

The USPSTF Recommendation on Intimate Partner Violence: What We Can Learn From It and What Can We Do About It

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Introduction

In March, 2004, the third U.S. Preventive Service Task Force (USPSTF/Task Force) released their updated recommendations on routine screening for family and intimate partner violence (IPV). The Task Force, an independent panel of private sector experts in primary care and prevention appointed by the Federal Government, is charged with making recommendations on the effectiveness of clinical prevention services. Relying on an evidence report prepared by the University of Oregon Evidence-based Practice Center and a series of value judgments about the effectiveness of screening and intervention for IPV, the USPSTF concluded that there is insufficient evidence to recommend for or against routine screening for IPV in the primary care setting (“I” recommendation). The Task Force states that it found no direct evidence that screening for IPV reduces disability or premature death, that there are no existing studies determining the accuracy of screening tools or the adverse effects of screening and interventions, and that there is only limited evidence as to whether interventions actually reduce harm to women. Applying current methods to evaluate the evidence, the USPSTF indicates that it had no scientific basis to determine the balance between the benefits and harms of screening for IPV in the primary care setting due to the poor quality of the evidence on this topic.

The Task Force’s conclusion that there is insufficient evidence to recommend for or against screening for IPV may discourage the development of assessment and intervention services in the primary care setting for years to come. Professional medical societies use the Task Force’s recommendations as the basis for clinical practice guidelines. Private sector health care organizations and government agencies serving Medicare beneficiaries, military personnel, and veterans use the recommendations to determine whether a service should be offered or reimbursed. Published versions of the Task Force’s recommendations are used as textbooks to teach medical and nursing students about clinical preventive care.

The purpose of this exploratory paper is: (a) to describe the history of the Task Force’s recommendations on screening for IPV; (b) to enhance understanding of how the third USPSTF evaluates the effectiveness of preventive practices and develops recommendations; (c) to describe gaps in the evidence on the effectiveness of screening and intervention for IPV; (d) to examine the systematic evidence reviews and updated recommendations for other screening and counseling services; and (e) to identify strategies to address gaps in the evidence on screening for IPV and promote policies that support routine inquiry and intervention for IPV in the primary care setting.

Prior Recommendations for IPV

The first USPSTF, established in 1984, evaluated screening for IPV in a chapter on screening for violent injuries. The Task Force concluded that routine screening interviews and examinations for evidence of violent injuries were not advised and did not assign any rating to its recommendation. As part of the recommendation, the first Task Force informed clinicians that guidelines were available to evaluate victims of IPV and outlined steps describing how clinicians should manage IPV and injuries related to victimization.

The second USPSTF combined IPV, child abuse, and elder abuse into the topic of family violence and issued updated recommendations in 1996. The Task Force concluded that there was insufficient evidence to recommend for or against the use of specific screening instruments to detect family violence and assigned a “C” rating. The 1996 recommendation offered further explanation that including questions about physical abuse when taking a history from adult patients may be recommended on other grounds such as the substantial prevalence of undetected abuse among adult female patients, the potential value of this information in the care of the patient, and the low cost and low risk of harm from such screening. The second Task Force stated that, “Despite the limited and imperfect options for detecting and intervening in domestic violence, the benefits are substantial for those families where the cycle of abuse can be interrupted.”

A BRIEF HISTORY OF THE USPSTF

In 1984, the Public Health Service, part of the U.S. Department of Health and Human Services, established the USPSTF to provide advice to health professionals about the use of commonly delivered preventive health care services. The approaches and criteria adopted by the first USPSTF were modeled on those developed by the Canadian Task Force on Preventive Care Services. The Canadian Task Force has conducted systematic reviews of the available scientific evidence on selected preventive care services since 1979 (Wolfe & Atkins, 2001).

The first Task Force was disbanded in 1989 with the release of the *Guide to Clinical Preventive Services* (1989), a review of the evidence for some 169 screening tests, counseling interventions, immunizations, and chemopreventive regimens. The first Task Force graded recommendations on a 5-level (A to E) scale to reflect the quality of supporting evidence for age groups ranging from infancy to old age. A second, smaller Task Force was convened by the Public Health Service in 1990. It worked more closely with public and private sector partners, adopted policies for disclosure of conflicts of interest, and modified the methods for reviewing evidence and making recommendations (Wolfe and Atkins, 2001). Its work resulted in the publication of a second edition of the *Guide* in 1996, which covered over 200 interventions in 70 areas of clinical preventive care practice.

The third USPSTF was convened in 1998 by the Agency for Health Care Research and Policy, an agency of the U.S. Department of Health and Human Services. When Congress changed the name of this agency to the Agency for Healthcare Research and Quality (AHRQ) in 1999, it made Federal support for the work of the Task Force explicit and provided support for evidence syntheses that are developed by academic Evidence-based Practice Centers (EPCs). EPCs conduct systematic evidence reviews and produce detailed technical reports summarizing the evidence of effectiveness for a preventive practice.

Current Methods

The third USPSTF has separated the processes of reviewing the evidence and developing the recommendations. The Task Force categorizes each preventive practice as a screening service or a counseling service. The Task Force has developed two analytic frameworks to identify linkages in the evidence that must be present for screening services and counseling services to be considered effective. The analytic framework for screening topics requires evidence linking screening to reduced morbidity and/or mortality as well as evidence linking treatment to reduced morbidity and/or mortality. The analytic framework for counseling services focuses on evidence that the behavioral/counseling intervention works, but does not require any direct evidence that assessment for the specified condition leads to reduced morbidity and/or mortality. Both analytic frameworks evaluate the adverse effects of screening/assessment and intervention.

