print through the Agency for Healthcare Research and Quality Publications Clearinghouse (telephone, 800-358-9295; e-mail, ahrqpubs@ahrq.gov).

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* For a list of the members of the U.S. Preventive Services Task Force, see the Appendix.

SUMMARY OF THE RECOMMENDATION

The U.S. Preventive Services Task Force (USPSTF) found insufficient evidence to recommend for or against routine screening of parents or guardians for the physical abuse or neglect of children, of women for intimate partner violence, or of older adults or their caregivers for elder abuse. This is a **grade I recommendation**. (See **Appendix Table 1** for a description of the USPSTF classification of recommendations.)

*The USPSTF found no direct evidence that screening for family and intimate partner violence leads to decreased disability or premature death. The USPSTF found no existing studies that determine the accuracy of screening tools for identifying family and intimate partner violence among children, women, or older adults in the general population. The USPSTF found fair to good evidence that interventions reduce harm to children when child abuse or neglect has been assessed (see Clinical Considerations). The USPSTF found limited evidence as to whether interventions reduce harm to women and no studies that examined the effectiveness of interventions in older adults. No studies have directly addressed the harms of screening and interventions for family and intimate partner violence. As a result, the USPSTF could not determine the balance between the benefits and harms of screening for family and intimate partner violence among children, women, or older adults. (See **Appendix Table 2** for a description of the USPSTF classification of levels of evidence.)*

CLINICAL CONSIDERATIONS

The USPSTF did not review the evidence for the effectiveness of case-finding tools; however, all clinicians examining children and adults should be alert to physical and behavioral signs and symptoms associated with abuse or

neglect. Patients in whom abuse is suspected should receive proper documentation of the incident and physical findings (for example, photographs, body maps); treatment for physical injuries; arrangements for skilled counseling by a mental health professional; and the telephone numbers of local crisis centers, shelters, and protective service agencies.

Victims of family violence are primarily children, female spouses/intimate partners, and older adults. Numerous risk factors for family violence have been identified, although some may be confounded by socioeconomic factors. Factors associated with child abuse or neglect include low income status, low maternal education, non-white race, large family size, young maternal age, single-parent household, parental psychiatric disturbances, and presence of a stepfather. Factors associated with intimate partner violence include young age, low income status, pregnancy, mental health problems, alcohol or substance use by victims or perpetrators, separated or divorced status, and history of childhood sexual and/or physical abuse. Factors associated with the abuse of older adults include increasing age, non-white race, low income status, functional impairment, cognitive disability, substance use, poor emotional state, low self-esteem, cohabitation, and lack of social support.

Several instruments to screen parents for child abuse have been studied, but their ability to predict child abuse or neglect is limited. Instruments to screen for intimate partner violence have also been developed, and although some have demonstrated good internal consistency (for example, the HITS [Hurt, Insulted, Threatened, Screamed at] instrument, the Partner Abuse Interview, and the Women's Experience with Battering [WEB] Scale), none have been

validated against measurable outcomes. Only a few screening instruments (for example, the Caregiver Abuse Screen [CASE] and the Hwalek–Sengstock Elder Abuse Screening Test [HSEAST]) have been developed to identify older potential victims of abuse or their abusive caretakers. Both of these tools correlated well with previously validated instruments when administered in the community but have not been tested in the primary care clinical setting (1).

Home visit programs directed at high-risk mothers (identified on the basis of sociodemographic risk factors) have improved developmental outcomes and decreased the incidence of child abuse and neglect, as well as decreased rates of maternal criminal activity and drug use.

DISCUSSION

Approximately 1 million abused children are identified in the United States each year (2). In 1999, an estimated 1100 children died of abuse and neglect (3). It is likely that reported abuse captures only a fraction of all cases. Estimates of the prevalence of intimate partner violence in the United States indicate that 1 to 4 million women are physically, sexually, or emotionally abused by their intimate partners each year (4, 5), with 31% of all women reporting abuse at some point in their lifetimes (6). Although violence by women against men also occurs, women are 7 to 14 times more likely to suffer severe physical injury from an assault by an intimate partner (7).

