JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

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

US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

IMPORTANCE Intimate partner violence (IPV) affects millions of US residents across the lifespan and is often unrecognized. Abuse of older or vulnerable adults by a caregiver or someone else they may trust is common and can result in significant injury, death, and long-term adverse health consequences.

OBJECTIVE The US Preventive Services Task Force (USPSTF) commissioned a systematic review to evaluate the benefits and harms of screening for IPV, abuse of older adults, and abuse of vulnerable adults.

POPULATION The recommendation on screening for IPV applies to adolescents and adults who are pregnant or postpartum, and women of reproductive age. The recommendation on screening in older and vulnerable adults applies to persons without recognized signs and symptoms of abuse or neglect.

EVIDENCE ASSESSMENT The USPSTF concludes that screening for IPV in women of reproductive age, including those who are pregnant and postpartum, and providing or referring those who screen positive to multicomponent interventions has a moderate net benefit. The USPSTF concludes that the benefits and harms of screening for caregiver abuse and neglect in older or vulnerable adults are uncertain and that the balance of benefits and harms cannot be determined.

RECOMMENDATION The USPSTF recommends that clinicians screen for IPV in women of reproductive age, including those who are pregnant and postpartum. (B recommendation) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for caregiver abuse and neglect in older or vulnerable adults. (I statement)

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Group Information: The US Preventive Services Task Force (USPSTF) members are listed at the end of this article.

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Summary of Recommendations

Population	Recommendation	Grade
Women of reproductive age, including pregnant and postpartum women	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age, including those who are pregnant and postpartum. See the Practice Considerations section for information on evidence-based multicomponent interventions and for information on IPV in men.	B
Older or vulnerable adults	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for caregiver abuse and neglect in older or vulnerable adults. See the Practice Considerations section for additional information.	I

USPSTF indicates US Preventive Services Task Force.

See the Summary of Recommendations figure.

Pathway to Benefit

To achieve the benefits of screening it is important that those who screen positive are evaluated and, if appropriate, are provided or referred for evidence-based interventions that include multiple components and ongoing support.

Mission Statement

The US Preventive Services Task Force (USPSTF) works to improve the health of people nationwide by making evidence-based recommendations on effective ways to prevent disease and prolong life.

Importance

Intimate partner violence (IPV) affects millions of US residents across the lifespan and is often unrecognized.[1-3] Nearly one-half of US adult women (47%) and men (44%) report experiencing sexual violence, physical violence, or stalking in their lifetime.[1,3] Approximately one-half of US adult women (49%) and men (45%) report experiencing psychological aggression by an intimate partner in their lifetime.[1,3] Women, compared with men, experience higher rates of sexual violence (20% vs 8%), stalking (13.5% vs 5.2%), severe physical violence (32.5% vs 24.6%), and adverse health and social consequences associated with IPV (87% vs 60%).[1,3] Some evidence suggests that incidence, severity, and frequency of IPV increase and protective factors decrease during public health emergencies.[1,4]

Abuse of older or vulnerable adults by a caregiver or someone else they may trust is common and can result in significant injury, death, and long-term adverse health consequences.[1,5,6] More than 1 of 10 (11%) adults 60 years or older report experiencing at least 1 type of abuse or neglect in the past year.[1,5] Vulnerable adults, including persons who require care due to a physical or mental disability, are more likely to experience violent victimization and maltreatment regardless of age compared with adults without those vulnerabilities.[1,7]

USPSTF Assessment of Magnitude of Net Benefit

The USPSTF concludes with moderate certainty that screening for IPV in women of reproductive age, including those who are pregnant and postpartum, and providing or referring those who screen positive to multicomponent interventions with ongoing support has a **moderate net benefit**.

The USPSTF concludes that the **evidence is insufficient** on screening for caregiver abuse and neglect in older and vulnerable adults and that the balance of benefits and harms cannot be determined.

See **Table 1** for more information on the USPSTF recommendation rationale and assessment and the eFigure in the Supplement for information on the recommendation grade. See the **Figure** for a summary of the recommendations for clinicians. For more details on the methods the USPSTF uses to determine the net benefit, see the USPSTF Procedure Manual.[8]

Practice Considerations

Patient Population Under Consideration

The recommendation on screening for IPV applies to adolescents and adults who are pregnant or postpartum, and women of reproductive age who do not have recognized signs and symptoms of IPV. The recommendation on screening in older and vulnerable adults applies to persons without recognized signs and symptoms of abuse or neglect.

