U.S. Preventive Services Task Force

Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Recommendation Statement

▶ See related Putting Prevention into Practice on page 577.

This summary is one in a series excerpted from the Recommendation Statements released by the U.S. Preventive Services Task Force (USPSTF). These statements address preventive health services for use in primary care clinical settings, including screening tests, counseling, and preventive medications.

The complete version of this statement, including supporting scientific evidence, evidence tables, grading system, members of the USPSTF at the time this recommendation was finalized, and references, is available on the USPSTF website at http://www.uspreventiveservicestaskforce.org.

A collection of USPSTF recommendation statements reprinted in *AFP* is available at http://www.aafp.org/afp/uspstf.

Summary of Recommendations and Evidence

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services *(Table 1)*. **B recommendation.** This recommendation applies to women who do not have signs or symptoms of abuse. See the Clinical Considerations section for more information on effective interventions.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect. **I statement.** See the Clinical Considerations section for suggestions for practice regarding the I statement.

Rationale

IMPORTANCE

IPV and abuse of elderly and vulnerable adults are common in the United States but often remain undetected. Nearly 31 percent of women and 26 percent of men report experiencing some form of IPV in their lifetime. Approximately 25 percent of women and 14 percent of men have experienced the most severe types of IPV in their lifetime.[1-3] These estimates likely underrepresent actual rates because of underreporting. In addition to the immediate effects of IPV, such as injury and death,[4,5] there are other health consequences, many with long-term effects, including sexually transmitted diseases,[6] pelvic inflammatory disease,[7] and unintended pregnancy.[8] Rates of chronic pain, neurologic disorders, gastrointestinal disorders, migraine headaches, and other disabilities are also increased.[9-11] IPV in women is also associated with preterm birth, low birth weight, and decreased gestational age.[12-14] Individuals experiencing IPV often develop chronic mental health conditions, such as depression, posttraumatic stress disorder, anxiety disorders, substance abuse, and suicidal behavior.[15-19] For adolescents and young adults, the effects of physical and sexual assault are associated with poor self-esteem, alcohol and drug abuse, eating disorders, obesity, risky sexual behaviors, teen pregnancy, depression, anxiety, suicidality, and other conditions.[20,21]

Little information is available on the prevalence of abuse among noninstitutionalized elderly or vulnerable adults, although reported rates range from 2 to 25 percent.[22,23]

DETECTION

For IPV, there is adequate evidence that available screening instruments can identify current and past abuse or increased risk of abuse. Several instruments used in more than one study were highly sensitive and specific.

The USPSTF found inadequate evidence on the accuracy of screening instruments for elderly or vulnerable adults.

BENEFITS OF DETECTION AND EARLY INTERVENTION

The USPSTF found adequate evidence that effective interventions can reduce violence, abuse, and physical or mental harms for women of reproductive age.

The USPSTF found inadequate evidence that screening or early detection reduces exposure to abuse or reduces physical or mental harms or mortality for elderly and vulnerable adults.

Table 1. Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Clinical Summary of the USPSTF Recommendation

Population	Asymptomatic women of childbearing age	Elderly or vulnerable adults
Recommendation	Screen women for intimate partner violence, and provide or refer women who screen positive to intervention services. Grade: B	No recommendation Grade: I statement
Risk assessment	Although all women are at potential risk of abuse, factors that elevate risk include young age, substance abuse, marital difficulties, and economic hardships.	
Interventions	Adequate evidence from randomized trials supports a variety of interventions for women of childbearing age that can be delivered or referred by primary care, including counseling, home visits, information cards, referrals to community services, and mentoring support. Depending on the type of intervention, these services may be provided by clinicians, nurses, social workers, nonclinician mentors, or community workers.	
Balance of benefits and harms	Screening and interventions for intimate partner violence in women of childbearing age are associated with moderate health improvements through the reduction of exposure to abuse, physical and mental harms, and mortality. The associated harms are deemed no greater than small. Therefore, the overall net benefit is moderate.	The USPSTF was not able to estimate the magnitude of net benefit for screening all elderly or vulnerable adults (i.e., adults who are physically or mentally dysfunctional) for abuse and neglect because there were no studies on the accuracy, effectiveness, or harms of screening in this population.
Relevant recommendations from the USPSTF	The USPSTF has made recommendations on screening for depression in adults, and screening and counseling to reduce alcohol misuse in adults. These recommendations are available at http://www.uspreventiveservices taskforce.org.	

NOTE: *For the full recommendation statement and supporting documents, go to http://www.uspreventiveservices taskforce.org/.*

USPSTF = U.S. Preventive Services Task Force.

HARMS OF DETECTION AND EARLY INTERVENTION

For IPV, the USPSTF found adequate evidence that the risk of harm to the individual from screening or interventions is no greater than small.

For elderly and vulnerable adults, the USPSTF found inadequate evidence on the harms of screening or interventions.

USPSTF ASSESSMENT

The USPSTF concludes with moderate certainty that screening women of childbearing age for IPV has a moderate net benefit.

The USPSTF concludes that the benefits and harms of screening elderly or vulnerable adults for abuse are uncertain and that the balance of benefits and harms cannot be determined.

