Complete Summary

GUIDELINE TITLE

Prevention and treatment of violence against women: systematic review and recommendations.

BIBLIOGRAPHIC SOURCE(S)

MacMillan HL, Wathen CN. Prevention and treatment of violence against women: systematic review and recommendations. London (ON): Canadian Task Force on Preventive Health Care (CTFPHC); 2001 Sep. 62 p. [108 references]

Wathen CN, MacMillan HL. Prevention of violence against women: recommendation statement from the Canadian Task Force on Preventive Health Care. CMAJ 2003 Sep 16;169(6):582-4. [28 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

A complete list of planned reviews, updates and revisions is available under the What's New section at the Canadian Task Force on Preventive Health Care (CTFPHC) Web site.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Violence against women (also known as domestic violence, intimate partner violence, wife abuse, spousal violence, or spousal abuse)

GUIDELINE CATEGORY

Prevention
Screening
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers

GUIDELINE OBJECTIVE(S)

To summarize what is known about the distribution and determinants of violence against women, and evaluate the evidence for effectiveness of any intervention aimed at preventing violence against women

TARGET POPULATION

Women (pregnant and non-pregnant) residing in Canada

INTERVENTIONS AND PRACTICES CONSIDERED

Screening

1. Routine screening for violence against women (pregnant or non-pregnant)
2. Screening of men as perpetrators of domestic violence
3. Use of screening tools:
    - Conflict Tactics Scales (CTS) and an expanded version (CTS2)
    - Psychological Maltreatment of Women Inventory (PMWI)
    - Index of Spouse Abuse (ISA)
    - Measure of Wife Abuse (MWA)
    - Abuse Risk Inventory for Women (ARI)
    - Wife Abuse Inventory
    - Abusive Behavior Inventory (ABI)
    - Partner Abuse Scale (Physical and Non-physical)
    - Composite Abuse Scale (CAS)
    - Colorado Behavioral Risk Factor Surveillance System (BRFSS)
    - Partner Violence Screen (PVS)
    - Woman Abuse Screening Tool (WAST)

- Abuse Assessment Screen (AAS) for pregnant women

Counseling and Treatment

1. Primary care counseling
2. Referral to shelters
3. Referral to post-shelter advocacy counseling
4. Referral to personal and vocational counseling
5. Batterer/couples interventions (e.g., group and couples counseling)

MAJOR OUTCOMES CONSIDERED

Screening

- Sensitivity, specificity, and positive and negative predictive values of screening tools

Treatment

Primary outcomes

- Incidence of physical, sexual or emotional abuse by men against their female partners

Secondary outcomes

- Use of safety behaviors, social support, community resources, etc. following intervention

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

MEDLINE, PsycINFO, CINAHL, HealthStar and Sociological Abstracts were searched from the respective database start dates to March 2001 using appropriate database specific keywords such as "domestic violence", "spouse abuse", "sexual abuse", "partner abuse", "shelters" and "battered women", among others. The reference lists of key papers were hand searched. Both primary authors reviewed all titles and abstracts according to established inclusion/exclusion criteria to arrive at a final pool of papers for review. Key papers from after the search end date and identified by external reviewers were included.

Inclusion/Exclusion Criteria

A priori inclusion/exclusion criteria were based on the analytic framework (see Figure 1 in the original guideline document). "Violence against women" was defined to mean physical and psychological abuse of women by their male partners, including sexual abuse and abuse during pregnancy. For the critical appraisal, the focus was on the effectiveness of interventions. The key outcomes of interest were physical and mental health outcomes, and as such it was decided *a priori* to critically appraise only studies that reported these outcomes (and in some cases the intermediate outcomes outlined in the original guideline). As the review progressed, it was decided to revise the inclusion criteria to include batterer treatment programs. Other aspects of the analytic framework that were reviewed descriptively were the burden of suffering/epidemiology of domestic violence, the effectiveness of screening, and studies of primary prevention or interventions at the level of policy (i.e., beyond the scope of primary care practice).

NUMBER OF SOURCE DOCUMENTS

The search yielded 2185 citations. Hand searching and the focused update in March 2001 added 22 citations to the pool. A total of 237 papers appeared from titles/abstracts to match inclusion criteria; these were retrieved in full for further review. The final pool included 97 papers, 22 of which met the criteria for critical appraisal, and the rest of which were considered for descriptive review for other aspects of the analytic framework and sections of the manuscript.

