

# SCREENING FOR INTIMATE PARTNER VIOLENCE

An evidence map to outline the volume and type of evidence related to screening for Intimate Partner Violence for the UK National Screening Committee

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**The UK National Screening Committee secretariat is hosted by the Department of Health and Social Care**

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# About the UK National Screening Committee (UK NSC)

The UK National Screening Committee (UK NSC) advises ministers and the NHS in the 4 UK countries about all aspects of [population](#) and targeted screening and supports implementation of screening programmes.

Conditions are reviewed against [evidence review criteria](#) according to the UK NSC's [evidence review process](#).

Read a [complete list of UK NSC recommendations](#).

UK National Screening Committee, Southside, 39 Victoria Street, London, SW1H 0EU

[www.gov.uk/uknsc](http://www.gov.uk/uknsc)

Blog: <https://nationalscreening.blog.gov.uk/>

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# Summary

This document discusses the findings of the evidence map on screening for intimate partner violence (IPV).

Evidence maps are a way of scanning published literature to look at the volume and type of evidence in relation to a specific topic. They inform whether the evidence is sufficient to commission a more sustained analysis on the topic under consideration. This evidence map aims to assess the volume and type of evidence published on the effectiveness of IPV screening programmes in healthcare settings. It places particular focus on pregnant women and adults in the general population who were not previously known to be experiencing IPV. This evidence map will support a wider discussion on whether the UK National Screening Committee (UK NSC) should commission further work on this topic.

Based on the findings of this evidence map, further work on screening for IPV should not be commissioned at present. The existing evidence is limited, consisting mainly of small studies conducted in specific healthcare contexts not directly comparable to the UK setting, for example there is a large volume of US-based studies. Few studies evaluated outcomes of interest, with most focusing only on detection or referral. Critical gaps remain around primary and secondary outcomes, including whether screening reduces IPV, physical and psychological morbidity, and mortality, or prevents adverse events such as increased abuse, retaliation, emotional distress, and negative maternal or neonatal health outcomes. Evidence is also lacking for key populations and settings, including men, LGBTQ+ groups, ethnic minority populations and mental health services. Overall, the evidence base remains too narrow to justify changes in current recommendations.

It is recommended that the UK NSC archive this topic until new, high-quality evidence becomes available. At present, there is minimal evidence on the impact of IPV screening in UK populations of interest, and the international evidence also remains limited. This is confirmed by the minimal evidence found in this 2025 review, but also the previous UK NSC 2019 evidence map. Any future requests to review the evidence for screening for IPV should be submitted through the UK NSC's open call for topics.

# Introduction and approach

## Background and objectives

The UK National Screening Committee (UK NSC) external reviews (also known as evidence summaries or evidence reviews) are developed in keeping with the UK NSC evidence review process to ensure that each topic is addressed in the most appropriate and proportionate manner. Further information on the evidence review process can be accessed [online](#).

Screening for intimate partner violence (IPV) is a topic currently due for an update external review.

Domestic violence and abuse (DVA) encompass any incident or pattern of controlling, coercive, threatening, or violent behaviour between family members or intimate partners aged 16 and over <sup>1</sup>. It includes physical, sexual, psychological, emotional, and financial abuse, and is recognised as a major public health and societal issue with profound short- and long-term consequences <sup>2</sup>. IPV, a subcategory of DVA, refers specifically to abuse perpetrated by a current or former intimate partner <sup>3</sup>. It may involve physical, sexual, psychological, or emotional harm, and represents one of the most common and well-studied forms of DVA <sup>4</sup>. IPV is associated with substantial morbidity and mortality, disproportionately affecting women, and contributes significantly to the global burden of disease with serious health, social and economic impacts <sup>5</sup>. This evidence map focuses specifically on IPV within the context of screening interventions.

Globally, the World Health Organisation (WHO) estimates that nearly one in three women experience physical and/or sexual IPV or non-partner sexual violence in their lifetime <sup>5</sup>. IPV is recognised as a major public health and human rights concern by the WHO <sup>6</sup>. An estimated 2.3 million adults in England and Wales experienced domestic abuse between November 2023 to 2024 <sup>7</sup>; and DVA comprised about one-third of all violent crime recorded by the police <sup>8</sup>.

IPV individual risk factors include young age, pregnancy, long-term illness or disability, and mental health problems <sup>9–11</sup>, while relational risk factors include separation from a partner and history of violence <sup>12,13</sup>. Marginalisation, particularly affecting ethnic minority groups, and socioeconomic deprivation are also associated with higher risk of experiencing IPV <sup>14</sup>. Women are disproportionately affected and more likely to sustain severe physical, sexual and psychological harm, although men can also be victims, albeit at lower prevalence <sup>4</sup>. While measuring true prevalence of IPV is challenging due to variations in definitions, study methods, study populations, and underreporting, evidence suggests that around 27% of women and 15% of men in England have experienced IPV in their lifetime <sup>3</sup>.

The consequences of IPV span health, social and economic domains. Health consequences extend beyond immediate physical harm, encompassing long-term mental illness such as depression, post-traumatic stress disorder (PTSD), and suicidal ideation and behaviours <sup>3,10,15</sup>. Abuse during pregnancy is of particular concern, as it has been associated with adverse outcomes for both mother and child, including low birthweight, placental abruption, preterm labour and delivery, and miscarriage. It also increases behavioural risks of pregnant women such as the use of tobacco, alcohol, and illicit drugs, as well as poor maternal nutrition, among others <sup>16</sup>.

Social consequences include risks to other family members <sup>12</sup>, socioeconomic disadvantages <sup>14</sup>, and intergenerational health effects in offspring, including poorer physical and mental health, as well as reduced socioemotional and developmental outcomes <sup>13</sup>. A study in England found that

lifetime physical IPV experienced by women was associated with social housing tenure, low income, poor educational attainment, lower social class, and residence in areas of multiple deprivation <sup>14</sup>.

The economic consequences of IPV are wide-ranging, including substantial healthcare costs and productivity losses <sup>17</sup>. While the literature does not provide separate estimates for the costs of IPV in the UK, the costs of DVA in England and Wales were estimated at approximately £66 billion in 2016/17. The largest share arose from physical and emotional harm (£47 billion), followed by lost output due to time off work and reduced productivity (£14 billion), and costs to health services (£2.3 billion) <sup>18</sup>.