The third USPSTF assigns the evidence review for a topic to an Evidence-based Practice Center (EPC) operating under contract with the Agency for Healthcare Research and Quality. A “topic team” consisting of EPC staff and USPSTF liaisons is assembled to evaluate the evidence for a selected preventive practice. The topic team adapts the appropriate analytic framework and develops key questions that need to be supported with evidence. The topic team determines which studies are admissible for the literature review. A combination of criteria developed by the Task Force and value judgments are used to evaluate the quality of the evidence at three levels. When evidence is lacking or of insufficient quality, the team may rely on a chain of linkages to assess the effectiveness of a service. If evidence on the adverse effects of a screening or counseling service is inadequate or nonexistent, the topic team estimates what potential harms may occur. A draft report of the team’s findings, the systematic evidence review (SER), is reviewed by 4 to 6 external experts whose identities are not disclosed to the public.

It is the role of the Task Force to translate the evidence from the SER into recommendations. The Task Force examines the effect size, or in other words the magnitude of observed benefits and/or harms from a service, separately from the quality of the evidence, but then merges these two issues to make their recommendations. The Task Force uses a combination of criteria and value judgments to consider the evidence and to assess the net benefits to be expected from implementing a service. Despite the efforts of all of the Task Forces to formulate objective criteria, subjective judgments have a large role in evaluating the evidence and shaping the recommendations for preventive practices. For more information about the current methods, refer to the sidebar on evaluating the quality of the evidence.

EVALUATING THE QUALITY OF THE EVIDENCE

The topic team and the Task Force use a combination of objective criteria and subjective judgment to evaluate the quality of the evidence at three strata (see Table A). At stratum 1, a combination of formalized criteria, qualitative ratings, and expert (i.e. subjective) opinion are used to evaluate the study design and validity. There are standardized criteria to classify the research design. At Stratum 2, the topic team uses their judgment to evaluate the quality of the body of evidence for linkages in the analytic framework by grading three aggregate criteria as “good,” “fair,” or “poor.” At Stratum 3, the USPSTF assigns the grade of “good,” “fair,” or “poor” to the four criteria described in Table A. There are no formal systems for assigning grades to the evidence in strata 2 and 3 other than the tripartite, qualitative scoring scheme of “good,” “fair,” and “poor.”

Table A. Evaluating the Quality of Evidence at Three Strata

Stratum	Level of Evidence	Criteria for Judging Quality
1	Individual study	<ul style="list-style-type: none"> ▪ Hierarchy of research design ▪ Internal validity ▪ External validity
2	Linkage in analytical framework	<ul style="list-style-type: none"> ▪ Aggregate internal validity ▪ Aggregate external validity ▪ Coherence/consistency
3	Entire preventive service	<ul style="list-style-type: none"> ▪ Quality of evidence from stratum 2 for each linkage ▪ Degree to which there is a complete chain of linkages supported by adequate evidence to connect the preventive service to the health outcomes ▪ Degree to which the complete chain of linkages “fit” together ▪ Degree to which the evidence connecting the preventive service and health outcomes is “direct”

The Task Force places considerable importance on assessing the magnitude of all types of potential harms for a service including direct and indirect medical, psychological, and non-health harms. The USPSTF classifies benefits, harms, and net benefits on a 4-point scale as follows: “substantial,” “moderate,” “small,” and “zero/negative.” There are no standard quantitative definitions for these categorizations.

Magnitude of Effect

When the quality of the evidence for a service is judged to be good or fair, the Task Force estimates the magnitude of net benefit that can be expected from implementing a preventive service. If the evidence is determined to be of poor quality, the USPSTF does not estimate the magnitude of the net benefits based on the reasoning that it does not have the scientific basis to make conjectures about the magnitude. To assess the magnitude of benefits and harms, the third USPSTF had developed a process where the magnitude of effect is estimated in each study and a “conceptual confidence interval” is constructed to reflect the range of effect-size values in the studies reviewed. The Task Force assesses the magnitude of benefits by looking at the impact of the services on the population and the individual patient. Using “outcomes tables” prepared by the topic team, the Task Force estimates the magnitude of benefits. Outcomes tables compare outcomes that would be expected for a hypothetical primary care population with and without the preventive service.

Review Process

Three documents are produced for each preventive practice under consideration by the third USPSTF. The EPC drafts the SER and a shorter summary of the evidence that is suitable for publication in journals. The USPSTF chair or the Task Force liaisons serving on the topic team compose the first draft of the recommendation and rationale statement, which the full panel reviews and edits. Before the Task Force makes its final determination about a recommendation for a preventive practice, a draft of the SER is sent to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interest in the topic. Neither the identities of external experts nor other entities reviewing the SER are disclosed to the public.

The Evidence Review for IPV

IPV, child abuse, and elder abuse were reviewed as one topic by the third USPSTF (child abuse and elder abuse are not addressed in this paper). A topic team, consisting of three scientists from the Oregon Health & Science University EPC and two members of the USPSTF, conducted the evidence review on “Screening for Family and Intimate Partner Violence.” The topic team adapted the analytic framework for screening services to evaluate linkages in the evidence. Five key questions were identified (Table 1).

Table 1. Key Questions for Family and Intimate Partner Violence

1. Does screening for family and intimate partner violence reduce harm and premature death and disability?
2. How well does screening identify current harm or risk for harm from family and intimate partner violence?
3. What are the adverse effects of screening?
4. How well do interventions reduce harm from family and intimate partner violence?
5. What are the adverse effects of intervention?

