JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults

US Preventive Services Task Force Final Recommendation Statement

US Preventive Services Task Force

IMPORTANCE Intimate partner violence (IPV) and abuse of older or vulnerable adults are common in the United States but often remain undetected. In addition to the immediate effects of IPV, such as injury and death, there are other health consequences, many with long-term effects, including development of mental health conditions such as depression, posttraumatic stress disorder, anxiety disorders, substance abuse, and suicidal behavior; sexually transmitted infections; unintended pregnancy; and chronic pain and other disabilities. Long-term negative health effects from elder abuse include death, higher risk of nursing home placement, and adverse psychological consequences.

OBJECTIVE To update the US Preventive Services Task Force (USPSTF) 2013 recommendation on screening for IPV, elder abuse, and abuse of vulnerable adults.

EVIDENCE REVIEW The USPSTF commissioned a review of the evidence on screening for IPV in adolescents, women, and men; for elder abuse; and for abuse of vulnerable adults.

FINDINGS The USPSTF concludes with moderate certainty that screening for IPV in women of reproductive age and providing or referring women who screen positive to ongoing support services has a moderate net benefit. There is adequate evidence that available screening instruments can identify IPV in women. The evidence does not support the effectiveness of brief interventions or the provision of information about referral options in the absence of ongoing supportive intervention components. The evidence demonstrating benefit of ongoing support services is predominantly found in studies of pregnant or postpartum women. The benefits and harms of screening for elder abuse and abuse of vulnerable adults are uncertain, and the balance of benefits and harms cannot be determined.

CONCLUSIONS AND RECOMMENDATION The USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services. (B recommendation) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults. (I statement)

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The US Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific preventive care services for patients without obvious related signs or symptoms.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

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. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

Summary of Recommendations and Evidence

The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services (B recommendation) (**Figure 1**).

See the Clinical Considerations section for more information on effective ongoing support services for IPV and for information on IPV in men.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults. (I statement)

See the Clinical Considerations section for suggestions for practice regarding the I statement.

Rationale

Importance

Intimate partner violence and abuse of older or vulnerable adults are common in the United States but often remain undetected. Although estimates vary, IPV (including sexual violence, physical violence, and stalking) is experienced by approximately 36% of US women and 33% of US men during their lifetime. Severe physical violence is experienced by 21% of US women and 15% of US men during their lifetime.[1] Prevalence rates vary by age, race/ethnicity, and income. Estimates also vary for prevalence of elder abuse and abuse of vulnerable adults. A 2008 nationwide survey of US adults 60 years or older found that the prevalence of any abuse or neglect in the past year was 10%.[2] A 2004 survey of Adult Protective Services (APS) agencies found 40 848 substantiated reports of vulnerable adult abuse (in those aged 18 to 59 years) in 19 states.[3]

In addition to the immediate effects of IPV, such as injury and death, there are other health consequences, many with long-term effects, including development of mental health conditions such as depression, posttraumatic stress disorder (PTSD), anxiety disorders, substance abuse, and suicidal behavior; sexually transmitted infections; unintended pregnancy; and chronic pain and other disabilities.[4,5] Violence during pregnancy is associated with preterm birth and low birth weight[6] and adverse effects on maternal and infant health, including postpartum mental health problems[7] and hospitalization during infancy.[8]

Long-term negative health effects from elder abuse include death,[9] higher risk of nursing home placement[10] among those referred to APS, and adverse psychological consequences (distress, anxiety, and depression).[11]

Detection

The USPSTF found adequate evidence that available screening instruments can identify IPV in women. The USPSTF found limited evidence about the performance of IPV screening instruments in men.

The USPSTF found inadequate evidence to assess the accuracy of screening instruments designed to detect elder abuse or abuse of vulnerable adults when there are no recognized signs and symptoms of abuse.

Benefits of Detection and Early Intervention

The USPSTF found adequate evidence that effective interventions that provide or refer women to ongoing support services can reduce violence, abuse, and physical or mental harms in women of reproductive age. However, the USPSTF found inadequate direct evidence that screening for IPV can reduce violence, abuse, and physical or mental harms.