Definitions

IPV refers to physical violence, sexual violence, psychological aggression (including coercive tactics, such as limiting access to financial resources), or stalking by a current or former spouse or dating partner.[1,9]

Abuse of older adults refers to acts whereby a trusted person (eg, a caregiver) causes or creates risk of harm to an older adult.[1,10] For this definition, the Centers for Disease Control and Prevention (CDC) considers adults 60 years or older.[1,10] The term *caregiver* broadly refers to relationships with a provision of assistance with daily activities and an expectation of trust. *Abuse of vulnerable adults* refers to acts (eg, neglect) by persons in a caregiving role for persons 18 years or older who rely on a caregiver due to physical or mental disability, or both, and are unable to protect themselves.[1] The legal definition of vulnerable adults varies by state. Abuse of older adults or vulnerable adults includes physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, and financial or material exploitation.[1] The populations addressed in this recommendation are not mutually exclusive. For example, older adults may have disabilities that could categorize them as "vulnerable," and older or vulnerable adults may experience IPV.

Assessment of Risk of IPV

IPV affects persons of all ages, racial, ethnic, and socioeconomic backgrounds.[1] In a recent systematic review, individual factors that consistently increased the risk of IPV included experiencing other forms of violence within the relationship, alcohol misuse, and mental health factors (posttraumatic stress disorder, depression, threats of self-harm, borderline personality disorder).[1,11] Another systematic review reported unplanned pregnancy, having parents with a low level of education (eg, less than a high school diploma), and being young and unmarried are specific risk factors for IPV perpetrated against women.[1,12] Evidence suggests that pregnancy is associated with an increased risk of initiation of physical violence among women whose partners did not want the pregnancy and is also associated with an increased risk of continued physical violence during pregnancy in women with an unintended pregnancy who experienced physical violence prior to conception.[1,13]

Based on recent survey data, women identifying as Asian or Pacific Islander (27%), Black (54%), Hispanic (42%), Native American or Alaska Native (58%), multiracial (64%), or White (48%) report experiencing IPV in their lifetime.[3] IPV exposure can begin at an early age, with 27% of women reporting first contact of sexual violence, physical violence, or stalking at 17 years or younger.[3] In a 2019 Youth Risk Behavioral Surveillance System survey, adolescent girls and boys reported experiencing physical dating violence (9% and 7%, respectively) and sexual dating violence (13% and 4%, respectively).[1,14]

Table 1. Summary of USPSTF Rationale

Rationale	Intimate partner violence	Caregiver abuse of older or vulnerable adults
Detection	• Adequate evidence that available screening instruments can identify IPV in women of reproductive age, including during pregnancy and the postpartum period, when there are no recognized signs and symptoms of abuse. • Inadequate evidence about the performance of IPV screening instruments in men.	Inadequate evidence to assess the accuracy of screening instruments designed to detect caregiver abuse or neglect in older or vulnerable adults when there are no recognized signs and symptoms of abuse.
Benefits of early detection and intervention and treatment	• Adequate evidence that referring pregnant or postpartum women who screen positive for IPV to effective multicomponent interventions can reduce future abuse. • Inadequate direct evidence on screening for IPV to reduce abuse and adverse physical or mental consequences of violence. Evidence that directly compares screening followed by multicomponent interventions vs no screening is lacking. • Adequate evidence that multicomponent interventions have a moderate benefit in pregnant or postpartum women. • Due to an absence of studies of similar interventions in nonpregnant women of a similar age, evidence pertaining to interventions with multicomponent interventions was extrapolated from pregnant and postpartum women to women of reproductive age. • Inadequate evidence on screening or interventions for IPV in men and other populations.	Inadequate evidence that screening or early detection of caregiver abuse or neglect in older or vulnerable adults reduces exposure to abuse, physical or mental harms, or mortality in older or vulnerable adults.
Harms of early detection and intervention and treatment	• Inadequate evidence to determine the harms of screening for IPV. • Adequate evidence to determine harms of interventions for IPV. • Based on available evidence reporting no adverse effects, the magnitude of the overall harms of screening and interventions for IPV can be bounded as no greater than small.	Inadequate evidence on the harms of screening or interventions in older or vulnerable adults.
USPSTF assessment	Moderate certainty that screening for IPV in women of reproductive age, including those who are pregnant and postpartum, and providing or referring those who screen positive to multicomponent interventions has a moderate net benefit.	Benefits and harms of screening for caregiver abuse and neglect in older or vulnerable adults are uncertain and that the balance of benefits and harms cannot be determined.

Abbreviation: USPSTF, US Preventive Services Task Force.