The topic team limited their literature review for IPV to studies involving a physician or other health care provider in the process of screening or intervention. The topic team excluded intervention studies that did not use a comparison group. Studies testing the effectiveness of interventions to educate health care providers and/or increase screening rates, studies involving patients who presented with IPV-related trauma, and studies about mandatory reporting were also excluded. Of the 806 abstracts on screening for IPV that were reviewed, only 14 studies were eligible for the evidence review (see Table 2).

Table 2. Screening and Intervention Studies Included in the SER for IPV

Study Description	No. of Studies	Study Rating		
		Poor	Fair	Good
Comparison of IPV screening tools	6		2	4
Comparison of IPV screening instrument to interview	3	3*		
Internal consistency of IPV screening instruments	2		2	
Comparison of methods of administration of IPV screening instrument	3		3	
IPV Interventions			2	

*Major limitation for all three studies was “inappropriate reference standard (interview not defined)”

Of the 667 abstracts addressing interventions for IPV, only two studies met the inclusion criteria. Both of these studies evaluated IPV interventions with pregnant women in prenatal clinics (McFarlane et al, 2000; Parker et al, 1999). McFarlane et al. conducted a randomized clinical trial comparing three intervention groups while the study by Parker and colleagues was a non-randomized trial comparing two intervention groups. The topic team rated both studies as “fair” quality.

Gaps in the Evidence

The team concluded that there are only a few studies providing data on the detection and management of IPV to guide clinicians and that there are no studies meeting eligibility criteria that directly address the effectiveness of screening for IPV in reducing harm, premature death, and disability. Noting that none of the screening instruments for IPV have been evaluated against measurable IPV outcomes or verified episodes of abuse, the team concluded that the performance characteristics of screening instruments for IPV have not been adequately addressed. Two studies comparing brief screening instruments for IPV to the Conflict Tactics Scales were rated as “good” quality (Feldhaus et al, 1997; Sherin et al, 1998), but the team expressed concern that the Conflict Tactics Scales may not have undergone sufficient testing of its validity to qualify as a gold standard in these studies.

As previously noted, both of the IPV intervention studies that were evaluated in the evidence review were limited to pregnant women (McFarlane et al, 2000; Parker et al, 1999). The SER indicates that this evidence is flawed due to the absence of nontreatment groups (null controls) and the use of self-report outcomes to measure IPV. Based on their findings, the team advises that more studies are needed on the effectiveness of treatment programs for abused victims and treatment programs for perpetrators to provide evidence that

identification and intervention can lead to improved health outcomes, reduced violence, and improvements in quality of life, mental health, social support, self-esteem, and productivity.

Adverse Effects of Screening and Interventions for IPV

The topic team determined that there were no studies meeting inclusion criteria that address the adverse affects of screening and intervention for IPV. In the absence of evidence, the team speculates that false negative tests may discourage clinicians from seeking further histories from patients and inhibit identification of those who are truly at risk while false-positive tests may lead to inappropriate labeling and punitive attitudes. The SER provides a long list of other potential harms of screening for IPV as follows: psychological distress, escalation of abuse and family tension, loss of personal residence and financial resources, erosion of an established family structure, loss of autonomy for the victim and lost time from work, and loss of contact between children and established support systems including neighbors, siblings, school contacts, and peer groups. While the topic team excluded studies on mandatory reporting from the Systematic Evidence Review for IPV, the team references a study on mandatory reporting as the basis for speculating that retaliation and homicide are potential harms of screening. In addition, the referenced study on mandatory reporting does not address screening or intervention for IPV in the primary care setting (Sachs et al, 2002).

There are several significant problems with the evidence review on screening for IPV. The Task Force's decision to evaluate IPV as a screening practice forces this topic into a medical model that requires a greater burden of evidence. The direct linkage between screening and reduced morbidity and mortality would not be required if IPV had been evaluated as a behavioral assessment and counseling practice. The topic team excluded trauma studies from the evidence review due to the focus on screening asymptomatic patients, but the Task Forces' previous recommendations on screening for IPV clearly acknowledged the importance of injury-related health risks of IPV in the primary care setting. The limited evidence on screening and intervention for IPV during pregnancy is dismissed rather than given additional consideration for this high risk group. The potential adverse effects described in the evidence review are not based on any research that is relevant to screening for IPV and studies that have addressed the implications of screening for IPV in the primary care setting were not included in the evidence review. The emphasis on hypothetical adverse effects without considering the potential benefits of screening for IPV results in a misleading and unbalanced analysis of this topic. This evidence review would benefit from more involvement of IPV researchers and experts as well as survivors' perspectives to truly understand the implications of screening or not screening for IPV in the primary care setting.

Missing Evidence?

A randomized controlled trial of intervention with women who experienced IPV was excluded from the evidence review for IPV (Sullivan and Bybee, 1999). This study, which was not conducted in the primary care setting, involved women who spent at least one night

at a shelter and then received one-on-one advocacy counseling for 4-6 hours per week for ten weeks. The intervention group reported significantly less violence than controls (76% versus 89%; $F_{4,260} = 2.38, P < .05$) and had a lower risk of reabuse two years after the intervention. The intervention group reported that they were better able to obtain resources, had higher satisfaction with social support, and improved quality of life across time compared to the control group at the two-year follow-up. The Canadian Task Force on Preventive Health Care included this study in their evidence review on screening for IPV and concluded that there is fair evidence to refer women who have spent at least one night in a shelter to a structured program of advocacy services (CTF, 2001).