The recommendation on screening for IPV applies to women of reproductive age because the evidence demonstrating benefit of ongoing support services is predominantly found in studies of pregnant or postpartum women. The USPSTF extrapolated the evidence pertaining to interventions with ongoing support services from pregnant and postpartum women to all women of reproductive age.

The USPSTF found no studies on screening or interventions for IPV in men.

The USPSTF found inadequate evidence that screening or early detection of elder abuse or abuse of vulnerable adults reduces exposure to abuse, physical or mental harms, or mortality in older or vulnerable adults.

Harms of Detection and Early Intervention

The USPSTF found inadequate evidence to determine the harms of screening or interventions for IPV. Limited evidence showed no adverse effects of screening or interventions for IPV. The USPSTF determined that the magnitude of the overall harms of screening and interventions for IPV can be bounded as no greater than small. When direct evidence is limited, absent, or restricted to select populations or clinical scenarios, the USPSTF may place conceptual upper or lower bounds on the magnitude of benefit or harms.

The USPSTF found inadequate evidence on the harms of screening or interventions for elder abuse or abuse of vulnerable adults.

Clinical Considerations

Patient Population Under Consideration

This recommendation applies to women of reproductive age and older or vulnerable adults without recognized signs and symptoms of abuse (**Figure 2**). The studies reviewed for IPV included adolescents to women in their 40s.

See below for suggestions for practice regarding men and older and vulnerable adults.

Figure 1. USPSTF Grades and Levels of Evidence

What the USPSTF Grades Mean and Suggestions for Practice

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the Clinical Considerations section of the USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as the number, size, or quality of individual studies. inconsistency of findings across individual studies. limited generalizability of findings to routine primary care practice. lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of the limited number or size of studies. important flaws in study design or methods. inconsistency of findings across individual studies. gaps in the chain of evidence. findings not generalizable to routine primary care practice. lack of information on important health outcomes. More information may allow estimation of effects on health outcomes.
The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.	

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Definitions of IPV and Elder Abuse

The term "intimate partner violence" refers to physical violence, sexual violence, psychological aggression (including coercive tactics, such as limiting access to financial resources), or stalking by a romantic or sexual partner, including spouses, boyfriends, girlfriends, dates, and casual "hookups." Severe physical violence includes being hit with a fist or something hard, kicked, hurt by pulling hair, slammed against something, hurt by choking or suffocating, beaten, burned on purpose, or threatened with a knife or gun.[1]

The term "elder abuse" refers to acts whereby a trusted person (eg, a caregiver) causes or creates risk of harm to an older adult.[12] According to the Centers for Disease Control and Protection (CDC), an older adult is considered to be 60 years or older.[12] The legal definition of "vulnerable adult" varies by state but is generally defined as a person who is or may be mistreated and who, because of age, disability, or both, is unable to protect him or herself.[3] Types of abuse that apply to older or vulnerable adults include physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, and financial or material exploitation.

Assessment of Risk

Although all women of reproductive age are at potential risk for IPV and should be screened, a variety of factors increase risk of IPV, such as exposure to violence as a child, young age, unemployment,

Figure 2. Clinical Summary: Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults

Population	Women of reproductive age	Older or vulnerable adults
Recommendation	Screen for intimate partner violence (IPV) and provide or refer screen-positive women to ongoing support services Grade: B	No recommendation. Grade: I (insufficient evidence)

Risk Assessment	All women of reproductive age are at potential risk for IPV and should be screened. There are a variety of factors that increase risk of IPV, such as exposure to violence as a child, young age, unemployment, substance abuse, marital difficulties, and economic hardships. Risk factors for elder abuse include isolation and lack of social support, functional impairment, and poor physical health. For older adults, lower income and living in a shared living environment with a large number of household members (other than a spouse) are associated with an increased risk of financial and physical abuse.
Screening Tests	Several screening instruments can be used to screen women for IPV in the past year, such as the following: Humiliation, Afraid, Rape, Kick (HARK); Hurt/Insult/Threaten/Scream (HITS); Extended Hurt/Insult/Threaten/Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST). The USPSTF found no valid, reliable screening tools in the primary care setting to identify abuse of older or vulnerable adults without recognized signs and symptoms of abuse.
Treatments and Interventions	Effective interventions generally included ongoing support services that focused on counseling and home visits, addressed multiple risk factors (not just IPV), or included parenting support for new mothers. Studies that only included brief interventions and provided information about referral options were generally ineffective. The USPSTF found inadequate evidence that screening or early detection of elder abuse or abuse of vulnerable adults reduces exposure to abuse, physical or mental harms, or mortality in older or vulnerable adults.
Relevant USPSTF Recommendations	The USPSTF has made recommendations on primary care interventions for child maltreatment; screening for depression in adolescents, adults, and pregnant women; screening for alcohol misuse; and screening for drug misuse.

