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Screening for Intimate Partner Violence and for Caregiver Abuse of Older or Vulnerable Adults

An Evidence Report and Systematic Review for the US Preventive Services Task Force

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IMPORTANCE Intimate partner violence (IPV) and caregiver abuse of older or vulnerable adults are common and cause significant morbidity.

OBJECTIVE To review the evidence on screening and interventions for IPV and caregiver abuse among adults.

DATA SOURCES PubMed, Cochrane Library, and EMBASE through December 14, 2023; ongoing literature surveillance through March 21, 2025.

STUDY SELECTION Screening test accuracy studies, randomized clinical trials (RCTs) of screening or interventions for abuse, cohort studies reporting harms.

DATA EXTRACTION AND SYNTHESIS Dual review of abstracts, full-text articles, study quality, and data extraction; narrative synthesis of results.

MAIN OUTCOMES AND MEASURES Test accuracy; abuse exposure and associated morbidity, quality of life, and harms.

RESULTS Thirty-five studies were included (N = 18 358). Three RCTs (n = 3759) comparing IPV screening with no screening found no significant reduction in IPV or benefit for other outcomes over 3 to 18 months and 2 (n = 935) reported no harms of screening. Nine studies (n = 9800) assessed 9 tools to detect any type of past-year IPV exposure among women; sensitivity ranged from 26% to 87% and specificity ranged from 80% to 97%. Thirteen RCTs (n = 7425) evaluated heterogeneous interventions among women with screen-detected IPV. Of these, 1 RCT (n = 239) assessing the benefit of multiple perinatal home visits found a significant reduction in IPV (standardized mean difference, −0.34 [95% CI, −0.59 to −0.08]) and 1 RCT (n = 336) assessing behavioral counseling for multiple risks (IPV, smoking, depression, tobacco exposure) found significantly fewer recurrent episodes of IPV (standardized mean difference, −0.40 [95% CI, −0.68 to −0.12]). RCTs assessing brief counseling or advocacy interventions specific to IPV found no difference between groups in rates of overall IPV. Results for other outcomes were mixed. No studies evaluated screening or interventions for caregiver abuse among older or vulnerable adults. Two studies assessed the accuracy of different screening tools to detect caregiver abuse among older adults and found mixed results.

CONCLUSIONS AND RELEVANCE Although available screening tools may reasonably identify women with past-year IPV, RCTs of IPV screening did not show reduced IPV or improvement in other outcomes. Limited evidence suggested that home visiting and behavioral counseling interventions addressing multiple risk factors may lead to reduced IPV among pregnant or postpartum women. No studies assessed screening among vulnerable adults or treatment for caregiver abuse among older or vulnerable adults.

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Editorial

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Intimate partner violence (IPV) and caregiver abuse of older and vulnerable adults can cause acute and long-term adverse health and social outcomes. IPV refers to physical violence, sexual violence, psychological aggression (including coercive tactics), and stalking by a person with whom one has a close personal relationship, such as a current or former partner or spouse.[1] Approximately 47% of US women and 44% of men experienced some form of IPV in their lifetime and 7% of women and men experienced some form of IPV in the past year.[2] Women experience higher rates of contact sexual violence than men.[2] Pregnant populations, in particular, experience a high burden of disease related to IPV.[3]

Caregiver abuse of older adults (or elder abuse) refers to an intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes a serious risk of harm.[4] An estimated 11% of US adults 60 years or older experienced at least 1 form of abuse in the past year.[5] Caregiver abuse is defined similarly for vulnerable adults, including those 18 years or older who are dependent on others for their care because of a physical or mental disability.[6] Unlike IPV or abuse of older adults, there is no consistent definition used for vulnerable adults in ongoing surveillance or research. Vulnerable adults experience a higher prevalence of abuse compared with adults without disabilities, regardless of age.[7,8]

People who experience IPV may not disclose abuse unless directly questioned, due to fear, stigma, and other factors. Specific groups, including Asian, Black, and minority ethnic and immigrant women, may experience barriers to seeking help for abuse due to institutional racism, cultural norms, and factors associated with immigration (eg, language barriers, unfamiliarity with laws).[9] Routine screening could identify undetected or undisclosed abuse and lead to earlier interventions that may reduce future abuse and associated morbidity. In 2018, the US Preventive Services Task Force (USPSTF) recommended that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services but concluded that the evidence was insufficient for older or vulnerable adults.[10] The purpose of the current systematic review was to update the previous evidence review on the benefits and harms of screening for IPV and abuse of older and vulnerable adults to inform the USPSTF in updating its recommendation.

Methods

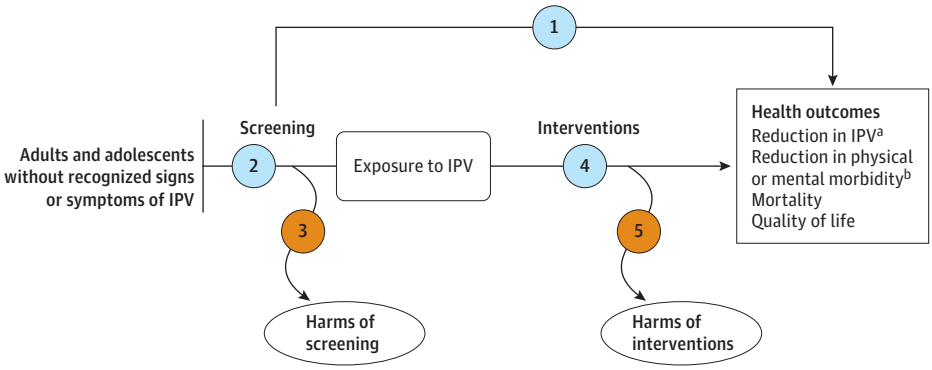
Scope of the Review

Figure 1 shows the analytic framework and key questions (KQs) for IPV that guided the review. The eFigure in the Supplement shows a similar framework for caregiver abuse of older and vulnerable adults. Methodological details including study selection, electronic search strategies, a list of excluded studies, detailed study-level results for all outcomes and for specific subpopulations, and contextual observations are available in the full evidence review.[12]

Data Sources and Searches

PubMed/MEDLINE, EMBASE, and the Cochrane Library were searched for articles published from 2017 through December 14, 2023. Studies

Figure 1. Analytic Framework: Screening for Intimate Partner Violence



Key questions

1. Does screening for current or past intimate partner violence (IPV) in adolescents and adults reduce exposure to IPV, physical or mental morbidity, or mortality?
2. What is the accuracy of screening questionnaires or tools for identifying adolescents and adults with current or past IPV?
3. What are the harms of screening for IPV in adolescents and adults?
4. How well do interventions reduce exposure to IPV, physical or mental morbidity, or mortality among screen-detected adolescents and adults with current or past IPV?
5. What are the harms of interventions for IPV in adolescents and adults?

Evidence reviews for the US Preventive Services Task Force (USPSTF) use an analytic framework to visually display the key questions that the review will address to allow the USPSTF to evaluate the effectiveness and safety of a preventive service. The questions are depicted by linkages that relate interventions and outcomes. For additional information, see the USPSTF Procedure Manual.[11]

[a]Includes reduction in the frequency or severity of intimate partner violence (IPV).

[b]Includes acute and chronic morbidity from physical abuse (eg, fractures, dislocations, brain injury), sexual abuse (eg, unwanted pregnancy, sexually transmitted infections), psychological abuse (eg, depression, anxiety, posttraumatic stress disorder), and financial abuse (eg, limiting access to money or other resources); health care utilization attributed to any form of abuse/neglect and associated physical and mental morbidity (eg, rates of emergency room visits); adverse perinatal outcomes (eg, miscarriage, low birth weight); social isolation; and quality of life.

published before 2017 were identified from previous systematic reviews for the USPSTF.[13] Targeted searches for unpublished literature were conducted via the Cochrane Library. Since December 2023, ongoing surveillance was conducted through article alerts and targeted searches of journals to identify major studies published in the interim that may affect the conclusions or understanding of the evidence and the related USPSTF recommendation. The last surveillance was conducted on March 21, 2025.