Studies report that the prevalence of IPV varies by sexual orientation.[1,15] According to the 2016/2017 National Intimate Partner and Sexual Violence Survey, 79% of women identifying as bisexual, 60% of women who identify as lesbian, and 53% of women who identify as heterosexual reported experiencing contact sexual violence in their lifetime.[1,15] In a recent systematic review, people who reported a gender that differs from their sex experienced increased prevalence of IPV (74 studies; n = 1 273 989 participants; relative risk, 1.7 [95% CI, 1.4-2.0]).[1,16]

Screening Tests for IPV

Screening for IPV often involves use of a brief questionnaire to assess current or recent abuse.[1] Several screening instruments can be used to detect IPV in the primary care setting, including but not limited to the Humiliation, Afraid, Rape, Kick (HARK)[17]; Hurt, Insult, Threaten, Scream (HITS)[18]; and Woman Abuse Screening Tool (WAST).[19]

Due to fear, intimidation, and lack of support, persons may not disclose abuse unless directly questioned and when questioned still may not disclose it.[1] Barriers to disclosure of IPV for persons experiencing abuse include concern about negative clinician attitudes, perception of safety, and concern about the consequences of disclosing abuse.[1,20] Facilitators to disclosure of IPV include a positive relationship with a clinician and clinicians directly asking persons experiencing abuse about IPV in private and safe settings.[1,20] According to a recent study, factors such as mistrust of police; fear of children being removed from the home; language barriers; and unfamiliarity with laws, rights, and services may contribute to barriers to seeking help for specific groups of women, including Asian, Black, immigrant, and "minority ethnic" women.[1,21] Further, mandatory reporting requirements of IPV can also elicit concerns in people experiencing abuse due to fear of negative consequences.[1,22] State and local reporting requirements vary from one jurisdiction to another, with differences in definitions, who and what should be reported, who should report, and to whom. Some states require clinicians (including primary care clinicians) to report abuse to legal authorities, and most require reporting of injuries resulting from guns, knives, or other weapons.[23]

Screening Intervals for IPV

The USPSTF found no evidence on appropriate intervals for screening.

Interventions for IPV

Based on the evidence, effective interventions generally address multiple factors related to IPV (such as depression rather than IPV alone), involve ongoing support services and multiple visits, and provide a range of emotional support and behavioral and social services.[1] In clinical trials, these interventions were conducted in pregnant or postpartum women. Effective multicomponent interventions were delivered over multiple sessions and combined components specific to IPV with components addressing health, family, or social needs that may be barriers or facilitators to ending abuse (eg, counseling for depression, postpartum and parenting support, training related to conflict resolution, and linkage to community services). Studies of interventions that provided brief counseling specific to IPV and the provision of information about referral options in the absence of multicomponent interventions generally did not demonstrate benefit.

Additional Tools and Resources

Intimate Partner Violence

The CDC's report "Intimate Partner Violence Prevention: Resource for Action" highlights strategies based on the best available evi-

Figure. Clinician Summary: Screening for Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults

