JOINING FORCES Joining Families

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FEATURED INTERVIEW

Universal Screening Versus Case Finding in Intimate Partner Violence (IPV)

An Interview with Harriet L. MacMillan, MD

Harriet L. MacMillan

Harriet L. MacMillan, MD, is a Professor in the Departments of Psychiatry and Behavioural Neurosciences, and Pediatrics at McMaster University in Hamilton, Ontario, Canada. She is a member of the Offord Centre for Child Studies and holds the Chedoke Health Chair in Child Psychiatry. Dr. MacMillan was the founding Director of the Child Advocacy and Assessment Program at McMaster Children's Hospital, a multidisciplinary program committed to reducing the burden of suffering associated with family violence. Dr. MacMillan's research focuses on the epidemiology of family violence, including prevention of child maltreatment and intimate partner violence. She has led randomized controlled trials investigating the effectiveness of such approaches as universal screening in reducing intimate partner violence and nurse home visitation in preventing the recurrence of physical abuse and neglect among children.

In This Issue

This edition of *Joining Forces Joining Families (JFJF)* is on screening for intimate partner violence (IPV) against women, a topic that has been controversial. Our interview is with Harriet L. MacMillan, MD, in which she explores some of the important issues for research, practice and policy on universal IPV screening compared to inquiry through clinical case finding. We also provide a summary of her work on these topics as well as our regular article, *Building Bridges to Research*, where we discuss screening in more detail. *Websites of Interest* provides links to the US Preventive Services Task Force as well as other sites related to IPV. As always, we appreciate the work of our readership, and wish you a productive and healthy summer.

Contents

Dr. McCarroll: How did intimate partner violence and child maltreatment become driving interests for you?

Dr. MacMillan: I was very influenced by my father, who was a pediatrician. I grew up hearing about the abuse and neglect that children experience. When I was in my pediatric residency I was struck by the fact that, if there was suspicion that a child was abused or neglected, there was a need to understand what happens to them. That became a major question for me. I also wanted to do child psychiatry. Being a pediatrician would enrich my ability to meet the needs of children and families as a child psychiatrist. During my training as a psychiatrist, I also began my master's degree in clinical epidemiology and biostatistics because I saw the need for training in methodology if I was going to do intervention research.

Dr. McCarroll: How would you recommend identifying women who have been abused?

Dr. MacMillan: The challenges are both to understand and to communicate. Simply asking a standard set of screening questions to everybody has been studied in two randomized controlled trials (MacMillan, et al., 2009; Klevens, et al, 2012). Neither study showed any benefits for women.

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Simply asking a standard set of screening questions to everybody has been studied in two randomized controlled trials. Neither study showed any benefits for women.

A screening test, to be effective, must have strong psychometric properties, but there also has to be an evidence-based intervention to which people are referred. We have to look at that overarching pathway to understand whether identification plus intervention leads to better outcomes. My concern is that people have been so preoccupied with the concept of identification that screening has taken on a life of its own and people assume that it does more good than harm. Recent studies have shown that screening does not lead to better health outcomes for women (Wathen & MacMillan, 2012).

Our clinical response does not have to be about screening. We do many things in our exchanges with patients depending on the nature of the diagnostic assessment. This is what is known as case finding rather than screening, and that distinction is important. We also need to appreciate that anything we do in encounters with patients takes time and it means that something else may not be done.

Dr. McCarroll: What training do you suggest for health care providers for identifying IPV?

Dr. MacMillan: Currently, people might only get one or two sessions, and it tends to be about the epidemiology of the problem. People need training in understanding how exposure to child maltreatment and IPV influences health. There needs to be more training about the actual clinical response when someone hears about patient exposure. Health care providers also need to know the evidence about what works and what does not. They also need to have a level of comfort and competence in discussing exposure to violence with their patients.

Dr. McCarroll: It might be easier to teach brief screening than case finding. Is teaching case finding more difficult and time consuming?