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to https://www.uspreventiveservicestaskforce.org.

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substance abuse, marital difficulties, and economic hardships.[13] However, the USPSTF did not identify any risk assessment tools that predict greater likelihood of IPV in populations with these risk factors.

Risk factors for elder abuse include isolation and lack of social support, functional impairment, and poor physical health.[14] For older adults, lower income and living in a shared living environment with a large number of household members (other than a spouse) are associated with an increased risk of financial and physical abuse.[15]

Screening Tests

Several screening instruments can be used to screen women for IPV. The following instruments accurately detect IPV in the past year among adult women: Humiliation, Afraid, Rape, Kick (HARK); Hurt, Insult, Threaten, Scream (HITS); Extended–Hurt, Insult, Threaten, Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST).

HARK includes 4 questions that assess emotional and physical IPV in the past year. HITS includes 4 items that assess the frequency of IPV, and E-HITS includes an additional question to assess the frequency of sexual violence. PVS includes 3 items that assess physical abuse and safety. WAST includes 8 items that assess physical and emotional IPV.

Most studies only included women who could be separated from their partners during screening, during the intervention, or both, so screening and the intervention could be delivered in private.

State and local reporting requirements vary from one jurisdiction to another, with differences in definitions, whom and what should be reported, who should report, and to whom. Some states require clinicians (including primary care providers) to report abuse to legal authorities, and most require reporting of injuries resulting from guns, knives, or other weapons.[16] For elder abuse, mandatory reporting laws and regulations also vary by state; however, most states require reporting.[17]

The USPSTF found no valid, reliable screening tools in the primary care setting to identify IPV in men without recognized signs and symptoms of abuse.

The USPSTF found no valid, reliable screening tools in the primary care setting to identify abuse of older or vulnerable adults without recognized signs and symptoms of abuse.

Screening Interval

The USPSTF found no evidence on appropriate intervals for screening. Randomized clinical trials (RCTs) of screening and interventions for IPV often screen for current IPV or IPV in the past year.

Box. Components of Effective Ongoing Support Services for Intimate Partner Violence

Format and Content

Home visits and counseling that address multiple risk factors (beyond just IPV)

Some examples of the home visit component include

- Tailored IPV-related information based on the individual's expressed needs and level of danger at each visit (eg, information addressing the cycle of violence, risk factors for homicide, choices available to the woman, safety planning, and other IPV resources in the community)
- Services related to parenting, problem-solving skills, and emotional support; linking families to community services; and prevention of child abuse

Some examples of the counseling component include

- Cognitive behavioral therapy aimed at reducing behavioral risks, including depression, IPV (emphasizing safety behaviors), smoking, and tobacco exposure; cognitive behavioral therapy aimed at risks specific to the individual

Duration, Frequency, and No. of Visits

Average duration ranged from 31 wk to 3 y; ongoing support services spanned the prenatal and postnatal periods

Frequency of ongoing support services varied and were often tailored to the individual or coincided with routine perinatal care visits (eg, weekly, biweekly, monthly, or quarterly)

Total average No. of sessions ranged from 4 to 14

Ongoing support services were delivered either at home or in perinatal care sites

Provider

Delivery of ongoing support services often required dedicated training and was performed by paraprofessionals; master's-level, trained social workers or psychologists; community health workers; and nurses

Abbreviation: IPV, intimate partner violence.

Interventions

No studies definitively identified which intervention components resulted in positive outcomes. However, based on the evidence from 3 studies,[18-20] effective interventions generally included ongoing support services that focused on counseling and home visits, addressed multiple risk factors (not just IPV), or included parenting support for new mothers. See the **Box** for more information about the components of effective ongoing support services. These studies were conducted in pregnant or postpartum women. Studies that only included brief interventions and provided information about referral options were generally ineffective.