Study Selection

Two investigators independently reviewed titles, abstracts, and full-text articles using prespecified eligibility criteria (eTables 1-2 in the Supplement). For all KQs, English-language studies enrolling populations recruited from primary care and emergency departments, conducted in countries categorized as "very high" on the Human Development Index,[14] were eligible.

Randomized clinical trials (RCTs) comparing screening with no screening were eligible for KQ1 (direct evidence of screening benefit) and KQ3 (harms of screening). For KQ1, eligible outcomes included exposure to IPV or caregiver abuse, morbidity attributed to abuse, and quality of life (eTables 1-2 in the Supplement). For KQ2 (screening test accuracy), eligible studies assessed the accuracy of screening tools designed to detect exposure to IPV or caregiver abuse compared with an acceptable reference standard. Only tools feasible for use in US primary care settings (ie, brief, easy to interpret) and appropriate for use when abuse is not suspected were eligible. For KQ4 (benefits of interventions) and KQ5 (harms of interventions), eligible studies had to assess an intervention that could be offered in or referred to from primary care (eg, counseling, case management, and referral to community services) compared with an inactive control group (no treatment, usual care, attention control, or wait-list control). For studies assessing the harms of screening (KQ3) or interventions (KQ5), such as labeling, stigma, or increased abuse and retaliation associated with the intervention, cohort studies with a concurrent control group were also eligible.

Data Extraction and Quality Assessment

For each included study, 1 investigator extracted information about the methods, populations, interventions, comparators, outcomes, timing, settings, and study designs. A second investigator reviewed data extractions for completeness and accuracy.

Two reviewers independently assessed the quality of each study as good, fair, or poor using predefined criteria developed by the USPSTF and informed by tools designed for specific study types. Details are available in the full report,[12] including individual study quality ratings. Disagreements were resolved with discussion or with an independent assessment from a third senior investigator.

Data Synthesis and Analysis

Findings for each KQ were summarized in tables, figures, and narrative format. For KQ4 (benefits of IPV interventions), standardized mean differences were calculated for commonly reported outcomes where applicable. Statistical significance was assumed when 95% CIs did not cross the null. All testing was 2-sided. Meta-analyses of screening or treatment studies was not conducted because there were too few trials that were similar in terms of populations, intervention types, screening tests, time frame of exposure, reference standards, and outcomes.

The overall strength of the evidence for each KQ was assessed as high, moderate, low, or insufficient based on the quality of the studies, consistency of results, precision of findings, risk of reporting bias, and limitations of the body of evidence using methods developed for the USPSTF (and the Evidence-based Practice Center program).[11,15] The applicability of the findings to US primary care populations and settings was assessed.

Results

Thirty-five studies (published in 40 articles) were included in this update (**Figure 2**). A list of full-text articles that were reviewed but excluded is in Appendix C of the full report.[12]

Intimate Partner Violence Results by Key Question

Benefits of Screening

Key Question 1. Does screening for current, past, or increased risk for intimate partner violence (IPV) in adults and adolescents reduce exposure to IPV, physical or mental morbidity, or mortality?

Three RCTs (n = 3759) directly compared universal IPV screening in a health care setting with no screening (**Table 1**)[16,18,19]; all were included in the 2018 review on this topic. One enrolled participants from 10 US primary care clinics,[16] 1 enrolled participants from a single New Zealand emergency department,[18] and 1 enrolled participants from a variety of Canadian clinical settings (12 primary care sites, 11 emergency departments, and 3 obstetrics and gynecology clinics).[19] Additional characteristics are summarized in Table 1. In the study set in various Canadian clinical settings, a research assistant conducted screening before a scheduled visit, then placed the completed screening questionnaire in the chart for the clinician if the screen result was positive; discussion of the positive findings, referrals, or treatment was left to the discretion of the treating clinician.[19] In the RCT set in US primary care settings, participants who screened positive were immediately shown a video providing support and information about a hospital-based IPV advocacy program and were encouraged to seek help and were provided a printout with local resources.[16] In the RCT set in an emergency department, women who screened positive (via face-to-face screening delivered by research assistants) were given information about referral options and an additional clinical assessment was conducted to assess safety.[18] No study found a statistically significant reduction in IPV among the screened group compared with a nonscreened control group (**Figure 3**) or difference between groups in mental health or health care utilization outcomes.

Accuracy of Screening for IPV

Key Question 2. What is the accuracy of screening questionnaires or tools for identifying adolescents and adults with current or past IPV?

Seventeen studies (n = 6119) assessed the accuracy of 14 different IPV screening tools (**Table 2**).[20-36] Most (15 studies) were included in the 2018 review of this topic, and 2 studies new to this update were both limited to pregnant populations.[24,35] Recruitment settings varied and included emergency departments,[22,23,29,30] primary care practices,[20,21,32,36] urgent care,[31] antenatal clinics,[24,35] and telephone or mail survey.[25-27] Most (15 studies) assessed the accuracy of tools designed to detect current or past-year IPV, and 1 study

Figure 2. Literature Search Flow Diagram: Screening for Intimate Partner Violence

KQ indicates key question; USPSTF, US Preventive Services Task Force.

[a]Some articles are included for more than 1 KQ.

Table 1. Intimate Partner Violence Key Question 1: Characteristics of Included Randomized Clinical Trials

Source, quality rating	Screening intervention	Comparison(s)	Recruitment setting, country	Study population, No. of participants	Race and ethnicity, %	Age, mean (SD), y	% With past-year IPV
Klevens et al,[16] 2012 Klevens et al,[17] 2015 Good	Computerized screening (3-item Partner Violence Screen); women with a positive response to ≥1 questions were shown a brief video providing support, information about a hospital-based IPV advocacy program, encouraged to seek help, and given a printout with resources (eg, local partner violence advocacy programs, 24-hour hotlines, women's shelters)	IPV resource list (no screening; all women received an IPV resource list) Control group: No screening; no-partner violence list control group	10 Primary health care clinics US	Women aged ≥18 y seeking clinical services who could be separated from a partner, or child aged >3 y n = 2708	Latina: 37 Non-Latina African American: 55 White non-Latina: 6 Other: 3	39 (15) Range NR	15[a]
Koziol-McLain et al,[18] 2010 Fair	In-person screening (3-item Intimate Partner Violence screen conducted by a research assistant); if ≥1 positive responses, women received a brief statement about the unacceptability of violence, were asked additional questions about safety, and received information about referral options Women with a positive response to safety questions[b] had additional services while in the ED	Usual care (no formal ED IPV screening policy)	1 ED New Zealand	Women aged ≥16 y presenting to the ED for care; 19% of included sample were presenting for an acute injury n = 344	Māori: 38 New Zealand European: 61 Non-Māori, non-New Zealand European: 2	Median, 40 (IQR, 27-59) Range, 16-94	18[c] (lifetime prevalence, 51%)
MacMillan et al,[19] 2009 Fair	In-person screening (8-item Woman Abuse Screening Tool) before clinic visit, clinician notification of women who screened positive;[d] all women were given a card that listed contact information of local agencies and hotlines for women exposed to violence	No screening before health care visit (screening completed after the clinic visit); at enrollment, women received the same resource card as the screening group	12 Primary care sites; 11 EDs; and 3 OBGYN clinics Canada	Women aged 18-64 y who had a male partner within the last 12 mo and could be separated from those accompanying them n = 707	NR	34 (NR) Range, 18-64	12

Abbreviations: ED, emergency department; IPV, intimate partner violence; IQR, interquartile ratio; NR, not reported; OBGYN, obstetrics and gynecology.

[a] Prevalence refers to the year before enrollment and based on recall at 12 months after enrollment. Measured using 18 questions from the National Violence Against Women Survey.