An additional 11 papers, suggested by expert reviewers and/or published after the search end date, were added, one of which met the criteria for critical appraisal.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

A. *Research design rating*:

I Evidence from at least one randomized controlled trial.

II-1 Evidence from controlled trial(s) without randomization.

II-2 Evidence from cohort or case-control analytic studies, preferably from more than one centre or research group.

II-3 Evidence from comparisons between times or places with or without the intervention; dramatic results from uncontrolled studies could be included here.

III Opinions of respected authorities, based on clinical experience; descriptive studies or reports of expert committees.

B. *Quality (internal validity) rating (see Harris et al., 2001)*:

Good A study that meets all design- specific criteria* well.

Fair A study that does not meet (or it is not clear that it meets) at least one design-specific criterion* but has no known "fatal flaw".

Poor A study that has at least one design-specific* "fatal flaw", or an accumulation of lesser flaws to the extent that the results of the study are not deemed able to inform recommendations.

*General design specific criteria by study type are outlined in Harris et al., 2001. Inclusion/exclusion criteria specific to a review topic are detailed in the Methods section of the individual review.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

This evidence was systematically reviewed using the methodology of the Canadian Task Force on Preventive Health Care. The Task Force of expert clinicians/methodologists from a variety of medical specialties used a standardized evidence-based method for evaluating the effectiveness of preventive interventions. The lead authors prepared a manuscript providing critical appraisal of the evidence. This included identification and critical appraisal of key studies, and ratings of the quality of this evidence using the Task Force's established methodological hierarchy (see Appendix 1 in the guideline document).

Procedures to achieve adequate documentation, consistency, comprehensiveness, objectivity and adherence to the Task Force methodology were maintained at all stages during review development, the consensus process, and beyond. These were managed by the Task Force Office, under supervision of the Chair, and ensured uniformity and impartiality throughout the review process. The basic methodology was updated in 2001 (see notes in Appendix 1 in the guideline document).

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

This manuscript was pre-circulated to the members in May 2001, and evidence for this topic was presented by the lead authors and deliberated upon at the June 2001 Task Force meeting. At the meeting, the expert panelists addressed critical issues, clarified ambiguous concepts and analysed the synthesis of the evidence. At the end of this process, the specific clinical recommendations proposed by the lead authors were discussed, as were issues related to clarification of the

recommendations for clinical application, and any gaps in evidence. The results of this process are reflected in the description of the decision criteria presented with the specific recommendations. The group and lead authors arrived at the final decisions on recommendations unanimously.

Subsequent to the meeting, the lead authors revised the manuscript accordingly.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendations for Specific Clinical Preventive Actions

A The Canadian Task Force (CTF) concludes that there is **good** evidence to recommend the clinical preventive action.

B The CTF concludes that there is **fair** evidence to recommend the clinical preventive action.

C The CTF concludes that the existing evidence is **conflicting** and does not allow making a recommendation for or use of the clinical preventive action, however other factors may influence decision-making.

D The CTF concludes that there is **fair** evidence to recommend against the clinical preventive action.

E The CTF concludes that there is **good** evidence to recommend against the clinical preventive action.

I The CTF concludes that there is **insufficient** evidence (in quantity and/or quality) to make a recommendation, however other factors may influence decision-making.

The CTF recognizes that in many cases patient specific factors need to be considered and discussed, such as the value the patient places on the clinical preventive action; its possible positive and negative outcomes; and the context and/or personal circumstances of the patient (medical and other). In certain circumstances where the evidence is complex, conflicting or insufficient, a more detailed discussion may be required.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The manuscript was sent by the Task Force to four independent experts in the field (identified by Task Force members at the meeting). Feedback from these experts was incorporated into a subsequent draft of the manuscript.

Recommendations from the following organizations regarding prevention and treatment of violence against women were also reviewed: the US Preventive Services Task Force, the American Medical Association´s Council on Scientific Affairs, the Society of Obstetricians and Gynaecologists of Canada, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendation grades (A-B-C-D-E-I) are indicated for each recommendation. These definitions are repeated following the recommendations.

Screening

Women: Due to the lack of a demonstrated link between screening and the reduction of violence outcomes, the Canadian Task Force concludes that there is insufficient evidence to recommend for or against routine screening for violence against either pregnant or non-pregnant women (**I Recommendation**). This 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 of other health problems.

Men: The Task Force concludes that there is insufficient evidence to recommend for or against primary care screening of men as perpetrators of domestic violence (**I Recommendation**).