Suggestions for Practice Regarding the I Statement and Other Populations

Potential Preventable Burden

Older or Vulnerable Adults | Prevalence estimates of elder abuse and abuse of vulnerable adults vary. A 2008 nationwide survey of US adults 60 years or older found that the prevalence of any abuse or potential neglect in the past year was 10%.[21] Elder abuse has a number of long-term negative health effects, including death,[9] higher risk of nursing home placement[10] among those referred to APS, and adverse psychological consequences (distress, anxiety, and depression).[11] A 2004 survey of APS agencies identified 40 848 substantiated reports of vulnerable adult abuse (in those aged 18-59 years) in 19 states.[3]

Women Not of Reproductive Age | Based on the age categories reported by the CDC, approximately 4% of women aged 45 to 54 years and more than 1% of women 55 years or older have experienced rape, physical violence, or stalking by an intimate partner in the past 12 months.[22]

Men | More than 33% of men have experienced sexual violence, physical violence, or stalking by an intimate partner in their lifetime.[1] Approximately 34% of men report any psychological aggression by an intimate partner in their lifetime. Among men who experience sexual violence, physical violence, or stalking, more than 10% experience at least 1 form of an IPV-related adverse effect, such as feeling fearful, feeling concerned for safety, injury, missing days of work or school, and needing medical care.[1]

Potential Harms

Some potential harms of screening in older or vulnerable adults, women not of reproductive age, and men are shame, guilt, self-blame, retaliation or abandonment by perpetrators, partner violence, and the repercussions of false-positive results (eg, labeling and stigma).

Current Practice

Older or Vulnerable Adults | Limited evidence suggests that screening is not commonly occurring in practice; 1 study found that more than 60% of clinicians have never asked their older adult patients about abuse.[23]

Women | While not specific to age, evidence suggests that screening for IPV is not commonly occurring in practice. A recent systematic review found that rates of routine screening vary and are typically low, ranging from 2% to 50% of clinicians reporting "always" or "almost always" routinely screening for IPV.[24]

Men | No data are available on current screening practice in men.

Additional Approaches to Prevention

The Health Resources and Services Administration (HRSA) Strategy to Address Intimate Partner Violence (2017-2020) identifies priorities for reducing IPV, including training the health care and public health workforce to address IPV.[25] HRSA also developed a toolkit[26] for clinicians and health centers to help implement screening and interventions for IPV. The National Hotline on Domestic Violence has information about local programs and resources across the country.[27] The Administration for Children and Families has funded a compendium of state statutes and policies on domestic violence and health care.[28]

The CDC,[29] Substance Abuse and Mental Health Services Administration–HRSA Center for Integrated Health Solutions,[30] US Department of Veterans Affairs,[31] Administration for Community Living,[32] and the Administration on Aging's National Center for Elder Abuse[33] also have additional resources available for clinicians.

Useful Resources

The USPSTF has made recommendations on primary care interventions for child maltreatment[34]; screening for depression in adolescents,[35] adults, and pregnant women[36]; screening for alcohol misuse[37]; and screening for drug misuse.[38]

Other Considerations

Research Needs and Gaps

There are several key research gaps related to IPV. The USPSTF recognizes that a significant body of evidence is lacking for men. The CDC has conducted studies demonstrating the prevalence and importance of IPV in men; however, there is a lack of research on screening and interventions to prevent IPV in men. Research is needed in all areas related to the accuracy of screening tools for men, and trials are needed that examine the effectiveness (benefits and harms) of screening and interventions for IPV in the primary care setting in men without recognized signs and symptoms of abuse.

More research is also needed on the most effective characteristics of ongoing support services for reducing IPV. In particular, more RCTs that compare the benefits and harms of screening (plus ongoing support services or referral for women who screen positive) vs no screening are needed, where support services may include more frequent and intensive interventions such as home visits, cognitive behavioral therapy, or other forms that address multiple risk factors. These studies should evaluate the optimal duration, format, and method of delivery.