Dr. MacMillan: Teaching history-taking and case finding is more than asking a standard set of questions. This is a sensitive area and people need very clear input as to what to ask. Scripts can be helpful in training people how to incorporate such questions within the context of diagnostic assessment, but ideally, over time, people need to have experience in incorporating such inquiry within the art of history-taking.

Dr. McCarroll: You have been involved in research and policy on family maltreatment with the Canadian Task Force on Preventive Health Care and the World Health Organization (WHO) as a member of their Guidelines Development Group on Responding to Intimate Partner Violence and Sexual Violence against Women (WHO, 2013). Are you involved in other work with the WHO?

Dr. MacMillan: There is a *Lancet* series on early child development underway. I was asked by WHO to be part of that group given my area of focus on violence because WHO sees that it is important to consider children's exposure to violence within the context of early child development. How violence intersects with other areas of health is being thought about more often. The plan is for a four-part series to come out sometime next year.

Dr. McCarroll: Speaking of world health, the U.S. has seen a huge influx of immigrants over the past 10 years or so. What do you think that means for the cultural issues with regard to understanding violence? Do you think that people in other countries understand violence differently than we do in the Western world or is violence violence?

Dr. MacMillan: There are differences across the countries and much of it has to do with the

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Joining Families

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Research, Practice, and Policy on Identifying Women Exposed to Intimate Partner Violence (IPV)

By James E. McCarroll, PhD, and Robert J. Ursano, MD

Knowledge of a patient's exposure to IPV within the context of a diagnostic assessment (i.e., case finding) has the potential to improve diagnostic accuracy and determine approaches to treatment.

Harriet L. MacMillan, MD, has a distinguished career studying and writing on practices and policies for how best to identify IPV against women, in addition to many other topics in family violence.

Why Not Universal Screening?

Screening for IPV against women is controversial. The Canadian Task Force on Preventive Health Care (CTFPHC) found insufficient evidence to recommend for or against universal screening of women for IPV (Wathen & MacMillan, 2003; MacMillan & Wathen, 2003). In 2013, the CTFPHC appraised the US Guideline on Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults and recommended against its use in Canada. In the opinion of the CTFPHC, the available evidence does not justify routine IPV screening. One of Dr. MacMillan's major points is that before clinicians can routinely screen women for abuse, there must be evidence that such screening does more good than harm. Two key elements must be considered: (1) does the screening identify the condition and (2) does the subsequent intervention lead to a favorable outcome such as the reduction of violence? Dr. MacMillan's response to the first question was that, "Yes", there are good screening instruments for use in primary health care settings, including emergency departments. For the second question, she believes that except for a few promising programs, there is a lack of evidence on interventions to which health care providers can refer women, that will reduce violence or impact other important outcomes. Nevertheless, she advised clinicians to maintain a high index of suspicion when assessing patients. Knowledge of a patient's exposure to IPV within the context of a diagnostic assessment (i.e., case finding) has the potential to improve diagnostic accuracy and determine approaches to treatment, for example, of co-morbid mental health conditions.

Training for Inquiring about IPV

Among the controversies about IPV screening are how clinicians are trained and how they might conduct screening. In a study in Ontario, Canada, variability was found in programs regarding the amount and methods for IPV training of health care professionals (Wathen, et al., 2009). Of 222 programs in dentistry, medicine, nursing, and other health professions, 57% reported some form of IPV-specific education with undergraduate nursing (83%) and allied health programs (82%) being the highest. Fewer than half the medical (43%) and dentistry (41%) programs offered IPV content in their curricula.

A survey of physicians and nurses in Ontario identified eight factors related to whether routine inquiry was conducted: preparedness, self-confidence, professional supports, the nature of the abuse inquiry, practitioner consequences of asking, comfort following disclosure, practitioner lack of control and practice pressures (Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007). There are factors that facilitate and those that impede clinicians' decisions to address IPV with female patients. Professional experience with disclosures was the key element influencing how clinicians addressed IPV.