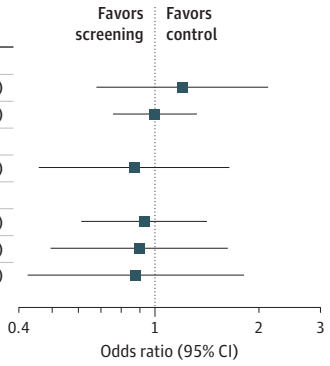
[b] Women who screened positive were asked questions about personal danger or children/elderly in the home who are in danger. If questions indicated a safety concern, the ED clinician was notified and a referral was made to the hospital social worker or community specialist.

[c] Estimate based on a questionnaire described by authors as a compilation of the Partner Violence Screen and Abuse Assessment Screen that asks about current (past-year) abuse. Considered positive if 1 of 3 questions was answered positively.

[d] The completed screening questionnaire was placed in the chart. Any discussion of the positive finding was left to the discretion of the treating clinician.

Figure 3. Benefit of Intimate Partner Violence Screening Interventions for Reducing Intimate Partner Violence Exposure (Key Question 1)

Source	No. of participants	Comparison	Follow-up, mo	Odds ratio (95% CI)
Klevens et al,[16] 2012 (primary care)				
NVAW ≥1	1807	Usual care	12	1.20 (0.68-2.13)
NVAW ≥1	1802	Resource list	12	1.00 (0.76-1.32)
Koziol-McLain,[18] 2010 (ED)				
CAS ≥7	344	Usual care	3	0.87 (0.46-1.64)
MacMillan,[19] 2009 (mixed)				
CAS ≥7	707	Resource list	6	0.93 (0.61-1.41)
CAS ≥7	707	Resource list	12	0.90 (0.50-1.62)
CAS ≥7	707	Resource list	18	0.88 (0.43-1.81)



CAS indicates Composite Abuse Scale; ED, emergency department; NVAW, National Violence Against Women survey.

each assessed a tool designed to detect lifetime exposure to IPV[30] and accuracy for predicting future IPV (3-5 months).[27] Reference standards varied across studies, with the majority using self-report diagnostic questionnaires and only 1 study using a semistructured interview.[30] All but 5 studies[24,28,32,33,35] were conducted in the US. Prevalence of current or past-year IPV ranged from 10% to 29%.

Accuracy of Detecting Past-Year or Current IPV

Nine studies reported on the accuracy of 9 different screeners for detecting past-year IPV (Abuse Assessment Screen [AAS], ACTS [Afraid/Controlled/Threatened/Slapped or Physically Hurt], HARK [Humiliate, Afraid, Rape, Kick], HITS [Hurt, Insult, Threaten, Scream], Electronic HITS [E-HITS], Partner Violence Screem [PVS], Parent Screening Questionnaire, Woman Abuse Screening Tool [WAST], and WAST-Short), with most enrolling only women (or a majority of women).[21,23-26,29,32,33,35] Across all screeners, sensitivity varied widely, with estimates ranging from 26% to 87%; specificity estimates ranged between 80% and 96% (**Figure 4**). The 2 studies limited to pregnant populations found relatively low sensitivity for the ACTS (66%),[24] WAST-Short (26%), and AAS (51%).[24,35] One study enrolling men only (n = 53) from an emergency department found low sensitivities for the PVS and HITS for detecting psychological abuse (35% and 30%, respectively) and physical abuse (46% for both tools).[29]

Six studies reported on the accuracy of a tool in identifying ongoing or current relationship violence.[20,22,31,34-36] Accuracy varied widely with sensitivity ranging from 46% to 94%, and specificity ranged from 38% to 95%. One of the newly included studies that focused on pregnant women evaluated both the WAST-Short and the AAS to assess IPV at the first-trimester visit.[35] Using a threshold score of 2 on the WAST-Short, sensitivity was 37% and specificity was 96%. The AAS had a very low sensitivity (12%) but high specificity (100%) based on a threshold score for a positive screen of 1.

Harms of Screening

Key Question 3. What are the harms of screening for IPV in adults and adolescents?

Two RCTs (n = 935) reported on harms of screening for IPV; both were included in KQ1 (eTable 3 in the Supplement).[18,19] In 1 RCT enrolling women from various Canadian health care settings, authors used the Consequences of Screening Tool to measure the effect of being asked IPV screening questions within 14 days of screening (regardless of screening test results); results indicated that being asked IPV screening questions was not harmful.[19] The other RCT reported that no adverse events were reported by participants, clinicians, or research staff; however, it is not clear whether adverse events were prespecified or how they were monitored.[18]

Benefits of Interventions

Key Question 4. How well do interventions reduce exposure to IPV, physical or mental morbidity, or mortality among screen-detected adolescents and adults with current or past IPV?

Thirteen RCTs (17 articles; n = 7425) evaluated an intervention for populations with screen-detected IPV or considered at risk for IPV (**Table 3**), 7 (n = 2644) enrolled populations who were pregnant or had recently given birth,[37,38,41-45] and 6 (7 articles; n = 5712) evaluated interventions for nonpregnant populations.[46-52] Most (11 RCTs) were included in the prior review on this topic, and 2 were new to this update.[41,42] All but 4 RCTs were conducted in the US, including 1 each in Australia[46] and Norway[41] and 2 in Hong Kong.[44,52] Diverse categories and terms were used to describe the race and ethnicity of enrolled participants (Table 3). Among the 9 studies set in the US, 1 was limited to African American women[38] and another enrolled mostly Black women (80%).[50] Two RCTs enrolled mostly White participants (80% and 87%),[49,51] and others enrolled a more diverse population. Included studies assessed heterogeneous interventions (eTable 4 in the Supplement). Studies enrolling pregnant or postpartum participants tended to include components relevant to pregnancy or parenting not specific to IPV, such as education about child development, counseling about other factors associated with adverse perinatal outcomes (eg, substance abuse, postpartum depression), or home visits providing routine perinatal support. Studies enrolling populations for whom perinatal status was not an inclusion criterion assessed brief counseling interventions that varied in delivery format, content, and intensity.

Benefit of Interventions Among Pregnant and Postpartum Populations

Two RCTs (n = 882) assessed the benefit of multiple perinatal home visits that incorporated IPV assessment and advocacy components with other support services (eg, parenting support, referral to community services); 1 found a statistically significant reduction

Table 2. Intimate Partner Violence Key Question 2: Characteristics of Included Studies

Source, quality rating	Screener(s)	Timing of IPV exposure	Study population, No. of participants	Recruitment setting, country	Race and ethnicity, %	Age, mean (SD), y	Female, %	Pregnant, %
Chen et al,[20] 2005 Fair	HITS	Current	Women aged ≥18 y, predominantly Hispanic, currently involved with a partner n = 113	Family practice clinics US	Hispanic: 50 Non-Hispanic Black: 12 Non-Hispanic White: 36 Non-Hispanic Other: 2	36 (NR) Range NR	100	9
Dubowitz et al,[21] 2008 Fair	PSQ	Past year	English-speaking adult caregivers with a child younger than 6 y seen for a well-child visit n = 200	Pediatric primary care clinic US	Black: 92 White: 3 Mixed: 5	Median, 24 Range NR	94 (mothers)	NR
Ernst et al,[22] 2004 Fair	OVAT	Current	English-speaking patients at the ED n = 306	ED US	African American: 16 Asian or other race: 15 Caucasian: 49 Hispanic: 20	34 (10) Range NR	70	NR
Feldhaus et al,[23] 1997 Fair	PVS	Past year	English-speaking women aged ≥18 y at ED who were noncritical ISA, n = 255 CTS, n = 230	ED US	Black: 19 Hispanic: 30 White: 45 Other: 6	36 (16) Range NR	100	NR
Hegarty et al,[24] 2021 Fair	ACTS	Past year	Women aged ≥16 y not accompanied by another person n = 1067	Antenatal clinic Australia	Aboriginal or Torres Strait Islander: 1 Born outside Australia: 45	33.2 (4.5) Range,18 to 48	100	100
Iverson et al,[25] 2013 Fair	HITS	Past year	Female veterans aged ≥18 y who were found through VHA database and who reported an intimate relationship in past year n = 160	Mailed survey US	Non-White: 20 White: 80	48 (NR) Range, NR	100	NR
Iverson et al,[26] 2015 Fair	HITS E-HITS	Past year	Female veterans aged ≥18 y who were found through VHA database and who reported an intimate relationship within the past year n = 80	Mailed survey US	Non-White: 14 White: 86	49 (NR) Range NR	100	NR
Koziol-McLain et al,[27] 2001 Fair	BRFSS (violence screen)	Prediction of future (3-5 mo) partner abuse	English-speaking women aged ≥18 y n = 409	Telephone survey US	American Indian/ Alaskan Native: 1 Asian/Pacific Islander: 2 Black: 4 Hispanic/ Spanish origin: 12 White: 91 Other: 3	46 (16) Range, 18 to 93	100	NR
MacMillan et al,[28] 2006 Fair	PVS WAST	Past year	English-speaking (and reading) women aged 18-64 y presenting for their own health care visit who were not too ill to participate n = Unclear; 2339 completed the gold-standard CAS	2 Family practices, 2 EDs, and 2 women's health clinics Canada	NR	37 (12) Range NR	100	NR