Timely identification of IPV is crucial as it allows prompt referral to appropriate support services <sup>19</sup>. A wide range of questionnaires and structured tools exist designed to screen for IPV in healthcare settings. One of the most widely used instruments is the Hurts, Insults, Threatens, Screams (HITS) scale, which has shown high sensitivity and specificity across contexts <sup>11</sup>. Other validated tools include the Woman Abuse Screening Tool (WAST) and the Abuse Assessment Screen (AAS) <sup>20,21</sup>. Practices vary, with tools often being adapted rather than standardised. There is currently no universally recommended screening tool for use in the UK.

Screening in healthcare contexts poses unique challenges, as disclosure depends on victims' trust in clinicians, fear of further violence and availability of safe follow-up pathways <sup>22</sup>. There is strong consensus that IPV is underreported, with stigma, fear, and safety concerns being the primary barriers <sup>1</sup>. Consequently, the effectiveness of screening may depend not only on the psychometric properties of the tools used but also on factors such as the context in which screening takes place, the skills and training of healthcare professionals, and the willingness of individuals to disclose abuse <sup>23</sup>. A screening programme is not merely a single test; it is a comprehensive pathway that begins with identifying individuals eligible for screening and concludes with the reporting of outcomes.

While a wide range of interventions — such as counselling, therapy, and referral to specialist services — are available, evidence on their effectiveness remains limited <sup>19</sup>. This uncertainty is reflected in UK guidance: the UK NSC does not recommend population-wide screening, whereas the National Institute for Health and Care Excellence (NICE) advises routine enquiry in specific health settings, supported by staff training and formal referral pathways <sup>24–26</sup>. Against this backdrop, the current evidence map seeks to assess whether new evidence published since the 2019 UK NSC review justifies re-evaluating screening for IPV and to identify persisting research gaps regarding the effectiveness of routine screening programmes.

## Previous review on screening for intimate partner violence

The UK NSC currently recommends against screening for IPV. The Committee based this recommendation on the evidence provided by the 2019 review carried out by the School of Nursing and Midwifery and the School of Health and Related Research (SchARR) at the University of Sheffield <sup>27</sup>. The review concluded the available evidence is still insufficient to recommend a change to the current UK NSC recommendation on population-wide antenatal or non-pregnant adult screening programmes for partner violence. Although IPV was identified as a significant health problem affecting large numbers of women and men, the available prevalence data were limited by inconsistent definitions, variable quality, and gaps relating to ethnicity, pregnancy, and clinical settings. While some screening tools showed good sensitivity and specificity in women, the evidence base was small, of low quality, and largely non-UK, with almost no data available for men. Evidence on interventions following screening was also weak: most non-UK trials showed little or no impact on key outcomes such as violence exposure or mental health, with only limited benefit in pregnant and postpartum women. Finally, only two

non-UK studies directly assessed the effectiveness of screening, finding no significant benefit across a range of outcomes and providing no evidence on harms, mortality, or outcomes in pregnancy, children, or different ethnic groups.

## Aims of the evidence map

Evidence maps are rapid evidence products which aim to gauge the volume and type of evidence relating to a specific topic.

This evidence map was developed to assess whether a more sustained review on screening for IPV should be commissioned and to evaluate the volume and type of evidence on key issues related to screening for IPV.

The aim was to address the following question:

1. What is the volume and type of evidence on the reported effectiveness of IPV screening in healthcare settings?

The scope of the review included individuals aged 16 and above, including pregnant individuals, who were not previously known to be experiencing IPV. Specifically, it examined the effectiveness of IPV screening for adults in general healthcare settings, for pregnant women within antenatal care, and across different healthcare contexts such as general practice and antenatal services. The map also considered whether effectiveness varied across specific subgroups, including those defined by sexual orientation and ethnicity. The aim was to determine whether significant new evidence had emerged since the last UK NSC reviews to justify a more detailed evaluation, while also identifying gaps in the existing evidence base to inform future research priorities.

The findings of this evidence map provide a basis for discussion to support decision-making on whether there is sufficient evidence to justify commissioning a more sustained review of IPV screening.

The aim of this document is to present the information necessary to inform UK NSC decision-making processes.