Barriers to Screening for IPV

Physicians and nurses were asked (1) what they experienced as barriers to screening women for IPV and (2) what has helped or would help make screening easier for them (Beynon, Gutmanis, Tutty, Wathern & MacMillan, 2012). The majority of respondents were female nurses (81.1%). Both nurses (61.5%) and physicians (58.0%) reported that they had not received formal IPV training and had received few disclosures (less than 20) in the past year. The top barriers were lack of time, behaviors attributed to women (e.g., returning to the abuser and defending him), lack of training, language and cultural practices (e.g., abuse as accepted in their culture and fearing that the police would not protect them), and partner presence. Both nurses and physicians described the need for training. IPV inquiry is emotionally charged and complex for both providers and patients.

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Partner violence is an exposure, not a symptom or a specific condition.

Screening for IPV in Different Settings with Different Populations

A randomized trial was conducted to determine whether IPV screening reduces violence or improves health outcomes for women (MacMillan, et al., 2009). As a part of this trial, several screening methods were compared to determine the optimal approach amongst different methods. Female patients in emergency departments, family practices and women's health clinics were compared on three approaches: a face-to-face interview with a health care provider (physician or nurse), a written self-completed questionnaire, and a computer-based self-completed questionnaire (MacMillan, et al., 2006). For the three methods, two screening instruments were compared: the Woman Abuse Screening Tool (WAST) (Brown, Lent, Schmidt & Gast, 2000) and the Partner Violence Screen (PVS) (Feldhaus, et al., 1997). The WAST has eight items that address the relationship and physical, sexual, and emotional abuse. The PVS has three items: one addresses physical abuse and the other two address feelings of safety. The 12-month prevalence of IPV ranged from 4.1% to 17.7% depending on the instrument used, screening method, health care setting and populations screened. Among the approaches tested, women preferred self-completed questionnaires over face-to-face inquiry. Based on the findings of this study, the measure and approach selected for use in the IPV screening randomized trial (MacMillan, et al., 2009) was the self-completed written form of the WAST. Screening in health care settings may over-identify IPV (high false positive rate) and care should be taken in how abuse is identified. In addition, screening alone may under-identify characteristics of women, partners, and relationships that could indicate abuse and other health concerns when conducted through clinical case finding (Wathen, et al., 2008).

Effectiveness of Screening for IPV

The Ontario randomized trial showed that the women in the screened group did not experience greater reduction in violence or benefit in health outcomes, compared with the control group (MacMillan, et al., 2009). There was no evidence to indicate that IPV screening improved outcomes for women. The lack of effectiveness of universal screening, as demonstrated in the Ontario trial, was replicated in a subsequent US-based trial (Klevens, et al., 2012). These two trials suggest that clinical case finding tailored to the individual woman's situation and presentation is indicated, rather than universal screening.

Conclusions

In reviewing the research on screening for IPV, Wathen and MacMillan (2012) concluded that two randomized trials of universal IPV screening showed no health or quality of life benefits and there is little evidence of benefit of services to which women could be referred following a positive screen in a health care setting. The following are their recommendations. Partner violence is an exposure, not a symptom or a specific condition. Therefore, abused women will have different needs for services, including ways to stay safe, and treatments for co-morbid mental health issues like depression and post-traumatic stress disorder that take into account exposures to IPV. Women are also likely to present at different stages in their readiness to address partner violence. Advice for clinicians includes the need for competency in case finding and diagnostic assessment in the context of specific physical and mental health concerns. Among the key concerns for practitioners are privacy, respect, co-occurrence of IPV with mental and physical health problems, and the roles of other practitioners and helping organizations for women exposed to IPV. Women should be assessed according to their presenting history including symptoms and risks. Research goals are also important for evaluation of other IPV primary prevention intervention programs and community-based services.

References

Beynon C, Gutmanis I, Tutty L, Wathern CN & MacMillan HL. (2012). Why physicians and nurses ask (or don't) about partner violence: a qualitative analysis. *BMC Public Health; 12:* 473. http://www.biomedcentral. Com/1471-2458/12/473.