Canadian Task Force Recommendation for IPV

The Canadian Task Force's evidence review and recommendations for IPV are contained in the report, "*Prevention and Treatment of Violence Against Women*" (CTF, 2001). The Canadian Task Force concluded that there is insufficient evidence to recommend for or against routine screening for IPV with pregnant and nonpregnant women (I recommendation), but adds that this recommendation is "distinct from the need for clinicians to include questions about exposure to domestic violence as part of their diagnostic assessment of women. This information is important in caring for the patient and may influence assessment and treatment for other problems." The Canadian Task Force issued separate recommendations for different types of interventions for IPV. The Canadian Task Force concluded that there is insufficient evidence to recommend counseling of abused women by primary care clinicians and referrals to shelters, personal counseling, and vocational counseling, but determined that there is fair evidence (level 1) to refer women who have spend at least one night in a shelter to a structured program of advocacy services (grade B recommendation) based on the evidence from the randomized controlled trial by Sullivan and Bybee (1999).

The Canadian Task Force does not separate the processes of reviewing the evidence and developing recommendations. The Canadian Task Force conducted a more comprehensive literature review with broader inclusion criteria to evaluate the evidence on screening for IPV compared to USPSTF's evidence review on screening for IPV. In addition to the randomized controlled trial studies of advocacy services for abused women, studies on screening men as potential perpetrators, interventions for batterers/couples, and research on social and policy interventions for IPV were reviewed in the Canadian Report. The analytic framework that the Canada Task Force adapted to screening for IPV requires the same linkages in the evidence as those identified by the USPSTF, namely that the evidence establishes a link between screening for IPV and improved health outcomes and that the evidence demonstrates that IPV interventions reduce subsequent violence.

The Canadian Task Force also acknowledged the lack of studies on the adverse effects of screening and intervention for IPV. Their discussion of potential harms focused on descriptive studies about the risk of reprisal violence for victims using shelters (Berk et al, 1986, Ferris et al, 1999). The Canadian Task Force acknowledged a potential harm that the USPSTF overlooked—the adverse effects of doing nothing to address IPV in the primary care setting. The importance of this potential harm is reiterated by the Canadian Task

Force's recommendation that research should be conducted on the potential harms from failing to identify women who experience abuse either through not screening or false negatives during screening.

Other Screening and Counseling Services

The majority of screening services that have been evaluated by the USPSTF involve some type of medical testing such as screening for chlamydial infection, screening for lipid disorders, screening for colorectal cancer, screening for type 2 and gestational diabetes, and screening for bacterial vaginosis. Counseling services typically address lifestyle issues and risk behaviors such as diet, physical activity, tobacco use, and vitamin supplementation to prevent cancer and coronary heart disease. The following discussion examines the evidence reviews and recommendations for several screening and counseling services that are recommended as routine preventive practices by the third USPSTF. Some of the screening services recommended by the third USPSTF have gaps in the evidence similar to those identified for screening for IPV. There are also significant gaps in the evidence for two recommended counseling services. The evidence reviews and recommendations for these two counseling services suggest that the evidence on screening for IPV may be a better fit with the analytic framework and key questions for counseling services.

Screening for Depression

Overview and Gaps in the Evidence

The third USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up (B recommendation). The EPC at the Research Triangle Institute-University of North Carolina conducted the evidence review for depression (USPSTF, 2002). Studies on screening for depression were only considered for review if the screening instrument was compared with a criterion standard. The evidence on screening for depression is compromised by the same problem that the USPSTF noted for IPV—there is no universally accepted criterion standard for depression. Comparison studies on screening instruments for depression use different criterion standards.

The topic team decided to rely on a chain of direct and indirect linkages to assess the effectiveness of screening for depression. The analytic framework for screening was adapted so that only indirect evidence was required to link the screening test for depression to improved depression scores/indices through case identification that will, in turn, lead to effective treatment as a result of the screening. There was little evidence available on the potential harms of screening and treatment of depression other than data on medication side effects. Based on the performance of screening instruments for depression, the topic team estimates that more than one-half of the patients who screen positive for major depression will be false-positives. Potential harms of false-positive screening tests described in the SER include the effects of labeling and the costs and adverse effects of unnecessary treatment.

Implications for IPV

The third USPSTF concluded that brief, accurate, and feasible screening tests for depression are available even though there is no criterion standard for depression. This is similar to the state of the knowledge regarding screening tools for IPV. The studies examining the performance of screening instruments for depression that are evaluated in the SER on screening for depression should be reviewed to identify parallel strategies for IPV to address concerns about the lack of a criterion standard. Applying the adapted analytic framework on screening for depression to screening for IPV could allow a more realistic assessment of the evidence and linkages between screening for IPV and interventions and improved health outcomes while waiting for better science.

The third USTSTF concluded that the health benefits of screening for this prevalent problem are likely to outweigh any potential harms of screening for depression. Lifetime prevalence levels for depression based on community-based services range from 4.9% to 17.1% while the prevalence of major depression is 6%-8% in the primary care setting (USPSTF, 2002). The lifetime prevalence of IPV is estimated at 31% of all women while prevalence rates of abuse among clinical samples range from 4-44% within the past year and 21-55% over the lifetime (USPSTF, 2004). The Task Force could use the same rationale to support screening for IPV as it used for screening for depression. However, it must be noted that there are a substantially greater number of clinical trials that could be included in the review for depression, enough to conduct a meta-analysis on outcomes and a preliminary cost benefit analysis. As the IPV field moves forward, investigators will do well to examine carefully these trials and their review to discern the advantages and disadvantages of various design and measurement issues in this relatively comparable area of inquiry.

Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

Overview

The third USPSTF recommends screening and behavioral counseling to reduce alcohol misuse by adults, including pregnant women, in the primary setting (B recommendation).

