UK National Screening Committee

Antenatal and non-pregnant adult screening for partner violence

08 November 2019

Aim

1. To ask the UK National Screening Committee (UK NSC) to make a recommendation, based on the evidence presented in this document, whether antenatal or non-pregnant adult screening for partner violence meets the UK NSC criteria for a systematic population screening programme.

Current recommendation

2. Antenatal and non-pregnant adult screening for partner violence is not currently recommended in the UK.

3. This recommendation was last considered by the UK NSC in 2013, where the review concluded that there was insufficient evidence for the introduction of a population screening programme for partner violence based on the following reasons.

    3.1. The review acknowledged that partner violence is a common and important issue with significant implications for the health of individuals and their families as well as the health, social, and legal services.

    3.2. The review also found that screening programmes may increase the identification of partner violence. However, it was not the only way to increase identification and does not improve the uptake of services. Other methods of increasing referrals appeared to be as effective.

    3.3. There was also a lack of evidence on effective interventions for those who do identify themselves, thus, it was concluded that screening may not lead to a reduction in the level of partner violence or increase positive health outcomes.

4. In addition to the review, comments from stakeholders in response to the 2013 review included a desire to explore the existing evidence around partner violence in men.

2019 Evidence summary

5. The 2019 evidence summary was undertaken by School of Nursing and Midwifery and School of Health and Related Research (ScHARR), University of Sheffield in accordance to the UK NSC evidence review process https://www.gov.uk/government/publications/uk-nsc-evidence-review-process/uk-nsc-evidence-review-process.

6. The 2019 summary aimed to evaluate whether the evidence is available to support population-based antenatal and/or non-pregnant adult screening for partner violence. It updates the evidence on the following key questions identified in the previous review in both pregnant and non-pregnant women as well as addressing these questions across time for men.

   6.1. What is the prevalence of partner violence in the UK in women and men? (criterion 1)

   6.2. How accurate are partner violence screening tools in women and men? (criterion 4)

   6.3. What is the reported effectiveness of interventions after partner violence is disclosed by men and women? (criterion 9)

   6.4. What is the reported effectiveness of partner violence screening for men and women in a healthcare setting? (criterion 11 and 13)

7. The review focused on low-risk settings such as general practice and outpatient clinics, excluding high risk settings such as sexual health, alcohol or drug misuse, mental health, children and vulnerable adults' services, and emergency departments. This is because the review was specifically interested in whether routine screening of the type practiced in high-risk settings should be adopted in low-risk settings. The exception was for pregnant women, where high-risk settings which only serve pregnant and postnatal women, such as obstetric care, were included.

8. Based on the synthesis of evidence against the UK NSC criteria, this review concluded that population-wide antenatal and non-pregnant adult screening programmes for partner violence should not be introduced in the UK at the current time. This recommendation was made for the following reasons.

   8.1. From 16 studies and 6 surveillance reports, this review found that there is a high prevalence of lifetime partner violence, varying between 12% and 24% across the UK nations. Partner violence is an important health problem that affects large numbers of women (pregnant or

not) and men across different ethnicities and sexual orientation. However, the review found that there was insufficient data related to ethnicity, pregnancy, and to different clinical settings. In addition, the quality of the studies was mixed with inconsistent definitions used, and small and inadequate sampling. **Criterion 1 Not Met**

8.2. Three test accuracy studies showed that there are screening tools which report good sensitivity and specificity in women. There was only one study in men, which was a feasibility study introducing a tool for gay men. As each study assessed a different index screening tool and only one study was conducted in the UK, there is a low volume of studies to recommend the use of any single tool in the UK. The studies were also small and of low quality. **Criterion 4 Not Met**

8.3. From 10 non-UK trial publications reporting on 9 interventions, including clinical-based advocacy, counselling, CBT, and provision of information, the results were not strong enough to meet the criterion. Evidence from 5 trials in non-pregnant women showed that there were almost no statistically significant associations on important outcomes such as partner violence exposure or mental health. There was inconsistent evidence on the outcomes of partner violence knowledge and safety promoting behaviours. There were no studies focused on men. Evidence from 4 trials on pregnant and postpartum women favoured interventions for the following outcomes: reduced partner violence exposure (4 studies, 1 did not reach statistical significance), improved pregnancy outcomes (1 study), and safety promoting behaviours (1 study). However, the evidence was still of insufficient quantity and quality to draw strong conclusions overall. **Criterion 9 Not Met**

8.4. There were only 2 non-UK studies (one good quality RCT) addressing the effectiveness of screening, which found no statistically significant effect from screening across an important range of outcomes, including partner violence exposure, physical harms, hospitalisation or ambulatory visits, physical or mental health, quality of life, and knowledge of partner violence and available resources. There were no studies addressing mortality, maternal outcomes, neonatal outcomes, child safety and well-being, or the harms from screening. There were also no studies on screening in men, pregnant women, or any stratified data by ethnicity or sexual orientation. Therefore, it is not known whether population partner violence screening in the UK in low risk settings or in pregnancy would provide more benefit than harm. **Criterion 11 and 13 Not Met**

Consultation

9. A three-month consultation ending on the 2nd October 2019 was hosted on the UK NSC website. Direct emails were sent to 20 stakeholders (see **Annex A**).

10. No comments were received following the public consultation.

Recommendation

11. The Committee is asked to approve the following recommendation:

    An antenatal and/or non-pregnant adult population screening programme for partner violence is not recommended in the UK.

Criteria (only include criteria included in the review)	Met/Not Met
Section 1 - Criteria for appraising the viability, effectiveness and appropriateness of a screening programme	
The Condition	
1. The condition should be an important health problem as judged by its frequency and/or severity. The epidemiology, incidence, prevalence and natural history of the condition should be understood, including development from latent to declared disease and/or there should be robust evidence about the association between the risk or disease marker and serious or treatable disease.	**Not met**
The Test	
4. There should be a simple, safe, precise and validated screening test.	**Not Met**
The Intervention	
9. There should be an effective intervention for patients identified through screening, with evidence that intervention at a pre-symptomatic phase leads to better outcomes for the screened individual compared with usual care. Evidence relating to the wider benefits of screening, for example, those relating to family members, should be taken into account where available. However, where there is no prospect of benefit for the individual screened then the screening programme shouldn't be further considered.	**Not Met**
The Screening Programme	
11. There should be evidence from high quality randomised controlled trials that the screening programme is effective in reducing mortality or morbidity. Where screening is aimed solely at providing information to allow the person being screened to make an "informed choice" (e.g. Down's syndrome, cystic fibrosis	**Not Met**

carrier screening), there must be evidence from high quality trials that the test accurately measures risk. The information that is provided about the test and its outcome must be of value and readily understood by the individual being screened.	
13. The benefit gained by individuals from the screening programme should outweigh any harms for example from over diagnosis, overtreatment, false positives, false reassurance, uncertain findings and complications.	**Not Met**

List of organisations contacted

1. Association for Improvements in the Maternity Services
2. Brian Dempsey, University of Dundee
3. British Psychological Society
4. Broken Rainbow
5. Faculty of Public Health
6. Jane Herriott
7. Mankind
8. Norma Sarsby, North East London NHS Foundation Trust
9. PHE Young Person and Adult Screening Programmes
10. Lisa Summers, PHE Screening Programmes
11. Refuge
12. Respect UK
13. Royal College of General Practitioners
14. Royal College of Midwives
15. Royal College of Nursing
16. Royal College of Physicians
17. Royal College of Physicians and Surgeons of Glasgow
18. Royal College of Physicians of Edinburgh
19. Standing Together
20. Women's Aid