Brown JB, Lent B, Schmidt G & Sas G. (2000). Application of the woman abuse screening tool (WAST) and WAST-Short in the family practice setting. *Journal of Family Practice; 49(10)*: 896–903.

Feldhaus KM, Koziol-McLain J, Amsbury HL, Norton IM, Lowenstein SR & Abbott JT. (1997). Accuracy of 3 brief screening questions for detecting partner violence in the Emergency Department. *Journal of the American Medical Association; 277*: 1357–1361.

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BUILDING BRIDGES TO RESEARCH

What is Screening?

By James E. McCarroll, PhD, MPH

In general, screening is conducted to reduce morbidity and mortality through early identification of a condition and early treatment.

Among the conceptual and statistical issues involved in screening are the purpose, population screened, setting, accuracy, and whether treatments exist and are effective. The term screening itself can be misused and misinterpreted. Screening for IPV highlights this complexity.

What is screening?

In general, screening is conducted to reduce morbidity and mortality through early identification of a condition and early treatment. According to the public health model, the two criteria for its effectiveness of a screening test are that (1) there must be an accurate test for the condition, one that includes accepted standards, and (2) evidence exists that screening can prevent adverse health outcomes (Cole, 2000). Additional requirements for screening tests are (1) that it is reasonably quick, (2) it is safe and acceptable to the person screened and to the person performing it and (3) the properties of the screening test (sensitivity, specificity, positive predictive value and others) are known and acceptable (Jekel, Katz, & Elmore, 2001).

Properties of screening tests.

Sensitivity and specificity are two important measures of how well the test performs. Sensitivity is the test's ability to detect a condition when it is present (screen positive); specificity is the test's ability to indicate that the person does not have the condition (screen negative). These two measures have important implications depending on how important it is to identify the condition. Both false negative and false positive results can have serious implications for the person screened and for the provider. For example, if the screen is for a very serious disease, sensitivity should be extremely high in order to avoid false negatives (i.e., those who screen negative when they actually have the condition). On the other hand, if specificity is low producing false positives, people can be incorrectly identified leading to worry, misdirected treatment and other unintended consequences. Two additional statistical measures of screening tests are the positive and negative predictive values. Respectively, these indicate the probability of having or not having the condition. In addition to psychometric properties, clinical judgment and screening skill in diagnostic assessment are required.

What is clinical case finding and how does it differ from screening?

Clinical case finding involves including questions about IPV exposure as part of history-taking based on the patient's clinical presentation, as compared to screening, which involves administering a standard set of questions to everyone, regardless of their presentation.

References

Cole TB. (2000). Is domestic violence screening helpful? *Journal of the American Medical Association, 284(5)*:551–553.

Jekel JF, Katz DL, & Elmore JG. (2001). *Epidemiology, Biostatistics, and Preventive Medicine,* 2d Edition. Philadelphia, PA: Saunders, pp. 261–273.

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Gutmanis I, Beynon C, Tutty L, Wather CN & MacMillan HL. (2007). Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health; 7(12)*: 1–11. doi:10.1186/1471-2458/7/12.

Klevens J, Kee R, Trick W, Garcia D, Angulo FR, Jones R, & Sadowski LS. (2012). Effect of screening for partner violence on women's quality of life. *Journal of the American Medical Association; 308(7)*: 681–689.

MacMillan HL & Wathen CN. (2003). Violence against women: integrating the evidence into clinical practice. *Canadian Medical Association Journal*; *169(6)*: 570–571.

MacMillan HL, Wathen CN, Jamieson E, Boyle M, McNutt L, Worster A, … McMaster Violence Against Women Research Group. (2006). Approaches to screening for intimate partner violence in health care settings. *Journal of the American Medical Association; 296*: 530–536.