The systematic evidence review (SER) for alcohol misuse, conducted by the EPC at the Research Triangle Institute-University of North Carolina, focuses on behavioral counseling interventions to reduce alcohol misuse (USPSTF, 2004). The third Task Force, indicating that an in-depth examination of screening instruments for alcohol consumption had been conducted by the second USPTSF in 1995, chose to do only a brief update on screening tools for alcohol misuse. Consequently, the topic team did not review the evidence on the efficacy of screening tools for alcohol misuse.

Gaps in the Evidence

Screening instruments for alcohol consumption that are commonly used in the primary care setting rely on self-report outcome measures. The second Task Force concluded that the reliability of patient report was highly variable and that there was significant variability in the sensitivity and specificity of screening instruments for different levels or patterns of alcohol consumption (USPSTF, 1996). In the update on screening tools

for alcohol consumption, the third USPSTF reports that recent studies support the effectiveness of screening instruments commonly used in the primary care setting (USPSTF, 2004). Self-report outcome measures for alcohol consumption are more reliable than alternative measures such as biochemical tests and collateral interviews (Babor et al, 2000; Del Boca & Noll, 2000).

Even with new evidence on the development and evaluation of screening tools for alcohol use, challenges persist. The SER indicates that there is no consistency in terms of definitions to describe the range of problematic alcohol use patterns. The performance of different screening instruments commonly used in the primary care setting depends on the pattern of drinking being detected. The sensitivity and specificity of screening instruments such as the AUDIT and the CAGE questionnaire vary by age and gender of the patient. In a recent, good-quality systematic review, different criterion standards, some of which rely on self-report outcome measures, had been used to evaluate the performance of screening instruments for alcohol consumption (Fiellin et al, 2000). The topic team did not look for evidence that screening for alcohol misuse improves health outcomes so this linkage in the analytic framework was not addressed in the SER.

The topic team identified several issues regarding the evidence on behavioral counseling interventions for alcohol misuse. There is little direct or indirect evidence linking counseling interventions for alcohol misuse to improved medical, social, or psychological outcomes (USPSTF, 2004). Of the admissible counseling intervention studies for alcohol misuse that examined long-term health outcomes, the only statistically significant outcome for counseling was fewer self-reported hospital days among the intervention group compared to the control group in a study by Flemming et al. (2002). Studies on the long-term impact of alcohol misuse interventions reported no differences between intervention and control groups in morbidity rates, mortality rates, or alcohol consumption at 10-year follow-up (Wutzke et al, 2002), no differences in problem scores (Anderson & Scott, 1992; Richmond et al, 1995; Scott & Anderson, 1990; WHO, 1996), and no differences in general health, smoking, depression, and injuries (Flemming et al, 1997; Anderson & Scott, 1992; Scott & Anderson, 1990; Flemming et al, 1999; Manwell et al, 2000).

The safe level of alcohol consumption during pregnancy is not known. With regard to counseling women on alcohol misuse during pregnancy, only three randomized controlled trials of interventions with pregnant women met inclusion criteria and the results were conflicting (Handmaker et al, 1999; Chang et al, 1999; Reynolds et al, 1995). Two studies failed to show any significant impact of counseling interventions on pregnant women's average alcohol consumption. The third study reported marginally statistically significant differences for fewer mean total drinks in the previous month and a higher percentage of women reporting abstinence in the intervention group versus the control group. Although evidence on the effectiveness of counseling interventions to reduce alcohol consumption during pregnancy is conflicting, the Task Force recommends screening and counseling pregnant women for alcohol misuse on the grounds that studies in the general adult population show that behavioral counseling interventions are effective among women of childbearing age.

The topic team was unable to identify any studies addressing the potential adverse effects for screening and counseling interventions for alcohol misuse. The topic team failed to estimate potential adverse effects of false negative tests and false positive tests as a result of screening for alcohol consumption. It seems reasonable that many of the potential adverse effects that the Task Force identified for screening for IPV may also impact patients being screened for alcohol misuse. Pregnant women may be at particularly high risk of such potential harms due to the stigma and risks to the fetus associated with drinking during pregnancy.

Implications for IPV

Notwithstanding all the limitations and gaps in the evidence, the USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse with adults and pregnant women. This recommendation has important implications for screening for IPV. Studies similar to those described for self-report assessment of alcohol consumption can be designed to compare self-reports of IPV to police reports, vital statistics, restraining orders, and hospital records. This evidence should receive the same consideration from the USPSTF that the alcohol studies have. Clearly, gaps in the evidence linking screening to long-term health outcomes should not be considered a fatal flaw for IPV since this linkage was not even addressed in the evidence review on screening for alcohol misuse. The failure to address any potential psychosocial harms of screening for alcohol misuse makes a good argument to challenge why so much emphasis was placed on hypothetical adverse effects in the evidence review on screening for IPV.

Screening for Visual Impairment in Children less than Age 5 Years

Overview

The third USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children less than age 5 years (B recommendation). In 2001, the EPC at the Research Triangle Institute-University of North Carolina issued a summary of the evidence on screening for visual impairment with children age 5 or younger. At the time of the evidence review, the topic team determined that there was little high-quality data on the performance of screening tests, that none of the available studies were performed in the primary care setting by usual caregivers, and that there were no trials comparing treatment to no treatment for children with amblyopia. The Task Force initially concluded that the evidence was lacking for the effectiveness of treatment of amblyopia in the primary care setting. Prior to finalizing the draft recommendations, two new studies from one randomized clinical trial on screening preschool children for amblyopia and additional data on treatment interventions for preschool amblyopia were identified. In an updated report, the USPSTF announced that these new studies filled evidence gaps that had been previously noted (USPSTF, 2004).