What does the USPSTF recommend?	**Women of reproductive age including those who are pregnant and postpartum:** Screen women of reproductive age, including those who are pregnant and postpartum for intimate partner violence Grade B
	Older and vulnerable adults: The evidence is insufficient to assess the balance of benefits and harms of screening for caregiver abuse and neglect in older or vulnerable adults. I statement
To whom does this recommendation apply?	This recommendation applies to women of reproductive age, including those who are pregnant and postpartum.
What's new?	This recommendation is consistent with the 2018 USPSTF recommendation.
How to implement this recommendation?	Screen women of reproductive age, including those who are pregnant and postpartum for intimate partner violence with use of a brief questionnaire to assess current or recent abuse. In those who screen positive, evaluate and if appropriate provide or refer for evidence-based interventions that include multiple components and ongoing support.
What additional information should clinicians know about this recommendation?	IPV affects persons of all ages, racial, ethnic, and socioeconomic backgrounds. In a recent systematic review, individual factors that consistently increased the risk of IPV included experiencing other forms of violence within the relationship, alcohol misuse, and mental health factors (posttraumatic stress disorder, depression, threats of self-harm, borderline personality disorder). When deciding whether to screen for caregiver abuse in older or vulnerable adults, clinicians should consider the following factors: • **Potential preventable burden for caregiver abuse of older adults:** Prevalence estimates of abuse in older adults vary, but abuse is common. Risk factors for experiencing abuse include isolation, lack of social support, functional impairment, poor physical health, cognitive impairment, low socioeconomic status, and history of being in an abusive relationship. • **Potential preventable burden for abuse of vulnerable adults:** Based on estimates from a recent survey in noninstitutional settings, persons with disabilities were more likely to experience violence (violent crime, rape or sexual assault, robbery, aggravated assault, and simple assault) compared with persons without disabilities (approximately 46 per 1000 persons with a disability vs 12 per 1000 persons without a disability). • **Potential harms:** Potential harms of screening for abuse in older or vulnerable adults include shame, guilt, self-blame, retaliation or abandonment by perpetrators, and the repercussions of false-positive results (eg, labeling and stigma).
Why is this recommendation and topic important?	Intimate partner violence (IPV) affects millions of US residents across the lifespan and is often unrecognized. Abuse of older or vulnerable adults by a caregiver or someone else they may trust is common and can result in significant injury, death, and long-term adverse health consequences.
What are other relevant USPSTF recommendations?	The USPSTF recommends screening for depression in adolescents and adults. The USPSTF found insufficient evidence to assess the balance of benefits and harms of primary care interventions to prevent child maltreatment in children and adolescents younger than 18 years without signs and symptoms of or known exposure to maltreatment. Related recommendations from the USPSTF are available at https://www.uspreventiveservicestaskforce.org/uspstf/
What are additional tools and resources?	**Intimate partner violence** The CDC's report "Intimate Partner Violence Prevention: Resource for Action" highlights strategies based on the best available evidence to help states and communities prevent IPV, support survivors, and lessen the harms of IPV (https://www.cdc.gov/violence-prevention/media/pdf/resources-for-action/IPV-Prevention-Resource_508.pdf). The National Academies of Sciences, Engineering, and Medicine's report "Essential Health Care Services Addressing Intimate Partner Violence" presents findings from research and deliberations and recommendations for leaders of health care systems, federal agencies, health care providers, emergency planners, and those involved in IPV research (https://nap.nationalacademies.org/catalog/27425/essential-health-care-services-addressing-intimate-partner-violence). The US Department of Veterans Affairs' Intimate Partner Violence Assistance Program is committed to helping veterans, their partners, and Veterans Affairs staff who are affected by IPV (https://www.socialwork.va.gov/IPV/Index.asp). **Abuse of older or vulnerable adults** The Administration for Community Living (ACL) features resources for older adults and adults with vulnerabilities. ACL's National Family Caregiver Support Program highlights services to provide state and community-based coordinated support for caregivers (https://acl.gov/programs/support-caregivers/national-family-caregiver-support-program). The CDC highlights information on abuse in older persons, including resources on strengthening prevention strategies (https://www.cdc.gov/elder-abuse/about/index.html). The National Institutes of Health's National Institute on Aging features several resources that could assist primary care clinicians who care for older adults, including information on healthy aging (https://www.nia.nih.gov/health/caregiving/healthy-aging-tips-older-adults-your-life) and spotting signs of abuse in older adults (https://www.nia.nih.gov/health/elder-abuse/spotting-signs-elder-abuse).
Where to read the full recommendation statement?	Visit the USPSTF website (https://www.uspreventiveservicestaskforce.org/uspstf/) or the *JAMA* website (https://jamanetwork.com/collections/44068/united-states-preventive-services-task-force) to read the full recommendation statement. This includes more details on the rationale of the recommendation, including benefits and harms; supporting evidence; and recommendations of others.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision-making to the specific patient or situation.

dence to help states and communities prevent IPV, support survivors, and lessen the harms of IPV (https://www.cdc.gov/violence-prevention/media/pdf/resources-for-action/IPV-Prevention-Resource_508.pdf).

The National Academies of Sciences, Engineering, and Medicine's report "Essential Health Care Services Addressing Intimate Partner Violence" presents findings from research and deliberations and recommendations for leaders of health care systems, federal agencies, clinicians, emergency planners, and those involved in IPV research (https://nap.nationalacademies.org/catalog/27425/essential-health-care-services-addressing-intimate-partner-violence).

The US Department of Veterans Affairs' Intimate Partner Violence Assistance Program is committed to helping veterans, their partners, and Veterans Affairs staff who are affected by IPV (https://www.socialwork.va.gov/IPV/Index.asp).

Abuse of Older or Vulnerable Adults

The Administration for Community Living (ACL) features resources for older adults and adults with vulnerabilities. ACL is focused on developing systems and programs that prevent abuse from happening, protecting persons from abusive situations, and supporting persons who have experienced abuse to help them recover (https://acl.gov/programs/protecting-rights-and-preventing-abuse). ACL's National Family Caregiver Support Program highlights services to provide state and community-based coordinated support for caregivers (https://acl.gov/programs/support-caregivers/national-family-caregiver-support-program).

The CDC highlights information on abuse in older persons, including resources on strengthening prevention strategies (https://www.cdc.gov/elder-abuse/about/index.html).