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People need training in understanding how exposure to child maltreatment and IPV influences health. There needs to be more training of health care providers about the actual clinical response when someone hears about patient exposure. They also need to know the evidence about what works and what does not.

importance of gender. Issues of gender-based violence and equity are extremely important in understanding cross-country comparisons. WHO refers to the ecological framework of violence: looking at risk and protective factors at the individual, the family, the community and then societal level. It is very hard to get high quality evidence about this, but there is some indication that in those countries where women are not valued in the same way as men, those societies have higher rates of violence.

Dr. McCarroll: What do you do clinically with a patient who has been treated violently and she is from another country?

Dr. MacMillan: One has to be respectful of people's countries of origin, but at the same time make it clear that violence is not acceptable. It is important with patients from other countries to listen to their experiences and to then indicate to them that abusive experiences are not something that anybody should have to face. This is another example where sensitivity is so important. It is not about criticizing a person's upbringing or homeland or family members; it is about helping to protect them and to focus on how the experience is not acceptable.

Dr. McCarroll: What do you find as the best approach to preventing IPV and child maltreatment?

Dr. MacMillan: For child maltreatment, the best evidence, and I have to declare my conflict of interest here, is for the Nurse Family Partnership (NFP), a targeted program provided to socially disadvantaged first time moms to prevent abuse and neglect. There are other programs that are promising like the Triple P (Positive Parenting Program), Howard Dubowitz's SEEK, and Early Start, another home visitation program developed in New Zealand.

Dr. McCarroll: Your preference seems to be for a family-based program as opposed to an individual clinical intervention.

Dr. MacMillan: It really depends on the focus. It is not going to be just one type of approach; it will be multiple approaches that work. But, in developing a program, we need outcome measures. Proxy measures are not enough. What are we doing at the family level, at the community and societal level to reduce IPV and child abuse and neglect?

Dr. McCarroll: It sounds like you are saying that we need more thoughtful approaches before we take off on something in an area where we really do not know a lot about what is going on. What are you currently researching?

Dr. MacMillan: If we are going to be innovative in considering ways to reduce violence we also need to think of approaches that ideally reduce more than one type of violence. For example, the terms IPV and domestic violence are often used interchangeably. I prefer intimate partner violence because it is more specific. Some people use the term domestic violence to include child maltreatment as well. We need to understand how types of violence overlap.

With colleagues, such as David Olds from the University of Colorado, Jeff Coben from West Virginia University, Susan Jack who is also here at McMaster, and Nadine Wathen at Western University, we have developed a curriculum with training on IPV embedded in the NFP to reduce intimate partner violence. Results from an early study on home visitation by nurses showed that when there are high rates of IPV in the home the benefits in reducing child maltreatment wash out (Eckenrode, 2000). We are in the midst of a randomized controlled trial (RCT) comparing the existing NFP program to the augmented program. Our sample now is almost 500 women and we are following them through to the end of the NFP program, until the child is 24 months of age. All the respondents have completed their six month postpartum interviews so we have about another 12 months to go. We are not analyzing data now, but we hear that the nurses are identifying IPV and discussing it with clients much more often than they did previously.

We published a summary of the preliminary work leading up to the trial including the conceptualization of the intervention itself (Jack et al., 2012). We are very happy with this work because we feel that it underscores a process by which modifications to an intervention can be evaluated. Does that mean that I think that every time there is a modification to an intervention that an RCT is required? Absolutely not, but I think when one is making a major change to an intervention, and in the case of the NFP, we want to make sure that we are doing more good than harm.

Dr. McCarroll: What are you hopeful about?

Dr. MacMillan: I am hopeful about a number of things. I believe that violence is

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What are we doing at the family level, at the community and societal level to reduce IPV and child abuse and neglect?

now perceived as a public health problem and that makes me hopeful. I also think that we are moving toward the use of evidence-based approaches more often in evaluating effectiveness. If you think back even ten or twenty years ago, we had very few randomized trials and now we are seeing high quality research examining the effectiveness of interventions. But, I think we have to continue building research capacity in this area. It is not an area that attracts a lot of researchers and it takes time to bring people along. I am very optimistic now.