Gaps in the Evidence

The third USPSTF found no direct evidence that screening for visual impairment in children leads to improved acuity. The new evidence to support screening children for visual impairment comes from a nested, randomized controlled trial of fair-quality where children were screened by orthoptists, eye exercise specialists, who administered a battery of

age-appropriate tests to young children at six different intervals (Williams et al, 2001). The new evidence on effective treatment is a good-quality randomized controlled trial evaluating two treatments for children with amblyopia where the results indicated significant improvement in both treatment groups but the study lacked a nontreatment group for comparison (Williams et al, 2002). There are no articles that met the inclusion criteria detailing the adverse effects of screening or intervention for visual impairment with young children. In their recommendation, the Task Force notes that labeling and the costs associated with further evaluation for false-positive results are potential harms of screening while disruption of normal eye development and temporary loss of visual acuity in the nonamblyopic eye are potential harms of treatment.

Implications for IPV

The USPSTF's recommendation on screening young children for visual impairment raises some important questions about the quality and quantity of evidence necessary to recommend a preventive practice. Can studies about screening and intervention for IPV conducted in non-primary care settings be extrapolated to the primary care setting? Will one or two good-quality randomized controlled trials demonstrating the effectiveness of interventions for IPV be sufficient evidence for the Task Force to recommend addressing IPV as a preventive practice even though there are no trials comparing treatment to no treatment? The topic team noted that ethical concerns about not offering treatment to children diagnosed with amblyopia is a barrier to conducting trials comparing treatment to no treatment. Interventions studies for IPV that lack nontreatment groups should be given the same consideration by the Task Force due to ethical concerns.

Physicians' Roles in Preventing Dental Caries in Preschool Children

Overview

The third USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride (B recommendation.)

The EPC at the University of North Carolina at Chapel Hill allowed cross-sectional surveys and case reports to be included in the evidence review for preventing dental caries in preschool children (USPSTF, 2004).

Gaps in the Evidence

The evidence review for the appropriateness of primary care clinicians' supplemental decisions for oral fluoride supplementation raises some intriguing questions about the quality of the evidence and linkages that must be supported to recommend a preventive practice. Ten of the twelve studies about physicians' knowledge and behaviors concerning fluoride supplementation reviewed by the topic team were cross-sectional surveys. As noted in the SER, this indirect evidence relies primarily on self-reported practices, has relatively low response rates, was conducted in the 1980s when dosing recommendations were different, and does not assess primary care providers' prescribing behaviors for individual children. These data raise concerns that some physicians do not know the fluoride status of their patients' water supplies which could lead to inappropriate prescribing and the risk of dental fluorosis.

Even with the broad inclusion criteria, the topic team was unable to identify any studies addressing parental adherence to primary care providers' prescriptions for oral fluoride supplementation. Indirect evidence from other studies indicates that parental adherence with fluoride supplementation is poor. There are concerns about the studies examining the effectiveness of fluoride supplementation to prevent dental caries in children. The available clinical trials used convenience samples without random assignment and did not use an intent-to-treat analysis which is typically employed in good quality clinical trials. Drop-out rates of study participants, when reported, were high. There are external validity concerns because several of the studies were conducted before the dosages for fluoride supplemental were changed and the two most recent trials were conducted overseas.

Regarding potential adverse effects, there is an increased prevalence and severity of dental fluorosis in the United States. Furthermore, there is good evidence that dental fluorosis, while mostly cosmetic, is clearly associated with the use of oral fluoride supplementation. The SER indicates that expert panels have reduced the dosage schedule for fluoride supplements twice since the dosage schedule was first developed, but there are no studies assessing the effects of these dosage changes on dental caries or fluorosis since the most recent changes in 1994.

Implications for IPV

The third Task Force justifies the physicians' role in the prevention of dental caries in preschool children on the basis that dental caries are a prevalent unmet need among children and that children are more likely to see a primary care provider than a dentist. In the absence of good-quality evidence that links the effectiveness of prescribing oral fluoride supplementation in the primary care setting to the prevention of dental caries in children, the USPSTF decided that the potential benefits outweigh the adverse effects of dental fluorosis and any other unidentified harms. A similar argument can be made for screening for IPV. IPV is a very prevalent women's health issue in the primary care setting. Why not prioritize this opportunity for prevention and early intervention by asking women about abuse and making the appropriate referrals while waiting for better science? Including descriptive research such as surveys on screening and intervention for IPV, as was done for fluoride supplementation, may provide more evidence to support indirect linkages between screening for IPV and interventions and improved health outcomes.

Counseling Services

Behavioral Interventions to Promote Breastfeeding

The third USPSTF recommends structured breastfeeding education and behavioral counseling programs to promote breastfeeding (B recommendation). The EPC at the Oregon Health and Science University conducted an evidence review and meta-analyses to evaluate the effectiveness of counseling, behavioral, and environmental interventions to improve breastfeeding (Guise et al, 2003).

The Evidence Review

The topic team evaluated randomized controlled trials and cohort studies involving any counseling or behavioral interventions for breastfeeding, conducted in a variety of settings by a variety of providers, as long as the referral originated from a clinician's practice. Assessment for breastfeeding status was not examined in the evidence review. The topic team did not evaluate the effectiveness of primary care providers' referrals to education and counseling programs for breastfeeding or patients' compliance with referrals.

Implications for IPV

The USPSTF's recommendation on behavioral interventions to promote breastfeeding offers valuable insight on the evidence required to recommend a counseling service. Evaluating IPV as a counseling service where primary care providers assess for IPV, advise patients about the health risks associated with victimization, and offer referrals to appropriate resources may allow a more realistic assessment of the available evidence and net benefits of IPV as a preventive service. Studies on IPV interventions conducted outside of the primary care setting could be included in the evidence review as long as the referrals originated from the primary care setting. Moving away from the medical model of evaluating IPV as a screening service to consider assessment and intervention for IPV as a counseling service may be a more effective way to make the connection between IPV and related health problems and integrate IPV into primary care.