The National Institutes of Health's National Institute on Aging features several resources that could assist primary care clinicians who care for older adults, including information on healthy aging (https://www.nia.nih.gov/health/caregiving/healthy-aging-tips-older-adults-your-life) and spotting signs of abuse in older adults (https://www.nia.nih.gov/health/elder-abuse/spotting-signs-elder-abuse).

Suggestions for Practice Regarding the I Statement and Other Populations

When deciding whether to screen for caregiver abuse in older or vulnerable adults or intimate partner violence in other populations, clinicians should consider the following factors.

Potential Preventable Burden

Caregiver Abuse of Older Adults | Prevalence estimates of abuse in older adults vary, but abuse is common.[1] Risk factors for experiencing abuse include isolation, lack of social support, functional impairment, poor physical health, cognitive impairment, low socioeconomic status, and history of being in an abusive relationship.[1,24-26] Based on nationwide data from a recent study in older adults, more than 1 in 10 older adults (12%) experienced a single form of abuse and 2% experienced multiple forms of abuse over their lifetimes.[1,27] Financial exploitation (35%) and neglect (34%) were the most commonly reported types of abuse.[1,27] Older adults are more likely to experience abuse by nonintimate partners (56%) but also experience IPV (23%) and abuse by nonintimate and intimate partners (21%).[28] Older adults experiencing abuse experience serious negative physical health effects and adverse psychological consequences, including distress, anxiety, and depression.[1,6,29]

Abuse of Vulnerable Adults | Based on estimates from a recent survey in noninstitutional settings, persons with disabilities were more likely to experience violence (violent crime, rape or sexual assault, robbery, aggravated assault, and simple assault) compared with persons without disabilities (approximately 46 per 1000 persons with a disability vs 12 per 1000 persons without a disability). In this survey, adults with cognitive disabilities were most likely to experience violence (83 per 1000 persons).[1,7] Women with disabilities are more likely to experience lifetime IPV[1,30] compared with men with disabilities, men without disabilities, and women without disabilities.[1,30] More than one-half (59%) of all violent acts experienced by vulnerable adults were committed by intimate partners, other relatives, or well-known acquaintances.[1,7]

IPV in Other Populations | Evidence suggests that IPV may be most common during adolescence and young adulthood[2]; however, women of all ages report IPV. Approximately 2% of women 45 years or older experienced first contact of sexual violence, physical violence, or stalking by an intimate partner in the past 12 months.[3]

IPV in Men | More than 44% of men report sexual violence, physical violence, or stalking by an intimate partner in their lifetime.[3] Among men who experience sexual violence, physical violence, or stalking, the most common IPV-related adverse effects include posttraumatic stress disorder symptoms, feeling fearful, feeling concerned for safety, injury, missing days of work or school, and needing legal services.[3]

Potential Harms

Potential harms of screening for abuse in older or vulnerable adults and for IPV in men and other populations include shame, guilt, self-blame, retaliation or abandonment by perpetrators, and the repercussions of false-positive results (eg, labeling and stigma).[1] Studies of harms were primarily conducted in person. Virtual visits may expand access to screening but may increase potential for harm due to a partner or caregiver overhearing responses to screening questions.[1]

Current Practice

Caregiver Abuse of Older or Vulnerable Adults | For abuse of older adults, mandatory reporting laws and regulations vary by state; however, most states require reporting.[1] The review found limited evidence on screening instruments to accurately detect caregiver abuse or neglect. The review did not find recent estimates of screening in clinical practice for abuse in older and vulnerable adults in the US.[1]

Other Related USPSTF Recommendations

The USPSTF found insufficient evidence to assess the balance of benefits and harms of primary care interventions to prevent child maltreatment in children and adolescents younger than 18 years without signs and symptoms of or known exposure to maltreatment.[31] The USPSTF recommends screening for depression in adolescents and adults.[32,33]

Update of Previous USPSTF Recommendation

This recommendation updates the 2018 USPSTF recommendation statement on screening for IPV and screening for abuse in older or vulnerable adults. In 2018, the USPSTF recommended that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services.[34] The USPSTF also concluded that the evidence was insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults.[34] The current recommendation statement is consistent with the 2018 recommendation. To highlight that the evidence base is strongest in those who are pregnant and postpartum, the USPSTF specified these populations in this recommendation statement. For abuse of older or vulnerable adults, the term "caregiver" was added before abuse or neglect when appropriate to clarify when the focus was on screening for abuse or neglect perpetrated by a caregiver or someone they trust.