The National Elder Abuse Incidence Study (NEAIS) estimates that approximately 551 000 older adults in domestic settings were abused and/or neglected during 1996 (8). The abuse of older adults takes many forms, including physical, sexual, and psychological abuse; financial exploitation; and neglect (9). In 90% of cases, the perpetrator of such abuse is a family member, usually an adult child or spouse (8). Harmful outcomes of family violence may include not only repercussions of acute trauma, including death or unwanted pregnancy, but also long-term physical problems and psychiatric disorders, such as depression, post-traumatic stress disorder, somatization, suicide, and substance abuse (10–20). In addition, children who witness intimate partner violence are at risk for developmental delay; school failure; violent behavior; and a variety of psychiatric disorders, including depression and oppositional defiant disorder (21–23).

The USPSTF focused this review on children, women, and older adults because they are the largest groups at risk for domestic violence in the general primary care setting and are most likely to have been the subjects of published studies. The USPSTF reviewed the evidence for the effectiveness of screening procedures and interventions in the primary care setting in reducing harmful outcomes of domestic violence against children, women, and older adults. Because no studies were found that directly addressed the impact of screening on reducing harmful outcomes, the USPSTF examined the accuracy of clinical screening in-

struments in identifying risk for current or future abuse and the efficacy of clinic-based interventions in reducing harmful outcomes.

Screening for child abuse in the primary care setting can involve a variety of techniques, including physical examination as well as screening questionnaires. Findings during a routine physical examination suggestive of abuse and/or neglect, such as burns, bruises, and repeated suspicious traumatic injury, have been described (24). All instruments designed to screen for child abuse and neglect were directed at parents, particularly pregnant mothers. Limited evidence suggests that these instruments had fairly high sensitivity but low specificity for identifying future child maltreatment when administered in the study populations, particularly when self-administered questionnaires were provided to pregnant mothers in a 2-step method, such as the Hawaii Risk Indicators Screening Tool followed by the Kempe Family Stress Inventory (25, 26). These questionnaires have not been widely tested in different populations. Newer brief instruments designed to identify women who are victims of intimate partner violence in primary care settings compare well with lengthier, previously validated instruments (1). Studies indicate that self-administered questionnaires elicit more positive responses than interviewer-administered questionnaires in emergency department settings (27), but the opposite was true in a Planned Parenthood clinic (28). No studies have evaluated the performance of screening instruments using verified outcomes of reported intimate partner abuse, although self-reported abuse may be a more accurately measured outcome than some verified outcomes (for example, police or social services reports). The USPSTF found few screening instruments for the detection of older adults who are the potential victims of abuse or their caretakers. None of the instruments available have been widely validated.

The USPSTF reviewed the evidence for the efficacy of interventions with children, women, and older adults in reducing harmful outcomes of family and intimate partner violence. The intervention trials identified “high-risk” women and children on the basis of various inclusion criteria that have not been validated, including sociodemographic characteristics, maternal substance use, low infant birthweight, and homelessness. A randomized, controlled trial with 15 years of follow-up indicated that nurse home visit programs (for example, the Nurse–Family Partnership program) during the prenatal and 2-year postpartum periods for low-income, first-time mothers can improve the short-term and long-term outcomes of child abuse and neglect (29, 30). When compared with the nonintervention group, the home visit group had improved outcomes, including decreased reports of child maltreatment, child injuries/toxic ingestions and emergency department visits, and maternal criminal activity and drug use. Several trials utilizing nurse home visits for varying lengths of time and with various program components for pregnant and postpartum mothers support these findings, although the out-

comes in these studies were short-term measures of child abuse and related factors (1). There were 2 studies of interventions to decrease intimate partner violence in women; both studies, which recruited only pregnant women, showed a trend (not statistically significant) in women reporting decreased violence after brief counseling or outreach interventions (31, 32). There are no studies of interventions initiated in the primary care setting with health outcomes for older children, women who are not pregnant, or older adults. Further research is required to identify screening tools that are valid in the general population and effective programs that decrease abuse outcomes and the health-related consequences of family and intimate partner violence.

No studies have directly addressed the harms of screening and intervention for family and intimate partner violence. False-positive test results, most common in low-risk populations, may compromise the clinician–patient relationship (33). Additional possible harms of screening may include loss of contact with established support systems, psychological distress, and escalation of abuse (34). However, none of these potential harms has been studied.

