Reviewer's report

Title: Office-based screening for domestic violence: use of a child safety questionnaire.

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Reviewer: Julie A Jonassen

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General

The manuscript “Office-based screening for domestic violence: use of a child safety questionnaire”, by Richard A. Wahl, Doris J. Sisk and Thomas M. Ball, describes the use of written, age-appropriate child safety questionnaires to identify domestic violence experienced by mothers of children presenting to a university out-patient general pediatrics clinic in 2001-2002 and 2002-2003. Embedded within these questionnaires, which asked a number of safety-related questions (4 separate age-appropriate questionnaires printed in English and Spanish), were four domestic violence questions that aimed to uncover current or prior abuse in the responding mothers. This active screening led to identification of current domestic abuse issues in about 2% of the mothers so screened, and identified past abuse in about 12-13% of the responding mothers; these percentages fall within many previously reported estimates of ongoing and prior domestic abuse in American women.

Domestic violence has been recognized as a profound medical and societal issue by numerous physicians and medical societies, although there have been relatively few reports discussing practical ways to enhance the detection of domestic violence through screening. It is highly commendable that the authors, in this well-written manuscript, have been successful in implementing an abuse-screening protocol for the mothers of their pediatric patient population. The title and abstract accurately reflect the findings reported in the manuscript and the discussion and conclusions appear to be well-balanced. As noted below, there are some ambiguities pertaining to the descriptions of study design, data collection, data analysis and data reporting that require clarification.

Discretionary Revisions (which the author can choose to ignore)

1. The paragraph on page 8 beginning with “The odds of identifying a parent…” would be more appropriate to the discussion than to the results.
2. While not explicitly addressed in the present study, it would be of great interest to learn more about the resources this pediatric practice has used to help the women they have identified as “at risk”. The authors acknowledge that as a consequence of implementation of the screening questionnaires, subsequent identification of women at risk for domestic violence often overwhelms their ability to provide follow-up support to those women. Any pediatric practice considering the implementation of such a screening protocol would greatly benefit from “lessons learned” about how to provide safety and support to their patients’ mothers who have been identified as being at risk for domestic abuse.

Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
1. What provisions did the authors make to ensure the mothers that any information disclosed on the questionnaires would be kept confidential?

2. The legend in Figure 1 describes "parents" being screened, although the paper actually focuses on mothers who were screened for abuse in the context of the pediatric safety questionnaire. Were any questionnaires administered to fathers? To grandmothers or other caregivers? If not, could the authors comment on if/why they were excluded?

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

1. The control for this study was termed “passive screening”, carried out for three months in 2000-2001 prior to the initial administration of the questionnaires. The number of reported cases of domestic violence in this 3-month interval (5 cases) was multiplied by 4, to achieve an estimate of the number of baseline estimated prevalence of domestic violence. There are several potential problems with this methodological control and several ambiguities about how data were collected and analyzed.
   a. The method by which these 3-month “passive screening” data were actually collected is not explained. Was the information obtained by chart review? By oral screening? By voluntary patient (or maternal) disclosure? This information should be explicitly described, including the actual number of patients (or mothers) who were passively screened.
   b. It is misleading to multiply the result from the 3-month control interval to estimate annual prevalence of DV in the “passive screening” population. This rate should be estimated using the actual number of cases reviewed and not the whole patient population as a denominator. A more accurate control group would include at least a year’s worth of information about passive screening, not just an estimated or extrapolated number. Even though it seems reasonable to predict that the apparent prevalence of domestic violence would be very low in the absence of explicit screening, the reliability of the data analysis would be strengthened if a year’s worth of real (not estimated) “passive” data were included. How feasible would it be to garner this information from a review of the charts of the entire patient population in 2000-2001?

2. The prevalence of past and current DV in each of the two study years is calculated using each year’s entire patient population as the denominator rather than the actual number of patients who actually completed the questionnaires each year. Although there is no easy way to determine whether the prevalence of DV is lower, higher or the same among the ~30% of the women who refused to answer the questionnaires, one could speculate that a woman who had positive findings for abuse would refuse to complete a questionnaire if she were concerned that in so doing, she might increase her risk for further abuse. Thus, expressing the rates on the basis of the whole patient population may well underestimate the true rates of DV among the mothers of this pediatric patient population. It would be more accurate to restrict the estimates of abuse prevalence to those women who were actually screened via questionnaire.

3. If a mother had more than one child who was seen in the clinic, she filled out a separate questionnaire for each child. In these instances, was a mother’s information about past and current abuse consistent from one child’s questionnaire to another?

4. When a mother completed multiple questionnaires, was the information about abuse tabulated once per mother (regardless of how many children) or once per child for each questionnaire answered? In other words, if a mother of 3 children reported current or prior abuse on all three questionnaires, did the authors identify this as one or four cases of DV?

5. The data presented in Figure 1 are somewhat confusing since the nature of the information varies from bar to bar. Some data refer to the number of pediatric patients screened while other data indicate current and past instances of identified domestic violence. It is not clear whether these data indicate abuse identified for each mother or abuse identified in each questionnaire (i.e., for each child). It would probably be more accurate (and clearer to the reader) to record the prevalence of abuse among the population of mothers who had been screened. The data depicted in the bar graph might be more readily understood if they were presented in a table.
6. Did any women complete the questionnaires in both years of the study? Among those women (how many?), was there any correlation between reported prior (or current) abuse from one year to the next? Such data would provide important information about the reliability of the questionnaire.

**What next?:** Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** Yes

**Declaration of competing interests:**

none