Supporting Evidence

Scope of Review

The USPSTF commissioned a systematic review[1] to evaluate the benefits and harms of screening for IPV, abuse of older adults, and abuse of vulnerable adults. The review also evaluated the evidence on the accuracy of screening tests for IPV and abuse of older or vulnerable adults and the benefits and harms of interventions for IPV and abuse of older or vulnerable adults. The scope of this review is similar to that of the prior systematic review.

Accuracy of Screening Tests

IPV

Accuracy varied across 17 studies evaluating screening tools to identify IPV.[1,35] The assessment tools were administered in emergency departments, primary care practices, urgent care, and antenatal clinics and by telephone or mail.[1,35] Most screening tools were designed to identify exposure to IPV within the past year. The remaining tools assessed current or ongoing IPV, lifetime abuse, or the ability to predict future IPV.[1,35] The majority of studies recruited adult women 18 years or older. One study included women as young as 16 years, and 1 study recruited men.[1,35] Studies assessed 14 different screening tools; most screening tools were assessed by a single study and used the longer structured 39-item Conflict Tactics Scale 2 (CTS2) as the reference standard.[1,35]

The 9 studies to detect exposure to IPV within the past year used 9 different screening tools: Abuse Assessment Screen; Afraid, Controlled, Threatened, Slapped or physically hurt screen; HARK; HITS; Electronic HITS (E-HITS); Partner Violence Screen; Parent Screening Questionnaire; and WAST and WAST-Short. Sensitivity ranged from 26% to 87% and specificity ranged from 80% to 97%.[1,35] Generally available screening tools may reasonably identify women experiencing IPV in the past year.[1,35] The review estimated that use of the HARK screening tool (80% sensitivity and 95% specificity) would result in 81 000 true-positive test results and 5000 false-positive test results (positive predictive value, 83%) in a population of 100 000 women with a 15% prevalence of IPV (similar to the prevalence rate of IPV reported in studies in US primary care settings).[1,35]

In a single study in men (n = 53) on the accuracy of the PVS screening tool in the emergency department to detect past-year IPV, sensitivity was low on both the Partner Violence Screen and HITS tools compared with CTS2 scores for psychological abuse (35% and 30%, respectively) and for detecting physical abuse (46% for both tools).[1,35,36] In 6 studies of tools to detect current or ongoing IPV, sensitivity ranged from 12% to 94% and specificity ranged from 38% to 100%.[1,35,37-42] In a single study focused on the accuracy of the Slapped, Things, Threaten tool in detecting lifetime IPV, sensitivity was 96% and specificity was 75%, compared with the reference tool (Index of Spouse Abuse).[1,35,43] In a single study (n = 409) of a 3-item tool to predict future abuse, sensitivity was 20% (95% CI, 13%-30%) and specificity was 96% (95% CI, 93%-98%).[1,35,44]

Abuse of Older Adults

The USPSTF reviewed 2 cross-sectional studies (n = 1055) on the accuracy of tools to detect abuse and neglect among adults 65 years or older.[1,35] In a study assessing the Hwalek-Sengstock Elder Abuse Screening Test (n = 139), accuracy was low (sensitivity, 46% [95% CI, 32%-59%] and specificity, 73% [95% CI, 62%-82%]) for detecting physical or verbal abuse in generally healthy older adults presenting for routine dental care.[1,35,45] In the other study using the Emergency Department Senior Abuse Identification screening tool to detect abuse, sensitivity was 94% (95% CI, 71%-100%) and specificity was 84% (95% CI, 76%-91%).[1,35,46] Both studies assessed 2 different tools in 2 different settings. Whether these results are applicable to routine primary care settings is uncertain.[1,35]

Abuse of Vulnerable Adults

The review identified no studies on screening tools to detect abuse and neglect of vulnerable adults.[1,35]

Benefits of Early Detection and Interventions

IPV

Generally, intervention benefit varied by intervention characteristics and recruited population.[1,35] Effective interventions involved ongoing support services, which included multiple visits with patients, addressed multiple risk factors (not just IPV), and provided a range of emotional support and behavioral and social services.[1,35] Studies delivering these multicomponent, multiple-visit interventions were conducted in pregnant and postpartum women and did not focus on nonpregnant women or on men.[1,35] Brief interventions generally did not demonstrate effectiveness, regardless of population (including pregnant or postpartum women or women who were not pregnant or recently delivered).[1,35]