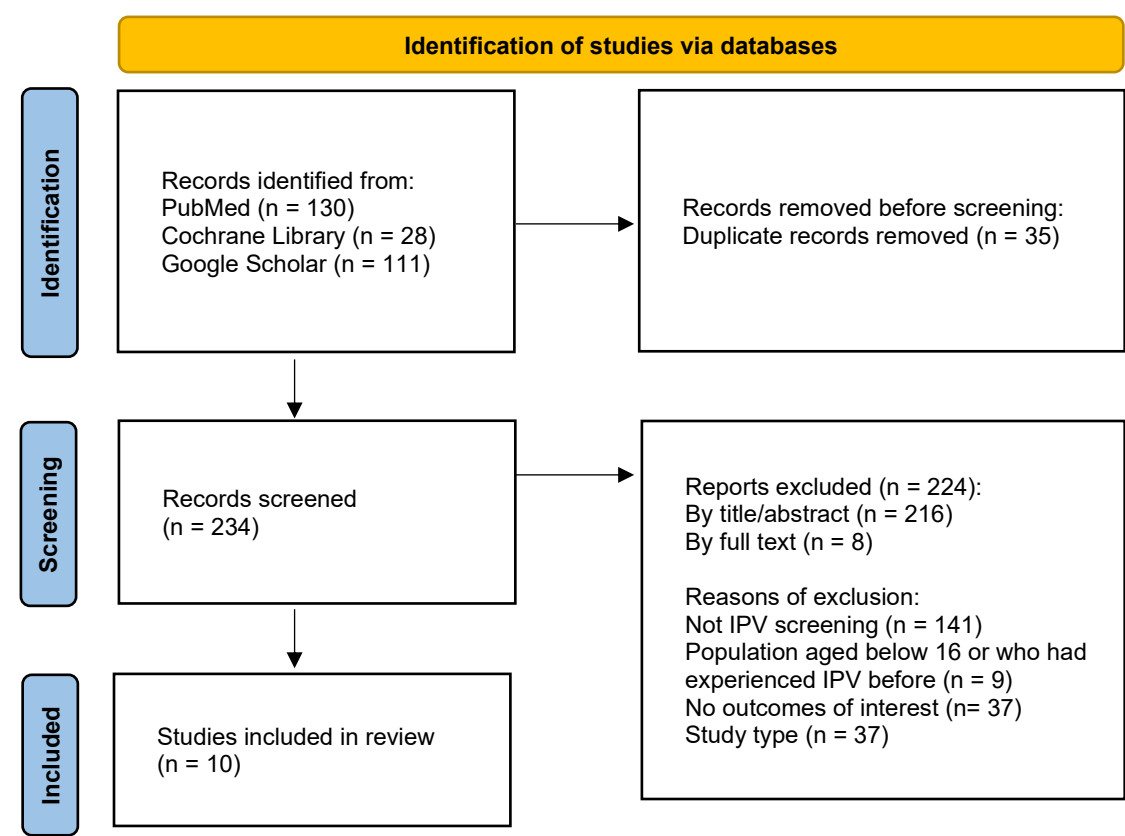
# Search methods and results

The searches were conducted on 30 July 2025 using 3 databases: PubMed, Cochrane Library and Google Scholar. The search period was restricted to October 2018 to July 2025. The detailed search strategies, including exclusion and inclusion criteria, are available in Appendix 1. One reviewer sifted all titles and abstracts. All references were reviewed at title and abstract level, though in some cases full texts were reviewed to clarify uncertainties. A formal quality appraisal of the evidence was not required, given the remit of the evidence map.

All references were screened by one reviewer at the title and abstract level using the inclusion and exclusion criteria. Where uncertainties arose during screening, entries were reviewed by a second reviewer to ensure consistency. To assure the quality of the process, a random 20% of abstracts were double screened by a second reviewer. Discrepancies were resolved through discussion with the second reviewer. Abstract reporting tables are available in Appendix 2.

The search returned 269 results. After automatic and manual de-duplication, 234 unique references were sifted for relevance to the evidence map question. A total of 10 references were included in the final evidence map. A flow diagram summarising the number of studies included and excluded is presented in Figure 1 below.

**Figure 1: Summary of included and excluded publications**



# Summary of findings

## Question: What is the volume and type of evidence on the reported effectiveness of IPV screening in healthcare settings?

The evidence base on the effectiveness of IPV screening in healthcare settings remains very limited. A total of 10 studies were included in the evidence map (Table 1). Only 6 out of the 10 studies reported the sample size, collectively encompassing over 150,523 participants. Of the papers identified, only 2 systematic reviews included UK-specific evidence <sup>28,29</sup>, while the remainder were conducted in other countries, including the US and Canada <sup>26,30–36</sup>. The systematic review by Miller et al. included 4 UK studies, published between 2003 and 2020, all of which assessed the effectiveness of IPV screening in community health clinics and primary care settings <sup>28</sup>. However, the outcomes reported were limited, and these are presented later in this section. Across the original UK-specific studies included in the systematic review, the total number of participants was 694,467 <sup>37–40</sup>. The systematic review by Feltner et al. included one UK study, published in 2007 and involving 232 women, which assessed the accuracy of an IPV screening tool in general practice <sup>29</sup>.

The studies included in this evidence map employed a range of designs: 4 systematic reviews <sup>28,29,35,36</sup>, 2 quality improvement studies <sup>32,34</sup>, 2 retrospective reviews of medical records <sup>26,33</sup>, 1 subgroup analysis using data from a randomised controlled trial (RCT) <sup>31</sup>, and 1 cohort study <sup>30</sup>. The publication period ranged from 2018 to 2025.

Most studies (n = 7) focused on women, 3 of which included evidence on pregnant women <sup>28,29,34</sup>. Only 3 studies included male participants <sup>29,32,36</sup>. Other subgroups examined included ethnicity (1 study distinguished between "Hispanic or Latino" and "Non-Hispanic or Latino" <sup>26</sup>), race (1 study reported on Black women <sup>31</sup>), age group (1 study included "adolescents and adults", and "older and vulnerable adults" <sup>29</sup>), language (1 study included "English- and/or Spanish-speaking females" <sup>35</sup>), role (1 study included "caregiver adults" <sup>32</sup>), and occupation (1 study included veteran women <sup>33</sup>).

The studies were conducted across diverse healthcare settings. Four took place in primary care, including ambulatory primary care clinics, women's primary care settings, Veterans Health Administration (VHA) primary care clinics, and primary care practices <sup>26,29,30,33</sup>. Two were conducted exclusively in emergency care settings: one in an urban paediatric emergency department <sup>32</sup> and another across emergency departments and trauma centres in the US <sup>36</sup>. Two examined reproductive health contexts, namely a private obstetrics and gynaecology practice <sup>34</sup> and stand-alone family planning clinics <sup>35</sup>. One study focused on community-based supervision programmes <sup>31</sup>, while another broadly reported on interventions in hospitals (51%), community health centres (41%), and home visitation programmes (7%) <sup>28</sup>. One study involved telephone-based assessment <sup>36</sup>.

The studies employed a wide range of IPV screening interventions. Several tested specific tools, such as the Humiliation, Afraid, Rape, Kick (HARK) questionnaire (n=2) <sup>29,30</sup>, the HITS or Extended-HITS (E-HITS) scale (n=3) <sup>29,33,34</sup>, the WAST or WAST-Short (n=1) <sup>29</sup>, and the Addressing Reproductive Coercion in Health Settings (ARCHES) tool (n=1) <sup>35</sup>. Other interventions included a computerised programme based on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model (n=1) <sup>31</sup>, secondary screening for severe violence using Danger Assessment items (n=1) <sup>26</sup>, and a nonverbal screening card as part of a quality improvement initiative (n=1) <sup>32</sup>. Additional reports described institutional or clinician-administered protocols in emergency or trauma care (n=1) <sup>36</sup>. Overall, the studies reflected substantial variation in IPV

screening methods, ranging from structured questionnaires to technology-assisted and system-level approaches.

It is also worth noting that, during the screening of titles and abstracts for this evidence map, several studies were identified that focused primarily on the adoption and implementation of IPV screening tools, rather than on the effectiveness of screening in reducing IPV or improving health outcomes. These were excluded as out of scope. However, such evidence is likely to become relevant in the future, once a stronger evidence base exists to support recommendations for IPV screening in the UK, as it may help to inform best implementation practice.