Dr. McCarroll: Thank you for your insights and for your work.

Dr. MacMillan: You are welcome.

Website References

World Health Organization Guidelines
Development Group on Responding to Intimate Partner Violence and Sexual assault (2013) http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf

Nurse Family Partnership
http://www.nursefamilypartnership.org/

Triple P
http://www.triplep.net/glo-en/home/

SEEK
http://umm.edu/programs/childrens/services/child-protection/seek-project

Early Start
http://homvee.acf.hhs.gov/document.aspx?rid=3&sid=38

References

Eckenrode J et al., (2000). Preventing child abuse and neglect with a program of nurse home visitation. *Journal of the American Medical Association; 284(11)*:1385–1391.

Jack SM, Ford-Gilboe M, Wathen CN, Davidov DM, McNaughton DB, Coben JH, Olds DK & MacMillan HL.(2012). Development of a nurse home visitation intervention for intimate partner violence. *BMC Health Services Research; 12*:50. http://www.biomedcentral.com/1472-6963/12/50.

Klevens J, Kee R, Trick W, Garcia D, Angulo FR, Jones R, & Sadowski LS, 2012. Effect of screening for partner violence on women's quality of life: a randomized controlled trial. *Journal of the American Medical Association; 308(7)*:681–689.

MacMillan HL, Wathen CN, Jamieson E, Boyle MH, Shannon HS, Ford-Gilboe M, … McMaster Violence Against Women Research Group. (2009). Screening for intimate partner violence in health care settings: a randomized trial. *Journal of the American Medical Association; 302 (5)*:493–501.

Wathen CN & MacMillan HL. (2012). Health care's response to women exposed to partner violence. *Journal of the American Medical Association; 308(7)*: 712–713.

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MacMillan HL, Wathen CN, Jamieson E, Boyle MH, Shannon HS, Ford-Gilboe M, … McMaster Violence Against Women Research Group. (2009). Screening for intimate partner violence in health care settings: a randomized trial. *Journal of the American Medical Association; 302 (5)*: 493–501.

Wathen CN, & Jamieson E, MacMillan HL & the McMaster Violence Against Women Research Group, 2008). Who is identified by screening for intimate partner violence? *Women's Health Issues; 18*: 423–432.

Wathen CN, MacMillan HL with the Canadian Task Force of Preventive Health Care. (2003). Prevention of violence against women: Recommendation statement from the Canadian Task Force on Preventive Health Care. *Canadian Medical Association Journal; 169(6)*: 582–584.

Wathen CN, & MacMillan HL. (2012). Health care's response to women exposed to partner violence. *Journal of the American Medical Association; 308(7)*: 712–713.

Wathen CN, Tanaka M, Catallo C, Lebner AC, Friedman MK, Hanson MD, MacMillan HL. (2009). Are clinicians being prepared to care for abused women: A survey of health professionals education in Ontario, Canada. *BMC Medical Education*; 9I34 doi10.1186/1472-6920-9-34.

Websites of Interest

The US Preventive Services Task Force makes recommendations about preventive services in primary medical care **http://www.uspreventiveservicestaskforce.org/.**

The Centers for Disease Control and Prevention (CDC) has a number of publications on IPV as well as other health-related conditions such as injury and diseases.

Resources for IPV Victims and Providers:
http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/resources.html

Risk and Protective Factors in IPV:
http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/riskprotectivefactors.html

Futures Without Violence is a US-based non-profit organization focused on ending domestic and sexual violence. It is involved in community based programs, developing educational material, and public policy work. There are many subjects covered by this website including the effects of IPV on health and about screening for IPV **http://www.futureswithoutviolence.org/.**

The WHO published guidelines on responding to IPV and sexual violence against women. This publication has clinical and policy guidelines and a discussion of the issues involved in developing the guidelines. It also provides examples of clinical conditions associated with intimate partner violence, care for survivors, and training of providers. **http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/.**