Counseling to Prevent Tobacco Use and Dependence and Tobacco-Caused Disease

Overview

The third USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products (A recommendation). The Task Force also strongly recommends that clinicians screen all pregnant women for tobacco use and provide augmented pregnancy-tailored counseling for those who smoke (A recommendation). A systematic review of the evidence by a topic team was not conducted. Instead, the Task Force relied on a special report on tobacco use that was issued by a consortium of 30 representatives, consultants, and PHS staff and peer-reviewed by 70 external reviewers (USPHS, 2000). The consortium did not use the analytic framework for counseling services to identify linkages that must be present for a counseling service to be considered effective, but it did use many of the USPSTF's coding schemes and grading scales to evaluate the evidence on counseling to prevent tobacco use.

The Evidence Review

Since the analytic framework for counseling services was not used, key questions that examine the availability of effective, feasible, and reliable assessment tools, the acceptability of assessment by patients, and any adverse effects associated with assessment are not addressed in the report on tobacco use. In fact, there is no evaluation of the evidence on assessment tools for tobacco use even though assessment for tobacco use typically relies on self-report in the primary care setting. The report does note that self-reported tobacco use among pregnant women is less reliable than with other adult patients but this issue was raised within the context of limiting the meta-analysis of interventions for tobacco use with pregnant women to studies where abstinence data was biochemically confirmed.

Studies evaluating the effectiveness of counseling pregnant women for tobacco use compared intervention groups with “usual care” groups versus nontreatment groups. The consortium’s report does not address the adverse effects of screening or counseling patients on tobacco use. Consequently, there is no way of knowing what information the Task Force used to weigh the potential harms relative to the benefits of counseling patients on tobacco use to develop their recommendations.

Implications for IPV

The grade “A” recommendation for counseling to prevent tobacco use and dependence indicates that several gaps in the evidence including evidence on the accuracy, effectiveness, and acceptability of assessment, studies on adverse effects, and the absence of nontreatment groups in intervention studies can be overlooked when the Task Force perceives that the magnitude of benefit is significant with a prevalent issue such as tobacco use. Evaluating IPV as a counseling service would eliminate the need for direct evidence linking screening to improved health outcomes and, based on the evidence review for tobacco use, may require very little evidence on the effectiveness of assessment. Intervention studies for IPV with usual care groups for comparison should be given the same consideration as tobacco intervention studies with pregnant women since the ethical concerns of not providing referrals to patients disclosing IPV is as serious a concern as not counseling pregnant women who disclose tobacco use.

Conclusion and Recommendations

The third USPSTF and the Canadian Task Force have identified gaps in the evidence and the need for more rigorous studies on the effectiveness of screening and intervention for IPV in the primary care setting. Both Task Forces have the difficult job of making inferences from imperfect evidence to develop national policies on complex social issues. The methods used to evaluate the evidence and develop recommendations are still evolving. Topics supported by decades of research where funding far exceeds what has been available to IPV researchers still have persistent gaps in the evidence, which has not precluded the third USPSTF from recommending these services. One or two fair to good quality studies on the effectiveness of a service can be the tipping point from insufficient evidence to the USPSTF recommending that service.

In a recent letter to the editor of the *Annals of Internal Medicine*, Dr. John Nelson, President of the American Medical Association (AMA), stated that the AMA stands by its health-promoting practice of routine inquiry for abuse based on emerging research and clinical experience that assessment and intervention can improve the safety of victims and their children. The AMA’s policy on routine inquiry for abuse places a premium on the opportunity for prevention versus a “wait and see” approach of asking patients who present with signs or symptoms of family violence IPV (Nelson, 2004). The USPSTF should apply the same rationale to screening for IPV that it has used to recommend other screening and counseling services where the evidence is still lacking but the potential for prevention is significant.

While waiting for better science as well as more consistent, reliable methods to evaluate the evidence, there are several strategic steps that can be taken to advance the research agenda on IPV and to work with the USPSTF to conduct a more informed and equitable assessment of the net benefits of screening for IPV in the primary care setting.

RECOMMENDATIONS TO THE USPSTF

1. Examine IPV as a Topic and Issue Separate Recommendations

The USPSTF should evaluate IPV as a separate topic. The Task Force should issue separate recommendations on screening for IPV and interventions for IPV as the Canadian Task Force has done. In addition, the Task Force should issue a separate recommendation on screening pregnant women for IPV based on the existing evidence. The Task Force should use the same standards and considerations to evaluate the net benefits of screening pregnant women for IPV as were applied to screening pregnant women for alcohol use and counseling pregnant women on tobacco use since IPV during pregnancy is also a prevalent problem with significant health consequences.

2. Increase Involvement of IPV Researchers and Experts

The USPSTF should develop procedures that will ensure that IPV researchers and experts have more input in the evidence review process and development of the recommendations. Using a consensus approach to evaluate the evidence similar to the report on tobacco use would allow a more extensive peer review process and a comprehensive assessment of the benefits and implications of screening for IPV. The Task Force's recommendation on counseling to prevent tobacco use relied primarily on a report that was developed by a consortium of 30 representatives, consultants, and public health staff and peer-reviewed by 70 external reviewers whose identities were disclosed to the public. This type of approach is likely to lead to a better informed and more realistic evaluation of the benefits and harms of screening for IPV.