Only 2 studies reported primary effectiveness outcomes. One assessed the potential harms of IPV screening and found no adverse effects among adult women <sup>29</sup>. Harms assessed included labelling, stigma, or increased abuse and retaliation associated with the intervention <sup>29</sup>. The same study also assessed the reduction of episodes of IPV: 3 RCTs comparing IPV screening with no screening found no significant reduction in IPV over 3 to 18 months <sup>29</sup>. Another study reported no impact on length of stay in the emergency department following IPV screening <sup>32</sup>. The remaining 8 studies did not report primary effectiveness outcomes. Importantly, studies only addressed one of the three primary outcomes of interest (adverse events) in this evidence map. Neither reduction in episodes of IPV nor prevention of IPV was reported.

All studies reported secondary effectiveness outcomes. Across these studies, only 2 (identification of IPV and information provision and referral to services) of the 8 secondary outcomes of interest were reported. No evidence was found for physical or psychological morbidity, mortality, maternal outcomes, neonatal outcomes, children's safety and wellbeing, or quality of life.

Three studies found that women disclosing IPV were successfully connected to follow-up services, such as therapy, access to safe housing, and psychosocial visits, across primary care and multi-setting contexts <sup>26,28,30</sup>. Two others reported additional benefits: one found increased social support among Black women in community supervision programmes <sup>31</sup>, while the other noted greater awareness of available IPV resources, improved perceptions of provider empathy, safer responses to unhealthy relationships, and reduced pregnancy coercion among women in family planning clinics <sup>35</sup>. However, the latter emphasised that robust evaluative evidence remains scarce <sup>35</sup>.

Seven studies reported on IPV detection and screening accuracy. Regarding IPV detection, in non-emergency settings, one study in a private obstetrics and gynaecology clinic found that introducing the HITS tool increased disclosure rates by 7.5% <sup>34</sup>. In veteran primary care clinics, screen-positive rates were higher among women of childbearing age (8.1–11.0%) compared with older women (5.6–7.4%) <sup>33</sup>. Iverson et al. reported that among 185 women screening positive for past-year IPV who completed secondary screening in primary care settings, 33.0% screened positive for severe IPV <sup>26</sup>. In emergency care, one study found that structured screening protocols significantly increased the number of IPV cases identified compared with non-standardised approaches <sup>36</sup>. Another reported that screening by frontline clinical personnel yielded comparable screen-positive rates to the rates found in studies using externally funded research staff <sup>28</sup>. In paediatric emergency care, one study showed that sustained caregiver screening rates could be achieved <sup>32</sup>.

Regarding screening tools' accuracy, one systematic review found that HARK demonstrated high accuracy in a sample of 232 women in detecting IPV in primary care settings in the UK <sup>29</sup>. In contrast, accuracy was lower in a sample of 53 men, with the Partner Violence Screen (PVS)

and HITS showing low sensitivity for psychological and physical abuse in emergency departments in the US <sup>29</sup>. Across other tools, sensitivity and specificity varied widely, with some showing high accuracy for identifying lifetime IPV, while a tool designed to predict future abuse performed poorly <sup>29</sup>. The review concluded that, although available tools may reasonably identify women with past-year IPV, RCTs of screening did not demonstrate reductions in IPV or improvements in other outcomes <sup>29</sup>.

The evidence map highlights several important gaps and limitations. Study populations were largely restricted to women, with few including men and none focusing specifically on LGBTQ+ groups or ethnic minority populations. Several studies relied on small sample sizes (fewer than 150 participants), limiting the robustness of findings. Evidence was concentrated in particular healthcare settings — primary care, emergency departments, and obstetrics/gynaecology practices — leaving little or no evidence from others, such as mental health services. Importantly, evidence is scarce regarding IPV screening effectiveness outcomes. Only one study reported on the reduction of IPV and found no significant impact. Most studies focused on detection and referral, while key outcomes such as prevention of IPV, morbidity, mortality, neonatal outcomes, children’s wellbeing, and quality of life were not reported. Finally, only 2 systematic reviews included UK-based studies, leaving the evidence base heavily weighted towards the US context and highlighting a scarcity of UK-specific data.

Table 1. Summary of included studies

| <b>Abbreviated citation</b>        | <b>Setting</b>                                                                                | <b>Population</b>      | <b>Interventions</b>                                                                                                                                                                                                                                                                   | <b>Outcomes</b>                                                                                                        |
|------------------------------------|-----------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| Chung et al. (2025) <sup>30</sup>  | Ambulatory care clinics; US                                                                   | Female adult patients  | IPV screening using HARK assessment                                                                                                                                                                                                                                                    | Primary: not reported<br>Secondary: referral to support services                                                       |
| Feltner et al (2025) <sup>29</sup> | Primary care and emergency departments; US, UK, Canada, Australia, New Zealand, Norway, Spain | Adolescents and adults | IPV screening tools including AAS, Afraid, Controlled, Threatened, Slapped or physically hurt screen, HARK, HITS, E-HITS, PVS, WAST, WAST-Short, Parent Screening Questionnaire, Slapped, Things, Threaten (STaT), Ongoing Violence Assessment Tool (OVAT), Ongoing Abuse Screen (OAS) | Primary: adverse events from intervention; reduced episodes of IPV<br>Secondary: detection of IPV (screening accuracy) |

|                                             |                                                                                                              |             |                                                                                                                      |                                                                                                                 |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| Goddard-Eckrich et al. (2022) <sup>31</sup> | Community supervision programmes; US                                                                         | Black women | SBIRT model                                                                                                          | Primary: not reported<br>Secondary: reception of IPV services and social support                                |
| Iverson et al. (2018) <sup>26</sup>         | Primary care; US                                                                                             | Women       | Secondary screening tool consisting of 3 items from the Danger Assessment                                            | Primary: not reported<br>Secondary: detection of IPV; follow-up psychosocial visits                             |
| Mancheno et al. (2021) <sup>32</sup>        | Urban paediatric emergency department; US                                                                    | Adults      | Quality improvement initiative using a nonverbal screening card                                                      | Primary: impact on the length of stay in the emergency department<br>Secondary: post evaluation screening rates |
| Miller et al. (2021) <sup>28</sup>          | Various healthcare settings; UK, Australia, Canada, Spain, New Zealand, India, Lebanon, Turkey, Iran, Guinea | Women       | IPV screening administered by frontline clinical personnel                                                           | Primary: not reported<br>Secondary: screen-positive rate; referral to follow-up services                        |
| Miller et al. (2023) <sup>33</sup>          | VHA primary care clinics; US                                                                                 | Women       | E-HITS                                                                                                               | Primary: not reported<br>Secondary: screen-positive rate                                                        |
| Price et al. (2023) <sup>34</sup>           | Private suburban obstetric and gynecologic practice; US                                                      | Women       | HITS screening tool, the investigator-developed Duluth model tool, a case management log, and a team engagement plan | Primary: not reported<br>Secondary: IPV disclosure rate                                                         |
| Sabloak et al. (2024) <sup>35</sup>         | Family planning clinics; US                                                                                  | Women       | ARCHES tool                                                                                                          | Primary: not reported<br>Secondary: Information provision of                                                    |