(continued)

Table 2. Intimate Partner Violence Key Question 2: Characteristics of Included Studies (continued)

Source, quality rating	Screener(s)	Timing of IPV exposure	Study population, No. of participants	Recruitment setting, country	Race and ethnicity, %	Age, mean (SD), y	Female, %	Pregnant, %
Mills et al,[29] 2006 Fair	HITS PVS	Past year	Men aged ≥18 y in the ED who were triaged to the medical or trauma sections n = 53	ED US	African American: 75 White: 22 Other: 4	40 (11) Range, 20-62	0	NA
Paranjape et al,[30] 2003 Fair	STaT	Lifetime	English-speaking women aged 18-64 y in the nonacute section of ED n = 75	ED US	African American: 40 Black Caribbean: 11 Caucasian: 34 Other: 15	36 (10) Range NR	100	NR
Paranjape et al,[31] 2006 Fair	STaT	Current or most recent relationship	English-speaking women aged 18-65 y n = 240	Urgent care US	African American: 91[a] Other: 9	38 (10) Range NR	100	NR
Sohal et al,[32] 2007 Fair	HARK	Past year	Women aged ≥17 y who had been in an intimate relationship in the last year n = 232	General practice waiting rooms UK	Black British, African, or Caribbean: 25 Indian, Pakistani, or Bangladeshi: 18 White British: 40	35 (NR) Range, 18-70	100	NR
Wathen et al,[33] 2008 Fair	WAST	Past year	English-speaking (and reading) women aged 18-64 y with a male partner in the last year n = 5604	Primary, acute, and specialty care centers Canada	NR	Overall: NR Range NR Screen group: 39 (NR) Range NR	100	Overall: NR Screen group: 8
Weiss et al,[34] 2003 Fair	OAS AAS	Current	ED patients with a current partner who were not too ill to participate (due to trauma, drug overdose, alcohol intoxication, or other condition) n = 856	ED US	African American: 22 Hispanic: 18 White: 51	36 (NR) Range NR	62	NR
Zapata-Calvente et al,[35] 2022 Fair	WAST-Short AAS	Before pregnancy During pregnancy	Women attending first- and third-trimester visits n = 592	Public primary care antenatal clinic Spain	Nationality: Spanish: 88 Other: 9 Missing: 9 Race and ethnicity NR	31.82 (5.61) Range NR	100	100
Zink et al,[36] 2007 Fair	Unnamed[b]	Current	English-speaking mothers in a relationship with a steady partner for ≥1 y and ≥1 child aged 3-12 y n = 393	Pediatric and family medicine clinics US	African American/ other: 51 White: 49	Median, 31 Range, 18-58	100	NR

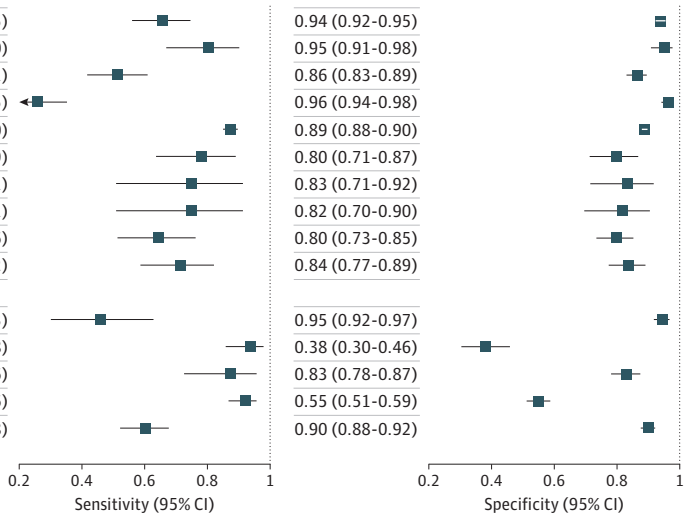
Abbreviations: AAS, Abuse Assessment Screen; ACTS, Afraid/Controlled/Threatened/Slapped or Physically Hurt; BRFSS, Behavioral Risk Factor Surveillance System; CAS, Composite Abuse Scale; CTS, Conflict Tactics Scale; ED, emergency department; HARK, Humiliation, Afraid, Rape, Kick; HITS, Hurt, Insult, Threaten, Scream; E-HITS, Extended HITS; IPV, intimate partner violence; ISA, Index of Spouse Abuse; NR, not reported; OAS, Ongoing Abuse Screen; OVAT, Ongoing Violence Assessment Tool; PSQ, Parent Screening Questionnaire; PVS, Partner Violence Screen; STaT, Slapped, Things, Threaten; VHA, Veterans Health Administration; WAST, Woman Abuse Screening Tool.

[a] Only African American reported.

[b] Five-item unnamed screener was designed to assess relationship quality and safety using nongraphic language.

Figure 4. Accuracy of Screening Tools for Detecting Past-Year, Current, or Future Intimate Partner Violence Exposure (Key Question 2)

Source	Setting	Tool	Sensitivity (95% CI)	Specificity (95% CI)
Past year				
Hegarty et al,[24] 2021	PC	ACTS	0.66 (0.56-0.75)	0.94 (0.92-0.95)
Sohal et al,[32] 2007	PC	HARK	0.80 (0.67-0.90)	0.95 (0.91-0.98)
Zapata-Calvente et al,[35] 2022	Prenatal	AAS	0.51 (0.42-0.61)	0.86 (0.83-0.89)
		WAST-S	0.26 (0.18-0.35)	0.96 (0.94-0.98)
Wathen et al,[33] 2008	Mixed	WAST	0.87 (0.85-0.90)	0.89 (0.88-0.90)
Iverson et al,[25] 2013	VA	HITS	0.78 (0.64-0.89)	0.80 (0.71-0.87)
Iverson et al,[26] 2015	VA	HITS	0.75 (0.51-0.91)	0.83 (0.71-0.92)
		E-HITS	0.75 (0.51-0.91)	0.82 (0.70-0.90)
Feldhaus et al,[23] 1997	ED	PVS	0.65 (0.51-0.76)	0.80 (0.73-0.85)
		PVS	0.71 (0.59-0.82)	0.84 (0.77-0.89)
Current				
Zink et al,[36] 2007	PC	Not named	0.46 (0.30-0.63)	0.95 (0.92-0.97)
Paranjape et al,[31] 2006	Urgent care	STa T	0.94 (0.86-0.98)	0.38 (0.30-0.46)
Ernst et al,[22] 2004	ED	OVAT	0.87 (0.73-0.96)	0.83 (0.78-0.87)
Weiss et al,[34] 2003	ED	AAS	0.92 (0.87-0.96)	0.55 (0.51-0.59)
		OAS	0.60 (0.52-0.68)	0.90 (0.88-0.92)