Pregnant and Postpartum Populations | Thirteen studies (n = 7425) assessed the effectiveness of interventions in persons with screen-detected IPV (or at risk for IPV). Of these, 7 studies (n = 2644) assessed effectiveness of interventions during pregnancy and the postpartum period.[1,35] In the 3 studies that assessed intensive services, interventions were delivered in home visits or outpatient settings to pregnant and postpartum women.[1,35] Two home-visit intervention studies[47,48] (n = 882) that included multiple visits over 1 to 2 years found lower rates of IPV in women assigned to the intervention group compared with the control group.[1,35] In 1 study, IPV events were lower in the intervention group (7.50 events per person-year) compared with

the control group (9.55 events per person-year) at 3 years, but the difference was not statistically significant (incident rate ratio of average IPV events per person-year, 0.86 [95% CI, 0.73-1.01]).[47] The other home-visit study found statistically significant lower mean CTS2 scores from baseline in the intervention group compared with the control group at 2 years (−40.82 vs −35.87; mean difference in change from baseline scores, −4.95; $P < .001$).[48] The third trial (n = 913) enrolled women who screened positive for one of several risk factors for adverse perinatal outcomes (cigarette smoking, environmental tobacco smoke exposure, depression, and IPV); those randomized to the intervention received counseling specific to each identified risk factor.[1,35] In the subgroup of women who screened positive for IPV at baseline (n = 306), those receiving the intervention had significantly 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' gestation) (2 vs 9 women; $P = .03$).[1,35,49] Interventions were delivered over a mean of 4.7 sessions (range, 4-10 sessions) over 5 months.[1,35,49]

In 4 studies assessing brief clinic-based interventions in pregnant and postpartum women, 3 focused on counseling specific to IPV.[1,35] Of those 3 studies, 2 found no group differences in rates of IPV,[50,51] and 1 found mixed results for subtypes of IPV[52] (the benefit was significant for psychological and minor physical abuse and not for severe physical and sexual abuse).[1,35]

Nonpregnant Women | Three studies (n = 3759) compared screening with no screening for IPV and found no benefit when screening was followed by brief interventions.[1,35,53-55] In these trials of adult women (mean age, 34 to 40 years), 1 study reported including 5% pregnant women, the other 2 studies did not report including any pregnant or postpartum women, and none included adolescents or men.[1,35] Studies assessed screening followed by brief education and referral options for women who screened positive.[1,35] Trials did not provide ongoing support services and did not report the proportion of women receiving intensive services after referral.[1,35] None of the 3 studies reported improvements in screened groups compared with groups that were not screened on health outcomes, including IPV, quality of life, or mental health outcomes.[1,35]

Six trials enrolling nonpregnant women measured changes in overall IPV incidence. Five trials reported on specific categories of IPV.[1,35] Generally, compared with studies enrolling pregnant and postpartum populations, studies in nonpregnant women provided fewer visits with less contact time and did not provide education or support specific to child development, parenting, or risk factors related to adverse perinatal outcomes (other than IPV, such as depression and smoking).[1,35] Four studies reported no group differences in rates of overall IPV or combined physical and sexual violence.[1,35,56-59] One study reported mixed results on IPV subtypes.[1,35,60] Interventions in nonpregnant women primarily included brief counseling, provision of information, and referrals.[1,35]

Other Populations | A study assessing interventions for new parent couples (n = 368 couples, described as male and female partners) found no significant group differences in IPV rates at 15 or 24 months.[1,35,61] The review identified no eligible screening or intervention studies for IPV in men.

Abuse of Older Adults

There were no identified studies on benefits of screening or early interventions in older adults.[1,35]

Abuse of Vulnerable Adults

There were no identified studies on benefits of screening or early interventions in vulnerable adults.[1,35]

Harms of Screening or Treatment

IPV

Two trials in adult women reported on harms of screening for IPV and identified no adverse effects of screening.[1,35] One randomized clinical trial (n = 591) developed a specific tool, the Consequences of Screening Tool, to measure the consequences of IPV screening, such as "Because the questions on partner violence were asked, I feel my home life has become (less difficult… more difficult)."[1,35,55] Results indicated that being asked IPV screening questions was not harmful to women immediately after screening.[1,35] Another trial (n = 399) reported no adverse events; however, it was unclear whether events were prespecified or how they were monitored.[1,35,54]

Five trials reported on harms of interventions and identified no significant harms associated with the interventions.[1,35] One trial assessing a brief counseling intervention surveyed women at 6, 12, and 24 months about survey participation (including potential harms) and found no group differences in the percentage of women who reported harms. The authors concluded no harms were associated with the intervention.[1,35,58,62] Among women who reported that their abusive partner was aware of their participation in the trial, the number of negative partner behaviors (eg, got angry, made her more afraid for herself or her children, or restricted her freedom) was not significantly different between groups.[1,35] In another trial that asked by telephone whether violence frequency increased after taking part in an antenatal clinic study, the authors reported no adverse events related to study participation by women.[1,35,52] Other trials also reported no harms associated with interventions; however, it was unclear how harms were measured or assessed.[1,35,48,59,60]