|                                      |                                              |                          |                                          |                                                                                                                                                          |
|--------------------------------------|----------------------------------------------|--------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                      |                                              |                          |                                          | IPV-related resources; patient perception of provider empathy; knowledge acquisition of violence-related resources; odds-reduction of pregnancy coercion |
| Teichman et al. (2023) <sup>36</sup> | Emergency departments and trauma centres; US | Female and male patients | Institutional formal IPV screening tools | Primary: not reported<br>Secondary: detection of IPV                                                                                                     |

Abbreviations: AAS, Abuse Assessment Screen; ARCHES, Addressing Reproductive Coercion in Health Settings; E-HITS, Extended Hurt, Insult, Threaten, Scream; HARK, Humiliation, Afraid, Rape, and Kick; HITS, Hurt, Insult, Threaten, Scream; IPV, Intimate Partner Violence; OAS, Ongoing Abuse Screen; OVAT, Ongoing Violence Assessment Tool; PVS, Partner Violence Screen; SBIRT, Screening, Brief Intervention, and Referral to Treatment; STaT, Slapped, Things, Threaten; UK, United Kingdom; US, United States; VHA, Veterans Health Administration; WAST, Woman Abuse Screening Tool; WAST-Short, Woman Abuse Screening Tool-Short.

# Conclusions

The findings of this evidence map are unlikely to influence current recommendations on screening for IPV, as no new evidence was identified that would meaningfully alter existing conclusions. Although studies were conducted across a range of healthcare settings, including primary care, obstetrics/gynaecology, and emergency departments, the overall evidence base remains limited. Most studies focused narrowly on detection and referral, relied on small samples, and excluded key populations such as men, LGBTQ+ groups, and many ethnic minority communities. Only 2 reviews included UK-based studies, leaving the evidence base heavily weighted towards US contexts. Substantial evidence gaps therefore persist, particularly regarding the impact of screening on the prevention of IPV, and on long-term health and wellbeing outcomes.

## Recommendations

On the basis of this evidence map, the volume and type of evidence related to IPV screening remain insufficient to justify an updated review at this stage. This is the second mapping exercise on this topic, and it similarly concludes that the available evidence is too limited to support changes to current recommendations. It is therefore recommended that the topic be archived until new, high-quality research becomes available to address the existing gaps. Such studies should provide evidence on: (1) the effects of IPV screening on men, LGBTQ+ groups, and ethnic minority populations; (2) the effectiveness of IPV screening in underrepresented healthcare settings, such as mental health services; and (3) robust evaluations of outcomes beyond detection and referral, including the impact of screening on preventing IPV episodes, morbidity, mortality, neonatal outcomes, child wellbeing, and quality of life. Furthermore, to strengthen relevance to local practice, future research should preferably be based on UK-specific data. Any future requests to review the evidence for screening for IPV should be submitted through the UK NSC's open call for topics.

# Appendix 1 — Search strategy for the evidence map

## Databases and platforms searched

PubMed® (National Library of Medicine), the Cochrane Library (Cochrane Database of Systematic Reviews, Issue 8 of 12, July 2025; Cochrane Central Register of Controlled Trials, Issue 8 of 12, July 2025), and Google Scholar (searched July 2025).

## Search dates

All searches were run on 28th July 2025.

## Search strategies

Search terms for PubMed

1. "IPV"[Title/Abstract] OR "partner abuse"[Title/Abstract] OR "domestic abuse\*"[Title/Abstract] OR "battered women"[Title/Abstract] OR "battered wi\*"[Title/Abstract] OR "battered husband"[Title/Abstract] OR "battered men"[Title/Abstract] OR "intimate partner violence"[Title/Abstract] OR "domestic violence"[Title/Abstract] OR "spous\* abuse"[Title/Abstract]
2. "screening"[Title/Abstract] OR "screening programme"[Title/Abstract] OR "screening program"[Title/Abstract] OR "identification"[Title/Abstract] OR "detection"[Title/Abstract]
3. "pregnancy"[Title/Abstract] OR "pregnant"[Title/Abstract] OR "antenatal"[Title/Abstract] OR "perinatal"[Title/Abstract] OR "postpartum"[Title/Abstract] OR "maternal health"[Title/Abstract] OR "women"[Title/Abstract] OR "men"[Title/Abstract] OR "adult"[Title/Abstract] OR "adults"[Title/Abstract] OR "people aged 16 and over"[Title/Abstract] OR "individuals aged 16 and over"[Title/Abstract]
4. "effectiveness"[Title/Abstract] OR "outcomes"[Title/Abstract] OR "referral\*"[Title/Abstract] OR "safety"[Title/Abstract] OR "impact"[Title/Abstract] OR "identification rate\*"[Title/Abstract] OR "detection rate"[Title/Abstract] OR "support service\*"[Title/Abstract] OR "service utilization"[Title/Abstract] OR "service utilisation"[Title/Abstract] OR "service use"[Title/Abstract] OR "morbidity"[Title/Abstract] OR "mortality"[Title/Abstract] OR "PTSD"[Title/Abstract] OR "mental health"[Title/Abstract] OR "stigma"[Title/Abstract] OR "distress"[Title/Abstract] OR "wellbeing"[Title/Abstract] OR "anxiety"[Title/Abstract] OR "depression"[Title/Abstract] OR "trauma"[Title/Abstract] OR "miscarriage"[Title/Abstract] OR "low birth weight"[Title/Abstract] OR "prematurity"[Title/Abstract] OR "preterm birth"[Title/Abstract] OR "isolation"[Title/Abstract] OR "quality of life"[Title/Abstract] OR "QOL"[Title/Abstract] OR "QALY"[Title/Abstract]
5. "United Kingdom"[Title/Abstract] OR "UK"[Title/Abstract] OR "England"[Title/Abstract] OR "Scotland"[Title/Abstract] OR "Wales"[Title/Abstract] OR "Northern Ireland"[Title/Abstract] OR "Britain"[Title/Abstract]
6. "2018/10/01"[Date - Publication] : "2025/07/28"[Date - Publication]
7. 1 AND 2 AND 3 AND 4 AND 5 AND 6