ACTS indicates Afraid/Controlled/Threatened/Slapped or Physically Hurt; AAS, Abuse Assessment Screen; ED, emergency department; E-HITS, electronic HITS; HARK, Humiliation, Afraid, Rape, Kick; HITS, Hurt, Insult, Threaten, Scream; OAS, Ongoing Abuse Screen; OVAT, Ongoing Violence Assessment Tool; PC, primary care; PVS, Partner Violence Screen; STaT, Slapped, Things, Threatened; VA, Veterans Affairs; WAST, Woman Abuse Screening Tool; WAST-S, Woman Abuse Screening Tool—Short.

in IPV at 2 years (standardized mean difference, −0.34 [95% CI, −0.59 to −0.08]),[43] and the other found a lower rate of IPV at 3 years associated with the intervention, but the difference was not statistically significant (**Figure 5**).[37] Four RCTs evaluated brief clinic-based counseling; 3 of these assessed a counseling intervention specific to IPV and 2 found no difference between groups for overall rates of IPV,[41,45] while 1 found mixed results for subtypes of IPV (Figure 4).[44] The remaining RCT assessed a clinic-based behavioral counseling intervention for women with 1 or more risk factors for adverse perinatal outcomes (IPV, depression, smoking, environmental tobacco exposure). In the subgroup who screened positive for IPV at baseline (n = 306), those receiving the intervention had fewer recurrent episodes of IPV during pregnancy and postpartum (odds ratio, 0.48 [95% CI, 0.29-0.80]) and fewer very preterm neonates (≤33 weeks) (2 vs 9 women; *P* = .03) than the control group, but no statistically significant difference was found in rates of low–birth weight neonates (<2500 g), very low–birth weight neonates (<1500 g), or preterm birth (<37 weeks) (Figure 4).[38-40] Last, 1 RCT enrolling new parents (n = 368 couples) with a history of verbal abuse found no statistically significant difference between groups randomized to a skills-based relationship education intervention or wait-list control for measures of IPV exposure at 15 or 24 months (eTable 6 in the Supplement).[42]

Benefit of Interventions Among Nonpregnant Populations

Six RCTs (n = 5712, described in 7 articles) enrolled populations for whom perinatal status was not an inclusion criterion and assessed brief counseling or advocacy interventions for women who screened positive for IPV. Interventions varied in delivery format, content, and intensity (eTable 4 in the Supplement). Five RCTs reported on IPV outcomes; of these, 4 found no significant difference between groups in rates of overall IPV[46,50] or combined physical and sexual violence,[48,49] and 1 reported on subtypes of violence only and found mixed results (**Figure 6**).[52] Detailed IPV results are summarized in eTables 6 and 7 in the Supplement. Few reported on other outcomes, such as quality of life and depression, and most found no significant effect for these outcomes (Figure 6; eTable 7 in the Supplement).

Harms of Interventions

Key Question 5. What are the harms of interventions for IPV in adolescents and adults?

Five RCTs (7 articles; n = 1413) assessing interventions for IPV reported on harms; all are included in KQ4, and all were included in the previous report.[43,44,46,47,50,52,53] In searches for the current review, we identified 1 companion study of a previously included RCT reporting on longer-term outcomes.[47] Two RCTs specifically surveyed women about potential harms, and 3 did not describe how harms were ascertained.[43,50,52] No study reported significant harms associated with the intervention.

Benefits of Screening for Caregiver Abuse Among Older or Vulnerable Adults

No studies were found addressing KQs 1, 3, 4, and 5, and only 2 studies were found relevant to KQ2 assessing the accuracy of different tools to detect caregiver abuse among adults 65 years or older. One study (n = 139) enrolled participants presenting for routine dental care and found poor accuracy for the Hwalek-Sengstock Elder Abuse Screening Test for detecting physical or verbal abuse (sensitivity, 46%; specificity, 73%).[54] The second study (n = 916) enrolled participants presenting to multiple US emergency departments who were not critically ill and found that the Emergency Department

Table 3. Intimate Partner Violence Key Question 4: Characteristics of Included Randomized Clinical Trials

Source, quality rating	Intervention	Control	Recruitment setting, country	Study population, No. of participants	Race and ethnicity, %	Age, mean (SD), y	Female, %
Pregnant/postpartum							
Bair-Merritt et al,[37] 2010 Fair	Home visits from paraprofessionals over 3 y;[a] direct services related to parenting, conflict resolution, emotional support; linking families to community services, including IPV shelters/ advocacy groups	Usual care	Hawaiian hospitals US	Mothers aged ≥18 y who gave birth between 1994 and 1995 on Oahu to children rated as high risk for maltreatment n = 643	Asian or Filipino: 28 Caucasian: 12 Native Hawaiian or Pacific Islander: 33 No primary ethnicity or other: 27	NR % by age range: ≤18 y: 22 19-25 y: 47 ≥26 y: 31	100
El-Mohandes et al,[38] 2008 Kiely et al,[39] 2010 El-Mohandes et al,[40] 2011 Fair	Counseling delivered during prenatal visits (4-8 sessions) and postpartum visits (2 sessions) aimed at reducing behavioral risks (depression, IPV, smoking, and tobacco exposure) [b]	Usual care	6 Prenatal care sites in the District of Columbia US	African American women aged ≥18 y, ≤28 wk of gestation who screened positive for depression, IPV, smoking, or tobacco exposure n = 913	African American: 100	25 (SE 0.2)	100
Flaathen et al,[41] 2022 Fair	Culturally sensitive tablet-based video intervention featuring digital storytelling about IPV and safety behaviors (7 min) provided in multiple languages	Control video[c]	Routine antenatal care settings at 19 maternal and child health centers Norway	Pregnant women (any gestational age) aged ≥18 y attending routine antenatal checkups without their partner or other family members who screened positive for previous and/or recent IPV n = 317	Native Norwegian speakers: 76 Nonnative speakers: English: 0.8 Somali:1.2 Urdu: 1.6 Other: 20	32 (5)	100
Heyman et al,[42] 2019 Fair	Skills-based program delivered to new parents during infant's first 8 mos (2 in-home visits, 6 telephone visits) combined with videos and workbook activities focused on relationship or parenting skills	Wait-list control[d]	Maternity units in 2 large hospitals in the exurbs of New York City US	New parents (couples) in a committed relationship who spoke English, with ≥1 member aged ≤30 y and ≥1 member who had been verbally aggressive toward the other in the previous 6 mo but no reported male-to-female physical IPV ever n = 368 couples	Men/women: Hispanic/Latino (any race): 22/18 Non-Latino African American: 19/16 Non-Latino multiracial/other: 6/7 Non-Latino White: 53/59	Men: 29 (5) Women: 27 (4)	NA
DOVE Trial Sharps et al,[43] 2016 Fair	IPV empowerment intervention embedded into a home visiting program; (3) 15- to 25-min sessions during pregnancy and 3 postpartum sessions during home visits	Standard home visiting protocol[e]	Urban and rural perinatal home visiting programs US	Women aged ≤14 y, ≤32 wk of gestation who were low income (ie, Medicaid eligible), enrolled in a home visiting program, and screened positive for IPV n = 239	African American: 47 White non-Hispanic: 42 Other:10 Missing:1	24 (5)	100
Tiwari et al,[44] 2005 Fair	Culturally tailored IPV empowerment intervention/counseling (one 30-min session delivered by midwife with counseling degree) focused on enhancing independence and providing advice on safety and problem-solving	Usual care (wallet-sized card with community resources for abused women)	Public antenatal clinic Hong Kong	Chinese women <30 wk of gestation who screened positive for abuse by a partner during their first antenatal appointment n = 110	Chinese women (living in Hong Kong): 100	28 (NR)	100
Zlotnick et al,[45] 2011 Fair	Counseling (based on interpersonal psychotherapy); four 60-min sessions during pregnancy and 1 session within 2 weeks of delivery)	Control (educational materials and list of IPV resources)	Primary care and OBGYN clinics US	Women aged 18-40 y who screened positive for past-year IPV n = 54	Black: 11 Hispanic: 43 White: 39 Other/multiracial: 8	24 (5)	100
Nonpregnant							
Hegarty et al,[46] 2013 Hegarty et al,[47] 2020 Fair	Brief IPV counseling intervention (1-6 sessions, depending on needs) delivered by primary care physicians trained to deliver the intervention	Usual care	Family practice clinics in Victoria Australia	Women aged 16-50 y who screened positive for fear of their partner in the past 12 mo[f] n = 272 (52 physicians)	Born outside Australia: 18 English not first language: 6	38 (8)	100