Trials of ongoing support services should enroll women of all ages, including nonpregnant women and women beyond reproductive age. These trials will help with understanding the types of post-screening, ongoing support services that can be most effective, and the patients for whom they are most effective.

More research is also needed in all areas related to the accuracy of screening tools in the primary care setting for elder abuse and abuse of vulnerable adults when there are no recognized signs and symptoms of abuse. High-quality RCTs are also needed on the effectiveness (benefits and harms) of screening and interventions in the primary care setting to prevent such abuse.

Discussion

Burden of Disease

Intimate partner violence is a significant public health problem. According to the CDC, 36% of US women and 33% of US men experience sexual violence, physical violence, or stalking by an intimate partner during their lifetime.[1] The prevalence of lifetime psychological aggression is 36.4% in women and 34.3% in men. Lifetime severe physical violence is experienced by 21% of women and 15% of men.[1] The most commonly reported effects of IPV include feeling fearful (61.9% of women and 18.2% of men) and concern for safety (56.6% of women and 16.7% of men).[39] Women and men with a history of sexual violence, stalking, or physical violence committed by an intimate partner were more likely to report experiencing asthma, irritable bowel syndrome, frequent headaches, chronic pain, difficulty sleeping, and limitations in their activities than women and men without a history of such violence.[39]

Intimate partner violence is more common in younger women; thus, women of reproductive age have a higher prevalence of IPV than older women. Approximately 14.8% of women aged 18 to 24 years have experienced rape, physical violence, or stalking by an intimate partner in the past 12 months, compared with 8.7% of women aged 25 to 34 years, 7.3% of women aged 35 to 44 years, 4.1% of women aged 45 to 54 years, and 1.4% of women 55 years or older.[22] Intimate partner violence during pregnancy can have significant negative health consequences for women and children, including depression in women, low birth weight and preterm birth, and perinatal death.[6,7]

Abuse of older or vulnerable adults is also a significant public health problem. Estimates of prevalence vary. A nationally representative survey (N = 3005) of community-dwelling adults aged 57 to 85 years estimated that 9% had experienced verbal mistreatment, 3.5% financial mistreatment, and 0.2% physical mistreatment by a family member.[40] Among older adults, intimate partners constitute the minority of perpetrators in substantiated reports of elder abuse. According to data from a national survey of APS agencies, across all substantiated abuse reports involving a known perpetrator among adults older than 60 years (N = 2074), approximately 11% of reports involved a spouse or intimate partner. The most common perpetrators of elder abuse are adult children (about 33% of cases) and other family members (about 22% of cases).[3]

The USPSTF found few studies reporting on recent estimates of the prevalence of abuse in populations of vulnerable adults. The 1995-1996 National Violence Against Women Survey (N = 6273) found that women with severe disability impairments were 4 times more likely to experience sexual assault in the past year than women without disabilities.[41]

Scope of Review

The USPSTF commissioned a systematic evidence review to update its 2013 recommendation on screening for IPV, elder abuse, and abuse of vulnerable adults. The scope of this review is similar to that of the prior systematic review, but in the current review[42,43] the USPSTF also examined the evidence on IPV in men and adolescents. The current review did not examine screening or interventions for perpetration of IPV.

Accuracy of Screening Tests

The review identified 15 fair-quality studies (n = 4460) assessing the accuracy of 12 different IPV screening tools. All studies enrolled adults, and most enrolled only women or a majority of women; 1 study included only men.[44] The recruitment settings varied; 5 studies recruited from emergency departments, 4 from primary care practices, 1 from urgent care, and 3 by telephone or mail survey. Most studies assessed a tool designed to identify persons experiencing IPV within the past year; however, 4 studies reported on the accuracy of 5 tools for identifying current (ongoing) abuse, 1 assessed the accuracy of detecting lifetime abuse, and 1 assessed the accuracy of a tool for predicting future (within 3 to 5 months) abuse.

Five studies reported on the accuracy of 5 different screening tools (HARK, HITS, E-HITS, PVS, and WAST) for detecting any past-year IPV in adult women. Sensitivity ranged from 64% to 87% and specificity from 80% to 95%. Most screening tools were assessed by only 1 study.