## Search terms for the Cochrane Libraries

1. [Title Abstract Keyword:] "intimate partner violence" OR IPV OR "domestic violence" OR "partner abuse" OR "spous\* NEXT abuse" OR "domestic NEXT abuse\*" OR "battered women" OR "battered NEXT wi\*" OR "battered husband" OR "battered men"
2. [Title Abstract Keyword:] screening OR "screening programme" OR "screening program" OR detection OR identification
3. [Title Abstract Keyword:] pregnant OR pregnancy OR antenatal OR perinatal OR post-partum OR "maternal health" OR women OR men OR adult\* OR "people aged 16 and over" OR "individuals aged 16 and over"
4. [Title Abstract Keyword:] effectiveness OR outcome\* OR referral\* OR safety OR impact OR "identification NEXT rate\*" OR "detection rate" OR "support NEXT service\*" OR "service utilization" OR "service utilisation" OR "service use" OR morbidity OR mortality OR "mental health" OR PTSD OR stigma OR distress OR wellbeing OR anxiety OR depression OR trauma OR miscarriage OR "low birth weight" OR "prematurity" OR "pre-term birth" OR isolation OR "quality of life"
5. [Title Abstract Keyword:] "United Kingdom" OR UK OR England OR Scotland OR Wales OR "Northern Ireland" OR Canada OR "United States" OR USA OR America OR France OR Germany OR Italy OR Japan OR "European Economic Area" OR EEA
6. 1 AND 2 AND 3 AND 4 AND 5

## Search terms for Google Scholar

1. "intimate partner violence" OR "domestic violence" OR "partner abuse" OR "relationship abuse" OR "spous\* abuse" OR "domestic abuse" OR "battered women" OR "battered wife" OR "battered husband"
2. "IPV screening"
3. pregnant OR women OR men OR adult\*
4. effectiveness OR outcome\* OR referral OR safety OR impact OR morbidity OR mortality OR "mental health" OR PTSD OR stigma OR distress OR wellbeing OR anxiety OR depression OR trauma OR miscarriage OR "neonatal birthweight" OR isolation OR "quality of life"
5. "United Kingdom" OR UK OR England OR Scotland OR Wales OR "Northern Ireland" OR Canada OR "United States" OR USA OR America OR France OR Germany OR Italy OR Japan OR "European Economic Area" OR EEA
6. healthcare setting OR clinical setting
7. 1 AND 2 AND 3 AND 4 AND 5 AND 6

## Numbers of results for each database and question if applicable

PubMed: 130

Cochrane Library: 28

Google Scholar: 111

Total: 269

**Total unique results after de-duplication: 234**

## Inclusions and exclusions

### Inclusion Criteria:

- **population:** Individuals aged 16 and above (including pregnant individuals) not previously known to be experiencing IPV
- **intervention:** IPV screening programme
- **comparator:** Usual care or none
- **outcomes**

#### *Primary outcomes:*

- reduced episodes of IPV (physical, sexual, psychological)
- prevention of IPV (such as, during pregnancy, one year after screening, or first visit, as defined by trial authors)
- adverse events from intervention (such as, increased abuse, retaliation, emotional distress, labelling, stigma)

#### *Secondary outcomes:*

- identification of IPV
- information provision and referrals to support agencies (including take-up rates when available)
- physical and psychological morbidity (such as, physical trauma, chronic medical conditions, acute and chronic mental health conditions such as PTSD, anxiety, depression; sexual trauma, unintended pregnancy, sexually transmitted diseases)
- mortality
- maternal outcomes (such as, miscarriage, antepartum haemorrhage, premature labour, abruptio placentae)
- neonatal outcomes (such as, birthweight, Appearance, Pulse, Grimace, Activity, and Respiration (APGAR) scores at 1 and 5 minutes, stillbirth, perinatal death)
- children's safety and well-being
- quality of life, social isolation, self-esteem
- **timing**
  - outcomes measured during pregnancy (including antenatal care), postpartum, or at specified follow-up points
  - for adults: outcomes measured at the time of screening, immediately after, or during follow-up periods defined by individual studies

- **setting:** Studies in the UK prioritised. Evidence also considered from comparable English-speaking countries (including the Group of Seven (G7) and the European Economic Area (EEA))
- **study design (in order of preference)**
  - randomised controlled trials
  - quasi-experimental studies
  - cohort studies
  - systematic reviews of any of the above
- **time frame:** Studies published from October 2018 to present

#### **Exclusion Criteria:**

- **population**
  - individuals known to be experiencing IPV
  - individuals under age 16
  - studies on domestic abuse that do not specifically distinguish IPV
- **intervention**
  - studies not involving an IPV screening programme
  - studies including ambiguously defined IPV screening programmes or screening programme protocols
- **comparator:** Not applicable
- **outcomes:** Studies not reporting on any of the specified primary or secondary outcomes or other relevant screening outcomes
- **timing**
  - studies measuring outcomes outside of pregnancy, postpartum, or pre-specified follow-up periods
  - studies measuring outcomes outside the screening period or follow-up timeframes defined within the study
- **setting:** Studies from countries other than the UK and selected comparable English-speaking countries
- **study design:** Any study design not listed under inclusion criteria
- **time frame:** Studies published before October 2018

## Appendix 2 – Abstract reporting

Question: What is the volume and type of evidence on the reported effectiveness of IPV screening in healthcare settings?

The full text was consulted to identify relevant information for all citations.

### Citation 1

Chung et al. (2025) <sup>30</sup>

### Study type

Cohort study

### Objectives

To describe the process and relevant outcomes of implementing the Zero Suicide framework with IPV intervention.

### Components of the study

**Population:** Female adult patients who were seen at University of Texas Health Houston McGovern Medical School Physicians ambulatory primary care clinics.

