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Responding to domestic violence in primary care
We know more about what works but questions remain

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The recent publication of findings from the first randomised controlled trial in the United Kingdom on domestic violence marks a suitable opportunity to take stock of what we know about responding to domestic violence in primary care. Abuse against women by intimate partners (intimate partner violence; IPV) is a major public health problem worldwide. More than one in four women experience IPV at some time in their lives, and these women and their children have an increased risk of severe short term and long term health consequences, both physical and mental. The social and economic costs of IPV are enormous; in 2008 the annual cost of IPV in the UK was estimated to be £15 730m (£18 720m; $24 740).

The primary care response to women who experience IPV is important, not least because a meta-analysis of qualitative studies has highlighted that such women see healthcare professionals as potential sources of support. Although several recently published randomised controlled trials and systematic reviews have advanced our knowledge about effective responses in primary care, our understanding of how best to manage this complex and challenging problem remains incomplete.

Whether sufficient evidence exists to recommend screening for IPV in healthcare settings is debatable. Structured instruments have been designed to help identify women who are experiencing IPV in the primary care setting. A recent systematic review found that the HITS instrument, which comprises four questions, had the best predictive power and reliability. Some clinicians recommend adopting a low threshold for asking direct questions about abuse (which is effectively case finding). Any inquiry process forms a brief interview in itself when accompanied by information about the reason for asking (“because the problem is common”), or the availability of specialised services, or when doing so offers a clear message about the practitioner’s willingness to discuss the problem and provide support.

Some studies have shown positive effects of inquiry alone. A Canadian randomised trial conducted in settings including primary care found no harm from inquiry. It also found that both the intervention and control groups improved in terms of the primary outcomes “repeat IPV” and “quality of life” up to 18 months after screening in analyses adjusted to account for women lost to follow-up. All women (intervention group and control group) were given a card with information on specialised services, and all were asked by researchers to self complete a screening tool, so all experienced a form of inquiry. The difference between the groups was that the intervention group completed the screening tool before seeing the clinician, and if the woman screened positive results were passed to the clinician for possible use in the consultation.

A systematic review of screening studies that focused on programme mechanisms identified four components that increased rates of disclosure or identification of IPV. These were a commitment to investment and support for screening implementation at high levels in the organisation or institution concerned, effective screening protocols, thorough initial and ongoing training of healthcare staff, and the facility to immediately access or refer to onsite or offsite support services (or both).

Three recent cluster randomised trials in primary care have added greatly to what is known about effective interventions for women who do disclose that they experience IPV. The recent Identification and Referral to Improve Safety (IRIS) trial conducted in the UK evaluated an intervention that comprised training for clinicians, a computer prompt to ask about abuse within the medical record, and a referral pathway to a named IPV advocate—an earlier systematic review having shown the effectiveness of advocacy services. It showed increased referral to an advocate.

The Australian Mothers’ AdvocateS In the Community (MOSAIC) trial that examined the effect of non-professional mentor support for pregnant and recent mothers found a significant difference in mean abuse scores at 12 months, with weak evidence of effectiveness for other outcomes. A trial conducted in family planning clinics in an urban area in northern California, United States, that examined the effects of an intervention comprising education, harm reduction strategies, and provision of information on further local resources showed that reports of a partner applying psychological pressure to become pregnant or sabotaging contraception were significantly reduced in the intervention group compared with controls. Women in the intervention group were also more likely to report ending their relationship because it was unhealthy or because they felt unsafe. However, only four clinics were included in...
the study and the duration of follow-up was only three months, so the findings should be interpreted with caution.

Debates about the clinical importance of some of these effects are ongoing. A systematic review also found that psychological interventions delivered to women and children may be helpful. A brief counselling intervention delivered by general practitioners that is based on the “readiness to change” concept is currently being evaluated in an Australian trial that plans to report later this year. Translational research is needed to inform implementation of interventions on a larger scale and enable interventions to be tailored to different health service systems. Many questions remain to be answered by both primary research and secondary analysis of primary studies through systematic review and meta-analysis. The cost effectiveness of interventions aimed at reducing exposure to and the effects of interpersonal violence needs further exploration. The usefulness of screening or routine inquiry regarding IPV in men (both perpetrators and victims) in the primary care setting should be investigated, along with the potential of offering interventions in primary care for men who want to change their behaviour.

A major barrier to preventing IPV is that it is still a stigmatising and often hidden problem. This silence could be broken by clinicians routinely enquiring about the problem, and the growing evidence of the effectiveness of interventions accessed from primary care indicates that a strategy of routine inquiry about IPV in primary care should be more widely adopted.

Competing interests: The author has completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declares: no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years; no other relationships or activities that could appear to have influenced the submitted work.

Provenance and peer review: Commissioned; not externally peer reviewed.


Cite this as: BMJ 2012;344:e757
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