Interventions for Pregnant & Non-Pregnant Women

Primary Care Counseling: The Task Force concludes that there is insufficient evidence to recommend for or against counseling of abused women by primary care clinicians, although decisions to do so may be made by the clinician and patient on other grounds (**I Recommendation**).

Referral to Shelters: The Task Force concludes that there is insufficient evidence to recommend for or against referral to shelters, although decisions to do so may be made by the clinician and patient on other grounds (**I Recommendation**).

Referral to Post-Shelter Advocacy Counseling: The Task Force concludes that there is fair evidence (level I, fair) to refer women who have spent at least one night in a shelter to a structured program of advocacy services as outlined in the study by Sullivan & Bybee (Sullivan & Bybee, 1999) (**B Recommendation**).

Referral to Personal and Vocational Counseling: The Task Force concludes that there is insufficient evidence to recommend for or against referral to personal or

vocational counseling, although decisions to do so may be made by the clinician and patient on other grounds (**I Recommendation**).

Interventions for Men and/or Couples

Batterer/Couples Interventions: The Task Force concludes that there is conflicting evidence regarding the effectiveness of batterer interventions (with or without partner participation) in reducing rates of further domestic violence (Dunford, 2000; Harris et al., 1988; Edelson & Syers, 1991; Brannen & Rubin, 1996; Dutton, 1986; Chen et al., 1989; Palmer et al., 1992; Saunders, 1996; Dobash et al., 1996; Gondolf, 1999; Davis & Taylor, 1999) (**C Recommendation**).

Grades of Recommendations for Specific Clinical Preventive Actions

A The Canadian Task Force (CTF) concludes that there is **good** evidence to recommend the clinical preventive action.

B The CTF concludes that there is **fair** evidence to recommend the clinical preventive action.

C The CTF concludes that the existing evidence is **conflicting** and does not allow making a recommendation for or use of the clinical preventive action, however other factors may influence decision-making.

D The CTF concludes that there is **fair** evidence to recommend against the clinical preventive action.

E The CTF concludes that there is **good** evidence to recommend against the clinical preventive action.

I The CTF concludes that there is **insufficient** evidence (in quantity and/or quality) to make a recommendation, however other factors may influence decision-making.

The CTF recognizes that in many cases patient specific factors need to be considered and discussed, such as the value the patient places on the clinical preventive action; its possible positive and negative outcomes; and the context and/or personal circumstances of the patient (medical and other). In certain circumstances where the evidence is complex, conflicting or insufficient, a more detailed discussion may be required.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Screening

Maneuver: Screening Women (pregnant or non-pregnant)
Level of Evidence:
Studies assessing psychometric properties of tools available, but no studies assessed screening to intervention outcomes.

Maneuver: Screening Men
Level of Evidence:
No studies available

Interventions for Pregnant & Non-Pregnant Women

Maneuver: Primary Care Counseling
Level of Evidence:
No studies available.

Maneuver: Referral to Shelters
Level of Evidence:
No studies available.

Maneuver: Referral to Post-Shelter Advocacy Counseling
Level of Evidence:
Level I, fair

Maneuver: Referral to Personal and Vocational Counseling
Level of Evidence:
No studies available.

Maneuver: Batterer/Couples Interventions
Level of Evidence:
Level 1, good
Levels I, II-1, and II-2 all poor
One fair systematic review

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

There is a high prevalence and significant impairment associated with violence against women (both pregnant and non-pregnant). However, there is a lack of evidence regarding the effectiveness of screening for preventing abuse. In terms of interventions, the benefits of several strategies in treating both men and women are unclear, primarily due to a lack of suitably designed research that measures appropriate outcomes.

Summary of Risk Indicators for Domestic Violence Against Women

Female risk indicators (of being a victim)

- witness abuse during childhood
- demographic factors (including age <25 years*; low socioeconomic status; less than high school education**; unemployment)
- having a former partner; or currently separated or divorced
- history of behaviour problems (childhood, adolescence)
- growing up without both or either parent(s)
- growing up with family conflict
- low IQ
- co-morbid health conditions (e.g., obstetric, gynecologic symptoms and substance abuse)

Pregnant female risk indicators (of being a victim)

- having an unwanted pregnancy
- demographics (including being unmarried, less well-educated and younger)
- number of stressful life events
- increased parity

Male risk indicators (of being an abuser)

- alcohol and/or drug use (especially binge drinking)
- demographic factors (including younger age, low socioeconomic status; less than high school education)
- witnessing abuse during childhood
- unemployment
- mental health or previous behavioral problems (e.g. depressive symptoms; behavioral problems in childhood)
- use of violence toward children
- growing up without both parents
- sexual aggression toward female spouses