**Sample or population size:** 13,957

**Geographic location/country focus:** US

**Intervention:** IPV screening using the HARK assessment (n= 4,008)

**Focus on pregnancy (including postpartum):** no mention of pregnant women in the study

### Outcomes reported

**Primary:** Not reported

**Secondary:** All female patients who reported IPV were connected to services, including therapy and access to a safe place.

### Conclusions

The Zero Suicide framework with IPV intervention had a positive impact on screening and treatment outcomes among patients, indicating the feasibility in implementation and program adoption.

## Citation 2

Feltner et al. (2025) <sup>29</sup>

### Study type

Systematic review

### Objectives

To review the evidence on screening and interventions for IPV and caregiver abuse among adults.

### Components of the study

**Population:** Adolescents and adults (age 18 years or older)

**Sample or population size:** Sample size not reported. Thirty-five studies met the inclusion criteria.

**Geographic location/country focus:** US, UK, Canada, Australia, New Zealand, Norway, Spain

**Intervention:** IPV screening; The studies to detect exposure to IPV used different screening tools: AAS; Afraid, Controlled, Threatened, Slapped or physically hurt screen; HARK; HITS; Electronic HITS (E-HITS); PVS; Parent Screening Questionnaire; WAST and WAST-Short; STaT; OVAT; and OAS

**Focus on pregnancy (including postpartum):** Study includes both pregnant and non-pregnant populations

### Outcomes reported

**Primary:** Harms of IPV screening: 2 trials in adult women in Canada and New Zealand reported on harms of screening for IPV and identified no adverse effects of screening. Reduced episodes of IPV: 3 RCTs comparing IPV screening with no screening in the US, New Zealand and Canada found no significant reduction in IPV over 3 to 18 months.

**Secondary:** Detection of IPV

### Conclusions

Although available screening tools may reasonably identify women with past-year IPV, RCTs of IPV screening did not show reduced IPV or improvement in other outcomes. Limited evidence suggested that home visiting and behavioural counselling interventions addressing multiple risk factors may lead to reduced IPV among pregnant or postpartum women. No studies assessed screening among vulnerable adults or treatment for caregiver abuse among older or vulnerable adults.

## Citation 3

Goddard-Eckrich et al. (2022) <sup>31</sup>

### Study type

Subgroup analysis using data from a randomised controlled trial

### Objectives

This study aims to evaluate the effectiveness of different modalities (computerised self-paced versus case manager) of a brief, evidence-based IPV prevention intervention entitled Women Initiating New Goals of Safety (WINGS) on (1) increasing social support; (2) increasing linkage to IPV services; (3) increasing IPV self-efficacy; and (4) increasing the numbers of days of abstinence from drug use.

### Components of the study

**Population:** Black women in community supervision programs who have experienced IPV and have a substance use history

**Sample or population size:** 128

**Geographic location/country focus:** US

**Intervention:** The computerised WINGS intervention was an applied IPV SBIRT model, which provided a one-session, computerized self-paced assessment that allowed legal system-involved women who use drugs to (1) identify and disclose IPV, (2) provide feedback on their risks for IPV, (3) develop self-efficacy to protect themselves from IPV, (4) raise awareness of drug-related triggers for IPV, (5) develop safety plans considering substance-related risks for IPV, and (6) enhance social supports and linkages to IPV services.

**Focus on pregnancy (including postpartum):** Women irrespective of pregnancy status (no mention of pregnant women in the study)

**Comparator:** Not applicable

### Outcomes reported

**Primary:** Not reported

**Secondary:** Receipt of IPV services; Increases in social support

### Conclusions

Although both conditions showed significant reductions in the number of days of abstinence from substance use among this subgroup of Black women, the findings showed differential effectiveness between the computerised WINGS arm and the case manager WINGS arm in improving social support and linkage to services. These findings may indicate that different modalities of WINGS may work better for specific activities and point to the need for a hybrid format that optimises the use of distinct modalities for delivering activities.

## Citation 4

Iverson et al. (2018) <sup>26</sup>

### Study type

Retrospective review of medical records

### Objectives

The VHA has implemented screening for past-year IPV in some healthcare facilities along with secondary screening of risk for severe violence among those screening positive in order to facilitate follow-up care for high-risk patients. The authors evaluated the adoption, penetration, and effectiveness of secondary screening as a tool to facilitate timely follow-up services.

### Components of the study

**Population:** Women screening positive for past-year IPV. Ethnicity: distinguished between "Hispanic or Latino" and "Non-Hispanic or Latino"

**Sample or population size:** 774

**Geographic location/country focus:** US

**Intervention:** Secondary screening of risk for severe violence among those screening positive. This secondary screening tool consists of 3 items from the Danger Assessment to assess increasing severity of violence, strangulation and lethality.

**Focus on pregnancy (including postpartum):** The article does not mention pregnancy or postpartum focus

**Comparator:** Not applicable

### Outcomes reported

**Primary:** Not reported

**Secondary:** IPV detection; follow-up psychosocial visits

### Conclusions

Secondary risk assessment following IPV screening may expedite access to psychosocial follow-up care in integrated healthcare settings. The low adoption and modest penetration of the secondary risk screening, along with the evidence that secondary screening is associated with timely psychosocial follow-up services suggest a need to modify recommendations and/or tailor implementation strategies to enhance the uptake and reach of IPV secondary screening.

## Citation 5

Mancheno et al. (2021) <sup>32</sup>

### Study type

Quality improvement initiative

### Objectives

The authors implemented an IPV screening and referral program in an urban paediatric emergency department and aimed to screen 30% of patient families for IPV by January 1, 2017.

### Components of the study

**Population:** Adults

**Sample or population size:** Over 100,000

**Geographic location/country focus:** US

**Intervention:** A quality improvement initiative using a nonverbal screening card to screen families when the caregiver was the sole adult present and spoke English and/or Spanish, and the patient was medically stable. Interventions included education, culture of screening initiatives, feedback, and process changes to emergency medical record documentation.

**Focus on pregnancy (including postpartum):** Non-pregnancy scenarios (no mention of pregnancy or postpartum focus)

**Comparator:** Not applicable

### Outcomes reported

**Primary:** Length of stay in the emergency department

**Secondary:** Post-evaluation caregiver screening rates

### Conclusions

Both IPV screening and documentation rates demonstrated greatest improvement and sustainability after process improvements over other initiatives.