There were no identified studies that reported on harms of screening or interventions in men.[1,35]

Abuse of Older Adults

There were no identified studies on harms of screening or interventions in older adults.[1,35]

Abuse of Vulnerable Adults

There were no identified studies on harms of screening or interventions in vulnerable adults.[1,35]

Response to Public Comments

A draft version of this recommendation statement was posted for public comment on the USPSTF website from October 29 to November 25, 2024. In general, most comments agreed with the recommendation statement. Some comments requested the USPSTF highlight the potential harms that could be associated with screening. The USPSTF is deeply concerned about the risk of harm associated with IPV screening. While the USPSTF found limited evidence of harms in its review of the evidence, the recommendation statement specifies that optimal delivery of screening occurs in safe and private settings. The USPSTF also included materials that clini-

cians can use to support survivors of abuse in the Additional Tools and Resources section. Several comments expressed concern that the I statement for caregiver abuse might be interpreted as a recommendation against screening. The USPSTF wants to clarify that its I statement is not a recommendation for or against screening for caregiver abuse in older or vulnerable adults. The I statement indicates that the evidence is insufficient to assess the balance of benefits and harms and is a call for more research. In the absence of evidence, clinicians should use their judgement as to whether to screen their patients. The Suggestions for Practice Regarding the I Statement section highlights factors that clinicians can consider in determining whether to screen. The Research Needs and Gaps section calls for additional evidence needed for the USPSTF to make a future recommendation.

Research Needs and Gaps

See **Table 2** for research needs and gaps related to screening for IPV and caregiver abuse of older or vulnerable adults.

Table 2. Research Needs and Gaps in Screening for Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults

To fulfill its mission to improve health by making evidence-based recommendations for preventive services, the USPSTF routinely highlights the most critical evidence gaps for making actionable preventive services recommendations. We often need additional evidence to create the strongest recommendations for everyone and especially for people with the greatest burden of disease. In this table, we summarize key bodies of evidence needed for the USPSTF to make recommendations for Screening for Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults. For additional information and detail on research needed to address these evidence gaps, see the Research Gaps Taxonomy table on the USPSTF website (https://www.uspreventiveservicestaskforce.org/home/getfilebytoken/yj6JY8HJZtbnv5qDPxS3PX).
Intimate partner violence
Studies are needed to assess the accuracy of screening tools in at-risk populations.
Studies of interventions that have been shown effective in pregnant and postpartum women are needed in other populations.
Studies of screening followed by interventions that have been shown effective in pregnant and postpartum women are needed in other populations.
Caregiver abuse of older or vulnerable adults
Studies are needed to assess the accuracy of screening tools for caregiver abuse in older adults and caregiver abuse in vulnerable adults, especially tools that can be delivered in the primary care setting and consider the abilities (and vulnerabilities) of these populations to engage in screening.
Studies are needed on the benefits and harms of screening for and interventions to reduce caregiver abuse in older or vulnerable adults.

Abbreviation: USPSTF, US Preventive Services Task Force.

Recommendations of Others

IPV Screening Recommendations

The American Academy of Family Physicians supports the 2018 USPSTF recommendation to screen for IPV in all women of reproductive age and provide interventions for women who screen positive.[63] The American Medical Association recommends that physicians routinely inquire about physical, sexual, and psychological abuse.[64] For persons experiencing abuse, it recommends that physicians and patients work together to develop exit plans for emergencies and consider referrals to appropriate care and resources.[64] The American Academy of Neurology recommends routine screening in all patients for past and ongoing violence.[1,35,65] The American Academy of Pediatrics recommends that pediatricians be alert to signs and symptoms of exposure to IPV in caregivers and children.[1,35,66] The American College of Obstetricians and Gynecologists recommends screening for IPV in all pregnant women over the course of pregnancy and offering educational materials on IPV, even if no abuse is acknowledged.[67] The Women's Preventive Services Initiative recommends that adolescents and women be screened for interpersonal and domestic violence at least annually.[68]

Abuse of Older and Vulnerable Adults Screening Recommendations

The American Academy of Family Physicians supports the 2018 USPSTF recommendation.[63] The American Medical Association and the American Academy of Neurology recommend routinely screening all patients for abuse and neglect.[64,65] The American College of Obstetricians and Gynecologists recommends screening persons 60 years or older for signs and symptoms of mistreatment, following appropriate state guidelines, and referring persons who screen positive to appropriate care.[69]

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