(continued)

Table 3. Intimate Partner Violence Key Question 4: Characteristics of Included Randomized Clinical Trials (continued)

Source, quality rating	Intervention	Control	Recruitment setting, country	Study population, No. of participants	Race and ethnicity, %	Age, mean (SD), y	Female, %
Miller et al,[48] 2011 Fair	Counseling and education for IPV/reproductive coercion and assistance contacting resources (1 session during clinic visit)	Usual care[g]	4 Family planning clinics in Northern California US	Women aged 16-29 y who agreed to a follow-up interview n = 904 (4 clinics)	Asian/ Pacific Islander/other: 13 Black: 28 Hispanic: 30 Non-Hispanic multiracial: 7 White: 23	NR % by age range: 16-20 y: 44 21-24 y: 33 25-29 y: 24	100
Miller et al,[49] 2016 Fair	Counseling and education for IPV and supported referrals to victims' services (1 session during clinic visit)	Usual care[h]	25 Family planning clinics in Western Pennsylvania US	Women aged 16-29 y who agreed to a follow-up interview n = 3540 (17 clinics)	Black/African American: 13 Hispanic/Latina: 2 White 80 Multiracial or other: 4	NR % by age range: 16-20 y: 38 21-24 y: 36 25-29 y: 27	100
Rhodes et al,[50] 2015 Fair	Brief motivational intervention, manual-guided (1 session during ED visit, telephone booster 10 d later)	Assessed control No contact control	2 Affiliated urban academic EDs in Philadelphia, Pennsylvania US	Women aged 18-64 y who screened positive for IPV and heavy drinking n = 592	Asian: 1 Black: 80 Hispanic: 5 Native American: 3 Pacific Islander: 1 White: 18 Other: 6 Missing: 1	32 (NR)	100
Saftlas et al,[51] 2014 Fair	Motivational interviewing (one 60-min in-person session at baseline; three 10- to 15-min telephone sessions 1, 2, and 4 mo later)	Provision of written materials; referral to community-based resources on request	2 Family planning clinics in rural Iowa US	Women aged ≥18 y who screened positive for past-year IPV n = 204	Race: Non-White: 12 White: 87 Ethnicity: Hispanic: 11 Non-Hispanic: 88	NR % by age range: 18-19 y: 22 20-24 y: 40 25-29 y: 23 30-39 y: 0.9 ≥40: 0.06	100
Tiwari et al,[52] 2010 Tiwari et al,[53] 2012 Good	Counseling (1 in-person session focused on advocacy), 12 weekly telephone calls, 24-hour access to a hotline for additional support	Usual community care	Community center Hong Kong	Women aged ≥18 y who screened positive for IPV n = 200	Chinese: 100 By place of birth: Hong Kong: 38 Indonesia: 1 Mainland China: 61	38 (7)	100

Abbreviations: DOVE, Domestic Violence Enhanced Home Visitation Program; ED, emergency department; IPV, intimate partner violence; NR, not reported; OBGYN, obstetrics and gynecology.

[a] Over the course of the intervention, 13.6 weekly visits occurred in year 1 (on average), tapering to 25% participation by year 3.

[b] Each session focused on the specific risk factors identified during prenatal screening (not IPV alone).

[c] Per authors, the control video included general information about lifestyle promoting a safe pregnancy.

[d] The control group was offered a Couple CARE for Parents toddler program after the 24-month assessment period was completed; during the intervention period, control parents completed the same 4 questionnaires as intervention group when children were aged 8, 15, and 24 months.

[e] Standard care includes assessment and referral for IPV during first home visit; during subsequent visits, discussion of perinatal IPV only if indication or if woman raises a concern.

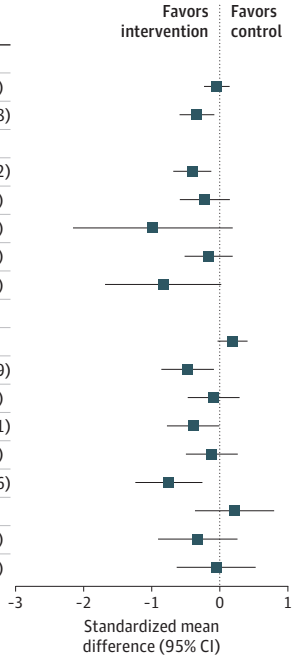
[f] Eligible physicians (for training) included those who worked 3 or more sessions per week, used electronic records, and 70% or more of their patients spoke English. Patients of eligible physicians were mailed a survey regarding participant and screening for fear of partner.

[g] Usual care described as 2 violence screening questions on clinic intake form and usual clinic protocol for positive disclosures during encounters.

[h] Usual care described as standard IPV question on intake sheet and referral if IPV was discussed.

Figure 5. Benefit of IPV Interventions in Studies Enrolling Pregnant or Postpartum Women (Key Question 4)

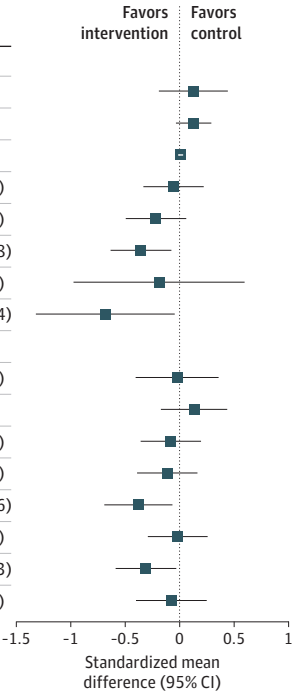
Source	Outcome	Measure	No. of participants	No. of sessions	Follow-up, mo	Standardized mean difference (95% CI)
Perinatal home visits						
Bair-Merritt et al,[37] 2010	Any IPV	CTS2	643	13	12	-0.04 (-0.23 to 0.14)
Sharps et al,[43] 2016	Any IPV	CTS2	239	6	24	-0.34 (-0.59 to -0.08)
Counseling (IPV+ other behavioral risks)						
El-Mohandes et al,[38] 2008	Any IPV	CTS2	336	6-10	5	-0.40 (-0.68 to -0.12)
	Low birth weight	<2500 g	306	6-10	5	-0.22 (-0.59 to 0.15)
	Very low birth weight	<1500 g	306	6-10	5	-0.98 (-2.16 to 0.19)
	Preterm birth	<37 wk	306	6-10	5	-0.16 (-0.52 to 0.19)
	Very preterm birth	<33 wk	306	6-10	5	-0.83 (-1.69 to 0.02)
Counseling (IPV only)						
Flaathen et al,[41] 2022	Any IPV	CAS-SF R	317	1	3	0.19 (-0.03 to 0.41)
Tiwari et al,[44] 2005	Minor physical violence	CTS2	110	1	5	-0.47 (-0.86 to -0.09)
	Severe physical violence	CTS2	110	1	5	-0.09 (-0.47 to 0.29)
	Psychological violence	CTS2	110	1	5	-0.39 (-0.78 to -0.01)
	Sexual violence	CTS2	110	1	5	-0.12 (-0.50 to 0.26)
	Depression	EPDS	110	1	5	-0.75 (-1.24 to -0.26)
Zlotnick et al,[45] 2011	Any IPV	CTS2	54	5	6	0.22 (-0.37 to 0.80)
	Depression	EPDS	54	5	6	-0.32 (-0.91 to 0.26)
	PTSD symptoms	DTS	54	5	6	-0.05 (-0.63 to 0.53)



CAS-SF R indicates Clinical Assessment Scales for the Elderly—Short Form (Other Rating); CTS2, Revised Conflict Tactics Scale; DTS, Distress Tolerance Scale; EPDS, Edinburgh Postnatal Depression Scale; IPV, intimate partner violence; PTSD, posttraumatic stress disorder.