Four studies reported on the accuracy of 5 screening tools for identifying ongoing or current abuse. Across all studies, accuracy varied widely (sensitivity, 46%-94%; specificity, 38%-95%). One tool, the Ongoing Violence Assessment Tool (OVAT), had acceptable sensitivity (86%) and specificity (83%) compared with the Index of Spouse Abuse (ISA).

One study enrolling men only from an emergency department reported on the accuracy of the PVS and HITS for detecting past-year IPV; sensitivity was low for both PVS and HITS for detecting psychological abuse (30% and 35%, respectively) and physical abuse (46% for both).

The review identified 1 fair-quality study assessing the accuracy of screening for abuse in the primary care setting in older adults when abuse is not suspected.[45] Screening was conducted using the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST), which includes 15 items. Compared with the Conflict Tactics Scale (CTS) (violence/verbal aggression scales combined), the H-S/EAST had a sensitivity of 46% (95% CI, 32%-59%) and specificity of 73.2% (95% CI, 62%-82%).

The review found no studies on the effectiveness of screening questionnaires or tools in identifying abuse and neglect of vulnerable adults.

Effectiveness of Early Detection and Treatment

Overall, 3 RCTs (n = 3759) found no direct benefit of screening for IPV in adult women (mean age range, 34-40 years) when screening was followed by brief counseling or referral. There were no significant differences between screening and control groups over 3 to 18 months for IPV, quality of life, depression, PTSD, or health care utilization outcomes. The RCTs compared universal screening for IPV in a health care setting with no screening; 1 study enrolled participants from 10 US primary care clinics, 1 from a single New Zealand emergency department, and 1 from a variety of Canadian clinical settings (12 primary care sites, 11 emergency departments, and 3 obstetrics-gynecology clinics). No RCTs enrolled men or adolescents, and none focused on pregnant women or reported outcomes separately by pregnancy status. Women who screened positive received brief counseling and referral; the trials did not directly provide ongoing support services, and the proportion of women who received more intensive services after referral was not reported.

Eleven RCTs (n = 6740) evaluated an IPV intervention in adult women with screen-detected IPV or women considered at risk for IPV. Five RCTs enrolled women during the perinatal period; all reported on IPV outcomes. Of these, the studies that were effective generally 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. Two home-visit interventions[19,20] found lower rates of IPV in women assigned to the intervention group than in those assigned to the control group; however, the difference between groups was small (standardized mean difference, −0.04 and −0.34, respectively), and only 1 study found a statistically significant difference (standardized mean difference, −0.34 [95% CI, −0.59 to −0.08]).[19]

Of the 3 RCTs enrolling pregnant women with screen-detected IPV that evaluated a counseling intervention, 2 found benefit in favor of the intervention.[18,46] One trial only reported on subtypes of violence; the benefit was significant for some subtypes of violence (psychological and minor physical abuse) but not others (severe physical and sexual abuse).[46]

One RCT assessing an integrated behavioral counseling intervention in women with 1 or more risk factors (smoking, environmental tobacco smoke exposure, depression, and IPV) reported on birth outcomes among the subgroup with IPV at baseline; significantly fewer women in the intervention group delivered very preterm neonates (≤33 weeks of gestation).[47] Many women with IPV at baseline (62%) also screened positive for depression and received counseling for depression in addition to counseling for IPV. Two RCTs reported on depression, and both found benefit in favor of the intervention (only 1 found a statistically significant benefit[46]); 1 of these studies also reported on PTSD symptoms and found similar scores in both groups.[48]

Six RCTs enrolled nonpregnant women; 4 measured changes in overall IPV incidence and found no significant difference between groups in rates of overall IPV exposure[49,50] or combined physical and sexual violence[51,52]; measures of IPV were either similar between groups or slightly higher in the intervention group. Two RCTs measured changes in quality of life after an IPV intervention; in both trials, scores were similar between intervention and control groups and differences were not statistically significant.[49,53] Interventions in nonpregnant women primarily included brief counseling, provision of information, and referrals but did not directly provide ongoing support services, and the proportion of women who received more intensive services after referral was not reported.

The review identified no eligible screening or intervention studies on IPV in men.

The review identified no eligible studies on elder abuse or abuse of vulnerable adults.

