RED

Guideline: Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: U.S. Preventive Services Task Force Recommendation Statement [2013]

Developer: U.S. Preventive Services Task Force

Summary: This is a high-quality guideline, but the CTFPHC does not recommend its use in Canada. In the opinion of the CTFPHC, available evidence does not justify routinely screening Canadian residents for intimate partner violence or abuse of elderly and vulnerable adults.

OVERVIEW This guideline focuses on screening for intimate partner violence (IPV) and abuse of elderly and vulnerable adults. IPV commonly goes undetected, but it has several potential adverse consequences. Immediate effects include injury and death, whereas long-term health consequences range from unintended pregnancy to increased rates of chronic pain, neurological disorders, gastrointestinal disorders and migraine headaches[1].

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen women of child-bearing age for IPV and provide or refer women who screen positive to intervention services (grade B recommendation)[1].

Further, the USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (those with physical or mental dysfunction) for abuse and neglect (I statement)[1].

According to police-reported data, Canadians' risk of IPV (both spousal and dating partner violence) is higher than the risk of non-spousal family violence or violence committed by strangers[2]. In 2010, 363 women per 100,000 population reported IPV, representing over 102,500 Canadians[2].

Little information is available on the prevalence of abuse among non-institutionalized elderly or vulnerable adults. In 2004, 3,370 incidents of violence against Canadians aged 65 years and over were reported to police[3]. Over one quarter (29%) of reported incidents against older people were committed by a family member[3].

This guideline was developed in the United States by a broad range of experts and is targeted toward clinicians.

RELEVANCE TO CTFPHC MANDATE All sections of this guideline are applicable to the CTFPHC mandate of prevention in primary care.

POPULATION The target populations for screening are individuals presenting for health care, specifically adult women for IPV screening and elderly and vulnerable adults for screening for abuse and neglect.

EVIDENCE REVIEW METHODS The National Library of Medicine's Medical Subject Headings (MeSH) keyword nomenclature was used to search Ovid MEDLINE and PsycINFO (2002 to January 9, 2012), the Cochrane Central Register of Controlled Trials (fourth quarter of 2011) and the Cochrane Database of Systematic Reviews (fourth quarter of 2011) for relevant English-language studies and systematic reviews. In addition, reference lists of papers were manually reviewed, and citations of key studies were searched using Scopus. A total of 8,368 abstracts were identified; 625 full-text articles were reviewed for relevance, of which 38 were included in the evidence synthesis.

GRADING SYSTEM The USPSTF assigns 1 of 5 letter grades to each recommendation: A, B, C, D or I[4]. These grades are based largely on the level of certainty of the net benefit associated with providing the service. For more information, see Table 1 and Table 2.

COMMENTARY Overall, the objective, health questions and target population of this guideline are well defined and clearly presented. Further, a high level of rigour was used to develop this guideline. However, in the opinion of the CTFPHC, there is currently insufficient evidence to recommend screening the general Canadian population for IPV or elder abuse.

It is important to note that the guideline included data from only one study that directly addressed the benefit of screening, and that study found no effect of screening on outcomes. The recommendation for screening is based on indirect evidence with considerable limitations. In addition, some of the indirect evidence of benefit for screening appears to depend on follow-up programs for victims of IPV that may not be widely available in Canada, and/or rely on clinician knowledge of available referral pathways.

Implementation of this guideline would be challenging, since clinical criteria for identifying IPV and elder abuse have limitations; further, definitions of what constitutes abuse may vary between contexts, and the legal obligations of providers differ between jurisdictions. These potential barriers to implementation are mentioned by the developers, but no advice is given about how to address them.

Although IPV and elder abuse are both important societal problems, available evidence does not justify screening for these conditions in Canada. The World Health Organization recently came to the same conclusion, through publication of its guideline *Responding to Intimate Partner Violence and Sexual Violence against Women*[6] which recommends against routine screening. Practitioners should remain alert to clinical clues of IPV or abuse and neglect of elderly and vulnerable adults and assess further when indicated on clinical grounds.

CTFPHC APPRAISAL COLOUR LEGEND

GREEN

This is a high-quality guideline that can be used to guide preventive care in Canada.

YELLOW

This is a high-quality guideline, but the CTFPHC has identified some concerns that may limit its applicability.

RED

This is a high-quality guideline, but the CTFPHC does not recommend its use in Canada.

Recommendations: U.S. Preventive Services Task Force

The full guideline can be found at: http://www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderfinalrs.htm

ASYMPTOMATIC WOMEN OF CHILDBEARING AGE

Screen women for intimate partner violence (IPV), and provide or refer women who screen positive to intervention services [Grade B].

ELDERLY OR VULNERABLE ADULTS

No recommendation [I statement].

TABLE 1 (see right): Summary of the U.S. Preventive Services Task Force grade definitions[4].

TABLE 2 (see below): Summary of the USPSTF levels of certainty regarding net benefit[4].

HIGH CERTAINTY: The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.

MODERATE CERTAINTY: The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as:

- The number, size, or quality of individual studies.
- Inconsistency of findings across individual studies.
- Limited generalizability of findings to routine primary care practice.
- Lack of coherence in the chain of evidence.

As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, or poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

LOW CERTAINTY: The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:

- The limited number or size of studies.
- Important flaws in study design or methods.
- Inconsistency of findings across individual studies.
- Gaps in the chain of evidence.
- Findings not generalizable to routine primary care practice.
- Lack of information on important health outcomes.

More information may allow estimation of effects on health outcomes.

REFERENCES

1. Moyer VA; U.S. Preventive Services Task Force. Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2013;158(6):478-486.
2. Sinha M. Section 2. Violence against intimate partners. In: *Family violence in Canada: a statistical profile, 2010*. Ottawa, ON: Statistics Canada; 2012. Available at: http://www.statcan.gc.ca/pub/85-002-x/2012001/article/11643/11643-2-eng.htm. Accessed 2013 Apr 16.
3. Elder abuse in Canada: a gender-based analysis—summary. Ottawa, ON: Public Health Agency of Canada; 2012. Available at: http://www.phac-aspc.gc.ca/seniors-aines/publications/pro/abuse-abus/gba-acs/index-eng.php. Accessed 2013 Apr 16.
4. Grade definitions: grade definitions after July 2012. Rockville, MD: U.S. Preventive Services Task Force; 2012. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm. Accessed 2013 Jun 16.
5. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013. Available at: http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf. Accessed 2014 Jan 16.