## Citation 6

Miller et al. (2021) <sup>28</sup>

### Study type

Systematic review

### Objectives

To investigate the utility of IPV screening administered by frontline clinical personnel.

### Components of the study

**Population:** Women

**Sample or population size:** Sample size not reported. Fifty-nine studies met the inclusion criteria.

**Geographic location/country focus:** UK (n = 4), Australia (n = 4), Canada (n = 2), Spain (n = 1), New Zealand (n = 1), India (n = 1), Lebanon (n = 1), Turkey (n = 1), Iran (n = 1), and Guinea (n = 1)

**Intervention:** IPV screening administered by frontline clinical personnel

**Focus on pregnancy (including postpartum):** The study includes both pregnant and non-pregnant women

**Comparator:** Not applicable

### Outcomes reported

**Primary:** Not reported

**Secondary:** Screen positive rate; referrals to follow-up services

### Conclusions

Successfully implementing IPV screening programs may be part of the solution to tackle this population health issue. The review emphasises the importance of ongoing provider trainings, readily available referral sources, and consistent institutional support in maintaining appropriate IPV screening programs.

## Citation 7

Miller et al. (2023) <sup>33</sup>

### Study type

Retrospective cohort study

### Objectives

The aims of this study are specifically to examine the population of women VHA primary care patients to report (1) the proportion of women screened at least annually each year since IPV screening was implemented, overall and as a function of childbearing age (Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM) dimension of reach); (2) the proportion of women who screened positive for IPV, overall and as a function of childbearing age (RE-AIM dimension of effectiveness); and (3) the extent to which VHA medical centres adopted IPV screening programs over time (RE-AIM dimension of adoption).

### Components of the study

**Population:** All women from all VHA sites who had at least one primary care visit within a VHA clinic

**Sample or population size:** Nearly 35,000

**Geographic location/country focus:** US

**Intervention:** The screening tool adopted by VHA was the 5-item E-HITS

**Focus on pregnancy (including postpartum):** Not focused specifically on pregnancy

**Comparator:** Not applicable

### Outcomes reported

**Primary:** Not reported

**Secondary:** Proportion screening positive at different cut-scores on the E-HITS

### Conclusions

The findings demonstrate that substantial progress has been made in implementing evidence-based IPV screening practices for women primary care patients during the early years of this effort, while also identifying areas for improving the reach and adoption of IPV screening practices. More needs to be done to ensure providers follow the veteran's directive for screening all women rather than recommendations for screening just women of childbearing age.

## Citation 8

Price et al. (2023) <sup>34</sup>

### Study type

Quality improvement initiative

### Objectives

To increase rates of screening for IPV, education, and follow-up of women being seen at a private obstetrics and gynaecology clinic to 52% in 90 days.

### Components of the study

**Population:** Women being seen at a private obstetrics and gynaecology clinic

**Sample or population size:** 664

**Geographic location/country focus:** US

**Intervention:** HITS screening tool, the investigator-developed Duluth model tool, a case management log, and a team engagement plan were implemented

**Focus on pregnancy (including postpartum):** Mixed pregnancy/non-pregnancy

**Comparator:** Not applicable

### Outcomes reported

**Primary:** Not reported

**Secondary:** Increase in the IPV disclosure rate (noted as the IPV positivity rate)

### Conclusions

The combined use of the HITS screening tool and the Duluth model tool were associated with increased rates of IPV screening. Women who screened positive for IPV were referred to appropriate resources.

## Citation 9

Sabloak et al. (2024) <sup>35</sup>

### Study type

Systematic review

### Objectives

The purpose of the study is to evaluate strategies used for screening patients for IPV and then subsequently supporting patients that have screened positive for experiencing IPV in the setting of a visit pertaining to abortion.

### Components of the study

**Population:** Women - across included studies, populations were generally English- and/or Spanish-speaking females aged 16–35

**Sample or population size:** Total sample size not reported. Nine studies met the inclusion criteria.

**Geographic location/country focus:** US

**Intervention:** The majority of studies employed the ARCHES tool for identification of IPV. Interventions included provider-facilitated discussions of IPV, a safety card with information about IPV and community-based resources, and referral pathways to directly connect patients with support services.

**Focus on pregnancy (including postpartum):** Focus is on abortion-related visits

**Comparator:** Not applicable

### Outcomes reported

**Primary:** Not reported

**Secondary:** Improvement in informing patients of available IPV-related resources; improvements in patient perception of provider empathy; acquisition of knowledge about violence-related resources by women who received the intervention; reduction in the odds of pregnancy coercion

### Conclusions

Screening for and intervening on IPV at abortion-related visits were associated with positive outcomes for patient safety and the patient-provider relationship. However, data on effective tools for identifying and supporting these patients was extremely limited. This review emphasised the unmet need for implementation and evaluation of IPV-specific interventions during abortion-related clinical encounters.

## Citation 10

Teichman et al. (2023) <sup>36</sup>

### Study type

Systematic review

### Objectives

To review research on current practices for IPV prevention in emergency departments and trauma centres in the US and provide evidence-based recommendations.

### Components of the study

**Population:** One study assessed both male and female emergency department patients, 5 assessed female ED patients, and 1 assessed female trauma patients.

**Sample or population size:** The sample size of the included studies ranged from 286 to 1,500. Seven studies met the inclusion criteria.

**Geographic location/country focus:** US (n = 6), Canada (n = 1)

**Intervention:** Institutional formal IPV screening tool at a trauma centre or emergency department. Examples of screening tools: "nurse-driven IPV screening protocol", "physician-administered IPV screening protocol", "protocol developed by Halpern et al.", "5-item indirect screening tool used by Fulfer et al".

**Focus on pregnancy (including postpartum):** Not pregnancy-specific; focus is on general adult trauma and emergency department patients

**Comparator:** Not applicable

### Outcomes reported

**Primary:** Not reported

**Secondary:** Identification of IPV

### Conclusions

There were very limited data addressing the topic of IPV screening and intervention in emergency medical settings, and the quality of the evidence was low. Implementation of a screening protocol is conditionally recommended to identify victims of IPV in adults treated in the emergency department and trauma centres. Although the purpose of screening would ultimately be to provide resources for victims, no studies that assessed distinct interventions met the inclusion criteria. Therefore, specific recommendations cannot be made related to IPV interventions.

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