Potential Harms of Screening and Treatment

Two fair-quality RCTs reported on harms of screening and identified no adverse effects of screening. One RCT developed a specific tool, the Consequences of Screening Tool (COST), 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)." Results indicated that being asked IPV screening questions was not harmful to women immediately after screening. Scores were similar across groups.

Five good- or fair-quality RCTs assessing IPV interventions reported on harms. No study found significant harms associated with the interventions. One RCT[49] assessing a brief counseling intervention surveyed women at 6 and 12 months about survey participation (including potential harms); there was no difference between groups in the percentage of women who reported potential harms, and the authors concluded no harms were associated with the intervention. 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.

The review identified no eligible studies on IPV in men.

The review identified no eligible studies on elder abuse or abuse of vulnerable adults.

Estimate of Magnitude of Net Benefit

The USPSTF concludes with moderate certainty that screening for IPV in women of reproductive age and providing or referring women

who screen positive to ongoing support services has a moderate net benefit. There is adequate evidence that available screening instruments can identify IPV in women. The evidence does not support the effectiveness of brief interventions or the provision of information about referral options in the absence of ongoing supportive intervention components. The evidence demonstrating benefit of ongoing support services is predominantly found in studies of pregnant or postpartum women. Studies that demonstrated no clear benefit in nonpregnant women, however, did not directly provide ongoing support services. Therefore, the USPSTF extrapolated the evidence pertaining to interventions with ongoing support services in pregnant and postpartum women to all women of reproductive age. More research is needed that includes ongoing support services for women who are not pregnant or postpartum or who are beyond reproductive age.

Because of the lack of evidence, the USPSTF concludes that the benefits and harms of screening for elder abuse and abuse of vulnerable adults are uncertain and that the balance of benefits and harms cannot be determined. More research is needed.

Response to Public Comment

A draft version of this recommendation statement was posted for public comment on the USPSTF website from April 24, 2018, to May 21, 2018. The USPSTF reviewed all comments and made revisions to the recommendation as appropriate. Some comments asked for clarification about the patient population, including whether men and older women were included in the recommendation. In response, the USPSTF clarified that it examined the evidence on the benefits and harms of screening for IPV in women of all ages and in men; the recommendation is based on the available evidence. Some comments suggested screening instruments for elder abuse. The USPSTF reviewed the suggested tools; however, none of the suggested screening instruments met the USPSTF's inclusion criteria (eg, those screening tools were developed or tested in populations with recognized signs or symptoms of abuse). The USPSTF clarified the types of screening instruments that are needed in the Research Needs and Gaps section. Last, the USPSTF added more details on the research gaps and suggested resources for practitioners.

Update of Previous USPSTF Recommendation

This recommendation replaces the 2013 USPSTF recommendation. It is consistent with the 2013 USPSTF recommendation, which was a B recommendation for women of childbearing age and an I statement for abuse in older or vulnerable adults. This recommendation incorporates new evidence since 2013 and provides additional information about the types of ongoing support services that appear to be associated with positive outcomes.

Recommendations of Others

The American Academy of Family Physicians,[54] American College of Obstetricians and Gynecologists (ACOG),[55] American Academy of Neurology,[56] American Academy of Pediatrics,[57] Institute of Medicine Committee on Preventive Services for Women,[58] and the HRSA-supported Women's Preventive Services Guidelines[59] are in favor of screening for IPV. The American Academy of Family Physicians recommends screening for IPV in all women of childbearing age and providing interventions for those who screen positive. ACOG recommends screening for IPV in all pregnant women and offering ongoing support services. The American Medical Association Code of Medical Ethics states that clinicians should routinely ask about physical, sexual, and psychological abuse.[60] The Canadian Task Force on Preventive Health Care[61] and the World Health Organization[62] indicate that current evidence does not justify universal screening for IPV. The Community Preventive Services Task Force recommends primary prevention interventions that aim to prevent or reduce IPV and sexual violence among youth.[63] The American Academy of Neurology[56] and ACOG[64] recommend screening for elder abuse. The Canadian Task Force on Preventive Health Care[61] concludes that the current evidence is insufficient to warrant a recommendation for screening.

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