3. Evaluate IPV as a Counseling Service

IPV may find a better fit with the analytic framework for counseling services, which does not require direct evidence that assessment leads to improved health outcomes. The USPSTF should evaluate the topic of IPV as a counseling service within the next two years.

4. Reevaluate the Adverse Effects of Screening for IPV and Consider the Potential Harm of Not Addressing IPV in the Primary Care Setting

The potential harms of screening for IPV should be reconsidered. The Task Force states that the weighing of the benefits and harms to assess the net benefits for a preventive practice is the most influential factor in their review of the evidence to develop recommendations. Due to a lack of studies on adverse affects for most preventive practices, the Task Force estimates the potential harms for most services. It is a tragic irony that while the Task Force found no evidence to support the adverse effects that are described in the evidence review on screening for IPV, there is considerable evidence that these harms will occur as a result of victimization. It is far more probable that patients who are being victimized by an intimate partner will continue to experience labeling, punitive attitudes, psychological distress, family tension, erosion of an established family structure, loss of

autonomy, lost time from work, increasing isolation from established support systems including neighbors, siblings, and peer groups and escalation of abuse if IPV is ignored in the primary care setting versus if patients are routinely screened for IPV. While the Task Force speculates that screening for IPV could lead to homicide, the harsh reality is that IPV is a leading cause of femicide and preincident risk factors include abuse during pregnancy (Campbell et al, 2003).

RECOMMENDATIONS TO IPV ORGANIZATIONS, RESEARCHERS, AND POLICYMAKERS

1. Create a National Panel to Develop a Strategic Research Plan for IPV

A national panel should be convened to develop and implement a strategic research plan that focuses on screening and intervention for IPV in the health care setting. Gaps in the evidence raised by the Task Force and solutions for how to overcome these gaps need to be specifically addressed in national research agendas for IPV. Randomized, controlled, multi-site intervention trials for IPV and validation studies on the reliability of self-reported IPV should be a research priority. This panel will need to monitor the USPSTF's methods for evidence review to ensure that the research agenda for IPV keeps pace with the evolving methodologies of the Task Force.

2. Evaluate the Implications of the USPSTF's Current Methods and Recommendations

Policymakers, researchers, service providers, and consumers should evaluate the evidence that the current methods used by the Task Force are the most effective way to develop recommendations on preventive practices. To date, studies indicate that primary care providers have variable and generally low awareness of and compliance with USPSTF recommendations (Woolf & Atkins, 2001). Hence, evidence is lacking that the Task Force's current methods and recommendations improve preventive health care. The complexity of many leading health concerns, the imperfect evidence for many preventive practices that have significant research budgets that span decades, and the need to identify and treat urgent, emerging health issues may require more dynamic, innovative methods to effectively address leading causes of preventable morbidity and mortality. Recognizing this disconnect, the USPSTF convened a Counseling and Behavioral Interventions Work Group in the 1990s to discuss how to adapt existing methods to issues raised by behavioral counseling interventions.

We need to work collaboratively with the USPSTF and other agencies to promote a rationale approach that balances good science with sound judgment, clinical experiences, expert opinions, and consumers' perspectives to evaluate screening for IPV and other preventive practices. Hopefully IPV researchers will soon complete the studies needed to convince the next Task Force that IPV can be effectively addressed as part of primary care. Our quest for better science and all of our efforts to promote IPV as a primary care issue must be informed by those who know best---survivors and patients who have experienced IPV.

APPENDIX A.

Year	CATEGORY/Topic	Language of Recommendation (specific to IPV)	Rating
1989	Screening for Violent Injuries	Routine screening interviews or examinations for evidence of violent injuries is not recommended. Both children and adults who present with multiple injuries and implausible explanation should be evaluated with attention to possible abuse or neglect. Specific guidelines are available for the evaluation of suspected victims of spouse abuse. Injured pregnant women and elderly patients should receive special consideration for this problem. Suspected cases of abuse should receive proper documentation of the incident and physical findings; treatment of physical injuries, arrangements for counseling by a skilled mental health professional; and the telephone numbers of local crisis centers, shelters, and protective service agencies. The safety of children of victims of abuse should also be ensured.*	No rating
1996	ADULT/OLDER ADULTS-COUNSELING/ Injury and Domestic Violence Prevention	There is insufficient evidence to recommend for or against the use of specific screening instruments for family violence, but including a few direct questions about abuse (physical abuse or forced sexual activity) as part of the routine history in adult patients may be recommended on other grounds. These other grounds include substantial prevalence of undetected abuse among adult female patients, the potential value of this information in the care of the patient, and the low cost and low risk of harm from such screening. All clinicians examining children and adults should be alert to physical and behavioral signs and symptoms associated with abuse and neglect. Various guidelines are available to help clinicians in recognizing abuse and neglect in children, spouses/partners, and elders. In all states, suspected cases of child abuse or neglect must be reported to local child protective services agencies. In most states, suspected elder abuse must also be reported. All individuals who present with multiple injuries and an implausible explanation should be evaluated with attention to possible abuse or neglect. Injured pregnant women and elderly patients should receive special consideration for this problem. Suspected cases of abuse should receive proper documentation of the incidence and physical findings (e.g., photographs, body maps); treatment of physical injuries; arrangements for counseling by a skilled mental health professional; and the telephone numbers of local crisis centers, shelters, and protective service agencies. The safety of children of victims of abuse should also be ensured.	C
2004	SCREENING/ Family and Intimate Partner Violence	The USPSTF found insufficient evidence to recommend for or against routine screening of parents or guardians for the physical abuse or neglect of children, of women for intimate partner violence, or of older adults or their caregivers for elder abuse.	I

*Language specific to child abuse not included.

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