Figure 6. Benefit of IPV Interventions in Studies Enrolling Nonpregnant Women (Key Question 4)

Source	Outcome	Measure	No. of participants	No. of sessions	Follow-up, mo	Standardized mean difference (95% CI)
IPV outcomes						
Hegarty et al,[46] 2013	Any IPV	CAS	272	1-6	12	0.13 (-0.19 to 0.44)
Miller et al,[49] 2016	Any IPV	CTS2	3540	1	12	0.13 (-0.03 to 0.29)
Rhodes et al,[50] 2015	Any IPV	CTS2	592	1 (+1 call)	3	0.01 (-0.01 to 0.03)
Tiwari et al,[52] 2010	Sexual violence	CTS2	200	1 (+12 calls)	5	-0.06 (-0.33 to 0.22)
	Physical violence	CTS2	200	1 (+12 calls)	5	-0.22 (-0.49 to 0.06)
	Psychological violence	CTS2	200	1 (+12 calls)	5	-0.35 (-0.63 to -0.08)
	Birth control sabotage	Unnamed	156	1	3-6	-0.19 (-0.97 to 0.60)
Miller et al,[48] 2011	Pregnancy coercion	Unnamed	156	1	3-6	-0.68 (-1.32 to -0.04)
Other outcomes						
Hegarty et al,[46] 2013	QOL	SF-12 MCS	188	1-6	12	-0.02 (-0.40 to 0.36)
	QOL	SF-12 MCS	166	1-6	24	0.13 (-0.17 to 0.44)
Tiwari et al,[52] 2010	QOL	SF-12 PCS	200	1 (+12 calls)	5	-0.08 (-0.36 to 0.20)
	QOL	SF-12 MCS	200	1 (+12 calls)	5	-0.11 (-0.39 to 0.16)
Hegarty et al,[46] 2013	Depression	HADS	200	1-6	12	-0.38 (-0.69 to -0.06)
Saftlas et al,[51] 2014	Depression	CESD–R10	204	1 (+3 calls)	6	-0.02 (-0.29 to 0.26)
Tiwari et al,[52] 2010	Depression	CBDI–II	200	1 (+12 calls)	5	-0.31 (-0.59 to -0.03)
Hegarty et al,[46] 2013	Anxiety	HADS	100	1–6	12	-0.08 (-0.40 to 0.25)



CAS indicates Composite Abuse Scale; CBDI-II, Beck Depression Inventory II (Chinese Version); CESD-R10, Center of Epidemiologic Studies Depression Scale, 10-item version; CTS2, Revised Conflict Tactics Scale; HADS, Hospital Anxiety and Depression Scale; QOL, quality of life; SF-12 MCS, 12-Item Short Form Health Survey Mental Component Summary.

Senior Abuse Identification screening tool had a sensitivity of 94% (95% CI, 71%-100%) and a specificity of 84% (95% CI, 76%-91%).[55] Detailed results are available in the full report.[12]

Discussion

This systematic review synthesized evidence relevant to screening for IPV and for caregiver abuse of older or vulnerable adults. **Table 4** summarizes the main findings of the evidence review for IPV. Consistent evidence from 3 RCTs (n = 3759) found no benefit of universal IPV screening among adult women.[16,19] Screening practices and interventions provided to those who screened positive for IPV varied and may not be applicable to many current US primary care settings. For example, in the RCT enrolling participants from various Canadian health care settings, participants were recruited between 2005 and 2006, and the authors imply that the positive IPV screen was flagged for clinicians by placing it in a paper chart and that the response to the positive screen was left to the discretion of the clinician.[19] Two other RCTs of screening included more standardized interventions for those who screened positive—either a brief/standardized video focused on advocacy and support plus a list of resources or referral options and an additional clinical assessment to assess safety and on-site support. Whether these interventions are widely applicable may depend on the availability of similar IPV resources, support for creating and maintaining a current list of resources and similar advocacy video intervention, or staffing resources to assess and address safety concerns that were available in the RCT set in an emergency department. We found no RCTs of screening enrolling men or adolescents, and none focused on pregnant women or reported outcomes separately by pregnancy status.

Potential harms of screening asymptomatic populations for abuse include false-positive screening results that lead to more in-depth inquiry or referrals from health professionals that would not lead to benefit, labeling, stigma, and risk of increased violence. Of the 2 RCTs reporting on harms of screening, only 1 assessed harms using prespecified outcomes and found no evidence of harm[19]; however, outcomes were measured over a short duration following screening (within 2 weeks).

Screening tools are available for clinical practice that may reasonably identify women experiencing past-year IPV. The estimates of screening test accuracy for detecting past-year IPV are derived from populations with an IPV prevalence (based on a reference standard) of 10% to 29%. The 2 studies that enrolled participants from primary care or mixed settings (primary care, obstetrics and gynecology, and emergency departments) reported an IPV prevalence of 23% and 14%, respectively. This is similar to the prevalence rate reported by the KQ1 RCT that enrolled women from US primary care settings (15%).

Evidence from 13 RCTs (n = 7425) evaluating interventions for women with screen-detected IPV was imprecise and often inconsistent and focused on heterogeneous interventions that varied in content, delivery setting, and intensity. Interventions targeted to pregnant women or new parents generally included components specific to supporting other pregnancy-related health problems and/or supporting parenting roles. The RCT assessing behavioral counseling during prenatal care found a reduction in both IPV and some adverse neonatal outcomes but had limitations. The intervention targeted multiple risk factors (smoking, environmental tobacco smoke exposure, depression, and IPV)[38]; improvement in birth outcomes among women reporting IPV at baseline may not have been attributable to IPV counseling. For example, among the subgroup of women reporting IPV at baseline, most (62%) reported being depressed, and those randomized to the intervention also received counseling for depression in addition to IPV.[40] Improvement in birth outcomes may have been attributable to counseling for depression rather than IPV counseling. Overall, evidence on the adverse effects of interventions was limited.

Trials are needed to assess the benefit of IPV screening among populations enrolled from prenatal or postnatal care settings given that some RCTs of treatment tailored to this population show benefit. Future RCTs of IPV screening should report on potential harms over a sufficient period following screening to assess potential psychosocial harms. Future research is needed to assess the accuracy of screening tools in more diverse populations, including men and same-sex populations and other populations that experience a high burden of IPV based on existing evidence, including transgender populations. Some existing studies have described the development of screening tools for use among transgender populations,[56-58] but no eligible studies were identified that externally validated these tools. In addition, studies assessing interventions among more diverse populations are needed, including same-sex couples and transgender populations.

Similar to the previous update for this topic, we found no studies directly assessing the benefit or harms of screening for caregiver abuse of older and vulnerable adults, and no studies of interventions. Two included studies assessed the accuracy of different tools to detect abuse and neglect of older adults (65 years or older) in diverse settings and populations.

Several gaps and future research needs relate to evidence specific to screening for abuse in older and vulnerable adults. Screening and interventions for this population are likely to be different than IPV given that some older or vulnerable adults may not have sufficient physical, mental, or financial abilities to engage in screening or interventions. For these situations, screening tools could be targeted to caregivers. Additional challenges to this research may include the legal requirements related to disclosure, underlying medical conditions of older patients (eg, cognitive impairments), and dependence on the perpetrator for caregiving and access to medical care, among other issues.

Limitations

First, the scope of this review focused on unselected or asymptomatic populations without signs or symptoms of abuse. Evidence assessing primary prevention of IPV or caregiver abuse of older and vulnerable adults and evidence related to screening and interventions for perpetrators of abuse was excluded. Second, this review did not evaluate clinician or patient preferences for how screening is implemented in primary care (eg, delivery platform and personnel). Last, for KQ2 (accuracy of screening), studies from emergency department settings were included; this may limit applicability to primary care.

