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Screening for intimate partner violence in health care settings is a contested arena

In relation to the article, *Intimate Partner Violence: are Australian nurses and midwives trained to provide care, ANJ May 2013*, we note with interest the discussion about intimate partner violence (IPV) nurse screening and the future research and what the authors, Fiolet, Sands and Nagle, propose on this important subject.

IPV is a significant public health problem, with substantial prevalence rates in clinical populations (Hegarty & Bush, 2002). We fully agree nurses are in an ideal position to identify and care for women affected by violence and that more can be done to support clinicians in this role.

The authors suggest that routine screening for IPV improves health outcomes for women. However, routine IPV screening is controversial (Taket et al., 2004). The authors respond to a systematic review, updating the United States Preventative Services Task Force (USPSTF) recommendation published last year (Nelson, Bougatsos & Blazina, 2012). This systematic review and the USPSTF state that, contrary to their previous recommendation (Nelson et al., 2004); they now support routine IPV screening. This surprising conclusion is challenged even by the authors of the major study that investigated screening outcomes for women (Wathen et al., 2013).

One of us led the most recent Cochrane review on screening for IPV in health care settings (Taft et al., 2013) which analysed eleven randomised trials and confirmed findings from many previous studies which reinforce that while screening can increase identification rates of women experiencing abuse, referrals to specialist family violence services are low, the costs associated with screening all women have not been determined but most importantly, there is no evidence that it improves the health or quality of life of abused women (Taft et al., 2013). The World Health Organization (WHO) has also recently published clinical guidelines which do not recommend routine screening of all women for violence. They suggest a case finding approach according to risk assessment (WHO, 2013).

Routine IPV screening has become policy in many health care settings, often with limited training, guidelines and support for clinicians (Feder et al., 2009). Whilst IPV screening may increase identification of women experiencing violence (NSW Department of Health, 2006; Taft et al., 2013; Vanderburg et al., 2010), government policy for routine screening assumes all women are screened and that those experiencing abuse are appropriately supported and referred to family services. This is often not the case, with nurses and other health care professionals experiencing significant barriers to their practice (Beynon et al., 2013; Furniss et al., 2007; Hooker, Ward & Verrinder, 2012; Jack et al., 2008). A thorough review of routine screening programs in health care settings across many high income countries found on average only 15-30% of women are actually screened (Stayton & Duncan, 2005).

Despite routine screening and policy in many health care settings, the controversy continues around the benefits of routine IPV screening. Many suggest that the compelling logic for screening (the overwhelming disease burden and the fact that screening increases identification and community awareness of violence) overrides the hard evidence (no improved health outcomes) and that routine screening is justified. Some suggest considering screening from an ethical framework and state that in some women, screening may do some good (beneficence) and studies have shown that it does no harm (non-maleficence) (Koziol-McLain et al., 2010).

This may be true,however screening policy does not guarantee women are asked about violence or that they receive the support and assistance required. Putting policy into place without nurse individual and system support and ongoing education means proposed or intended outcomes are less likely to occur.

A recent trial by scholars at Mother & Child Health Research, Latrobe University has been undertaken with Maternal & Child Health nurses in Victoria, to strengthen their family violence practices with vulnerable clients in the community (Taft et al., 2012). Results (soon to be published) suggest that nurse use of clinical tools, team strategies and improved collaboration with family violence services can make a difference to disclosure, safety planning rates and client care. However, nurses still face significant barriers to implementation of routine screening and further work is required to assess the sustainability of clinician screening in the post natal setting.

We believe that targeted screening of high risk groups of women such as those attending ante-natal, substance abuse or abortion clinics may be warranted due to the greater prevalence of IPV however; there remains insufficient evidence to justify universal routine screening of all women in any setting. Case-finding of women with symptoms suggestive of abuse may be a better strategy. But, much more needs to be understood about what systems and strategies best support clinicians to sustain supportive screening and referral practices. In the end, we need sound evidence of what clinicians can do to make sure women and children benefit from screening, safety planning and referral.

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References available on request.