"Couple" indicators (that female will be abused)

- marital conflict
- low socioeconomic status
- verbal aggression
- status other than married (including common-law)
- age difference > 10 years
- religious incompatibility

*while younger age is generally associated with increased rates of violence in women, some studies have found that physical and sexual violence increase with advancing age

**lower education of women was found to predict abuse in women, but was not found to be correlated with abuse in the Canadian General Social Survey

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Interventions in other (i.e., non-primary care) settings are reviewed for completeness, but recommendations on these were outside the scope of the systematic review.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation of preventive activities in clinical practice continues to be a challenge. To address this issue, Health Canada established a National Coalition of Health Professional Organizations in 1989. The purpose was to develop a strategy to enhance the preventive practices of health professionals. Two national workshops were held. The first focused on strengthening the provision of preventive services by Canadian physicians. The second addressed the need for collaboration among all health professionals. This process led to the development of a framework or "blueprint for action" for strengthening the delivery of preventive services in Canada (Supply and Services Canada: an Inventory of Quality Initiatives in Canada: Towards Quality and Effectiveness. Health and Welfare Canada, Ottawa, 1993). It is a milestone for professional associations and one that will have a major impact on the development of preventive policies in this country.

In 1991 the Canadian Medical Association spearheaded the creation of a National Partnership for Quality in Health to coordinate the development and implementation of practice guidelines in Canada. This partnership includes the following: the Association of Canadian Medical Colleges, the College of Family Physicians of Canada, the Federation of Medical Licensing Authorities of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Council on Health Facilities Accreditation, and the Canadian Medical Association.

The existence of guidelines is no guarantee they will be used. The dissemination and diffusion of guidelines is a critical task and requires innovative approaches and concerted effort on the part of professional associations and health care professionals. Continuing education is one avenue for the dissemination of guidelines. Local physician leaders, educational outreach programs, and computerized reminder systems may complement more traditional methods such as lectures and written materials.

Public education programs should also support the process of guideline dissemination. In this context, rapidly expanding information technology, such as interactive video or computerized information systems with telephone voice output, presents opportunities for innovative patient education. The media may also be allies in the communication of some relevant aspects of guidelines to the public. All of these technologies should be evaluated.

The implementation of multiple strategies for promoting the use of practice guidelines requires marshaling the efforts of governments, administrators, and

health professionals at national, provincial and local levels. It is up to physicians and other health professionals to adopt approaches for the implementation of guidelines in clinical practice and to support research efforts in this direction.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

MacMillan HL, Wathen CN. Prevention and treatment of violence against women: systematic review and recommendations. London (ON): Canadian Task Force on Preventive Health Care (CTFPHC); 2001 Sep. 62 p. [108 references]

Wathen CN, MacMillan HL. Prevention of violence against women: recommendation statement from the Canadian Task Force on Preventive Health Care. CMAJ 2003 Sep 16;169(6):582-4. [28 references] PubMed

ADAPTATION

Not applicable: Guideline was not adapted from another source.

DATE RELEASED

2001 Sep

GUIDELINE DEVELOPER(S)

Canadian Task Force on Preventive Health Care - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

The Canadian Task Force on Preventive Health Care (CTFPHC) is funded through a partnership between the Provincial and Territorial Ministries of Health and Health Canada.

GUIDELINE COMMITTEE

Canadian Task Force on Preventive Health Care (CTFPHC)

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

A complete list of planned reviews, updates and revisions is available under the What's New section at the Canadian Task Force on Preventive Health Care (CTFPHC) Web site.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Canadian Task Force on Preventive Health Care (CTFPHC) Web site.

Print copies: Available from Canadian Task Force on Preventive Health Care, Clinical Skills Building, 2nd Floor, Department of Family Medicine, University of Western Ontario, London, Ontario N6A 5C1, Canada.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Wathen CN, MacMillan HL. Interventions for violence against women: scientific review. JAMA. 2003 Feb 5;289(5):589-600. Available from the Canadian Task Force on Preventive Health Care (CTFPHC) Web site.
- Stachenko S. Preventive guidelines: their role in clinical prevention and health promotion. London (ON): Canadian Task Force on Preventive Health Care, 1994. Available from the CTFPHC Web site.
- CTFPHC history/methodology. London (ON): Canadian Task Force on Preventive Health Care, 1997. Available from the CTFPHC Web site.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on August 20, 2003. The information was verified by the guideline developer on September 18, 2003.

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