Table 4. Summary of Evidence for Screening for Intimate Partner Violence

Population, intervention, screener, time period	No. of studies (No. of participants)	Summary of findings	Consistency and precision	Study quality	Other limitations	Strength of evidence	Applicability
KQ1: Benefits of screening for IPV							
Women presenting for routine primary care (2 RCTs) and emergency care (1 RCT)	3 RCTs (n = 3759)	No significant difference between screening and control groups over 3 to 18 mo for IPV (3 RCTs), QOL (2 RCTs), or depression, PTSD, or health care utilization rates (reported by 1 RCT each)	IPV and QOL: consistent, imprecise Other outcomes: unknown consistency; imprecise	1 Good, 2 fair	Studies enrolled participants from different settings (US primary care settings, 1 New Zealand ED, and mixed Canadian health care settings) and used diverse screening processes	IPV and QOL: moderate for no benefit Healthcare utilization, depression, and PTSD: low for no benefit	Unselected adult women presenting for primary care and ED visits; 1 large US trial was set in primary care clinics only
KQ2: Accuracy of screening tests for detecting IPV							
Past-year IPV exposure (women)	9 Cross-sectional study (n = 9800)	Sensitivity of 9 screeners (AAS, ACTS, HARK, HITS, E-HITS, PVS, PSQ, WAST, WAST-Short) ranged from 26%-87% and specificity ranged from 80%-97%	Unknown consistency; imprecise	9 Fair	All screeners were assessed in only 1 study; reference standards varied across studies	Low	Women aged ≥16 y presenting for primary care, antenatal care, or ED visits
Past-year IPV exposure (men)	1 Cross-sectional study (n = 55)	Sensitivity of 2 screeners (PVS, HITS) ranged from 30%-71% and specificity ranged from 83%-88%	Unknown consistency; imprecise	1 Fair	2 different screeners assessed in a single study	Insufficient	Men presenting in an ED setting
Current/ongoing IPV exposure	6 Cross-sectional studies (7 screeners) (n = 2191)	Sensitivity of 7 screeners (AAS, HITS, OAS, OVAT, STaT, WAST-Short, unnamed screener) ranged from 12%-94% and sensitivity ranged from 38%-100%	Unknown consistency; imprecise	6 Fair	Most screeners were only assessed in a single study; 1 screener (AAS) was assessed in 2 studies, but 1 study administered only 4 of 5 items and studies used different reference standards	Low	Women aged ≥16 y presenting for primary care, antenatal care, or ED visits
Lifetime IPV exposure	1 Cross-sectional study (n = 75)	Sensitivity ranged from 64%-96% and specificity ranged from 75%-100% (using varying cutoff scores)	Unknown consistency; imprecise	1 Fair	Lifetime screening was assessed in only a single study	Insufficient	Women aged ≥18 y responding to a mailed survey
Future	1 Cohort study (n = 409)	Sensitivity: 20% Specificity: 96%	Unknown consistency; imprecise	1 Fair	Future IPV prediction was assessed in only a single study	Insufficient	Women aged ≥18 y recruited from the nonacute section of the ED
KQ3: Harms of screening for IPV							
Women presenting for routine primary care (1 RCT) and emergency care (1 RCT)	2 RCTs (n = 935)	2 RCTs concluded no adverse effects of screening were identified	Consistent; unknown precision	2 Fair	1 RCT did not report whether harms were prespecified; 1 assessed outcomes at initial screening visit, which may not be a sufficient time frame	Low for no harms	Adult women seeking care in various clinical settings

(continued)

Table 4. Summary of Evidence for Screening for Intimate Partner Violence (continued)

Population, intervention, screener, time period	No. of studies (No. of participants)	Summary of findings	Consistency and precision	Study quality	Other limitations	Strength of evidence	Applicability
KQ4: Benefits of treatment[a]							
Pregnant/postpartum (individual women)	6 RCTs (n = 2276)	IPV: 2 RCTs assessing multiple home visits found a reduction in IPV at 2 to 3 y associated with the intervention; however, the difference between groups in 1 RCT was not statistically significant; 4 RCTs evaluated brief clinic-based counseling; 3 assessing counseling specific to IPV found mixed results, and 1 assessing counseling targeting multiple risk factors (IPV, depression, smoking) found significantly fewer recurrent episodes among the subgroup who reported IPV at baseline QoL: 2 RCTs of counseling interventions found no significant difference between groups Depression: 2 RCTs of counseling interventions found mixed results Birth outcomes: 1 RCT assessing counseling for IPV and other risk factors found benefit from some measures but not others	Inconsistent; imprecise for IPV and depression Mostly consistent; imprecise for QoL Unknown; imprecise for birth outcomes	6 Fair	Studies assessed heterogeneous interventions; reduction in IPV and adverse perinatal outcomes in 1 RCT may be related to counseling for other risk factors (smoking, depression) and not IPV counseling alone	Low for IPV, depression and QoL; insufficient for birth outcomes	Participants enrolled from routine prenatal/perinatal care settings
Nonpregnant	6 RCTs (n = 5712)	IPV: 4 RCTs found no significant difference between groups in rates of overall IPV[46,50] or combined physical and sexual violence and 1 reported on subtypes of violence only and found mixed results QOL: 2 RCTs found no benefit for different QOL measures Mental health outcomes: anxiety, depression and PTSD were reported in 1 RCT with mixed results	Mostly consistent; imprecise for IPV Inconsistent; imprecise for other outcomes	1 Good, 5 fair	Studies assessed heterogeneous interventions using different outcome measures	Low for IPV (no benefit); insufficient for other outcomes	Women who screened positive for IPV during a routine primary care visit
Couples	1 RCT (n = 368 couples)	No statistically significant difference between groups for any measure of IPV at 15 or 24 mo after enrollment	Unknown; imprecise	1 Fair	Unclear fidelity to intervention	Insufficient	New parents in a committed relationship (couples, described as male and female partners) who screened positive for verbal abuse (but no prior physical IPV)
KQ5: Harms of treatment							
Individual women (pregnant and nonpregnant)	5 RCTs (n = 1413)	No study found significant harms associated with the interventions	Consistent; imprecise	1 Good, 4 fair	Studies did not comment on whether harms were prespecified or how they were ascertained; reporting bias not detected	Low for no harms	Women who screened positive for IPV during a routine primary care visit

Abbreviations: AAS, Abuse Assessment Scale; ACTS, Afraid/Controlled/Threatened/Slapped or physically hurt; E-HITS, Extended HITS; ED, emergency department; HARK, Humiliation, Afraid, Rape, Kick; HITS, Hurt, Insult, Threaten, Scream; IPV, intimate partner violence; KQ, key question; OAS, Ongoing Abuse Screen; OVAT, Ongoing Violence Assessment Tool; PSQ, Parent Screening Questionnaire; PTSD, posttraumatic stress disorder; PVS, Partner Violence Screen; QOL, quality of life; RCT, randomized clinical trial; SOE, strength of evidence; SPAN, Startle, Physiological Arousal, Anger, and Numbness; STaT, Slapped, Things, Threaten; WAST, Woman Abuse Screening Tool.

[a] SOE ratings for KQ4 were completed for outcomes reported on by more than 1 study each. For other outcomes, including anxiety, PTSD, and birth outcomes, SOE is insufficient due to unknown consistency, imprecision, and study limitations.

Conclusions

Although available screening tools may reasonably identify women experiencing IPV, RCTs of IPV screening did not show reduced IPV or improvement in other outcomes over 3 to 18 months. Limited evidence suggested that home visiting and behavioral counseling interventions that address multiple risk factors may lead to reduced IPV among pregnant or postpartum women. No studies assessed screening among vulnerable adults or treatment for caregiver abuse among older and vulnerable adults.

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