Clinical Considerations

PATIENT POPULATION

These recommendations apply to asymptomatic women of reproductive age and elderly and vulnerable adults. Reproductive age is defined across studies as ranging from 14 to 46 years, with most research focusing on women 18 years or older. The term "intimate partner violence" describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.[24]

A vulnerable adult is a person 18 years or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired because of a mental, emotional, long-term physical, or developmental disability, or dysfunction or brain damage. Definitions vary by state, and sometimes include the receipt of personal care services from others. Types of abuse that apply to elderly and vulnerable adults include physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, financial or material exploitation, and self-neglect.

Child abuse and neglect are addressed in a separate recommendation.

ASSESSMENT OF RISK

Although all women are at potential risk of abuse, factors that elevate risk include young age, substance abuse, marital difficulties, and economic hardships.

SCREENING TESTS

Several screening instruments can be used to screen women for IPV. Those with the highest levels of sensitivity and specificity for identifying IPV are Hurt, Insult, Threaten, Scream (HITS); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire–Short Form (CTQ-SF); and Woman Abuse Screen Tool (WAST).

The HITS instrument includes four questions, can be used in a primary care setting, and is available in English and Spanish. It can be self- or clinician-administered. HARK is a self-administered four-item instrument. STaT is a three-item self-report instrument that was tested in an emergency department setting.

The USPSTF found no valid, reliable screening tools to identify abuse of elderly or vulnerable adults in the primary care setting.

SCREENING INTERVAL

The USPSTF found no evidence on appropriate intervals for screening.

INTERVENTIONS

Evidence from randomized trials supports a variety of interventions for women of childbearing age, including counseling, home visits, information cards, referrals to community services, and mentoring support. Depending on the type of intervention, these services may be provided by clinicians, nurses, social workers, nonclinician mentors, or community workers. Counseling generally includes information on safety behaviors and community resources. In addition to counseling, home visits may include emotional support, education on problem-solving strategies, and parenting support. One study used a 20-minute nurse case management protocol focusing on a safety plan, supportive care, and guided referrals. No intervention studies were identified for elderly or vulnerable adults. See the discussion section at http://www.uspreventiveservicestaskforce.org for suggestions for practice in this population.

SUGGESTIONS FOR PRACTICE REGARDING THE I STATEMENT FOR ELDERLY OR VULNERABLE ADULTS

Potential Benefits. The estimated prevalence of elder abuse ranges from 2 to 10 percent according to a variety of definitions, methods, and sampling strategies.[22] One study indicated that one in 10 elderly adults may experience abuse, but only one in five or fewer cases are actually reported.[23]

Potential Harms. Although there is no direct evidence, the existing evidence regarding the lack of harms resulting from IPV screening suggests that the harms of screening elderly and vulnerable adults might also be small. Some potential harms of screening include shame, guilt, self-blame, fear of retaliation or abandonment by perpetrators, and the repercussions of false-positive results.

Costs. There is no evidence on the costs of screening for or interventions to reduce elder abuse.

Current Practice. Screening practices for elder abuse are limited for many reasons. Currently, there are no standards about how clinicians should ask elderly patients about possible abuse. In addition, there are varying definitions of abuse, a wide variety of mechanisms of elder abuse, no universal screening tools, wide-ranging risk factors, unclear guidance about whom to screen and what to do if abuse is identified, physician discomfort with

screening, and time constraints. Screening is not done routinely and varies by locality. However, all clinicians should be aware of the laws in their states for reporting suspected abuse. Not all states mandate reporting, and some provide clear guidance about what type of injuries should arouse suspicion.

USEFUL RESOURCES

The USPSTF has several recommendations that may be relevant, including screening for depression[25] and alcohol misuse (update in progress).[26]

Other useful resources include websites that contain materials useful to primary care clinicians. Clinicians often need guidance on how to address concerns about IPV with sensitivity and clarity, and how to screen for IPV and provide follow-up care. IPV introduces significant safety issues that compel a clinician to be fully informed on such aspects as sensitivity. Clinicians also need easy access to available tools, specific guidelines, and other related materials to help them develop a clinical environment dedicated to the safety of their patients. Guidance is also available on how clinicians can work with local community-based domestic violence programs to receive training, information, and other resources to ensure effective management of patients who are victims of IPV.

Clinicians should also be aware of their state and local reporting requirements. The laws vary from one jurisdiction to another, with differences in definitions, whom and what should be reported, who should report, and to whom. Although reporting suspected elder and child abuse is mandated in all 50 states and the District of Columbia, this is not the case with IPV. In addition, clinicians need to be familiar with requirements in the privacy regulations of the federal Health Insurance Portability and Accountability Act, which require that patients be advised on health information use and disclosure practices. Again, state laws regarding privacy issues or concerns vary.

The Centers for Disease Control and Prevention has resources available for those needing additional information at http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/resources.html.

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The "Other Considerations," "Discussion," "Update of Previous Recommendation," and "Recommendations of Others" sections of this recommendation statement are available at http://www.uspreventiveservicestaskforce.org/uspstf/uspsipv.htm.

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