RECOMMENDATIONS OF OTHER GROUPS

The American Academy of Pediatrics (35) and the American Medical Association (AMA) (36, 37) recommend that physicians remain alert for the signs and symptoms of child physical abuse and child sexual abuse in the routine examination. The Canadian Task Force on Preventive Health Care (CTFPHC) recommends that screening procedures aimed at identifying individuals at risk for experiencing or committing child maltreatment should be excluded from the periodic health examination (38). However, the CTFPHC recommends a program of home visitation for disadvantaged families during the perinatal period through infancy to prevent child abuse and neglect. The Centers for Disease Control and Prevention Task Force on Community Preventive Services found that home visitation programs aimed at children at high risk for maltreatment (for example, those born to single or young mothers or in low-income households, those of low birthweight) were effective in decreasing maltreatment episodes (39). The American College of Obstetricians and Gynecologists (ACOG) guidelines on domestic violence recommend that physicians routinely ask women direct, specific questions about abuse (40). The AMA encourages physicians to inquire routinely about their patients' domestic violence histories and refer those patients with violence-related problems for medical and/or community-based services (41). The CTFPHC concluded that there was insufficient evidence to recommend for or against routine screening for violence against women.

The ACOG and AMA (42) recommend that physicians routinely ask elderly patients direct, specific questions about abuse. The CTFPHC determined that there was insufficient evidence to include or exclude case finding for

elder abuse as part of the periodic health examination but recommended that physicians be alert for indicators of abuse and institute measures to prevent further abuse (43). The American Academy of Family Physicians notes that family physicians can provide early intervention in family violence through routine screening and the identification of abuse, and recommends that physicians be alert for the presence of family violence in virtually every patient encounter (44). Reporting child and elder abuse to protective services is mandatory in most states, and several states have laws requiring mandatory reporting of intimate partner violence (45, 46).

APPENDIX

Members of the U.S. Preventive Services Task Force are Alfred O. Berg, MD, MPH, *Chair* (University of Washington, Seattle, Washington); Janet D. Allan, PhD, RN, CS, *Vice-Chair* (University of Maryland Baltimore, Baltimore, Maryland); Paul Frame, MD (Tri-County Family Medicine, Cohocton, and University of Rochester, Rochester, New York); Charles J. Homer, MD, MPH (National Initiative for Children's Healthcare Quality, Boston, Massachusetts); Mark S. Johnson, MD, MPH (University of Medicine and Dentistry of New Jersey–New Jersey Medical School, Newark, New Jersey); Jonathan D. Klein, MD, MPH (University of Rochester School of Medicine, Rochester, New York); Tracy A. Lieu, MD, MPH (Harvard Pilgrim Health Care and Harvard Medical School, Boston, Massachusetts); C. Tracy Orleans, PhD (The Robert Wood Johnson Foundation, Princeton, New Jersey); Jeffrey F. Peipert, MD, MPH (Women and Infants' Hospital, Providence, Rhode Island); Nola J. Pender, PhD, RN (University of Michigan, Ann Arbor, Michigan); Albert L. Siu, MD, MSPH (Mount Sinai School of Medicine, New York, New York); Steven M. Teutsch, MD, MPH

*Appendix Table 1. U.S. Preventive Services Task Force Recommendations and Ratings**

Grade	Recommendation
A	The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. <i>The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.</i>
B	The USPSTF recommends that clinicians provide [the service] to eligible patients. <i>The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.</i>
C	The USPSTF makes no recommendation for or against routine provision of [the service]. <i>The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.</i>
D	The USPSTF recommends against routinely providing [the service] to asymptomatic patients. <i>The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.</i>
I	The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. <i>Evidence that the [service] is effective is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</i>

* The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to 1 of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

Appendix Table 2. U.S. Preventive Services Task Force Strength of Overall Evidence*

Grade	Definition
Good	Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes
Fair	Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of the evidence on health outcomes
Poor	Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes

* The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor).

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From the U.S. Preventive Services Task Force, Agency for Healthcare Research and Quality, Rockville, Maryland.

Disclaimer: The USPSTF recommendations are independent of the U.S. government. They do not represent the views of the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

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